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Exploring the perceptions of mental illness among Pedi psychologists in the Limpopo Province

Sehoana, Mahlodi Joslina

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Exploring the perceptions of mental illness among Pedi Psychologists in the Limpopo Province

A research report by

Mahlodi Joslina Sehoana

Master of Arts in Clinical Psychology by Coursework and Research Report

Supervisor: Sumaya Laher

Department of Psychology

University of the Witwatersrand

ABSTRACT

Mental illness is conceptualised differently across cultural and religious groups. Perceptions of mental illness that are held in communities play a role in the treatment sought and the response to treatment offered. This study explored the perceptions of mental illness among 9 Pedi Psychologists practising in the Limpopo province and the effect of culture, if any, on these perceptions. Seven of the participants were registered as clinical psychologists, one as an educational psychologist and one in the category of counselling psychology. The participants were practicing in the Sekhukhune and Capricorn districts of Limpopo. Semi structured interviews were conducted at the practitioners' rooms with each interview lasting approximately 1 hour. The interview schedule consisted of 27 questions divided into three sections: contextual questions; psychologists' perceptions of the Pedi culture and mental illnesses in general; and Pedi psychologist's approach to treating clients with cultural beliefs about mental illness. The findings of the study revealed that mental illness in the Pedi community is conceptualised differently to mainstream conceptualisations. The perceptions of mental illness held by the community influenced the type of treatment sought, with the choice of treatment often being traditional and spiritual healing. It is apparent given the findings of this study that more knowledge on the perceptions of mental illness across various groups is needed in the delivering mental health services in South Africa. The practitioners highlighted the importance of cultural competence in serving communities holding cultural and religious beliefs in relation to mental illness.

DECLARATION

I declare that this thesis is my own work. It is submitted in partial fulfilment of the requirements for the degree Master of Arts in Clinical Psychology by Coursework and Research Report in the Department of Psychology, University of the Witwatersrand, Johannesburg. It has not been submitted for any other degree or examination at any other university or institution.

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Mahlodi Joslina Sehoana

Date: _____

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CHAPTER 1: LITERATURE REVIEW

1.1. Introduction

According to the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision, DSM-IV-TR, American Psychiatric Association, 2000), mental illness is referred to as a:

> "*clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with significantly increased risk of suffering death, pain, disability or an important loss of freedom*" .

Mental illnesses occur in multiple societies but are perceived differently. What is considered normal or healthy in one society may be seen as abnormal in another society. It is imperative for the different perspectives across cultures to be explored in order for mental health practitioners to offer competent services across a multi-cultural population.

The aim of this study is to explore the perceptions of mental illness among Pedi psychologists in the Limpopo Province. The following review begins with contextualising mental illness amongst cultural understandings. This is followed by discussion on the perspectives of indigenous African cultures (of which the Pedi culture is a part) on mental illness and the treatment methods used in African cultures to alleviate mental illness. The literature review proceeds to introduce the origins and beliefs of the Pedi people in order to give a deeper understanding of the cultural group under study. The review concludes with a discussion of the conceptualisation and treatment of mental illness in the Pedi culture.

1.2. Culture and mental illness

Cultural groups vary in their values and way of life. With regards to the relationship between culture and mental illness, Swartz (1998, p.4) states that "*culture influences how individuals manifest symptoms, communicate symptoms, cope with psychological challenges and their willingness to seek treatment*". The values and beliefs of cultural groups influence the path of treatment and how the illness is expressed. In mental health care understanding the role that

culture plays on illness is important in diagnosing and treating mental illness, there are studies that have emphasised the importance of understanding the role of culture in the services of mental health care in South Africa (Swartz, 1998; Mpofu, Peltzer & Bojuwoye, 2011; Sam & Moreira, 2012; Sodi et.al, 2011).

The DSM IV-TR (4th ed., text revision, American Psychiatric Association, 2000) recognises the role of culture on mental illness, thus the inclusion of culture bound syndromes. This is a movement from the universalistic perspective that holds that all societies experience and express illness in the same manner. Culture bound syndromes are specific to a particular cultural group and though their expression may be similar to other disorders, they are recognised as contextual and thus help to explore the experience of the illness from the patient's perspective.

Furthermore, the perception of mental illness across cultures plays a role on the treatment measures sought. The perception of mental illness as a spiritual factor has led to most Africans seeking the services of spiritual and traditional healers as they are perceived to have the ability to transgress into the spiritual realm where the illness originates (Sorsdahl et.al, 2009). Swartz (1998) encourages professionals to investigate the cultures of their patients and increase their knowledge on their perceptions of illness and how this play out and affect treatment and diagnosis. The understanding of clients and their cultural beliefs facilitates for a move towards cultural competence.

1.3. Perceptions of mental illness in African culture

Traditional beliefs and practices regarding illness and health are still extensively followed in South Africa (Moletsane, 2004). These beliefs and practices form a coherent system that has maintained individual and social equilibrium for generations (Louw & Edwards, 1993). Amidst the differences across cultures and ethnicity in Africa, there still remains a general belief that diseases are sourced from external causes such as: "*a breach of a taboo or custom, disturbances in social relations, hostile ancestral spirits, spirit possession, demonic possession, evil eye, sorcery, natural causes, and affliction by God or gods*" (Nwokocha, 2010, p.4) .

1.3.1. Ancestral spirits

Ancestors are highly respected in the African context, it is believed that when a person dies he/she goes on to become an ancestor and integrates with ancestral spirits. The individual still keeps in contact with the family, watches over them and protects them from misfortune. Africans perceive the balance between the living and their ancestors as a dependent factor for health. If the behaviour of the living members does not please the ancestors they withdraw protection and cause illness within the living members (Manyike & Evans, 1998). Mental illness is thus alleged to be caused by ancestors in an attempt to make a family member aware that their ways displease them and should be changed (Uys & Middleton, 2010).

Additionally, diseases are recognised as having supernatural origins (Tsa-Tsala, 1997). Ezeabasili (1977) states that Africans perceive ill health to have material, moral, supernatural, and pre-natural causes which can be recognised through observation and divination by a prophet. Mental, emotional, and behavioural disorders are perceived as more than medical conditions requiring professional services such as those from Psychologists, medical doctors etc., but also as spiritual and social diseases to which spiritual answers are required (Vaughn, Jacquez, & Baker, 2009). According to Nwokocha (2010, p. 4), the spiritual problems are attributed to "*…demons, karma, witchcraft, ancestral service, or lack of moral strength"*.

In the African culture the community is an important determinant of most aspects including health and this is emphasised by the well-known African proverb "*Umuntu ngumuntu ngabantu*" which means a person is who they are because of other people (Manyike & Evans, 1998). In the African perspective the balance between the living members of the community, the environment and their ancestors is important in maintaining health (Saayman, 1992). Physical and mental illness occur when there is instability between an individual and their surroundings, which may include family, society and the ancestors of the individual (Ngirababyeyi, 2012).

1.3.2. Non observance of taboos or disregard of cultural norms

Africans still hold in high esteem the following of traditional customs, values and norms. Though African taboos differ across cultures, failure to observe taboos and disregard of cultural norms is believed to lead to illness. When one falls ill, it serves as an indicator that

the member needs to change their behaviour in order to please the ancestors and regain their protection (Manyike & Evans, 1998).

1.3.3. Spirit possession

According to African view some illnesses occur as a result of being possessed with an ancestral or other form of spirit. With the ancestral spirit, when a family member who possessed "*bongaka*" (traditional healing) passes away they are believed to transfer their gift onto another member of the family. The recipient of "*bongaka*" (traditional healing) starts by having certain dreams at night, and due to emotional conflict he loses appetite and becomes thin, thus he manifests some form of "anorexia nervosa" (Hadebe, 1986).The individuals may hallucinate but the response is different from that which may be given in the hospital setting where it might be perceived as a symptom of schizophrenia, instead such individuals are treated with respect because they have the ability to communicate with the ancestors (Manyike & Evans, 1998).

Additionally, one may be possessed by the spirit of a deceased person that has not been properly placed in the spiritual world through rituals carried out by his/her family (Ngubane, 1977). The Zulu refer to this spirit as "*Indiki*". According to Ngubane (1977), unlike the "*thwasa*" spirit this spirit is foreign; it causes illness and thus needs to be eradicated to restore the health of the victim. Treatment is sought from a diviner who will exorcise the spirit (Ngubane, 1977).

1.3.4. Amafufunyana

According to Ngubane (1977), Amafufunyana is described as a form of spirit possession that results from sorcery. It is recognised among the Zulu and the Xhosa cultures of South Africa. The spirit possession is caused by a mixture of soil and ants that are taken from a graveyard, supposedly having fed from a dead body; the mixture is then placed in the path of the targeted victim (Ngubane, 1977). After stepping on the mixture the victim will present with symptoms similar to those of hysteria, they throw themselves on the floor, tear off their clothes and they may even harm themselves through violent acts and try to commit suicide.

According to Zabow (2006), Amafufunyana is recognised as an indigenous name and concept for mental illness among the Xhosa people.

1.3.5. Witchcraft

Although most of the causes of illness are believed to be due to ancestral spirits, witchcraft is another phenomenon that is suspected when one suffers from mental illness. According to Hammond-Tooke (1989), there are two types of witchcraft: The witch who inherits the trait and functions at night and a witch who uses medicine to bring others misfortune. Hammond-Tooke (1989) refers to the terminologies of witches and sorcery in African terms, with witches being referred to as "*abathakathi*" in the Nguni and "*baloyi*" in the Sotho languages. The Sotho people, from whom the Pedi people originate, identify "night *boloyi*" which is witchcraft and "day *boloyi*" known as sorcery (Hammond- Tooke, 1989; Monnig, 1967). The sorcerer uses medicines which may be in the form of poison which when taken can cause illness. The Zulu call this illness "i*diiso*" and the Pedi refer to it as "*Selesho*" which occurs after one has been poisoned through food (Ngubane, 1977).

Witchcraft is motivated by numerous factors, with the most common being jealousy especially by people close to the victim who are not pleased with his/ her success and poison him/ her to cause mental illness (Konings, 1993).

Lombo (2010) conducted a study on mental healthcare practitioners' perspectives of mental illness within the Isixhosa cultural context. The research participants belonged to the Isixhosa ethnic group, were able to speak Isixhosa and were mental health care practitioners from various professions employed by Komani hospital for at least a period of three years. The study discovered that participants in the study generally perceived mental illness as characterised by strange behaviour as well as a painful disease where one loses his dignity. Scientific causes of mental illness were mentioned; however, more than half of the participants referred to mental illness as resulting from factors such as: failure to observe cultural practices, witchcraft and failure to accept the calling of being a traditional healer (*ukuthwasa*). The mental healthcare practitioners expressed that knowledge of these cultural causes makes it easier for them to manage and treat mental illness, as this gives them insight into the patient's own understanding of their illness. The family is used as a support system that aids the health care professionals with continued care.

Sorsdahl, Flisher, Wilson, and Stein (2009) conducted a study with a convenient sample of 50 traditional healers from those who attended a workshop conducted by the South African Depression and Anxiety Group (SADAG) in Mpumalanga province. The traditional healers were from Lydenberg, Sabi, Standerton, Bethal, Bushbuckridge and Komatipoort. The study focused on explanatory models of mental disorders and treatment practices among traditional healers in Mpumalanga, South Africa.

The findings of the study revealed that participants believed that mental illness resulted from factors such as family problems, substance abuse and poverty that were left untreated and progressively became more severe. Furthermore, the study revealed that the symptoms presented by a mentally ill patient are predominantly behavioural and include undressing and urinating in public, violent and aggressive behaviours not acceptable within those cultural boundaries. According to the traditional healers, the effects of mental illness extend beyond the illness itself; there are social factors involved such as the mentally ill losing their jobs and not being able to care for their families. They are also mocked by the community and became very lonely and isolated. According to the study the causes were described as including witchcraft, possession by an evil spirit, substance abuse, life stressors and calling to be a healer.

1.4. The treatment of mental illness in African cultures

Mental illness is treated in hospitals with the aid of professionals who have been trained to treat mental illness such as Psychologists, Psychiatrists and Psychiatric Nurses. The western approach of treatment which is used in the training of these professionals is used in the treatment of mental illness that people present with. However, in the African cultures treatment for mental illness is often sought from traditional healers, this is motivated by the belief that the cause of mental illness is more religious/spiritual than it is physical (Vaughn, Jacquez, & Baker, 2009). In African culture the traditional healer diagnoses the cause of illness, which may be brought about by the ways of the victim that do not please the ancestors or the relation one has with the environment, as it is believed balance is maintained through the relations one has with the environment, their fellow community members and the ancestors (Saayman & Kriel, 1992).

Hammond-Tooke (1989) distinguishes between two types of traditional healers: herbalists and diviners. The diviner is referred to differently across cultural groups in South Africa. The Xhosa refer to the diviner as "*imagqira"*, the northern Sotho as "*ngaka"*, the Southern Sotho as "*selaoli*" and the Venda and Tsonga as "*mangome"* (Truter, 2007). The diviner is called by the ancestors and trained by an experienced diviner. After training he/she then functions as a medium of communication between people and their ancestors. The diviner receives powers from the ancestors that allow for him/her to diagnose and provide medicine. According to Truter (2007), 90 % of diviners in South Africa are female.

The herbalist commonly known as "*inyanga"* utilizes medicines derived from different substances such as plants and roots to treat the illnesses that his clients present with (Hammond-Tooke, 1989). Unlike the diviner who is chosen by the ancestors; anyone who desires to be a herbalist may do so by acquainting himself with an experienced herbalist who will educate him on the different herbs (Truter, 2007). Traditional healers recognise the disorders treated by mental health care providers such as psychiatrists, however their methods differ as they consist mainly of herbal treatment, fortune telling, exorcism and rituals believed to help heal mental illnesses.

According to Mpofu, Peltzer and Bojuwoye (2011), some of the ways used to treat mental illness in African culture are through ritual enactment, dream interpretation, cleansing, scarification, aromatherapy and fumigation. Negative spiritual influences are removed through ritual enactment, the patient who has a spiritual influence that affects their health works in collaboration with the healer to name the spirit and then cast it into the wild or to a domestic animal. It is the belief that the malicious spirit has been cast away that leads the patient towards recovery (Mpofu, Peltzer & Bojuwoye, 2011). The treatment process takes a holistic approach.

Sorsdahl et al. (2009) in their study with a sample of 50 traditional healers reported a majority of the healers stating that they possessed the skills and knowledge required to cure a mental illness and often treated the patient by encouraging them to live with them in their home or visiting them on a regular basis. The duration of this treatment ranged from two weeks to a year and a half. In cases where the patients get violent and would not take their medicine the healers tie them with ropes and chains. All the healers reported that mentally ill

patients would be given "*muthi*" to drink and bathe with, while others described treatment involving sniffing herbs through the nose.

However there is not a sole reliance on traditional healing. Lombo (2010) working with a sample of mental health practitioners from Komani hospital found that mental health care users are often treated by traditional healers before being admitted to the hospital. The practitioners expressed the importance of understanding the cultural beliefs of patients as a factor in managing mental illness. Komani Hospital uses a bio-psychosocial approach which understands behaviour within a context of biological, psychological and social factors (Buamann, 1998). The mental health workers take into account the different factors that influence a patient in their treatment with the aim of treating the patient appropriately. The treatment measures consist of Psychotropic medicine and Counselling. The severity of the symptoms guide the practitioner on which method to use, a combination of treatments may be used (Lombo, 2010).

According to Uys and Middleton (2010), the priest of the African churches has become a modern development of the traditional care system of mental illness. The priests encourage faith in the supernatural and often become involved through faith healing in the treatment of the mentally ill (Uys & Middleton, 2010). The churches resulted from both integration of Christian principles and the African culture. Among these churches is the Zion Christian Church established by Engenas Lekganyane of the Pedi tribe (Afolayan, 2004). The church has blended Christianity with African beliefs. It provides an opportunity for the Africans to carry out their African rituals while still following the Christian faith (Afolayan, 2004).

According to Ashley, Deblois and D'Rourke (2006), there are accounts of demonic possessions and exorcism in the Christian bible. Mental illness would be referred to as evil spirit possession that needed to be cast out through exorcism. Roman Catholic churches still practice exorcism however the Church is now careful in differentiating between extraordinary events and mental illness (Ashley, Deblois & D'Rourke, 2006).

Healing ministry is common in most of the African initiated churches such as the Zion Christian church (ZCC) and the Christian Apostolic Church in Zion (CACZ). In these churches spiritual and material elements are combined to treat illness. The healer uses water

mixed with plants, salt or lime as medicine. This medicine is referred to as "*iziwasho*". Bad spirits referred to in Zulu as "*iminyama*" are believed to cause harm and illness to people; the spirits are then attacked through prayer and "*iziwasho*" by the healers (Elphick & Davenport, 1997). Most of the members of the churches joined in quest for treatment of a certain illness. According to Elphick and Davenport (1997), 80% of the members of the ZCC joined this church because of their illnesses and those of family, which they believed could be treated in the church.

1.5. The ancestry of the Pedi people

The Pedi people form part of the Sotho people. The name Sotho signifies "*batho ba baso*" which means black people (Monnig, 1967). As it is with the other Bantu communities of South Africa, the Sotho originated from Northern and Central Africa; they later migrated southward, leading to the Sotho people scattering as the years progressed. The separation led to the different categories: the Northern, Sothern and Western Sotho groups. The Pedi people form part of the Northern Sotho and reside in Limpopo previously known as the Northern Province.

Additionally, the Pedi find their origin in the Bahuretse branch of Bakgatla, a section of the Tswana branch of the Sotho (Setumo, 2005). According to Afolayan (2005), the Sotho people are estimated at about 7 million, making them the second largest African language group in South Africa. The Northern Sotho are often referred to as the Pedi people, however according to Joyce (2009), this is misleading as the Pedi are part of the larger group of the Northern Sotho, this misconception was formed largely by the fact that the Pedi were dominant around the 1650's among the Northern Sotho tribes.

In 1884, Chief Sekwati signed a contract with Boer leader Hendrick Potgieter giving him tittle to the land on which he had settled which was on the east of the Steelpoort. Succeeding Chief Sekwati was Chief Sekhukhune who during his chieftaincy was able to defeat most of his opponents (Setumo, 2005). Chief Sekhukhune initially had friendly relations with the Boer, these relations were however short-lived due to the continuous disputes over the land and labour. Magubane (1998) states that the struggles led to war between the Boer and the

Pedi which left the Pedi Empire destroyed after they lost 1000 warriors; Chief Sekhukhune was then arrested on the 28th of November 1897 and imprisoned in Pretoria.

Following the later defeat by the British the Pedi people were scattered across different areas of South Africa. They also resided in the heartland of the Pedi known as Sekhukhuneland, this land is situated between the Olifants River and the Steelpoort River; this area was incorporated into Lebowa homeland which was dedicated for the Northern Sotho in 1972 (Monnig, 1967). Due to the increase in population, the land was no longer able to hold the capacity for both cultivation and residence. The Pedi men then had to migrate to Johannesburg to find employment in mines, industries and in domestic work (Magubane, 1998). The women later joined the men primarily in the Gauteng Province working as domestic workers.

Despite the defeat in the 16th century the Pedi continue to hold their chieftaincy in reverence (Monnig, 1967). There is limited research on the developments of the Pedi people in the 21st century; however the people currently reside in different parts of South Africa for occupational and academic reasons. Polokwane in Limpopo Province remains the home of most of the Pedi people and they often return home during vacation breaks and leaves to spend time with family.

1.5.1. Pedi Culture Beliefs

The Basotho of which the Pedi form part of hold the belief that spirits can be malicious or good. The Pedi people practice ancestral worship, the Pedi word for ancestors is "*badimo*". Ancestral worship is based on the belief that when a person who has a good spirit or "*seriti*" dies they go on to become an ancestor, gaining supernatural powers that allow them to watch over their descendants who then worship them (Monnig, 1967).

The ancestors are to be respected and honoured by their descendants, who should remember through rituals to give thanks for their protection. In response to the respect they receive from the descendants the ancestors will bless them with good health, rain and good harvest. The ancestors use dreams to communicate with the living members. Of importance are those dreams that one can remember and recurrent dreams of one ancestor. The dreams usually

mean that the ancestor is displeased or is communicating an important message to the member of the family (Monnig, 1967). Similar to other African cultures, the protection of the community depends on the ancestors and among the Basotho each kin-group would receive protection from their own ancestors (Monnig, 1967).

According to Magubane (1998), the ancestors are believed to influence different parts of the lives of the living such as their health. It is believed that illnesses were caused by the ancestors and as with the other African cultures the way to healing is to appease the ancestors through animal sacrifices and carrying out a ritual or duty that was neglected. Some of the illnesses to date are believed to be induced by the ancestors such as: hysteria, insomnia and epilepsy (Magubane, 1998). The treatment of these illnesses is then sought from traditional healers referred to as "*dingaka*" who acquire the treatment from the ancestors. The medicine used in treating the illnesses is made of herbs and in some cases no medicine is needed, the patient just needs to carry out a ritual to appease the spirit that is displeased (Magubane, 1998).

The Pedi people were exposed to Christianity in 1860 through missionaries that came in contact with the then chief of the tribe, Sekwati (Monnig, 1967). The missionaries built mission stations and started converting most of the Pedi people into Christianity. The succeeding chief, Sekhukhune was not pleased with the conversion of most of the members as they were no longer observing customs, obligations and duties of the tribe. To date most Pedi people follow the religion of Christianity, most form part of the African initiated churches one of which is based in Limpopo and founded by a Pedi leader, the Zion Christian Church (Muller, 2011).

1.6. Mental illness in the Pedi culture

The Pedi culture relates to the African perspective on the belief that community is the basis of health. In the Pedi culture the saying is that "*motho ke motho ka batho*" which holds the same meaning as the Zulu saying "*Umuntu ngumuntu ngabantu*": a person is who they are because of other people in the community (Manyike & Evans, 1998). Although there is limited literature on the Pedi culture and their perspectives of mental illness, traditional beliefs and practices are still widely adhered to. There is a belief that mental illness is caused by witchcraft which is referred to as "*Boloi*". The witch is believed to cause mental illness

driven by jealousy and to harm the wellbeing of others. Ignoring the call to be an ancestor is perceived as another cause of mental illness, when one refuses to be possessed by the spirit of a traditional healer who has passed they are punished through mental illness for disregarding the call.

Mavundla, Toth and Mphelane (2009) conducted a study in Makhuduthamaga local municipality found in Sekhukhune District Municipality which finds residence to the Pedi people; the study revealed that there is stigma attached to the mentally ill, their caregivers and families. According Mavundla, Toth and Mphelane (2009), the stigmatisation could be motivated by the cultural context and beliefs of the community. Mental health care facilities are however made available to the Pedi community through the Department of Health which is striving to avail the services of mental health practitioners to all the district hospitals in the Limpopo Province (Department of health and Social development, Limpopo, 2008).

According to Kakuma et.al (2010), stigma leads to unfair discrimination and victimisation of those with mental illness. This goes beyond negative attitudes and includes the distribution of services such as housing and employment. Additionally, although services are offered for mental health care, negative attitudes towards mental illness create a fear and resistance to use them because of the fear of being discriminated and being perceived as weak. In the absence of mental health care the mental illness worsens and the victims become prone to substance abuse and crime which has resulted in many ill patients being incarcerated.

In response to the high levels of stigmatisation in South Africa, Kakuma et.al (2010) sought to identify methods of raising awareness and reducing stigmatization with respect to mental illness. The study discovered that there a number of anti-stigma activities in place, both governmental and non-governmental sectors are encouraging education to reduce stigmatization. The South African Department of Health leads public awareness and education campaigns with the assistance of organisations such as South African Depression and Anxiety Group (SADAG), Mental Health Information Centre (MHIC) and South African Federation for Mental Health (SAFMH). The programmes, with special reference to SADAG, collaborate with communities and mental health care providers to educate the public on mental illness.

The materials used are appropriate for both the literate and illiterate and they are culture and context specific, targeting the myths and attitudes of different cultures and communities (Kakuma et.al, 2010). The study also emphasises the usage of context specific anti-stigma interventions for South Africa. Beliefs around mental illness, its causes and treatment vary and the stigmatisation will depend on the conceptualisations of mental illness in a particular context. These programmes however hold the limitation that there are no formal reports given to highlight their progress (Kakuma et.al, 2010).

1.7. The Pedi approach to the treatment of mental illnesses

Sodi in his study in Madu, Baguma and Pritz (1996) identifies the three phases of indigenous healing conducted in Limpopo, known then as the Northern Province, in an area called Naphuno which is inhabited by Pedi people. The three phases of healing outline the approach that the Pedi indigenous healing has towards mental illness treatment.

The initial phase

Through connection with the spiritual realm, the traditional healer is aware of the visitation of the patient before they arrive, he/ she is then able to prepare for the patients' treatment. The traditional healer use bones to divine which are called "*ditaola*" in Pedi. This is used as a diagnostic tool and once the diagnosis is formulated, the healer provides a form of treatment. The patient's diagnosis is derived from the bones and the clinical impression of the traditional healer which is communicated to them (Madu, Baguma and Pritz, 1996).

The treatment phase

The first phase of treatment includes medicines that differ from those used in western medical practice in the form herbs, animal parts, oily substances, soil and sea water. As with other African traditions, the ancestors are believed to protect the living and maintaining a healthy relationship with them promotes health. The second phase of treatment includes rituals that aid in protecting the home of the patient and restoring their relationship with the ancestors (Madu, Baguma and Pritz, 1996). The relationship between the individual and the ancestors is important as Saayman (1992), emphasises a balance in this relationship can help one prevent

illness. An example of such a ritual is found in the study of a woman whose symptoms served as an indicator of the ancestors being displeased; she received a recommendation that she slaughter an Ox to restore the balance in her relationship with the ancestors. As mentioned in Lombo (2010), the family plays a central role in the recovery of the patient, the final stage aims to reconstitute the family system to ensure the patient returns to a family that is well informed and equipped with skills to deal with potential future conflicts and tensions.

Termination phase

After observing the recovery of the patient the healer makes use of subjective reports from the relatives of the patient to establish if the healing was successful. The process will be terminated based on the informed satisfaction of the healer.

The Pedi relate to other African cultures in that they also hold the belief that mental illnesses are a spiritual factor that can be resolved through visits to the traditional healer who is equipped to resolve the illness through divinations and connection with the ancestors who protect homesteads and help in maintain health. Healing is not only on the part of the individual who is ill; the family is also involved in the healing process and serve as support for the patient. The limited literature on the Pedi perspectives of mental illness makes it difficult to identify aspects that differentiate the Pedi people‘s beliefs and approaches to mental illness from the other Indigenous African cultures. This study attempts to close that gap.

Conclusion

In conclusion mental illness is perceived differently throughout Africa, although there is a relation in the perception that mental illness is caused by spiritual and physical factors. Cultural values and beliefs play a role in the response that is given to mental illness. There also appears to be a need for mental health practitioners to be culturally informed and aware in order to identify the diverse perspectives of mental illness and respond appropriately within a given cultural context. The treatment of mental illness in Africa is sought not only from hospitals but from traditional healers as well. There are rituals that are performed to resolve mental illnesses. The Pedi culture relates to other African cultures in terms of the

believed aetiology of illness and treatment measures. However their beliefs have rarely been explored. Therefore this study seeks to explore the beliefs and perspectives of the Pedi with respect to mental illness.

CHAPTER 2: METHODS

This chapter highlights the methods that were used in conducting this study.

2.1. Aim of the study

The aim of this study was to explore the perceptions of mental illness among Pedi Psychologists in the Limpopo province and the influence of their culture, if any, on these perceptions.

2.2. Rationale of the study

Barlow and Durand (2005) state that due to the lack of a worldwide definition of mental illness it is difficult to have a single definition for the concept. Mental illness can be understood differently by different people of different cultures and religions as there is no universal definition. Each culture has its own beliefs, customs and reactions to illnesses, including mental illnesses. This contradicts the traditional view of abnormal psychology based on cultural universality; which suggests that there is a fixed set of mental illnesses and the manifestations of those disorders are the same across different cultures (Eshun & Gurang, 2009). There is an increasing body of literature arguing for an understanding and recognition of illness that goes beyond the current Eurocentric conceptualisations (Bass, Bolton & Murray, 2007; Kakuma et.al, 2010; Padayachee & Laher 2012). However African and South African understandings of illness remain under-researched despite the multitude of cultures in the country and the continent.

Furthermore, we are living in an ever-changing diverse and multicultural society which also traverses into the therapeutic context where individuals are influenced by their backgrounds, experiences and socialisation in different cultures and societies (James & Prilleltensky, 2002; La Roche & Maxie, 2003). These individuals are then treated with primarily Western modes of treatment. According to Myers (2006), each culture's treatment needs to be taken into consideration taking into account the socio-cultural conditions found in each culture. Contextually relevant coping mechanisms need to be recognised and contextually relevant avenues of intervention need to be used. It is thus important for mental health practitioners to understand the different perceptions of mental illness across cultures in order to offer culturally competent and appropriate services to people of varied backgrounds.

Additionally, in the South African context the mental health programme, formulated in 1997, has made it possible for mental health care to be available to rural areas. However there is little acknowledgement of the role of indigenous African cultural understandings and treatment of mental illness. There is an increasing need for a cross cultural approach to the treatment of mental illness and the need to explore different population's perceptions as these services are offered to a diverse population that is still rooted in their cultural customs and beliefs (Magubane, 1998).

With these issues in mind, this study sought to explore the perceptions of mental illness among Psychologists belonging to the Pedi culture of Limpopo province in the Northern part of South Africa and the possible role their culture plays on their perceptions. It is also directed at gaining an understanding of the experiences of offering psychotherapy in the Pedi community and the perceptions of mental illness with the community.

2.3. Research questions

1. What are the perceptions of Pedi Psychologists on mental illness?

2. What influence does culture have, if any, on these perceptions?

2.4. Sample

A non-probability purposive sampling technique was used for this study. This type of sampling was selected as it allows for the selection of participants with some defining characteristic and who hold data needed for the study (Maree, 2007, p.79). Furthermore, non-probability purposive sampling aids in obtaining the richest possible source of information needed to answer the research question. The participants used for this study were from the Pedi culture and served the Pedi community, their experience and cultural background was significant for the study. Participants were found through the PSSYSA database and with the help of the local committee. In the process of seeking more participants snowball sampling was utilised to access more participants. Once available participants were accessed, through the database, I was able to get referrals to possible participants from those already interviewed.

The participants served in both the Capricorn and Sekhukhune districts. According to Akinboade (2008), Capricorn district has a population that accounts for about 10% of the province's population. Polokwane, the economic hub of the province, has the highest population in the Capricorn district. Additionally it is reported that the majority of the residences of Polokwane are from rural areas (Akinboade, 2008).The Sekhukhune district has a population of about 1,125,000 and almost 95% of this population lives in rural areas (Ziervogel & Taylor, 2008).

I was able to access nine psychologists from three areas of practice which are: Clinical, Educational and Counselling psychology. The participants were varied in their practice environments. R1 and R6 were clinical psychologists in private practice. R2, R4, R7, R8 and R9 were clinical Psychologists working in Government hospitals both in Capricorn district and Sekhukhune district. R3 was an educational Psychologist in private practice and R5 was a counselling Psychologist practicing in an educational institution. The participants comprised of five females and four males. The participants were Africans of the Pedi culture. The years of practice ranged between 1 and 15 years with most of the participants having practiced for more than four years. Participants worked with a variety of people in the community from different socioeconomic and geographical backgrounds. There was a representation of psychologists practicing and serving in urban, semi urban and rural areas. Additionally, participants were exposed to different types of clients and problems.

2.5. Instruments

A semi-structured interview was used for this study. Semi-structured interviews are used to gain detailed information on a participant's beliefs or perceptions about a certain topic under study. This method is helpful in providing the researcher and participants with flexibility (De Vos, 2002). An interview schedule (See Appendix D) was designed based on the literature, including the gaps in literature, and the study's research questions. Interview schedules from two previous studies that explored perceptions of mental illness in Muslim psychologists (Laher & Ismail, 2012) and Hindu psychologists (Padayachee & Laher, 2012) were also used to construct the schedule for this study.

The interview schedule (See Appendix D) consisted of 27 questions which were divided into three sections: contextual questions, psychologists' perceptions of the Pedi culture and

mental illnesses in general and Pedi psychologist's approach to treating clients with cultural beliefs about mental illness. The interviews took between 45 minutes and 1 hour per person. The contextual questions were helpful as the participants were based in different institutions in terms of practice, the questions addressed the types of clients that they dealt with and the common problems they are faced with in their practice.

The second section addressed the perceptions that the participants held in relation to mental illnesses and the role that their cultural background held on this, it was apparent that with westernisation some of the participants related more with western forms of understandings than culturally influenced perceptions. The third section explored the work that the participants undertook with clients who held indigenous beliefs to their mental illness. Additionally it addressed the attitude towards alternative treatment such as that offered traditional healers and faith healers. The interview schedule was piloted by two readers at the University of the Witwatersrand and my research supervisor.

2.6. Research design

A qualitative approach was taken for this study to allow for a deeper exploration of information needed in addressing the topic under study; exploring perceptions of mental illness among participants and the influence of the Pedi culture, if any, on these perceptions. Qualitative research is a realistic and interpretative approach which aims to understand the meanings people attach to phenomena such as actions, beliefs, values etc. found within social worlds. Furthermore it gives a thorough understanding of the social world of the participants by learning about their social circumstances, their experiences, perspectives and histories (Lewis & Ritchie, 2003).

2.7. Procedure

A list of Pedi Psychologists in the Limpopo province was compiled using the Psychological Society of South Africa (PSYSSA) Limpopo database and my knowledge of working with psychologists from the Pedi culture. Potential participants were contacted telephonically and via e-mail and were invited to participate in the study. The subject information sheet (See Appendix A) was used to give participants further information about the study. Once a

Psychologist consented to participate, a convenient time and place was arranged for the interview. The participants were given participation consent forms for the interview to be conducted (Appendix B) and for the recording of the sessions (Appendix C) to sign before conducting the interview.

Furthermore, the participants were reminded about the voluntary nature of the study and that they could withdraw from the study or refuse to answer certain questions during the interview. The interviews were conducted using the designed interview schedule (Appendix D). I was able to build a good rapport with the participants which allowed the participants to be comfortable and free to share their thoughts and experiences. Probes were used to gain further understanding where needed, however the interview schedule was still used as guidance to cover areas essential for the study. The interview method used allowed for the participants to freely share their experiences and add more information to add to the study. At the end of the interview, gratitude was verbally expressed to the participants for their participation and they were offered a summary of the results on request once completed.

2.8. Data analysis

Once the interviews were done, the data was analysed using thematic content analysis. Thematic analysis assists in organising and summarising findings from a large diverse body of research (Mays, Popay & Pope, 2007). Furthermore, this method of analysis is used for identifying, analysing and reporting themes within the data collected. The six phases by Braun and Clarke (2006) were used to conduct the thematic content analysis. The first step entailed getting familiar with the data collected through reading through the transcripts. Secondly, initial codes were derived from the data. In the third step, I started searching for themes in the data; thereafter the themes identified were reviewed. The fifth step included the defining and naming of themes and finally, the production of the report.

2.9. Ethical considerations

Ethical clearance was obtained from the Human Research Ethics Committee at the University of the Witwatersrand (MCLIN/13/001 1H). At the interview, both verbal and signed consent on an informed consent form were being obtained. The participants were informed of the

voluntary basis of the study, through the consent form and information letter (See Appendix C & A). Informed consent was obtained from the participants and the terms of consent clearly outlined. The consent forms were given to the participants before the interview began. The participants were informed that they are allowed to withdraw from the study at any time or refrain from answering any of the questions in the interview which make them uncomfortable.

The information gathered in the interviews is kept confidential and the identifiable information of the participants is not used in the research report. Data was collected within a community of psychologists who work together hence in order to protect confidentiality participants, pseudonyms are used in the report. In order to protect the confidentiality of clients, participants were urged to not reveal the identity or confidential information of their clients and in order to guarantee this, I was careful in transcribing to attach pseudonyms in order to protect the confidentiality of clients. Tape recordings and transcripts will be stored for five years in a locked cupboard at the university to facilitate conference presentation and publication. Thereafter they will be destroyed.

The findings of the study will be made available to the participants once available and on request. Participants are free to contact the interviewer or her supervisor for any questions or feedback regarding the study. The contact details were made available on the subject information sheet (see Appendix A). Feedback will take the form of a one to two page summary sheet that outlines the study and its findings.

2.10. Self-Reflexivity

Self-reflexivity is used to determine the validity and legitimacy of a qualitative study. The researcher in being reflexive notices the effect that they have on their research results, Pillow (2003) states that reflexivity refers to the extent that the results of the study are affected by the researcher and their method of conducting the research. The researcher‘s own views, beliefs and perspective may have affected the final outcome of the research. It was thus important for me to be aware of how my personal characteristics such as race, ethnicity, age, gender etc. would affect the research process. Self-reflexivity involves on-going self-awareness on the part of the researcher (Pillow, 2003, p.78).

This study explores the perspectives of Pedi Psychologists on mental illness. Since I am from the Pedi culture, it was imperative for me to be aware of my own perspectives influenced by my own background, experiences and beliefs. Furthermore, I was aware of my own perspectives towards mental illness in the Pedi culture to ensure not imposing them on the participants. Having worked in the mental health care system in Limpopo Province with the Pedi culture and currently studying Clinical Psychology, I was careful to try and regulate the biases informed by my beliefs, perceptions and experiences which may have negatively influenced the study. Sharing the same cultural background with the participants often led to the participants assuming that I already understood their responses and thus they would be tempted to give short responses or signal in a certain direction without elaborating, I made use of probes to get more coherent and in depth responses from the participants. My research supervisor was used for support and reflections where guidance was needed.

Conclusion

This chapter explored the methods applied for collecting and analysing data. In the next chapter, the results obtained from the thematic content analysis will be presented.

CHAPTER 3: RESULTS

Nine Pedi psychologists were interviewed in the Limpopo province. The participants were found in the Sekhukhune district and Capricorn district of the province. Semi-structured interviews were conducted and transcribed. Interviews were analysed using thematic content analysis. Four themes with subthemes emerged from the data. The four themes were: Psychologist's perceptions of mental illness; perception of mental illness in the Pedi community; the limited understanding of mental health services; and psychotherapy with clients holding cultural and religious beliefs to their mental illness. The findings of the study are presented below:-

3.1. Psychologist's perceptions of mental illness: definition, causes and treatment

3.1.1. Definition

In their definition of mental illness the participants made reference to the understanding of mental illness as per the DSM IV-TR criteria. Participants (n=9) referred to mental illness as a condition that affects social, occupational and personal functioning. According to R2, "*I can say it's a matter or condition that would interfere with one's daily living or occupational functioning and also interpersonal*". R9 reported, "*I think a mental condition is that matter that will impact on a person's general functioning whether it be socially, occupationally, personally and whether it be interpersonal… a person not being able to function under normal circumstances*". The inability to carry out normal tasks that one would be able to carry out under normal circumstances and the inability to function in the community were unanimous definitions among the participants.

Additionally, (n=8) participants emphasised the importance of taking into consideration the influence of culture and society in defining mental illness. It was expressed that mental illness needs to be understood according to the perceptions of the community and context in which it is found. According to R2:

> "*I can say it's a matter or condition that would interfere with one's daily living, occupational functioning and interpersonal…and that it is also perceived by the community as behaviour that is not acceptable and I can say it can be contextual in that regard*".

R6 expressed mental illness can be perceived differently across cultures and what is perceived as normal in one society may not be in another:

> "*I would look at mental illness as within a context or within a community…mental illness has to encompass within it what within that community is considered normal and what is considered abnormal… plus emphasising difference in cultures, I don't know if you understand what I am saying, because obviously we are very varied persons based on our socialisation, culture and beliefs, norms and whatsoever, so all those have to be put into one bucket …*".

R5 added *"… individuals are different, culture plays a very important role and belief system also plays a significant role".*

3.1.2. Causes

In relation to the causes of mental illness all the participants made reference to environmental and social problems including stressors as the causes of mental illness. R1 expressed "*Family conflicts, loses, it could also be some stressors and general stressors. Among teenagers it could be relationships and adjustment …*" Furthermore, R2 emphasises the effect of socio-economic status on mental illness in the community:

> "*With regard to poverty for instance you might find that you do not have adequate nutrition and the family is not stable, constant pressure, you are under pressure of finance as well as constant depression and this can eventually act as some form of psychosis*".

R3's response highlighted how different factors and stressors can affect mental illness:

> "*I think one would not be able to single out just one cause or factor, I think its multiplicity and a combination of factors, and it could be stressful situations, there are difficulties that people encounter in their lives which of course would result in stress and in very serious cases of depression".*

Additionally reference was made to genetic dispositions as aetiological factors. R8 reported, "*…obviously there would be genetic predispositions that would also contribute towards mental illness"*. R2 added, "*The cause is genetic, there are some predispositions of genes…*" R2 further addressed the link between heredity and mental illness "*on the genetic side you might find that mental illness runs in the family, the mother or the father is also suffering from the same condition…one may end up with mental illness due to that, of which is also common*".

3.1.3. Treatment

With regard to treatment, (n=9) participants expressed using psychotherapy for the treatment of mental illness. The common approach among participants was to integrate different modalities informed by the presentation of the client. This is illustrated through R4's response "*I go eclectic and that is how I have been trained; that I do not have to see the challenge from one side, so it depends with the case and the flexibility of my client".* R6 expressed the point that using different modalities helps to view the presentation of the client from different perspectives including patients presenting with varying beliefs:

> *"Commonly I think my preference is to be integrative, it's what we call eclecticism. I think it's always what for me works. I mean you are a complex being psychologically, I always feel if one goes one route sometimes you might not address other issues or even if it's one issue that needs to be addressed psychologically…though yes, I would say I see myself moving more towards the CBT model because I mean restructuring somebody's cognitive or maybe thoughts or schemas whatsoever even as an African if you come here with something that is more African I can restructure it or I can challenge you using CBT".*

Furthermore R9 related that cognitive behavioural interventions were useful in the community they served in:

> "*I work eclectically in any way but then with the population that we work with most of the time we do use Cognitive Behavioural Interventions or theoretical models in terms*

of understanding what they are going through. I think it's the one that is very practical in terms of the population that we are working with".

Five of the participants made special reference to the use of the multidisciplinary team to meet the holistic needs of the clients. R7 stated:

"*I asses what other things are needed to help this person because when we talk about the person we talk about a holistic being and then we need to approach a person also in a multidisciplinary perspective. So you need to refer when the need arrives*".

One of the participants (R1) working in private practice highlighted that this helps with treating clients within their financial bounds:

"*I would normally refer them to a Psychiatrist as well, depending on the problem, but I do not really have a problem referring to a Psychiatrist. I have sometimes with other cases and I find it working… and I am able to reach my patients psychologically than if I am trying alone and trying very hard by the time you think that you are getting somewhere the medical aid is exhausted and the person has not really benefited from all your efforts*".

3.2. PERCEPTIONS OF MENTAL ILLNESS IN THE PEDI COMMUNITY

3.2.1. Definitions and causes

All the participants expressed that the clients that they are exposed to believe mental illness to be caused by factors such as witchcraft and punishment from the gods. With regards to witchcraft, participant 6 expressed "*...people will tell you about witchcraft or bad luck, this are some of the causal components that they attach to it".* R4 highlighted the beliefs in the community and how they can be expressed in the session:

"*...If somebody is presenting with substance induced or is maybe schizophrenic or is dealing with delusions and hallucinations they will say "ba mo shapile ka tholwane"*

(the person has been bewitched) so then in English it may sound difficult …but given the cultural aspect you may understand what they are saying…".

Despite the varying understandings of the different forms of mental illness; the knowledge that the participants have, given their background, made it easier to understand the difficulties that their patients were facing even when stated using cultural terms.

Furthermore ancestral punishment was referred to by few of the participants (n=3), R2 stated

"normally they attribute this to the issue of ancestors, that one should appease the ancestors and they would do that; if they do not see any improvements that is when they will resort to the western treatment, that is the last resort because when mental illness surface, especially psychosis, they would attribute to ancestral or witchcraft usually and they would try exhaust in that area first. Consulting you know, the inyanga and sangoma (traditional healers)..."

Additionally punishment may be from having gone against cultural norms and values, R6 shared:

"*there is always somebody being accused, maybe somebody did something wrong and is being punished…people who maybe did not follow the deceased's ways, ka sepedi bare "lentsu la mohu a le thshelwe" (in the Pedi culture there is a saying that the relates that "the deceased's words need to be heeded/observed") hence it will be like your being punished by the ancestors for not having followed the deceased's request or ways or something like that, so those are some of things they would attach to mental illness or what is responsible".*

Majority of the participants (n=9) expressed that there has been a shift in the perceptions of mental illness, with people moving towards more westernised understandings of mental illness and being able to seek mental health services R8 describes this:

"*I would say there is a shift because initially it was seen as something that is more spiritual, something that is witchcraft related, they would never really relate it to the environmental stressors that one comes into contact with…but I think there is a shift we cannot say we are there completely but we have quite a few percentage that would really relate it to stressors or to biology…"*

3.2.2. Treatment

Following the beliefs on the causes of mental illness; treatment is sought from traditional healers and spiritual healers as the cause is believed to be spiritual rather than medical. The participants (n=7) related that patients that come in have been to seek treatment for mental illness at traditional healers or spiritual healers before they make use of the mental health care services. This is illustrated through R2's response:

"*Usually our clients before, especially in the mental health care, most of them before they could end up here in the hospital you find that they have been consulting traditional healers and herbalists …and faith healer as well, because we have a lot of ZCC members here so you find that most of them they go through the extend that they also consult the faith healers before they could end up here. Usually they use the hospital as the last resort in most cases that is what I have observed…"*

Additionally, R1 emphasised the first choice of treatment as being that of indigenous healers "*…Africans will always start from African basis, they will go consult first before they come… we are secondary to them we are not primary to their approach*".R4 attempted to give the hierarchy of the route to treatment:

"*First entry is traditional healers, second is spiritual healers, third is hospital, no person presenting with mental illness that I have seen without going through a spiritual or traditional healer, they first try the two and then come to the hospital*".

R1 reiterated that cultural forms of treatment are often mixed with religious forms in seeking treatment:

> "*…culture in the Pedi culture goes a long way, we always mix it with a bit of religion and some will believe that if I am like this I must go and appease the ancestors; some will say I must go to church and be prayed for and perform church rituals, some will say I must go and do traditional rituals…*".

According to R6 "*I think even the Christian orientation nowadays a lot of people believe in it and they go through that prayer, meetsi (water) and stuff …so I think that's the direction that they still go in terms of treatment*."

3.3. Limited understanding of mental health services

All the participants related that there was limited understanding of mental illness services apparent in the communities they served in. The community reflected not having enough information of what mental health services especially those offered by psychologists are. Consulting with doctors and indigenous healers where tangible medicine is given seemed to be preferable over psychology where communicating is the basis of treatment; the patients struggle to comprehend this technique. R4 shared of an experience often encountered with patients at the end of a therapy session that highlights the limited information on the role of a therapist:

> "*…at the end of your session they will ask you "Doctor, where is the medication?", forgetting that you are a psychologist and not a doctor… the elderly ones you will have a full session with them but at the end you will be surprised when you ask, "how do you feel?" and they ask you for medication*".

R 9 reiterated this, adding on the challenge that this presents for the process of therapy:

> "*it's a challenge to actually say to them this is the diagnosis that I think is happening and that is related to intervention in terms of they wouldn't really understand what you are saying in terms of your intervention because they would think "I just come*

here and I talk" , they are expecting you to give them something because I think traditionally when you go to the doctor they give you something to fix that, then in therapy I think psychologically in psychotherapy when patients come you don't always do that, we actually work together".

In attempting to deal with this the practitioners (n=6) use educational outreach programmes to reach out to the community. R9 shared the projects they run in communities with the members to raise awareness of mental illness and the services offered

"*We do outreach and awareness campaigns; we work with other departments such as psychiatry. When there are mental health weeks we go to the community and psycho-educate them and some people are able, through those campaigns, to identify other people in their families and communities to go consult and that is helpful*".

R8 added:

"*...we would be invited on radio, we do go to schools and now that it is mental awareness month, July, there are plans to really go to the communities as multidisciplinary teams to go and try to educate the community members on that. We will be educating them on the different roles that are played by different professionals in mental health*".

R7 shared the outlining of the role of therapist helps to add understanding and challenges therapy stereotypes:

"*some will say "if I go to a therapist people will regard me as being crazy", so I think people still do not understand and when we go to the clinics what we always emphasise when we do health talks is to keep conscientising people "...I am a psychologist, this is my role, this is how I am going to help and this are the challenges we look at", you need to specify*".

Furthermore, R6 related that despite the efforts by their departments to reach out there are some difficulties with reaching out to rural areas in the province:

> "*for me now the concern is what about those that do not have easy access to transport to come to town or maybe sources of information or means of communication; They are the ones that are disadvantaged…we would say maybe its 90 % information being shared but that is in town and semi urban areas, when we start to move maybe 50 km out of town then obvious the information sharing starts to be reduced*".

Five of the participants expressed that the Disability grant offered for mentally ill individuals has been a pull towards treatment in mental health care facilities. The Grant requires for the patients to stay in treatment and adhere to treatment, thus leading to the increased number of patients consulting. R2 stated:

> "*…one would come for treatment because they want the grant… psychosis and mental retardation specifically, they would come and they will not even miss the sessions because they want the Disability Grant because of poverty that they are experiencing, which we are aware of"*.

3.4. Psychotherapy with patients holding cultural or spiritual beliefs to their illness

Participants (n=3) related that practicing in a community where spiritual and traditional beliefs to mental illness are held can be difficult as they feel the need to be sensitive to the beliefs of the clients. In response to this R1 stated "*The main aim of therapy is not to change the beliefs of the person… it's to help them, find a way to deal with what is happening to them at that time; you are not there to cancel or condemn their beliefs… you help them through*…".

Additionally five of the participants emphasised the importance of not disregarding the client's beliefs and allowing them to express their beliefs in order to understand them from their own perspective. According to R4, "*I have to understand their cultural background and how they view mental illness in order for me to try and intervene. I have to be on the same boat in terms of the understanding*". R6 added "…*we always say to understand somebody*

from their vintage point or from their phenomenological point or experience, so we need to take that into account in our practice …we need to understand where this person comes from". R9 further stated:

> "*I would not dismiss that (their belief), it would be something that I think maybe we need to look at and understand where this person is coming from … I would not want the person to take what I say is mental illness just like that but I would like to understand where the person is coming from and try to take it from there. I would move from that person's frame of reference and intervene in a way in which I would give the person insight in understanding what is really happening*"

The participants related often using psycho-education in therapy with patients to try and get them to understand the treatment they are offering and challenge some of the beliefs that are not conducive for the patient. R2 expressed the need to explain the process to the client in an effort to educate:

> "*…you help the patient gain insight so that you are able to continue with therapy for; one to continue with therapy the patient should also understand where the therapy is taking him as an individual. Once the patient understands that then it becomes easier for you to work with the patient so most of the time it's what the patient brings to you and I also help patients to understand their condition in a way that will also make sense to him or her.*"

This is further emphasised by R4 stating the importance of being careful to disregard the beliefs of the client while educating them:

> "*Remember you have to understand them from their own perspective but as a psychologist you also have a role to educate, so educating them brings insight to what is going on…if you just say traditional healing or spiritual healing has got nothing to do with that, they will default*"

Furthermore participants related that they would make use of the skills acquired through training to respond to patients holding cultural and religious beliefs to their mental illness, R2

"*I would do what is expected of me, I would help the patient and apply my knowledge and help the patient in that regard with the knowledge that I have acquired and try help the patient adjust…".*

In addition five of the therapists expressed that despite their own beliefs they would not discourage a client from seeking alternative treatment, R1 shares *"Sometimes even the patient would suggest that I still have to exhaust different sources like go to the traditional healers …if it's from the patient its ok".* Furthermore the participants expressed using their therapeutic skills to explore the information clients received from alternative healing in sessions to support the clients and explore the material further. One participant mentioned using a form of approach called harmony restoration therapy, R1:

> "…*harmony restoration therapy brings together all the western, the cultural and your traditional opinions and beliefs and in terms of treatment it encompasses them all so that for example, if a person believes that its demons and whatever and whatever you can refer them to a pastor, because as long as they believe it's a demon there is nothing you can do, you're not going to crack through them,… so there is nothing wrong with getting a patient , referring them to a pastor to pray for them and then they come back to you and continue so your integrating the different approaches*".

Two of the participants mentioned the need for research that explores the traditional and cultural treatments and possibly using them in conjunction with the western forms of treatment. R2:

> "*I think a lot of research is needed in order for us to demarcate the cause between the western and the traditional point of view, because if you are to treat the patient who is in line to be the next inyanga or sangoma and you are treating them from western perspective you may see little, if no improvement… this issues should actually complement each other, the western and the African way, it must not be like this one is better than the other…that Is where we sometimes get it wrong…".*

R6 reiterated by stating that western and African treatments can be combined however, there needs to be more studies to contribute African psychology:

> "*I don't think we can match them and win because like I said psychology is a western movement and from our African world we didn't have it, so now I want to still say more of western psychology dominates and African psychology is still at an infantile age…So that is what we need now, to grow it so that we reach a point where we can fairly compare…at the same time we don't want comparison because comparison in itself is not going to help us because all societies now are mixture of different cultures but you see culture is not static: its dynamic, it evolves …let's move towards integrating, even in psychology, our African psychology comes in…obviously we need to integrate it in conceptualisation, definitions and even treatment".*

Conclusion

The perceptions of the psychologists seem to be influenced by their training which is based on the western approach. The participants are aware of the influence of cultural beliefs in their daily practice and aspire to be culturally sensitive in their treatment methods. In the Pedi community, as reported by the participants, it is apparent that indigenous beliefs are still held in response to the understanding of mental illness and the treatment thereof, however culture is evolving and flexible hence there are community members who are open to western forms of treatment. Psychotherapeutic skills are used by the practitioners when faced with clients holding indigenous beliefs regarding their illnesses, there is however an expressed need to have more studies done to add to the knowledge of dealing with indigenous beliefs in therapy.

CHAPTER 4: DISCUSSION

This chapter discusses the themes presented in the results chapter by locating them within the current research in the field. The structure of the discussion mirrors that of the results where psychologist's perceptions of mental illness with regards to the definition, causes and treatment are discussed first. This is followed by perceptions of the Pedi community with regards to the causes, definitions and treatment of mental illness. The limited understanding of mental health care services follows and lastly the discussion on psychotherapy with patients holding cultural or spiritual beliefs to their illness.

4.1. Psychologist's perceptions of mental illness: definition, causes and treatment

4.1.1. Definition

Mental illness is conceptualised differently across different communities, it differs across different cultural and ethnic groups (Mokgobi, 2012). In this study, a common understanding among the practitioners was that mental illness influences one's functioning in different aspects of life, this being: cognitive, social and occupational functioning.

This is congruent with the widely accepted Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision, American Psychiatric Association, 2000) which refers to mental illness as the condition that causes distress and an impairment in social, occupational and personal functioning.

It is apparent that although the practitioners subscribed to the western form of training; they have an understanding that belief systems play a role in the understanding of mental illness thus making reference to cultural and spiritual influences. This signifies a holistic approach that takes into consideration the different aspects that influence an individual. This approach is similar to the bio-psychosocial approach used at Komani hospital where various factors are taken into consideration even in the treatment of mental illness (Lombo, 2010).

Additionally, participants stated being aware of and conscious of the idea that the understanding of mental illnesses can be influenced by one's context, including their cultural background. Matsumoto and Juang (2004), state that culture plays a role in the behaviour of

community members and shapes how behaviour is perceived. Mental illness would therefore be perceived in the Pedi community with the influence of the values and beliefs held by the members of the community.

According to Eshun and Gurung (2009), with the influence of population growth and mobilisation, therapists are set to come into contact with people from varying backgrounds that influence their background. Furthermore, it would be an injustice to keep generalising and using the Eurocentric understanding of mental illness that does not take into account the experiences of the people under study (Eshun & Gurung, 2009). Given practice in a multicultural society such as South Africa, there remains a need for culturally inclined and conscious practitioners. This further poses a challenge for training institutions to incorporate into the training of practitioners the various cultural and religious beliefs with regard to mental illness.

It is apparent that as the mental health care system grows and reaches more communities in the Limpopo Province and South Africa, an understanding of each cultural group and its conceptualisation of illness would benefit in offering competent services and adding to literature.

4.1.2. Causes

With reference to the causes of mental illness, the professionals expressed stressors and genetic dysfunctions as the cause of mental illness. Stressors referring to the daily challenges that one faces that can lead to them developing a mental illness. According to Uys and Middleton (2010), a stressor is an event that is experienced as overwhelming and challenges the coping mechanisms that one has used previously to deal with such an event.

The identification of stressors as a possible cause of mental illness was referenced in a study done in the Limpopo province among 10 Sepedi speaking participants; the participants related that the cause of mental illness can be factors such as: unemployment, family disagreements, pre-existing general medical conditions and occupational problems (Shai, 2012). Without protective factors that help to alleviate the strain, such as family, the stressors can lead to psychological problems and illnesses. Petersen and Lund (2011) state that stress is

a universal term; however, the patterns in which it manifests are varied across communities. In the Pedi community, the common problems faced were: family problems, economic problems and occupational difficulties.

These findings are consistent with the work of Sorsdahl, Flisher, Wilson, and Stein (2010) who conducted a study among traditional healers in Mpumalanga Province; in the study social external factors are identified as leading to mental illnesses. 30 % of participants in the study referred to mental illness as being a product of family problems that were not dealt with; leading them to escalate and turn into illnesses. Taking into account the value of community and family in African cultures, disputes among family members can be stressful and deprive one of a social support structure.

Furthermore Sorsdahl, Stein and Lund (2012) refer to socio-economic status as one of the risk factors that contribute to psychological distress in the South African context. Kongolo (2009) refers to the Limpopo Province as being one of the provinces with the highest poverty rate; this serves as a risk factor to the social and individual problems that can arise as a result of the insufficiency of basic needs. In addition to this Sodi et.al (2011) relates that the socioeconomic status of community members in the Limpopo province often influence the choice of treatment sought in response to illnesses. Affordable means of treatment are sought, with traditional healers being more affordable as compared to western forms of treatment.

Additionally, genetic factors were reported as aetiological factors. Uys and Middleton (2010) make reference to genetic dispositions as aetiological factors. Genetic predispositions can present a problem in the community especially when the community is not aware of the role they play in mental health. Multidisciplinary focus is helpful in this regard as it assists to manage the clients presenting with illness due to genetic predispositions.

The practitioners seemed to have an understanding of mental illness that was holistic; taking into account the social and biological conditions that play a role in illness. The dominant understanding was however that which correlates with the DSM-IV-TR (American Psychiatric Association, 2000). There are limited studies that explore the perceptions of South African psychologists with specific cultural backgrounds, however in a study on Hindu psychologists (Padayachee & Laher, 2012) the practitioners also had conceptualisations of

mental illness that were congruent with the DSM-IV-TR, suggesting that practitioners are influenced largely by their training with regards to their understanding of mental illness.

4.1.3. Treatment

The practitioners use psychotherapeutic skills they have gained through training to contribute to the treatment of mental illness. Emphasis was put on the presentation of the client, which then directs the type of treatment measures that the participants follow. Integrating different frameworks was favoured by the participants; this is guided by the belief that different modalities each hold helpful ways of dealing with clients. Integrating different modalities came to the fore with the recognition that different factors influence human behaviour (Palmer & Woolfe, 2000). It is important to note that most of the participants (n=6) practised in government hospitals where they consulted with a lot of short term cases.

Furthermore the use of a multidisciplinary team in the treatment process is emphasised by the participants. Different professionals assist in treating the client where there is a need. This finding correlates with the work of Lombo (2010) who conducted a study among mental health practitioners within the isiXhosa culture group and it was found that the practitioners utilised a multidisciplinary team in working with mental health care users, professionals such as social workers, psychiatrist and nurses were used. This is encouraged, also among the Pedi practitioners, to work with the client holistically. In a province like Limpopo where as stated by Akinboade (2008) most of the residents are from rural areas, helping the client with a team may also assist in saving them travelling costs when services are at distant areas.

Of interest to this study is how the practitioners responded in treatment when faced with clients believing their illness to be caused by spiritual and cultural factors, this will be explored in the fourth theme.

4.2. Perceptions of mental illness in the Pedi community

4.2.1. Definitions and causes

The understanding of the Pedi community relating to mental illness, as discussed by the participants, correlated with those found in African literature that highlighted the perceptions

of mental illness in other cultural groups (Mashamba, 2007; Tsa-Tsala, 1997; Lombo, 2010; Manyike & Evans, 1998). The common understanding was of mental illness being caused by external forces to the human body such as spiritual factors. Patel (1998) states that the supernatural understanding of illness helps the community to understand their suffering and the steps that need to be taken to alleviate the stressful symptoms. The aetiological factors in the Pedi community correlated with those of the neighbouring cultural group of the vhavenda tribe. According to Mashamba (2007), traditional healers among the Vhavhenda tribe ascribed the cause of mental illness to factors such as witchcraft, evil spirits and the ancestors not being pleased with an individual.

Witchcraft is the common factor that is believed to be the source of mental illness in the Pedi community; this is believed to be caused by jealousy and used to bring harm. The perpetrator bewitches the victim in order to stand in the way of their success. According to Van Wyk (2004), jealousy is a major motivator for witchcraft and in terms of victimisation, people such as neighbours, friends and family members are often at risk. Crawford and Lipsedge (2004) on their study based in Kwa-Zulu Natal make reference to witchcraft being one of the major causes of illness.

Although the participants for this study did not specify on the different kinds of witchcraft practices present in the community. Hammond-Tooke (1989) illustrates that there are two types of witchcraft identified in the Pedi culture; distinction is made between sorcery, which happens in the day, and night witchcraft or rather "*boloi*" as referred to in the Pedi Language.

According to Mokgobi (2012), beliefs of witchcraft as causing mental illness are prevalent in African cultures. Spiritual and traditional healers play a role in treatment as they are believed to have a connection with the ancestors and the spiritual realm (Sohrdahl et.al, 2009). It is this belief that leads the community to utilising indigenous healers as the first line of treatment. According to Akrong, (2012) the African Christian charismatic movement also recognises witchcraft as a cause of illness and uses its services to treat the effects thereof. The notion of witchcraft as motivated by jealousy is explored by Patel (1998) who looks into the different types of witchcraft methods that cause mental illness, among these is the infliction of an evil spirit to cause illness. In the Pedi community this spirit is considered to be evil and its eradication may come through the ministry of the church or from traditional healers. The

concept of witchcraft has been so prevalent in parts of South Africa such that there have been numerous criminal cases related to people being accused of being witches in the Limpopo Province (Mokgobi, 2012).

In addition, ancestral punishment is related as one of the aetiological factors. The community believes that going against what the ancestors have ascribed would lead to mental illness. This can be through deeds that are displeasing and going against their commands. According to Monnig (1967), in the Pedi culture the ancestors are headed with respect and the respect given to them serves as a protective factor against illness, losing that protection makes one vulnerable to illness. In the Vhavenda culture, the ancestors are believed to contribute to a person's illness when they disobey them (Mashamba, 2007); this is closely related to the beliefs of the Pedi community.

Rituals are used in order to restore the peace between the individual and the ancestors. Mokgobi (2012) shares an example of such rituals that are used by the Pedi people as slaughtering animals as a sacrifice to the ancestors. Ancestral punishment is not only exclusive to the Pedi culture as being perceived as a cause of mental illness, it is a common also in other African Cultures such as the Zulu, Xhosa and other Sotho clans (Swartz, 1986; Lombo, 2010; Sodi et.al, 2011).

The concept of community plays a role in the wellness of the people and serves as one of the determinants of wellness. The balance between one and those around, including the environment, serves as a protective factor against illness (Ngubane, 1977). It is therefore important to keep in harmony with the people in the community building on the notion of Ubuntu (Manyike & Evans, 1998). It can be derived from this that the community plays a significant role in acting as a support structure for the community members and thus encourages mental health and support. According to Mkize and Uys (2004), in the African community when one falls ill, the people around them are the first to be communicated to about the illness and depending on the severity of the illness and its impact on behaviour, the person will either seek treatment or continue to live with the illness.

Engelbrecht and Kasiram (2012) state that Ubuntu within a community can serve as a protective and supportive factor for those affected by mental illness, this can help to combat stigma and uphold the balance between people in a community.

4.2.2. Treatment

The treatment measures sought in the Pedi community have traditional and spiritual healers playing a pivotal part as the first entry for treatment. Treatment is sought first with indigenous healers and at a later stage with mental health care services offered at hospitals etc. According Sorsdahl et.al (2009), studies conducted in South Africa illustrate that about 41–61% of patients with mental illness have consulted a traditional healer. Indigenous healers are often sought for treatment among South Africans; the services offered by them are suggested to at times be more accessible than those offered by mental health services (Sorsdahl et.al, 2009). In conjunction with the participants in this study who serve in hospitals around Limpopo, a study done with Xhosa practitioners from Komani hospital in the Eastern Cape revealed that the surrounding community often sought traditional healers for treatment of mental illness before approaching the services offered at the hospital (Lombo, 2010).

In his study Sodi (1987) explores the treatment measures by traditional healers using a case study with a traditional healer "ngaka" from Limpopo province. Among the therapeutic procedures used by the healer is the dance referred to as "malopo" which helps the patients with symptom relief. In addition to this there are other forms of treatment to illness illustrated, such as: rituals and sacrifices to appease and communicate with the ancestors, the use medicine formed from different natural ingredients such as roots and shrubs and also baths and application of different medications on the surface of the body (Sodi, 1987).

The treatment measures used by the traditional healers in the Pedi culture are found in most cultures in South Africa though the rituals and conceptualisations vary (Mpofu, Peltzer & Bojuwoye, 2011).The balance between one and their environment is emphasised as a measure for preventing illness (Sodi, 1987). In the quest to maintain the balance, some community members may use both the services of the western mental health care system and the

indigenous healing in an attempt to keep the balance and maintain the protection from what is perceived to be the cause of illness (Shai, 2012).

Shai (2012) highlights that treatment pathways are informed by the belief system of the patient and their family members. Severity of symptoms influences what kind of treatment is followed, in addition, financial factors and the location of the provider play a role; this is apparent more so in rural areas (Mkize & Uys, 2004). The traditional healers often stay in the same community and are available for 24 hours, making them more available as compared to western forms of treatment.

Furthermore, the services of traditional healers are reported to be more affordable as compared to those offered by western mental health care providers (Mkize & Uys, 2004). Peu, Troskie and Hatting (2001) add that the lack of transport and inadequate information on mental health care services play a role in the use of indigenous healers who are readily available for continuous care. In the Limpopo Province this correlates, the majority of the population stays in rural areas and travel to hospitals to seek services.

According to Swartz (1998), indigenous healing and healing through the African churches are the two leading measures followed for treatment in South Africa. This correlates with the Pedi community in which mental health services are reported to be sought from both sources.

According to Harrison (2004), Christianity is the leading religion in South Africa, almost a third of the Christian population is affiliated to African independent churches. This study was conducted in three districts in the province, one of them being the Capricorn district in which the Zion Christian Church is located. The ZCC is referred to as one of the places where clients seek relief of mental illness. Mokgobi (2012) refers to churches such as ZCC as African independent churches; in the church there are prophets who are referred to as "lebone" who under the leadership of the holy spirit can see what is to come and can help the receiver of the prophesy in preventing undesirable outcomes such as illness.

Christianity seems to be a faith that is commonly practiced in the Pedi community; the participants alluded that clients would often seek treatment through prayer and the services of the church. Elphick and Davenport (1997) and Truter (2007) relay the different treatment

methods that are offered by faith healers and these are in correlation with those found among the Pedi faith healers: the use of special water, prayer and the bible. It appears that in addition to cultural beliefs, religious beliefs also play a role in the perceptions of mental illness in the Pedi community

The use of faith healers in the treatment of mental illness is reported by Shai (2012), in a study that sought to identify pathways to illness, some of the participants had consulted with faith healers/ prophets before making contact with the mental health care system. It is however important to note that the pathways to illness as reported by Mkize and Uys (2004) and Shai (2012) are not in one direction, the community members may start with indigenous healers and then go on to the mental health care system or they may move from the mental health care system to indigenous healers. The movement of the patient is motivated by the severity of the illness and the beliefs held.

Culture is ever changing and new aspects are added to the beliefs held, which inevitably plays out in therapy; requiring for mental health professionals to be aware and competent to work with the beliefs that are brought into the room.

4.3. Limited understanding of mental health services

With psychology perceived as a western commodity, the community, especially the rural communities, struggle to understand the role of a therapist and the art of psychology according to the psychologists interviewed. According to Petersen et.al (2009), the incorporation of mental health services into primary health care services is still in progress. The study highlights that in some districts of Kwa-Zulu Natal there was still a limited number of mental health care providers. With the services of mental health care services being introduced into rural areas it is inevitable that there would still be limited understanding to the services offered.

The participants for this study related that more psychologists were being allocated into rural areas and this was helping in informing the community on the mental health care services offered, however there was still limited understanding of the services offered. A possible

attribution to these may be due to the cultural attributions of mental illness and possibly economic difficulties.

The stigma attached to mental illness is prevalent in African communities (Mkize &Uys, 2004; Kakuma et.al, 2011; Mavundla, Toth, & Mphelane, 2009). In this current study, the role of stigma in mental illness was not emphasised, however participants (n=5) expressed that the limited understanding of what mental illness can lead to those affected being alienated in their communities. In a study conducted in the Limpopo province among Pedi community members it was reflected that the perceptions of mental illness across cultural groups can lead to stigmatisation. An example of this is when punishment by the ancestors is perceived as a cause of mental illness, this can lead to the patients feeling embarrassed to be associated with mental illness (Shai, 2012). The delay in seeking mental health care can be influenced by the fear of stigma.

The participants related the importance of reaching out and educating the community on the services offered by mental health care services, however this does raise the challenge of whether educating the community is challenging their beliefs and serves as an attempt to convert their beliefs into the western forms of understanding. It is undebatable that offering the services to the rural area and urban is important however there is a need for cultural sensitivity.

There continues to be a need for literature that will guide mental health care providers on the different beliefs that are held and how this play out in the therapeutic relationship. Lombo (2010) urges for practitioners to be culturally sensitive in this regard. Mkize and Uys (2004) recommend that mental health care providers take to utilising psycho-education techniques to educate the community and indigenous healers on mental illnesses and the services that are offered at mental health care institutions.

Informing the community on the services offered is important in contributing to mental health; however there is a need for it to be done in a culturally sensitive manner keeping in mind the different beliefs that are held in the community which are either culturally or religiously motivated. To combat the challenge of the limited understanding of mental health services most of the participants related the use of outreach programmes to clinics and local

schools to educate the community and it was reported that the outcome of this programmes was positive. Kakuma et.al (2010) in the study conducted to raise awareness on stigma in the country referred to educational programmes as a key factor in raising awareness of the services offered. Outreach programmes assist in educating the community and offering exposure to services that they were not afforded historically.

4.4. Psychotherapy with patients holding cultural or spiritual beliefs to their illness

In their daily practice practitioners continuously encounter clients with different backgrounds. James and Prilleltensky (2002) and La Roche and Maxie (2003) state that backgrounds do play a role in the way clients interact in the therapeutic relationship**.** Esprey (2013) refers to the analytic third, which embodies the social aspects and backgrounds of both the client and the therapist. Though her paper is based on race in the therapeutic relationship, cultural and religious differences can play a major role in the interaction between client and therapist especially in a multicultural country such as South Africa. A recognition of this differences helps maintain the relationship in a genuine manner.

In dealing with clients in the Pedi community holding cultural and spiritual beliefs the participants related using their psychological techniques in order to address such matters in the room. This included exploring the problem and understanding it from the point of view of the client. Eshun and Gurung (2009) explore the challenges faced by practitioners in different settings and they relate that a therapists need to be able to value diversity and be able to effectively serve clients taking into consideration their cultural context. This includes having treatment techniques that are able to meet the needs of the community based on their social realities.

Additionally, therapist flexibility and continuous training in dealing with clients with different backgrounds is encouraged (Eshun & Gurung, 2009). According to Petersen and Lund (2011), most of the systems for training for psychotherapy in African countries are founded on the United States or the European models. This carries over the Eurocentric understanding of illness and it is for this reason that literature that explores African understanding of illness is needed to assist in identifying the presentations found in communities (Sodi et.al, 2011; Mpofu, Peltzer & Bojuwoye, 2011; Lombo, 2010; Padayachee & Laher, 2011 and Laher & Ismail, 2012).

The therapists were careful to not let their own beliefs impose on those of their clients. Although a few of the participants shared their beliefs, they related that they were conscious to not let this play out in the room or influence the way they worked with clients. Therapists are often encouraged to not impose their own beliefs on the client and it seems just as important to encourage the understanding of the beliefs held by different communities especially those in which a therapist is based in in order to offer culturally competent and sensitive therapy (Eshun & Gurung, 2009).

Given the changes in society with different cultures moving to different places, it is no longer appropriate for mental health providers to practice from a Eurocentric approach that does not take into account the cultures of varying societies and the roles this play on illnesses (Eshun & Gurung, 2009). Furthermore, instead of generalising, the therapeutic skills that practitioners have need to be tailored in such a way that they accommodate the context in which they find themselves.

Cultural sensitivity is vital, working in a multicultural society requires for a professional to be aware of the beliefs held by others and to not judge those beliefs however work with them in the room to assist the client. A few of the participants related that they would explore with their clients the role their beliefs played on their illness and use their skills to reflect on those beliefs that were adding to the stress. This technique reflects on cultural competence as reflected by Swartz (1998), which allows the therapist to investigate the cultural background of the client, understand their perspective of the world and use appropriate techniques to address the problems that arise. The practitioners at Komani hospital emphasised being aware of the cultural background of the client to understand their beliefs (Lombo, 2010).

There seemed to be an emphasis on staying within one's scope of practice, the therapists were sceptical about suggesting alternative treatment unless it was brought up by the client. Few of the participants related that they would allow their clients to seek alternative treatment and to work with the material from that treatment in the room to support the experience of the client. This suggests having an integrative approach that could both allow for difference and working with clients holding different beliefs to their mental illness. There is a movement that motivates for collaboration between traditional and western forms of healing; in order for

this to be effective more studies that explore indigenous healing need to be done in order to help give an understanding of this to the western community and training facilities.

The disability grant was stated by the participants to be a pull for clients to seek help from the mental health care providers. Given the economic challenges as stated by Kongolo (2009), the disability grant assists the families of those affected by mental illness to take care of them. Although the disability grant is dedicated to caring for the mentally ill, the pull that it has created to seeking mental health services serves as a positive factor and it assists the mental health care users to avoid defaulting from treatment. The grant is functioning as positive reinforcement. The pull that the disability grant offers towards mental health services has not been investigated, it is an interesting finding that would merit further exploration.

Conclusion

The conceptualisation of the Pedi psychologists is closely related to the western perception of mental illness. There is an influence from the training received, suggesting that western conceptualisation plays a role in how metal illness is perceived among the practitioners. Cultural sensitivity is emphasised in practice with clients holding cultural beliefs in relation to their mental illness, allowing them to still hold their beliefs and playing ones s role as a professional to offer mental health services. The conceptualisations of the community vary with those of the practitioners, suggesting that the community is still influenced by their cultural and religious beliefs in the conceptualisation of mental illness. The treatment of mental illness is sought from indigenous healers and the mental health services at a later stage or simultaneously. The difference in conceptualisation of mental illness emphasises the need for training that is competent across different cultural groups to allow for practitioners to be capable of taking into account the different beliefs they are presented with.

CHAPTER 5: LIMITATIONS AND RECOMMENDATIONS

This chapter explores the limitations of the study and recommendations for further research. The limitations to the study include: limitations with regard to literature on the Pedi culture's ancestry and perceptions of mental illness, the limitations with regards to the interview schedule, sampling and the possible influence of the researcher's ethnic background.

5.1. Limitations of the study

5.1.1. Limitations with regards to literature based on the Pedi ancestry and perceptions of mental illness.

This study explored the perceptions of mental illness among Pedi psychologists in the Limpopo province and the influence their culture has on this perceptions. There is limited literature on the Pedi ancestry and its mental illness perceptions and treatment. This made it difficult to compare the findings of the study to more previously researched work. Previous studies are helpful to locate whether there has been a shift in the conceptualisation of mental illness and to compare and confirm some of the findings from the study. This may have an impact on the validity of the responses by the participants. Studies from other South African cultural groups proved to be helpful in this regard.

5.1.2. Limitations with regards to the sample group

The study aimed to get practitioners from three categories of practice, namely: educational, counselling and clinical. However, it was difficult to locate and secure interviews with counselling and educational practitioners in the province, as a result (n=8) Clinical Psychologists were used for the study and they were able to give complex information that contributed immensely to the study. The participants for the study served in a variety of areas surrounding their places of practice, including rural areas, however most (n=8) of the participants were located in semi-urban areas and travelled to rural areas for outreach programmes and consultations. Practitioners based in rural hospitals and clinics would be helpful in giving data based on contextual reality and exposure to the community members there on a continuous basis. This would also help to put emphasis on the work done in the rural context where cultural beliefs are still upheld and there is minimal exposure to western perceptions.

Furthermore, participants in the study were from Sekhukhune and Capricorn district; there are other districts in the province that can contribute to literature, due to time constraints and unavailability of participants it was not possible to get more participants from the other districts in the province for this study.

5.1.3. Limitations with regards to the interview schedule

During data collection, the interview schedule proved to be long and most of the participants were not comfortable with the amount of time taken, the interview schedule was broad and it explored different aspects. To handle this, the schedule was used as a guide for the interviews to accommodate the flow of the practitioners' narrative without compromising on the data needed to address the topic under study.

5.1.4. Limitations relating to the researcher's ethnic background

As stated in the ethical considerations, the fact that I belong to the Pedi community was monitored extensively in an attempt to not influence the research process. However, the assumed ethnic commonality influenced the responses given by participants as they often assumed that I understood the concept they mentioned and they did not go into detail, probing and further exploration of topics and ideas was used in order to gain more complex information from the participants.

5.2. Recommendations for future research

The first recommendation proposed is for further studies on the perceptions of mental illness in the Pedi community by exploring the community member's perceptions of mental illness and treatment measures sought, such studies will add to work already done by other researchers such as Sodi (1989), Sodi et.al (2012) and Shai (2012). These studies can add more to the literature of the Pedi culture and understanding illness as it is conceptualised in its context.

Using community members as a sample will give first-hand information and possibly information that is not influenced by a western framework. Additionally, identifying the

definition of symptoms as expressed by community members is helpful in identifying their needs. This further reinforces the notion of understanding the client from their point of view.

Furthermore, in addition to this current study, an exploration of other practitioners' perceptions of mental illness within the Pedi culture such as psychiatrists, psychiatric nurses, general practitioners and other mental healthcare professionals will add to the understanding of illness within this specific context. The exploration of the conceptualisations of illness contributes to cultural competency among professionals and encourages the embracing of difference in a multi-cultural society.

This leads us to the next recommendation, which is for the collaboration of belief systems in the understanding and training of practitioners in the country. The participants for this study displayed that although they were from the same background as their patients, there was still a struggle and limited guidance with dealing with clients who present with cultural beliefs as the cause of their illness. In addition to western techniques, studies are needed that can help to incorporate responses to African beliefs in the psychotherapeutic setting.

There is a gap between the conceptualisations of illness between the participants and the community as reported by the practitioners. Taking this into account, it is important and recommended for practitioners to continue with cultural competence and flexibility in working with clients presenting with cultural and spiritual factors to the cause of their illness.

The limited understanding of mental health services by the community suggests that there is a need for more educational programmes in the Pedi community that explore the role of the mental health care system and the services offered.

CONCLUSION

This study explored the perceptions of mental among Pedi psychologists and the role that culture plays, if any, on these perceptions. Psychologists play an important role in the mental health care system; they come into contact with people who are affected with mental illness and psychological problems on a daily basis. In a cultural setting such as the Pedi community, it is important to identify the practitioner's perceptions and how they respond to the beliefs brought into the therapy setting by patients.

The findings of this study highlight that practitioner's perceptions of mental illness are influenced to a large extent by their training, hence their conceptualisation of illness correlates with the western understanding of mental illness. The practitioners are however aware and flexible in identifying the perceptions of the community members that vary with western perceptions. The community members are reported to hold cultural and spiritual understandings of mental illness, with aspects such as witchcraft and ancestral punishment being perceived as aetiological factors. Treatment measures followed by the community also vary with those offered by the practitioners with community members often having indigenous healing as the first entry of treatment.

Furthermore, the study reflects the limited understanding of mental health services among community members in the Pedi community; this is combated through educational programmes carried out in the community by the practitioners. Practitioners, in the pursuit for cultural competency and sensitivity, remain flexible in their practice and work with the patients using therapeutic skills and understanding the patient from their own perspective.

Following the findings of the study recommendations are made for more studies that explore the perceptions of mental illness among community members and other mental health care professionals in the province. Furthermore, the integration of cultural and spiritual conceptualisations in high education training is recommended to assist practitioners in dealing with clients holding cultural and spiritual beliefs; and to encourage cultural competence in the South African context.

It is hoped that this study contributes to the knowledge of mental illness conceptualisation in the Pedi culture and the perceptions of psychologists practicing within cultural contexts. Furthermore, it is hoped that the study adds to African literature in general.

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Appendix A: Subject Information Sheet

Psychology

School of Human & Community Development

University of the Witwatersrand

Private Bag 3, Wits, 2050

Tel: 011 717 4503 Fax: 011 717 4559

Dear Sir/Madam

My name is Mahlodi Joslina Sehoana and I am a Master's student at the University of the Witwatersrand. As part of my course I am required to complete a research project. My research focuses on exploring the perceptions of mental illness among Pedi Psychologists in the Limpopo Province. I would like to invite you to participate in this study.

Participation in this study is completely voluntary and you may withdraw at any time and there will be no negative consequence. Your participation would consist of a one-on- one interview with me where you will be asked several questions based on the topic mentioned above. You may decide to not answer some of the questions but it would be appreciated for you to answer all the questions to add to this research. No identifiable information will be used and pseudonyms will be used throughout the research, you will be referred to as participant A, participant B or C e.t.c. There will be tape recordings during the interview and those will be kept in confidentiality and destroyed upon completion of the research.

If required, feedback on the study will be available approximately six months after the interview. If you would like to enquire more about the study you are welcomed to contact me or my supervisor on the contacts provided below.

Your participation in this study will be highly appreciated.

Mahlodi Joslina Sehoana Supervisor: Sumaya Laher

0735467633

joslinsehoana@gmail.com

:(011) 717-4532

:sumaya.laher@wits.ac.za

Appendix B: Consent Form (Interview)

I, _____ consent to being interviewed by Mahlodi Joslina Sehoana, for her study exploring the perceptions of mental illness among Pedi psychologists. I understand that:

- Participation is completely voluntary.
- I may withdraw from the interview at any time for whatever reason.
- I may refrain from answering any questions.
- There are no risks or benefits associated with this study.
- The information provided will be kept and dealt with in a confidential manner.
- No information that can identify me or my clients will be included in the research report
- I will be referred to using pseudonyms (Participant A, B or C).
- The results will be made available to me, should I require them, approximately six months after the interview.
- I am aware that the results of the study will be reported in the form of a research report for the partial completion of the degree, Master of Arts in Psychology (Clinical).
- The research may also be presented at a local/international conference and published in a journal and/or book chapter.

Signed: _____

Date: _____

Appendix C: Consent Form (Recording)

I, _____ give my consent for my interview with Mahlodi Joslina Sehoana to be recorded for her study exploring the perceptions of mental illness amongst Pedi psychologists. I understand that:

- The recordings will be confidential and will only be accessed by Mahlodi and her supervisor
- The tapes and transcripts will be kept in a locked cupboard at the university for three years and then destroyed.
- The tapes and transcripts are stored to facilitate further research or analysis.

Signed: _____

Date: _____

Appendix D: Interview Schedule

Introduction: Hello

I'm Mahlodi. We spoke on the phone. I would like to thank you for agreeing to participate in my study. Before beginning with the interview, I would like to assure you that everything you say during this interview will be kept confidential, and only my supervisor and I will have access to the tapes. The tapes and transcripts will be destroyed after the relevant information has been obtained. Although I know who you are, confidentiality will be maintained by not disclosing any information that is of a personal nature in the report. Assigning a pseudonym to your information in the report, for example, Participant a or Participant B, will maintain confidentiality. Any information that you may reveal regarding your clients will also be kept confidential.

I would like to remind you that you maintain the right to withdraw from the study at any time during the interview. You also have the right to refrain from answering any question should you wish to do so. A feedback sheet in the form of a one to two page summary of the study and its findings will be provided to you upon request. The feedback will be available approximately 6 months after the collection of the data.

Before beginning the interview I will need you to read through and sign these two consent forms (See Appendix B & C).

Thank you. If you are ready we can begin the interview.

INTERVIEW SCHEDULE

A. Contextual questions

1. How long have you been practising as a psychologist?
2. What kinds of clients do you consult with? Not only their problems/pathologies but also their demographic characteristics especially population group, gender, religious affiliation?
3. What are the common problems that your clients present with?
4. What are the more general/practical problems you encounter with these clients/with assisting these clients?
5. In your opinion, do you feel your University training adequately prepared you in dealing with these problems, please elaborate?

B. Psychologists' perceptions of the Pedi culture and mental illnesses in general

6. Given your experience and training how would you define a mental illness?
7. What do you perceive to be the cause of mental illness?
8. What are the most common causes of mental illness in the clients you consult with?
9. How do you generally approach the treatment of mental illnesses in your practice?
10. How are mental illnesses perceived in the Pedi culture? /What are the common perceptions of Pedi people regarding mental illness?
11. How similar is this with the Western understanding of mental illness?
12. Do cultural beliefs affect the response the Pedi people have towards western treatments and intervention?
13. What is your opinion on the beliefs people have about the causes of mental illness e.g. mental illness being due to witchcraft, punishment from the gods, refusing a calling from the ancestors' etc.?
14. How do you as a psychologist interpret these perceptions?
15. What are your personal beliefs to the causes of mental illness and the treatment thereof? Please elaborate.
16. How, if in any way, does your culture influence your own perception of mental illness?

17. Do you feel your perception of mental illness has changed after your training in psychology? Please elaborate.

C. **Psychologists approach to treating clients with cultural beliefs about mental illness.**

18. How do you treat clients who have cultural beliefs regarding the cause of their illness? (Prompt with: what do you say to them?)
19. Would you treat such a client using Western forms of mental illness treatment?
20. In your experience, have people who believed their illness to be caused by cultural factors been open to seeking assistance from Western professionals? Or receiving Western forms of treatment?
21. In your opinion, could a Pedi person or any person be effectively treated by a traditional healer?
22. How do you feel about other forms of mental illness treatment, i.e. those offered by traditional healers, etc? Would you refer someone who seeks your help to one of these professionals?
23. In your opinion, is it possible for Western and traditional forms of treatment to work collaboratively?
24. According to you, what influence do cultural rituals and practices have on a person's illness?
25. To your knowledge, do you find that people tend to perform more religious or cultural rituals and practices when faced with a mental illness? Please elaborate.
26. In your experience, what responses have some of your clients had with regard to traditional forms of treatment? (Prompt with: did they find that it helped or didn't help?)
27. Do you have any further comments, or would you like to add any other information that you feel we have not discussed?

Thank you for your time and co-operation.