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An exploration of South African Muslim general practitioners perceptions of mental illness within Lenasia, a suburb of Johannesburg.

Mohamed, Zaakiyah

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An exploration of South African Muslim general practitioners perceptions of mental illness within Lenasia, a suburb of Johannesburg.

A research report by:

Zaakiyah Mohamed

Student number: 564924

Master of Arts in Clinical Psychology by Coursework and Research Report

Supervisor: Sumaya Laher

Department of Psychology

University of the Witwatersrand

Abstract

General practitioners (GP's) are often the first point of entry when seeking medical treatment. They are responsible for treating members of the community and thus their understanding and conceptualisation of mental illness will influence patient care. Additionally, GP's religious and cultural affiliations play an influential role in the aetiology and treatment of mental illness. Thus this study explored perceptions of mental illness in a sample of 10 Muslim GP's (5 male, 5 female) of Indo-Pak ancestry in the Lenasia area (Johannesburg, South Africa). Semi structured interviews were conducted with each GP which entailed 37 questions related to the GP's context, GP's perceptions of mental illness, the understanding of religion and culture, the treatment of mental illness and the aspect of spiritual illness. Thematic content analysis was used to analyse the data. From the results obtained, eight themes were salient; namely definitions and aetiology of mental illness as understood by GP's, the role of culture, the assimilated identity, Islamic beliefs regarding mental illness, GP's beliefs regarding spiritual illness, collaboration and referral to other healthcare professionals and finally influential factors affecting GP's. Based on the above themes it can be concluded that more awareness regarding the stigmatization of mental illness needs to be addressed. Furthermore, it is vital that healthcare professionals possess an understanding of the use of traditional healing as a mode of treatment amongst certain South African population groups. This study therefore paves the way for further research regarding the incorporation of cultural beliefs into mainstream theory.

Keywords: Islam, mental illness, culture, religion, stigma, spiritual illness, traditional healing.

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Declaration

I declare that this dissertation is my own unaided work. It is being submitted in partial fulfilment of the requirements for the Degree of Masters 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 before for any other degree or examination at any other university or institution.

_____

Zaakiyah Mohamed

Day _____ Date _____

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Chapter 1: Literature Review

1.1 Introduction

The Islamic faith provides guidelines of human behaviour. Principles, rules and laws are obtained from the Qur'an (the Revealed Book) and Sunnah (the sayings of the Prophet (pbuh)). These guidelines form part of a Muslim person's core belief system and thus contribute to the understanding of mental illness as well as the cause and treatment of such conditions. Muslims in South Africa have originated from different countries and can thus be described as Coloured, Indian, Black or White.

Indian Muslims have originated from India and this is illustrated by India having the world's third largest Muslim population (Hindu Existence, 2011). Islam is the second-most practised religion, after Hinduism in India. Islam arrived in India in the 12th century and there was thus an integration of Hindu and Muslim cultures (Dunn, 1986). Hence cultural assimilation occurred between Hindu and Muslim communities (Ally, 2008). Beliefs and practises from both Hinduism and Islam influenced each other significantly and therefore assimilation took place to create a new Indian identity that included beliefs from both religions (Ally, 2008). A large proportion of South African Indian Muslims originated from India and when they migrated to South Africa, they brought along these encompassed beliefs. Almost all South African Indians are either Muslim or Hindu (Byrnes, 1996). There is a small minority that are Christian. Mutual learning occurred among Hindus and Muslims in India and therefore beliefs, superstitions and practices also became intertwined (Ally, 2008). Both groups have similar beliefs regarding witchcraft, spirit possession and the evil eye (Ally, 2008). Furthermore, they both rely on religious practices and prayers or rituals when treating certain conditions. Prayer, traditions and religious texts all form an important part of both groups' lives. Both religions believe in the efficacy of prayers and remembering God.

Thus, in the literature review that follows, the perceptions that Western and other cultures hold regarding mental illness are discussed. Following this the literature review will focus specifically on the Islamic perspective regarding the causes of mental illness and the manner in which mental illness is perceived in the Islamic faith. The field of Islamic psychology is then introduced. In addition, the literature review will address the way in which mental

illness is understood and conceptualised in the Hindu religion. The similarities and differences among the Islamic and Hindu perspectives will be addressed thereafter. The literature review concludes with a brief discussion on general practitioners' perceptions of mental illness.

1.2 Western definitions of mental illness

A mental illness or mental disorder is defined according to the DSM-IV-TR (APA, 2004, p. xxxi) as "a clinically significant behavioural or a psychological syndrome or pattern that occurs in an individual and that is associated with present distress, disability or significantly increased risk of suffering death, pain, disability, or an important loss of freedom." Furthermore, the DSM-IV-TR (2004), which is one of the most widely used psychiatric classification systems, states that symptoms of a mental illness must cause clinically significant distress or impairment in occupational, social, or other important areas of functioning. From a western perspective as represented by the DSM-IV-TR (APA, 2004), there are five different contexts which play an influential role in the development of a mental illness. These include the biological, individual, family, social and cultural context (Wenar & Kerig, 2006). However the inclusion of cultural context and culture-bound syndromes has only been a recent development originally included only from DSM-IV (APA. 1994). Thus there is a move towards acknowledging cultural understandings of mental illness in the DSM-IV-TR (2004) but it is still underdeveloped.

1.3 Culture and mental illness

According to Watters (2010) before the inclusion of culture-bound syndromes, western mental health practitioners believed that all disorders that were listed in the DSM-IV (1994) were universal as people worldwide shared the same symptoms and cultural beliefs would not affect these disorders. The concept of cultural universality assumes that mental disorders and their manifestations are fixed and will occur across all cultures (Sue, Sue, & Sue, 2006). However, each individual will nevertheless rely on cultural beliefs when trying to understand their symptoms or illness (Watters, 2010). Thus "all mental illnesses, including depression, P.T.S.D. and even schizophrenia, can be every bit as influenced by cultural beliefs and expectations..." (Watters, 2010, p. 3).

Furthermore, western beliefs of the self, view the individual as personally accountable and therefore individuals should overcome their own problems by force of will-power. On the contrary, traditional cultures view the self as being inseparable from the role played within a kinship group (Watters, 2010). African culture tends to be more collectivistic and it is demonstrated by the phrase ‘‘I am, because we are; and since we are, therefore I am’’ (Meyer, Moore, & Viljoen, 2003, p. 536). Hence the community and families provide tremendous strength and support for those who are ill which promotes recovery.

For example people in Zanzibar held strong cultural perceptions of mental illness and Swahili spirit-possession beliefs were still present. People who had schizophrenia or spirit-possession were not ostracized but were accepted in the community and were treated with kindness (Watters, 2010). The illness was seen as the “work of outside forces” and therefore the person did not take up the identity of a schizophrenic (Watters, 2010, p. 5). Cultural and religious beliefs were used to alleviate the symptoms of the disease. These included using saffron paste to write phrases from the Quran on drinking bowls so that the patient could absorb the holy words which would subsequently provide cure from the illness (Watters, 2010).

On the other hand, psychiatric stigma has also been found to be common in non-Western societies, such as Chinese, Indian and Muslim societies (Fernando, Deane, & McLeod, 2010; Ng, 1997). Information presented by Laher and Khan (2011) indicates that a similar situation exists in South Africa where stigma is attached to mental illness amongst the Muslim people of Indian origin. Somatisation is also common in these societies primarily due to the stigma associated with having a mental illness (Cape, 2001). Negative attitudes which are formed by prejudice and misinformation leads to stigma developing (Satorius, 2007). Thus individuals with a mental ailment tend to displace their emotional symptoms and they are often demonstrated through physical and somatised symptoms. GP’s are often unaware of emotional symptoms and tend to treat the presenting and apparent problem.

Thus religion and culture may affect the risk of developing a mental illness and the diagnosis of a disorder. Culture and religion also affect the manner in which we define abnormal and normal behaviours and subsequently the way in which we treat disorders that occur by members of a specific culture or religion (Sue et al., 2006). Furthermore, racial or ethnic

groups that may be similar might present with different religious or cultural beliefs, values and behaviour patterns (Sue et al., 2006). This poses a problem particularly in light of the assumption of the universality of mental disorders in mainstream theory and practice.

1.3.1 Defining culture and religion

It is evident from this discussion that culture is an important construct in the understanding, diagnosis and treatment of mental illness and the understanding of culture are thus imperative. It is important for this study that the term culture be unpacked. Culture is defined as "shared learned behaviour which is transmitted from one generation to another for purposes of individual and societal growth, adjustment, and adaption: culture is represented externally as artefacts, roles, and institutions, and it is represented internally as values, beliefs attitudes, epistemology, consciousness and biological functioning" (Sue et al., 2006, p. 9).

According to Bhugra (2006, p.17), culture can be defined as "a common heritage or set of values, attitudes and beliefs which are shared amongst a large group of people". Brems states that culture "refers to any group that shares and transmits within it a certain set of values, beliefs, and/or learned behaviours" (2001, p. 52). Santrock (1999, p. 13) defines culture as "the behaviour patterns, beliefs and all other products of a particular group of people that are passed on from generation to generation". Sadock and Sadock (2007, p. 168) provide a very comprehensive definition of culture:

> Culture is a vast, complex concept that is used to encompass the barrier patterns and lifestyle for society – a group of persons sharing a self-sufficient system of action that is capable of existing longer than the lifespan of an individual and whose adherence are recruited, at least in part, by the sexual reproduction of the group members. Culture consists of shared symbols, artefacts, beliefs, values, and attitudes. It is manifested in rituals, customs, and laws and is perpetuated and reflected in shared sayings, legends, literature, art, diet, costume, religion, mating preferences, child-rearing practices, entertainment, recreation, philosophical thought, and government.

Thus culture is a multifaceted construct loaded with a plethora of meanings. For this study, the notion of culture as a shared system of meanings, beliefs and actions as they are

commonly accepted in a specific group of people is sufficient. However in this study with its focus on Muslim GP's of Indo-Pak ancestry, culture and religion are intertwined and it is often difficult to separate the two. Islam is a religion that is based on principles and guidelines from the Qur'an and Sunnah and although Muslims are encouraged to live their lives according to these guidelines, one's culture tends to influences one's way of life. Culture and religion both consist of rituals, practices and beliefs and among Muslims from Indo-Pak ancestry these cultural and religious beliefs have become incorporated to form a way of life.

Therefore for the purposes of this study, Muslim culture and religion as they pertain to those of Indo-Pak ancestry will not be distinguished. For this group of people their system of practising religion is their way of life. It defines who they are and how they live – in essence, their culture. However given the interplay between being Muslim and being of Indo-Pak ancestry, it becomes vital to examine both the Islamic and the Hindu perspective regarding mental illness.

1.4 The Islamic perspective regarding illness

Both mental and physical illness in Islam is firstly considered to be an atonement of one's sins but treatment is encouraged (Rassool, 2000). Illness is also seen as a means of cleansing, purifying and as a balance on the physical, emotional, mental and spiritual states (Rassool, 2000). Secondly, it is a firm belief of Muslims that both good and bad are ordained by Allah (Taqdeer); it is by the will of Allah if illness befalls a person. However the Quran makes mention that Allah will not place such a hardship on a person who will not be able to endure it. "On no soul doth Allah place a burden greater than it can bear. It gets every good that it earns, and it suffers every ill that it earns" (Ali, 2000, Quraan 2: 286). To elaborate, Muslims believe that all adversity, trials, tribulations as well as goodness comes from Allah. Thus illness, dying, suffering are seen as a test from Allah and part of each individual's life (Rassool, 2000). The Quran states "Be sure we shall test you with something of fear, hunger, some loss in wealth, lives or the produce (of your toil), but give glad tidings to those who patiently persevere" (Ali, 2000, Al-Baqarah, 2:155). Muslims are advised to deal with difficulties by exercising patience, engaging in meditation and prayers (Rassool, 2000). The Quran (Ali, 2000, 3:146) states "Allah loves those who are firm and steadfast (patient). Verse

(39:10) also states “those who patiently persevere will truly receive a reward without measure!" (Ali, 2000).

Thirdly, illness in Islam is viewed as a condition that arises due to an imbalance between the body and the soul or an unbalanced lifestyle (sleeping patterns, temperament, spiritual activities and remembrance of God**)** (Deuraseh & Abu Talib, 2005; Rassool, 2000). Holistic care of Muslims will need to take into consideration Islamic beliefs and practices that incorporate the physical, emotional and spiritual facets of the self (Rashidi & Rajaram, Culture care conflicts among Asian-Islamic immigrant women in US hospitals, 2001). According to Rashidi and Rajaram (2001) care from an Islamic perspective will need to include caring for the whole human being, that is, a balance between spirit (ruh), body (badan), and emotion (nafs).

The nafs plays an imperative role when discussing illness in Islam. The Quran mentions three different types of nafs, or self (Ashy, 1999). Al-Nafs Al-Ammarah is considered to be the unhealthiest state of the self (Ali, 2000, Quran, 12:35). It is the state of insensitivity and total imbalance (Ashy, 1999). This self is associated with the antisocial personality as the self is in conflict with society (Ashy, 1999). The second self is called Al-Nafs Al-Lawwama, the blaming self. This self is out of balance but has the desire and ability to become in tune (Ali, 2000, Quran, 75:2). This self is described as having inner conflicts, which can cause anxiety disorders as well as other psychological disorders (Ashy, 1999). The third self is one that is balanced and tranquil. It is termed Al-Nafs Al-Mutmainna, the calm peaceful self (Ali, 2000, Quran, 89:27). This is the ideal self and therefore one is in harmony in this state (Ashy, 1999). The Islamic perspective is holistic as physical, spiritual, psycho-social and environmental needs all have a role to play in the overall health of an individual (Rassool, 2000). The body and the soul are said to be closely intertwined and health is equilibrium and harmony (Rassool, 2000). Ghazali (1058-1111) revered as the most influential Muslim scholar after the prophet Muhammed (P.B.U.H) stated that diseases are either physical or spiritual (Haque, 2004). The latter were considered dangerous and were attributed to ignorance and deviation from God (Haque, 2004). Spiritual illnesses consisted of self-centredness, ignorance, addiction to wealth, fame and status, lust, cowardice, doubt, envy, deceit, calumny and avarice (Haque, 2004). Ghazali treated these illnesses by utilizing

therapy of opposites. He explained personality as “an integration of spiritual and bodily forces” (Haque, 2004, p. 368). He deemed that abnormality resulted when one was distant from God and hence closeness to God resulted in normality (Haque, 2004).

Lastly, illness in Islam is also considered to be caused by supernatural forces. It is commonly perceived that both physical and mental illness is caused by supernatural forces such as spirit possession (jinn) and black magic (Karim, Saeed, Rana, Mubbashar, & Jenkins, 2004). In Islam, witchcraft, sorcery, black magic falls under the term *‘sihr’* (Ally & Laher, 2008). The term sihr is translated as witchcraft and involves an act that will bring one closer to the devil (Ally & Laher, 2008). If one is affected by sihr or witchcraft, one could experience the following symptoms, namely lethargy, illness, bad dreams, hearing of voices, infertility, miscarriages, weight gain and accidents (Ally & Laher, 2008). Islam also distinguishes other spiritual illness, termed *“nazr”,* which means ill will or jealous intentions (Ally & Laher, 2008). When a person displays ill will or looks at another person, their possessions or personal characteristics with jealous or envious intentions, nazr may occur and is a cause of illness (Ally & Laher, 2008).

In addition, a person can become ill due to spirit possession, which is called *‘jinn’*. Jinn are described as a separate race that can appear in different forms and can cause harm by possessing a human (Ally & Laher, 2008, p. 47). They are responsible for physical and mental illness and in addition have the ability to destroy marriages, cause insanity, constant pain and epilepsy (Ally & Laher, 2008). Jinn possession can be compared to a psychotic episode but it can also be associated with non-psychotic disorders (Ally & Laher, 2008). If one is suffering from mental illness symptoms which are due to supernatural forces, treatment will be provided by Islamic faith healers (Ally & Laher, 2008).

Muslim scholars who lived centuries ago have contributed much in the medical and psychological field. Their contributions and writings form part of what today is called Islamic psychology. It is governed by religious principles and plays an important role when trying to understand the Islamic perspective regarding mental illness. It will thus be discussed hereunder.

1.5 Islamic psychology

Psychology is commonly defined as the "scientific study of behaviour and mental processes" (Alias, 2010). Islamic researchers have suggested that this definition is incomplete as it ignores the important concepts of the soul (psyche/nafs) and iman (belief) which influence one's behaviour and mental processes (Alias, 2010). Islamic psychology has thus been redefined as "the scientific study of manifestation of the soul in the form of behaviour and mental process" (Alias, 2010).

Islamic psychology is thus governed by religious principles. These principles are described in the Quran and the Sunnah. The core principal being Tawhid (oneness of Allah), or unity. The aim of Islamic principles is to achieve equilibrium between worldly and spiritual needs as this is essential for a balanced personality and mental health (Khalili, Murken, Reich, Shah, & Vahabzadeh, 2002).

Islamic psychology includes the moral principle whereby Muslim philosophers proposed that virtue and morality are the foundation of human happiness (Ashy, 1999). Moral principles are used to explain physical, psychological and social diseases (Ashy, 1999). The key to healthy living is balance and moderation in all activities and this will prevent the occurrence of diseases (Ashy, 1999). The principle of organisation, logic and imagination as well as philosophical principles are included in Islamic psychology (Haque, 2004).

The first Muslim philosopher was considered to be Al Ash'ath Bin Qais Al-Kindi (801-866). He wrote books on sorrow, dreams and philosophy and based his work partially on the works of Aristotle and Plato (Haque, 2004). Al-Kindi utilized cognitive strategies in the treatments of depression and discussed the purpose of the soul and intellect among humans (Haque, 2004). Following him, Ali Ibn Sahl Rabban At-Tabari (838-870) was the initiator in the field of child development. He wrote a medical book named Firdaus al Hikmah where he discussed ancient Indian texts. He emphasized that medicine and psychology were powerfully linked and encouraged psychotherapy to be used by physicians (Haque, 2004).

Following them, the Persian physician Abu Zayd Ahmed ibn sahl al-Balkhi (850-934) used the Quran and the Hadith of the Prophet (p.b.u.h) as the bases of his ideas. Al-Balkhi introduced the concept of al-tibb al-ruhani which is translated as 'spiritual health' or 'mental hygiene' (Deuraseh & Abu Talib, 2005). Al-Balkhi discussed diseases that were related to both the

body and the soul. He explained that since human beings compromise of both body and soul, human existence can only be healthy when the soul and the body are entangled (Deuraseh & Abu Talib, 2005). Al-Balkhi also stated that if the body gets sick, the nafs (psyche) loses a great amount of its cognitive and comprehensive ability and will thus be unable to enjoy the desirous aspects of life (Deuraseh & Abu Talib, 2005). On the other hand, if the nafs gets sick, the body will also find no enjoyment in life and may thereafter acquire a physical illness (Deuraseh & Abu Talib, 2005). Therefore psychological conditions play an instrumental role in physical health. On the contrary, when the nafs is strong, the bodily nature will also be strengthened because both work together to prevent and overcome illnesses (Deuraseh & Abu Talib, 2005).

Al-Balkhi also recognised psychosomatic conditions and explained that the body and the soul could either be healthy or sick, balanced or imbalanced (Deuraseh & Abu Talib, 2005). Imbalance in the body is demonstrated by fever, headache and other physical illnesses whereas illness in the soul is shown by anxiety, anger, sadness and related symptoms (Deuraseh & Abu Talib, 2005). He encouraged counselling, listening, preaching and giving patients advice are important aspects when dealing with psychological illnesses like sadness and depression (Deuraseh & Abu Talib, 2005).

Abu Bakr Mohammad Ibn Zakariya Al-Razi (Rhazes) (864-932) promoted psychotherapy and like al-Tabari he agreed that encouraging statements from doctors could assist and speed up patients' recovery (Al-Issa, 2000; Haque, 2004).

He believed that unexpected emotional outbursts had a restorative effect on psychosomatic, psychological and organic disorders (Haque, 2004). Razi criticized the works of Hippocrates and Galen and compared medical opinions of Arab and Greek scholars (Haque, 2004). In addition, Razi wrote a book regarding various ways to treat moral and psychological ills of the human spirit (Haque, 2004).

In the 8th century, a few other philosophers' contributions are worth noting. Al-Farabi (870-950) wrote a text on social psychology and was well known for his theory regarding the Model City. In essence, he believed that no human being can be isolated but we are all in need of company, social support and to be part of a society. Al-Majusi was a Persian scholar who wrote a book entitled The Royal Notebook (Haque, 2004). His book included topics

regarding mental diseases and the brain as well as anatomy and physiology. Majusi believed in natural healing and prevention of diseases and believed that medication or medical treatment should be the last resort (Haque, 2004).

Abd Allah Ibn Ibn Sina (980-1037), Avicenna, discussed the mind-body relationship, had theories on temperament, supported hypnosis and provided psychological explanations of certain somatic illnesses. Furthermore, he wrote about the different forms of intellect, those within man and those outside of man, namely potential and active intellect respectively. He proposed that cognition was not a mechanical procedure but involved intuition (Haque, 2004). He labelled melancholia (depression) a mood disorder and believed that it could include suspiciousness and phobias. Ibn Sina was amongst the first to use psychological measures to treat his patients (Haque, 2004).

Abu Hamid Muhammad Al- Ghazali (1058-1111) was influential in popularising the Islamic notion of the self. He also developed this further by introducing aspects related to cognition and neurology. For example, he postulated that bodily needs of the self were acknowledged and it included motor and sensory motives (Haque, 2004).

He also spoke about the differentiation between man and animals. These are Aql (intellect) and Irada (will). Intellect is the central quality that allows man to develop concepts and acquire knowledge. In man, will is dependent on intellect whereas amongst animals it is conditioned by appetite and anger (Haque, 2004). He also distinguished between knowledge that is innate or acquired (Haque, 2004). Ibn Rushd or Averroes (1126-1198) was also interested in the concept of intellect (Haque, 2004).

It is interesting to note that Ibn Al-Ayn Zarabi (D. 1153) who specialized in the art of healing did not mention the influence of evil spirits in the development of mental illnesses. He discussed physical and mental illness as well as treatment but remained objective and did not engage in cultural influences and their role in illness causation (Haque, 2004).

Islamic psychology and renowned philosophers' played an influential role in the understanding of mental illness centuries ago, which till today has impacted on current explanations of mental illness. Recently there has been a move to revive this Islamic

approach under the label of Islamic Psychology with the aim of incorporating these theories into mainstream psychology.

1.6 The Indian perspective regarding mental illness

The Indian perspective regarding mental illness predominantly stems from the Hindu religion. Hinduism is one of the oldest religions and represents a spectrum of beliefs and practices (Padayachee, 2010). Hindus believe in one supreme and absolute God, which is known as Atman (the human soul) or Brahma (the creator). However, Hindus also believe that God resides in every living creature (Padayachee, 2010).

The religion of Hinduism has its roots in religious texts and scriptures (Dalal & Misra, 2010). These include the Upanishads, the Bhagwad Gita, and the Vedas; as well as the Ramayana and Mahabharata epics (Padayachee, 2010). These scriptures present conceptualisations of spiritual and mental illness and thereby form part of Hindu culture, beliefs and practices (Padayachee, 2010).

Hindu beliefs and health are intrinsically linked. Good health is a balance of physical, emotional, mental and spiritual health. All of these elements are linked and thus an imbalance of any one will result in ill health. Mental health is reflected in Hinduism through spirituality, the unity of the body and mind, yoga and meditation (Murthy, 2009a). Thus Eastern systems of care focus on a holistic approach and emphasize the importance of the balance and well-being between the body and mind (Rashidi & Rajaram, Culture care conflicts among Asian-Islamic immigrant women in US hospitals, 2001) . In contrast, traditional Western care concentrates on bodily discomfort and cure (Rashidi & Rajaram, Culture care conflicts among Asian-Islamic immigrant women in US hospitals, 2001).

The Bhagavad-Gita, which is one of the key scriptures, illustrates the application of psychological interventions to life situations (Murthy, 2009a). Thus, Hinduism explains mental health in terms of four key aspects, namely, the holistic approach to health, yoga and meditation, Bhagavad-Gita and the theory of life stages (Murthy, 2009b). These aspects deal with the understanding of health and illness as well as the physical, the psychological and the life cycle and will be discussed hereunder (Murthy, 2009b).

Hinduism adheres to a holistic approach when discussing health and recognizes the body-mind relationship (Murthy, 2009b). The Ayurveda, which will be discussed further on, reflects the unity of the mind, body and environment as it mentions ways to promote health and prevent illness (Murthy, 2009b). These include treatment of illnesses which entail diet, fasting, medication as well as psychological interventions such as prayers and restrictions on daily activities (Murthy, 2009b).

The Bhagavad-Gita is a world renowned classical text and is cherished among all Hindus (Murthy, 2009b). The central part of the Gita is a poetic text which takes the form of a dialogue between Lord Krishna and Arjuna on a battlefield (Murthy, 2009b). The dialogue symbolized the reality of life and the role of religion during periods of crisis (Murthy, 2009b). According to Murthy (2009b) many scholars regard the dialogue an exceptional illustration of psychotherapy (Murthy, 2009b). Some scholars go on to relate the Gita with psychoanalysis and ascertain that the Gita plays a pivotal role in understanding human's psychological functioning (Murthy, 2009b).

The last important contribution to Hinduism is the concept of Ashramas or the four stages of life (Murthy, 2009b). It is proposed to be the ideal way of life as it regulates the life of individuals at all ages (Murthy, 2009b). It provides guidance and continues to be relevant in modern life (Murthy, 2009b). The four stages are called studentship, householder, forest dweller and ascetic (Murthy, 2009b). A valuable aspect is the idea that to achieve complete happiness and peace of mind, an individual needs to change himself and the environment does not need to change (Murthy, 2009b).

Other scriptures such as the Vedas, Yajur Veda and Rig-Veda have made mention that the mind is a functional element of atman (soul which is self) (Murthy, 2009a). The mind has been conceptualized as the inner flame of knowledge and is also explained as the basis of consciousness and the instrument of knowledge (Murthy, 2009a). The texts have depicted the importance of emotions, consciousness, inspiration and will power. Emotional states like envy, pleasure, grief, hostility and attachment are explained (Murthy, 2009a). Psychosis is termed unmad and is defined as a deluded state of mind (Murthy, 2009a). Furthermore the scriptures point out that an individual should prevent mental pain (depression) from occurring by praying. Prayers consist of mantras (rhymes) and its purpose is for noble

thoughts to enter the mind. Prayers for mental happiness, intelligence and healing are also dealt with in these texts. Former scriptures like the Upanishad and the Bhagawad Gita provide descriptions of the different states of mind, personality and cognitive distortions (Murthy, 2009a).

A complex system of medicine was developed in India, which was known as the Ayurveda (the science of life). Health according to the Ayurveda is defined as "a state of delight or a feeling of spiritual, physical and mental well-being" (Gielen, Fish, & Draguns, 2004, p. 299). The fundamental principle of health is the correct balance of the five elements (Bhutas) and the three humors (Dosas). A human being comprises of these five elements, namely; water, air, fire, earth and sky (Murthy, 2009a). The three humors are phlegm, bile and wind. A healthy person is one who "possesses various bodily constituents in the right quantity, neither too little, nor much" (Sinha, 1990, p. 5). Although different, this system can be compared to that of Hippocrates, who proposed the temperament theory.

A further concept that is central to Indian philosophy is the theory of the three modes of nature. These consist of Sattva (light, goodness, and purity), Rajas (action, energy, passion) and Tamas (darkness, inertia) (Murthy, 2009a). These qualities are used to clarify the various types of personalities, food and action (Murthy, 2009a). Furthermore, other mental symptoms are explained which resemble modern definitions of personality disorders, psychosis and mental retardation (Murthy, 2009a). There are also several variations of personality types due to a number of combinations of body types (Murthy, 2009a).

The Ayurveda describes three personalities. Firstly, the pure (satvic) mind is considered to be one that is not contaminated or tainted. It symbolizes the beneficent facet of intelligence. Secondly, the passionate (rajas) mind is regarded as tainted as it represents the violent features. Thirdly, the ignorant (tamas) mind is tainted with the deluded past (Murthy, 2009a). Sixteen personality types have been identified and its development is ascertained by the time of conception, the diet and drink of the mother during the gestation period (Murthy, 2009a). However, these 16 personality types correspond to 16 different mental disorders among Western models of classification, such as the ICD diagnosis (Murthy, 2009a). For example, *devgraheetand kafaj* is similar to schizophrenia.

The Ayurvedic texts describe insanity, spirit possession and epilepsy. Insanity according to the Ayurveda is defined as "the unsettled condition of the mind, understanding, consciousness, perception, memory inclination, character, behaviour and conduct" (Murthy, 2009a, p. 166). Diseases are said to be caused by either the excessive, deficient or improper use of one's mind or the misuse of intelligence (Murthy, 2009a). The aetiology of insanity consists of many superstitious beliefs, evil spirits, spirit possession and unclean states (Murthy, 2009a). The most common symptoms of insanity are confusion of intellect, deprived memory, fickleness of the mind, incoherent speech, anxiety and other symptoms that are related to spirit possession (Murthy, 2009a).

Hinduism also acknowledges that mental illness may be perceived as witchcraft, spirit possession and the evil eye (najar/nazr). Those who are bewitched present with symptoms of: loss of appetite, vomiting, lethargy, uneasiness, body pains, headache, fever, labour pains, infertility, miscarriages and constant crying in children (Ally, 2008; Padayachee, 2010). Psychological symptoms can include feelings of helplessness and despair, terror, agitation, lack of motivation, social withdrawal, insomnia and trauma-like states (Padayachee, 2010).

Amongst the Indian population, there is also the belief in *najar* (evil eye) that has its roots in Hinduism. Najar stems from another person's envy, jealousy or greed. It is a common belief among the Hindu population in India and those Hindu's that have migrated to Britain. A study was conducted in Britain among Gujarati Hindu families to determine if these beliefs still exist among them (Spiro, 2005). The study group involved 70 Hindu and Jain Gujarati households and the fieldwork was carried out over a period of four years (Spiro, 2005). The study found that while Hindu families do use biomedical services, they will continue to take precautions to avoid najar and *bhut* (ghost). Furthermore, the belief in supernatural forces as capable of causing illness was shown to be prominent (Spiro, 2005).

The presence of najar is not always easy to detect. In infants, the effects of najar can include excessive crying, jerking or refusal to eat. "Najar has the power to cause not only minor illnesses in children, such as poor appetites, but in some circumstances it can lead to serious disease or death" (Spiro, 2005, p. 66). Biomedical opinion is sought first but if symptoms continue, older female kin will be consulted to detect whether najar occurred and to treat it. Grandparents play an important role as they have expertise and knowledge. However, if

they are unable to treat the najar, only then will a person with spiritual powers be consulted. The methods used to treat and expel najar include water, chillies and limes (Spiro, 2005).

Hinduism also promotes the belief in spirit possession. Spirits or ghosts are termed bhut. According to Hindu belief, a spirit can linger as a bhut after death due to an unresolved grievance or an untimely death (Spiro, 2005). An untimely death is considered to be a 'bad' death as the deceased was unable to prepare himself, for example, an accident or death by violence. This premature death results in a bhut returning to haunt the family until the necessary rituals are performed (Spiro, 2005). Ghosts or bhut can also be caused by unfulfilled obligations, for example, unpaid bills or unfulfilled desires which can be linked to najar (Spiro, 2005). Ghosts are also related to reincarnation and karma. The transition of the soul from this world to the next incarnation necessitates completeness; therefore when there is unfinished business or an untimely death, the soul will linger as a ghost (Spiro, 2005). Ghosts are said to cause fever, illness, and death and this belief stems from religious texts. In addition, the character of a person changes as the bhut attempts to take over his or her soul (Spiro, 2005). The difference between najar and bhut is that najar is "characterised as a 'look' inflicted through jealousy, which then causes illness, but there remains a degree of human control..." (Spiro, 2005, p. 69). However, bhut is more difficult to detect as it may exist in a house, garden or tree and can cause fear (Spiro, 2005). Thus najar can be treated by rituals whereas bhut is more complex to exorcise.

Hinduism plays a significant function with regards to understanding mental health. The ancient religion provides wisdom, guidance and a way of life that explains human functioning in terms of one's body, mind and consciousness (soul) in health and illness (Murthy, 2009b) and similar to recent developments which coined the term 'Islamic Psychology," there has been a recognition of an Indian Psychology.

1.7 Indian Psychology

According to the Indian Psychology Institute, Indian psychology is based on Indian ethos, Indian philosophy, traditions, texts, yoga and spirituality (ipi.org.in). The aim of Indian psychology is to obtain clarity in the mind and bring an individual closer to self-realization (Cornelissen, Misra, & Varma, n.d). Its outcomes focus on spirituality and insights into one's

inner world (Cornelissen et al., n,d). Indian psychology is mostly unrecognized in mainstream which originates in western cultures (Shanti, 2002) and this is due to the difference between them. Indian psychology differs from western psychology as it is based on religio-philosophical traditions of India whereas mainstream psychology relies on science as its foundation (Shanti, 2002). These religio-philosophical writings are considered orthodox, unscientific and inaccessible (Shanti, 2002).

Furthermore, there is no clear distinction between philosophy, psychology and spirituality as together they form a comprehensive and practical understanding of human life (Dalal & Misra, 2010). There are four essential concepts that are part of Indian psychology and are known as the four life pursuits or *Purusharthas.* These entail *dharma* (virtues and rightful obligations), *artha* (material prosperity), *kama* (fulfilment of desires) and *moksha* (liberation) (Dalal & Misra, 2010). These four pursuits govern an individual's way of being and iterate that the attachment to this world and its material gains is purely temporary and insignificant. Thus attachment is claimed to destroy one's life (Dalal & Misra, 2010) and should be avoided.

The core of Indian psychology is issues about the inner world, the self, the mind and consciousness (Dalal, 2010; Shanti, 2002). Other important features regarding birth, death, existence, peace of mind and peace with the world as well as the manner in which one can deal with suffering and life changes (Shanti, 2002). It is a practical approach that guides one in methods to find joy, peace, and love as these features reside in each individual and form one's true self or pure consciousness (Wirth, n.d.). Thus the self (atman), the nature of the phenomenal world and the individuals as well as societies well-being are core components around Indian psychology (Shanti, 2002).

The nature of the self, Atman or Brahman, is described in Upanishads as "the fundamental reality whose nature is pure awareness" (Shanti, 2002, p. 4). This is the foundation of the whole creation and includes the mind (Shanti, 2002). The mind is termed Antahkaran and is defined as "the instrument of knowledge of inner world" (Shanti, 2002, p. 4). It comprises of four-fold constituents namely; the Manas (perceptions, feelings, desires, and thoughts), the Buddhi (intellect which is the faculty of discrimination and choice), Chitt (memory) and Ahankar (ego, sense of individuality) (Shanti, 2002).

Indian psychology is a complex concept to understand and requires inner purification (Shanti, 2002). This inner purification commands freedom of conditioned thinking, introspective orientation, existential questioning, critical self-examination and a willingness to change (Shanti, 2002). The highest state an individual can reach is that of self-realisation and it is the ultimate goal of life (Shanti, 2002). The new paradigm that is coming into view from Indian psychology is that solely pure consciousness is the fundamental reality and the truth of all creation (Shanti, 2002).

1.8 Similarities between the Islamic and traditional Indian perspectives

This literature review has discussed both the Islamic and Hindu perspectives and it is evident that they do indeed share features yet at the same time, there are noticeable differences. Firstly, both Hinduism and Islam consider health and illness holistically. Health not only includes physical well-being but spiritual, psycho-social, environmental and psychological are also important. Both religions agree that in order to prevent illness, a balance in one's life is needed. An imbalance between any facets will result in illness. Furthermore, both religions recognize the importance of the soul, the unconscious and the self. The body and soul are intertwined and a mind-body relationship exists.

Hinduism and Islam are both a way of life and therefore they are governed by religious principles and practices. Both religions possess valuable texts or scriptures and a person is encouraged to follow the guidance of these holy books. Prayers are an essential component of both religions and are used in times of health and illness. Furthermore, both religions are concerned with the afterlife and attachment to the material world is discouraged. Hinduism ascribes to the belief of reincarnation and the law of karma whereas Islam proposes life after death and the reward or punishment for one's good and bad deeds. The law of karma may also appear to be similar to the Islamic belief of taqdeer (predestination) whereby God preordains everything and hence good and bad are from God.

In terms of mental illness, both groups have similar beliefs regarding supernatural forces, witchcraft, evil eye and spirit possession. In terms of treatment, they both encourage the seeking of help from prayers, God and thereafter traditional healers. Furthermore, Hinduism differs in the practice of yoga and meditation which is not encouraged amongst Muslims but Zikr (incantation) and Salaah (five daily prayers) are encouraged. However, meditation can

be likened to zikr as they both involve incantations of religious words. Additionally, yoga involves complete concentration, peace and tranquillity via the movements of the body. Yoga is also considered to be beneficial to the health and physique of the body. Similarly, salaah also consists of bodily movements which are beneficial to the individual. Salaah also requires an individual to have absolute concentration, devotion and it is said to bring peace and calmness in oneself. The Ayurveda, which form parts of the Hindu religion, although different, can be compared to the prophetic medicine (Tibb-an-Nabawi) that Muslims are encouraged to follow, such as the eating of honey and black seed as a means of cure from all ailments.

Thus both religions understand illness in terms of a mind-body-soul connection and believe that balance and moderation is the key to health living. Hinduism and Islam have interacted with each other for centuries. The current Muslim culture amongst those of Indo-Pak ancestry includes features of both Hindu and Muslim religion and culture (Ally, 2008). Cultural assimilation occurred between the two religions and created a new Indian identity that comprised of beliefs, practices and traditions from both Hindu and Islamic traditions (Ally, 2008). This Indian identity is prominent among South African Indian Muslims and is important for GP's to take this into consideration when treating patients.

Furthermore, culture and religion play a crucial role in shaping public and professional attitudes towards mental illness. Muslim general practitioners from Indo-Pak origin follow Islamic practices as well cultural traditions and these beliefs will be reflected in their everyday life (Rashidi & Rajaram, Culture care conflicts among Asian-Islamic immigrant women in US hospitals, 2001). The cure of illness is not solely medication; rather Islamic care is seen within a holistic context (Rashidi & Rajaram, Culture care conflicts among Asian-Islamic immigrant women in US hospitals, 2001). Holistic care involves the physical, social, psychological and spiritual components of each person (Rashidi & Rajaram, Culture care conflicts among Asian-Islamic immigrant women in US hospitals, 2001). According to Rashidi and Rajaram (2001, p. 55) "a lack of understanding of Muslims and their cultural and religious traditions contributes to potential conflicts in health care." The Indo-Pak Muslim population has increased in South Africa and a large amount of Muslims reside in Lenasia. These residents are often seen to by Muslim general practitioners. General practitioners and medical professionals often follow a medical model and this could impact on their beliefs.

These practitioners should be skilled and knowledgeable regarding traditional beliefs that community members hold as well as religious beliefs.

GP's will thus need to be aware of making a making a diagnosis based on Western medicine and paradigms. It is necessary for them to be culturally aware and thus view the patient in terms of their background, culture and religion. Patients' perceptions of mental illness and what constitutes a mental illness will need to be evaluated. Furthermore, GP's own perceptions and understandings of spiritual illness, traditional healers, and the impact of religious beliefs will influence their diagnosis and treatment. Thus it is important to note that medical professionals should not influence or impose their beliefs onto patients.

The general practitioner is the first step in the medical process and it is thus important that practitioners and healthcare professionals are aware of religious and cultural values that can influence themselves as well as their patients. The perceptions of mental illness among general practitioners will now be discussed.

1.9 General practitioners perceptions of mental illness

The majority of mental health problems are first seen to and treated by general practitioners (Verhaak, 1993). Only a small number of patients are referred to psychotherapists, psychiatrists or social workers (Verhaak, 1993). Usually only severe cases of mental illness or patients suffering from psychosis are referred (Verhaak, 1993). Furthermore, men and younger patients are more likely to be referred than women and elderly patients respectively (Verhaak, 1993). The characteristics of the general practitioner also influence the decision of referral (Verhaak, 1993). Furthermore, 35% of referrals are made because the patient is not responding to the treatment issued by the general practitioner (Verhaak, 1993).

Thus the doctor-patient relationship plays a crucial role in health care, and relationships are formed through effective communication (van den Brink-Muinen, et al., 2000). Research has shown that communication styles of general practitioners influence outcomes such as patient compliance, satisfaction, recognition of mental disorders, referral and prescription rates (Deveugele, Derese, & De Maeseneer, 2002; van den Brink-Muinen, et al., 2000). It is thus imperative that general practitioners take the time to listen to patients' complaints, problems and feelings. Communication styles might also be determined by social, personal

and cultural factors like sex, age, education and ethnicity of doctors and patients (Deveugele et al., 2002). The social context of each patient is an important factor that general practitioners need to be aware of as socioeconomic factors often influence patients overall health (van den Brink-Muinen, et al., 2000).

Furthermore, research has shown that the employment status of general practitioners will influence the amount of time spent with the patient (van den Brink-Muinen, et al., 2000).

Self-employed general practitioners tend to focus on maximising workload by seeing as many patients as possible due to obtaining a fee for every patient seen, whereas general practitioners who obtain a fixed salary, feel less time pressure and hence have longer consultations with patients (van den Brink-Muinen, et al., 2000). Thus salaried general practitioners spend more time with their patient, and take time to find out their patients history and family background (van den Brink-Muinen, et al., 2000)

As mentioned previously communication is vital in the doctor-patient relationship, however, the information that is provided to the doctor is often dependent on the society's existing norms and values (van den Brink-Muinen, et al., 2000). Females tend to communicate more about psychosocial issues then males, who concentrate on biomedical problems (van den Brink-Muinen, et al., 2000). Younger individuals also communicate more easily than older patients and educated patients communicate more effectively with their doctors due to them being on a similar intellectual level (van den Brink-Muinen, et al., 2000). Research has shown that female, part-time and younger general practitioners pay more attention to psychosocial problems (van den Brink-Muinen, et al., 2000). Furthermore, patients and practitioners from different cultural backgrounds will have varying beliefs about health care which could affect the relationship and communication pattern between the practitioner and patient (van den Brink-Muinen, et al., 2000). Cultural differences could also influence both the patients and the practitioners view on the cause and treatment of the condition (van den Brink-Muinen, et al., 2000).

A study was conducted to determine UK general practitioners attitudes to medically unexplained symptoms (MUS) which is also known as somatisation (Reid, Whooley, Crayford, & Hotopf, 2001). A sample of 400 GPs was surveyed using questionnaires and respondents' attitudes towards the cause and management of MUS were recorded (Reid et

al., 2001). Medically unexplained symptoms such as headache, back pain, abdominal pain and fatigue could be considered to be a manifestation of somatisation. Somatisation often implies an underlying psychological distress and is often as a result of psychosocial stress (Reid et al., 2001). Emotional, mental, or psychosocial problems are thus expressed through bodily or physical symptoms (Sue et al., 2006). The patient will hence present these symptoms to the general practitioner, whose role is to treat and manage these complaints (Reid et al., 2001). The study revealed that the majority of GP'S found patients with MUS difficult to treat and manage (Reid et al., 2001). GP's were concerned about misdiagnosis or undiagnosed physical illnesses (Reid et al., 2001). In the course of the study, GP's made additional comments. Their attitudes can be revealed by the following comments:

"*I would like to have enough courage to tell the MUS persons that nothing is wrong; you are wasting your time and my time. You must try to learn to live with your symptoms"* (Reid et al., 2001, p. 521).

"Multidisciplinary team approach with initial exclusion of physical/biochemical pathology. Cognitive behaviour therapy with support from all" (Reid et al., 2001, p. 521).

"Once physical illness is excluded, counselling is often very helpful in working out causes and how to manage patients and how to minimize over-investigation. The patients frequently remain just as unhappy but at least they are not investigated/treated inappropriately" (Reid et al., 2001, p. 521).

These comments show that some GP's were willing to work together to help the overall well-being of the patient whereas others were not interested in the patients' needs and had negative attitudes towards somatisation symptoms. Furthermore, GP's did acknowledge that they have a role to play in managing patients with MUS by supporting patients and reassuring them and providing counselling and appropriate psychological management (Reid et al., 2001). Other attitudes that were revealed included that GP's have no involvement with such patients, not too get too involved in the management, to prevent inappropriate investigation and to refer patients for further investigation (Reid et al., 2001). However, often patients emotional problems are not recognised by general practitioners and only their somatic symptoms are noted (Cape, 2001). Further studies (cf: Jackson,

Kroenke, & Chamberlain, 1999; Pill, Prior, & Wood, 2001) were also conducted to determine GP's attitudes towards mentally ill patients.

An earlier study was conducted in the UK to determine religious and ethnic influences on patient's beliefs about mental illness in relation to their GP (Cinnirella & Loewenthal, 1999). Participants from five different religious groups were interviewed to determine whether there was a link between religion and beliefs in terms of mental illness (Cinnirella & Loewenthal, 1999). Participants were 52 females from the general public. They were from the following religious and ethnic groups: Pakistani Muslim, Indian Hindu, Orthodox Jew, White Christian and Afro-Caribbean Christian. Furthermore, their religious beliefs were explored as a factor when interacting with general practitioners (Cinnirella & Loewenthal, 1999).

Participants were also unaware regarding the difference between psychiatrists, psychologists and psychotherapists (Cinnirella & Loewenthal, 1999). They therefore felt that the GP would be the first person that they would seek help from but were aware that the GP would probably refer them to someone else if they present with depressive or schizophrenic symptoms (Cinnirella & Loewenthal, 1999). Participants illustrated their reluctance to consult with medical professional if they have depressive symptoms (Cinnirella & Loewenthal, 1999). A recent study provides evidence for patients' reluctance. A study was conducted amongst Sri Lankan doctors and medical students to investigate their attitudes toward mental illness (Fernando et al., 2010). The sample consisted of 74 doctors and 574 medical students. The results demonstrated that depression was more stigmatised, among doctors and medical students, in Sri Lanka than the UK and this was explained in terms of pervasive cultural differences or the lack of public health interventions (Fernando et al., 2010).

Muslim participants elucidated that seeking help from health professional is considered a sign of weakness and will thus have unpleasant effects on one's reputation in the community. Hence, a participant revealed that Muslim people hide conditions like depression as they are afraid that people will not accept them and will laugh at them (Cinnirella & Loewenthal, 1999). Participants expressed fear of being labelled and losing their community reputation (Cinnirella & Loewenthal, 1999). Prejudice exists more amongst

the older generation as the younger members are more likely to accept mental illnesses (Cinnirella & Loewenthal, 1999). Black and Muslim participants explained that mental illness is considered taboo and the family reputation is of utmost importance (Cinnirella & Loewenthal, 1999). Additionally, Muslim participants exemplified their predicament when stating that they and their family will be ostracized if someone in the community finds out that they went to see a psychologist, psychotherapist or social worker (Cinnirella & Loewenthal, 1999). They went further on to explain that they will be labelled which will subsequently affect their confidence, reputation as well as the chances of their children finding partners and getting married (Cinnirella & Loewenthal, 1999). In addition to the fear of community stigma, participants explained that some Muslim families believe that family and personal problems should be kept inside the home and not be broadcasted to friends or professionals (Cinnirella & Loewenthal, 1999). Thus Muslim participants were reluctant to disclose private matters; especially those concerning mental illness (Cinnirella & Loewenthal, 1999).

Furthermore, GP's were perceived as always being too busy to talk and communicate with patients and to assist them in dealing with stressful situations or life events (Cinnirella & Loewenthal, 1999). GP's were not people that they could rely on if all one wanted were a good listener. There was thus a stereotype that although GP's were caring and philanthropic, they were over-worked, stressed and were most likely to prescribe drugs to treat mental illness (Cinnirella & Loewenthal, 1999).

In addition, participants acknowledged that the race or ethnic identity and religious belief system of the health professional (general practitioner or psychiatrists) will affect their attitudes (Cinnirella & Loewenthal, 1999). Ninety two percent of the sample felt that it would be favourable to seek help from a general practitioner or health professional of the same race and/or religion. Participants found that a person of the same race or religion will be able to relate to them and better understand them as they share the same cultural and religious beliefs (Cinnirella & Loewenthal, 1999). Participants felt that general practitioners from another race or religious group will not be able to identify with them and will not fully grasp the extent of the problem. This feeling was shared among all of the groups. On the contrary, there was also fear about having a health professional from the same religion or ethnic group. Participants were concerned about confidentiality as the health professional

might form part of the same community and hence the news of the consultation could be spread in the community which will result in shame and embarrassment. All of the Muslim participants articulated this fear but at the same time they had indicated that they would prefer a professional from the same race and religion (Cinnirella & Loewenthal, 1999). Muslim participants stated that their depression was different from that of a white person as their family background and circumstances were different. Furthermore, Muslim participants felt that a practitioner from the same religion could be more useful as they could recommend certain prayers (readings from the Quran) that would be beneficial in treating the disorder (Cinnirella & Loewenthal, 1999).

Hindu participants also preferred professionals from the same religion due to shared cultural understanding and identity (Cinnirella & Loewenthal, 1999). Thus all the non-white groups expressed fear of being misunderstood by professionals that do not form part of the same group as them (Cinnirella & Loewenthal, 1999).

1.10 Conclusion

"A mental illness is an illness of the mind and cannot be understood without understanding the ideas, habits and predispositions — the idiosyncratic cultural trappings — of the mind that is its host" (Watters, 2010, p. 3). It is thus vital to consider the cultural background of each person as culture influences the perception and definition of mental illness (Watters, 2010). Western definitions and classification systems many not be universal and may not encompass cultural traditions or behaviours. Furthermore, various cultures may have different viewpoints of what constitutes as a mental illness. Non-western cultures often have a different way of thinking about mental illness and are influenced by their cultural beliefs, norms and values. This impacts tremendously on attitudes towards mentally ill patients and mental illness on the whole. General practitioners have a duty to serve the community and treat patients to the best of their ability. It is thus imperative that their perceptions of mental illness be explored as practitioners will deal with patients from various cultures and religions and will therefore need to respect the diversity of patients and not influence patients negatively. South Africa is a diverse country that includes many races, ethnic groups, cultures and traditions. It is thus advisable that Western belief systems are not followed blindly and cultural considerations should be taken into account. The

current study aims to determine the Muslim general practitioners perceptions of mental illness together with the role that Islam plays in their perceptions of mental illness.

Chapter 2: Methods

2.1 Aims of the study

The study aims to explore perceptions of mental illness among Muslim general practitioners of Indo-Pak ancestry who are practising in Lenasia, Johannesburg. The study aims to explore general perceptions amongst GP's but focuses on Muslim GP's to get a more nuanced understanding of the role of religion, particularly Islam, in understanding mental illness.

2.2. Rationale

General practitioners (GP's) are often the first step when seeking medical treatment and healthcare advice as they are often the family physician and the community doctor. They are thus responsible for treating all members of the community and are responsible for providing comprehensive care (Bentzen, et al., 1991). The general practitioner functions as a generalist who accepts everyone seeking care and does not limit access to services based on sex, age, and/or diagnosis (Bentzen, et al., 1991). Furthermore, the general practitioner is required to provide care irrespective of race, culture or social class (Bentzen, et al., 1991). In addition, the GP is required to identify all the problems that the patient presents and this includes acute problems, chronic illness, psychological problems and undifferentiated problems (Bentzen, et al., 1991). GP's have hence been considered to be the "gatekeepers" to the healthcare system and their critical role extends to providing quality care to mentally ill patients (Fernando et al., 2010). According to Dixon et al. (2008) 90% of patients with mental health problems use primary care services and approximately a third of GP's time is spent on mental health conditions. However research has indicated that many psychiatric patients have experienced discrimination at the hands of healthcare professionals (Fernando et al., 2010) Hence it is important to examine GP's attitudes towards mental illness in the South African context.

Furthermore, doctors tend to follow a medical model and social, emotional, psychological and cultural factors are sometimes unintentionally overlooked. Mental disorders cannot be separated from physical disorders and somatised psychiatric illnesses may be merged with

general medical illnesses and treated as such (Ng, 1997). Somatisation is also common in certain societies primarily due to the stigma associated with having a mental illness (Cape, 2001). According to Reid et al. (2001) patients often present with somatic complaints such as headaches, stomach-aches and other pain related symptoms. It is therefore the duty of the GP to determine whether a true organic condition exists or if somatic symptoms are masking a psychological or psychiatric condition. Thus individuals with a mental ailment tend to displace their emotional symptoms and they are often demonstrated through physical and somatised symptoms. GP's are often unaware of emotional symptoms as patients are reluctant to disclose such symptoms; subsequently, GP's tend to treat the presenting and apparent problem. Thus according to Pill, Prior and Wood (2001) 50% of cases, regarding symptoms of depression and anxiety, are undetected in the GP's surgery. Undetected psychiatric disorders result in personal and social costs for the patient (Hugo, Boshoff, & Traut, 2003). This is a serious problem in South Africa as undetected mental illness may lead to the loss of employment, criminal activity, substance abuse, suicide, homelessness, disruption of family life and stigma towards the patient and the family (Hugo et al., 2003).

Stigma has been found to be common in non-Western societies, such as Chinese, Indian and Islamic societies (Fernando et al., 2010; Ng, 1997). Information presented by Laher and Khan (2011) indicates that a similar situation exists in South Africa where stigma is attached to mental illness amongst the Muslim people of Indian origin. Negative attitudes which are formed by prejudice and misinformation leads to stigma developing (Satorius, 2007). Hence GP's perceptions of mental illness will be key as they are considered imperative members of the community. Dixon et al. (2008) claimed that medical practitioners had very similar views like the general population regarding mental illness. These perceptions were not always positive. This research thus chose to focus on GP's due to their significant contribution and service to the majority of the community.

As mentioned previously, GP's are family practitioners who form an important part of a community. Thus they may be influenced by their own cultural and religious beliefs or of those held by the community. According to Ng (1997) culture often can influence mental illness in terms of the perception, conception, experience of symptoms, classification, treatment, recognition, labelling and the course of mental illness. Furthermore, in these

societies supernatural, religious, magical and moralistic approaches to mental illness exist (Ally & Laher, 2008; Laher & Khan, 2011; Ng, 1997). Spiritual punishment or sorcery can also be said to be a cause of illness (Ally & Laher, 2008; Laher & Khan, 2011; Ng, 1997). Muslim doctors by virtue of having trained in a Western paradigm but having roots in an Indian Muslim household and community are well positioned to provide input on mental illness both from their perspective as well as their clients' positions.

Thus religion and culture of both the GP and their patients play a vital role in the manner in which mental illness us experienced, understood and interpreted. According to Hugo et al. (2003) there has been little research conducted regarding the attitudes towards mental illness in the South African community. South Africa has a diverse population consisting of various races, cultures and religions. Hence healthcare professionals need to be aware of the different beliefs and practices in order to provide culturally appropriate care. Ignorance regarding cultural disorders will lead to misdiagnosis and well as incorrect diagnosis, labelling and treatment (Hugo et al., 2003). It is thus important to determine general practitioners perceptions of mental illness and the manner in which it may influence patient care. The study thus concentrates on one community in South Africa which is rich in cultural and religious beliefs.

Furthermore, the study intends to focus specifically on South African Muslim GP's from Indo-Pak ancestry as Muslim GP's from Middle-Eastern, European, Arab or African ancestry, although Muslim, will have different cultural customs, traditions and beliefs as they are influenced by their country of origin. Hence, their perceptions of health and illness might differ to those GP's from Indo-Pak ancestry who have originated from India and thus have customs and practices from the Indian culture. Patients tend to often be Indian and Muslim and hence patients may have the same religious beliefs as their GP. General practitioners will therefore be able to relate to their patients due to shared cultural and religious understanding and identity. Psychiatric conditions can thus be assessed by keeping both the Western perspective and the religious/cultural perspective in mind when GP's are treating patients.

Aside from the practical contributions that this study will make, it will also contribute theoretically to a growing body of literature on cross-cultural perceptions of mental illness.

By virtue of interviewing GP's it also has the potential to cross-over the allied health professions of psychology and medicine and can contribute to the development of theory in both areas.

Thus this study seeks to explore perceptions of mental illness in a sample of Muslim GP's whose families were/are of Indo-Pak origin , who practice in the Lenasia area and whose patients are predominantly Muslim of Indo-Pak ancestry.

2.3 Research questions

How do Muslim general practitioners perceive mental illness?

What role does religion (Islam) and culture (Indian) appear to play in GP's perceptions of mental illness?

What are Muslim GP's attitudes towards traditional healers and spiritual healing practices?

2.4 Research design

A qualitative research design was utilized. The purpose of such a design is to obtain an in-depth and comprehensive understanding of the research topic. Furthermore qualitative research aims to report participant's views in a particular context (Struwig & Stead, 2001). Qualitative research thus strives to understand the viewpoints of the participants as participants are able to express subjectivity when answering questions (Struwig & Stead, 2001). In addition, data is not presented in a reductionistic, static or decontextualised manner. Participants' thoughts, feelings and behaviours are respected and acknowledged (Struwig & Stead, 2001).

2.5 Participants

A non-probability, convenience sample was used. A sample of ten Muslim general practitioners of Indo-Pak ancestry in private practice from the Lenasia area were interviewed for this research study. Participants were selected from this community as Lenasia has the biggest Muslim community in the Gauteng region. Details were obtained from community members regarding GP's that were most frequently visited. Thus GP's that were favoured and well established in the community were interviewed. Additionally, the first few GP's that were interviewed referred me to their colleagues who were practicing in the area. Thus elements of snowballing sampling were used in order to obtain participants.

GP's were contacted telephonically and the first five female and five male GP's that agreed to participate in the study, were interviewed. Thus a balanced sample was obtained in terms of gender due to female patients often visiting female practitioners and similarly, male patients visiting male GP's. In addition, I obtained a sample that consisted of both recently graduated as well as experienced GP's as their training, perceptions and views differed.

In terms of the GP's work experience, three (two males, one female) of the participants were practising as GP's in private practice for eight years and two participants (one male, one female) were practising for 11 years. Four of the participants were very well established and had been practising for a considerable length of time. Thus two female participants were practising as GP's for 28 and 32 years respectively whereas two male participants were practising for 30 and 40 years respectively. One participant was recently qualified and she had been practising for one and a half years.

Prior to working as a GP, participants had various levels of experience. Seven participants (four males, three females) worked in provincial and government hospitals and clinics for a number of years before practising solely as GP's. One male participant was a pharmacist for six years before studying medicine and thereafter working in the field of sports medicine for a period of time. One female participant worked as a GP but in a colleague's practice and another female participant worked as a locum doctor in another GP's practice for a year as well as spent four years in child practice in different clinics.

Regarding the types of patients GP's consulted with, four of the female participants noted that they see mostly woman, children and babies. Additionally, the four female participants also consulted with predominantly Indian Muslim patients, but other Indian patients were seen occasionally, like Hindus, Tamils and Christians. However, one female participant who did not have her own private practice, but worked in conjunction with others GP's in a private medical practice, consulted with both male and female patients who were predominantly Indian (50% Muslim, 50% Hindu) but she also consulted with Muslim black patients and patients from other races and religions.

All of the male participants had a mixed group of patients comprising of both male and female (adults and kids) and patients from different races and religions. However, four of

the participants claimed that the majority of patients they consulted with were Indian. Indians were comprised of Muslims, Hindu's, Tamils and Christians. Black patients were also seen. However, one participant reported to see a majority of black patients (60%) and an equal amount of Indian and Coloured patients. White patients were very rarely seen.

The pathologies that patients presented with were diverse and considered to be more medical or organic conditions. Male participants noted that chronic conditions like diabetes and hypertension were often seen as well flu's and upper respiratory infections. In terms of the presentation of mental illness, two participants reported that they hardly seen patients with mental illnesses (less than 1%). Another participant concurred and stated that mental conditions were seen less than 5%. However, two participants both acknowledged that 10% of their patients had a mental condition, however, if one was considering co-morbid conditions, than 30-35% of patients had mental conditions. All of the male participants noted that the predominant mental problems that presented were depression, anxiety and stress related conditions. Mood disorders and bi-polar were also seen and occasionally schizophrenia.

Female participants reported that they mostly encountered patients who had gynaecological related conditions. All of the participants agreed that they mostly seen female related conditions as well as paediatrics. However, flu's, upper respiratory tract infections and chronic diseases were also common. The percentage of mental conditions that were seen varied between 5%– 40%. One participant reported that she only seen about 2% of mental conditions. The predominant mental conditions were once again depression, anxiety, stress related conditions, PTSD and bi-polar.

2.6 Instruments

Semi-structured interviews with primarily open-ended questions were conducted. The interviews were an average of 45 minutes in length. The schedule was developed in conjunction with my supervisor based on the material explored in the literature review[1] as well as our collective experience as members of the community in which the research was conducted. Furthermore four interview schedules from previous studies were consulted (Ally, 2008; Ally & Laher, 2008; Padayachee, 2010). The interview schedule consisted of 37

[1] See Chapter 1

questions[2]. These were subdivided into five sections, namely contextual questions, general practitioners perceptions of mental illness, the understanding of religion and culture, questions on the treatment of mental illness and spiritual illness. The interview schedule was piloted on two Muslim GP's (from the JHB areas) and changes were made accordingly. It was also read by two lecturers at the University of the Witwatersrand to determine if the questions were suitable and appropriate. Following the recommendations from the pilot, the schedule was revised and thereafter utilized in the study.

2.7 Procedure

A list of GP's and their contact details was derived from the Lenasia community in Johannesburg as discussed in the sampling section. Participants were contacted telephonically. They were informed regarding the nature and purpose of the study. Participants were provided with information sheets, consent forms for both the interviews as well as for the recording of the interviews[3]. The interviews were conducted with participants who agreed to be involved in the study. I arranged a convenient time and place to conduct the interview with participants. The procedure was explained verbally to the participants' and both verbal and signed consent was sought[4]. All interviews were audio recorded and then transcribed with the participants consent.

2.8 Data analysis

Thematic content analysis was used in order to analyse the data. Thematic content analysis is considered to be an easily accessible and flexible method when analysing qualitative data (Braun & Clarke, 2006). It aims to determine themes or patterns in the data (Braun & Clarke, 2006). According to Braun and Clarke (2006), thematic content analysis involves six steps. The first step involves the reading and transcribing of the data. Secondly, initial codes were generated and thereafter codes were assembled into potential themes. The fourth step entailed the generation of a thematic map. The fifth step required each theme to be defined and named. The final step was the production of a report (Braun & Clarke, 2006). I have followed these guidelines by Braun and Clarke (2006) when conducting the thematic content analysis on the transcribed interview material.

[2] See Appendix D for interview schedule
[3] See Appendices A, B and C
[4] See Appendix B and C

2.9 Ethical considerations

Ethics clearance was obtained from the Human Research Ethics Committee (HREC Non-Medical) of the University of the Witwatersrand (Protocol number MCLIN/11/004 IH). Before conducting the interview, participants were informed both verbally and using an informed consent sheet that participation in the study is voluntary. Participants were informed that they have the option of withdrawing from the study at any time without any negative consequences. Participants were also informed that they may choose not to answer questions if they are uncomfortable with them and may withdraw their responses at any time. Although anonymity could not be guaranteed confidentiality was ensured in that no identifying information was used in the transcripts or this research report. Participants were referred to by a pseudonym (e.g. Participant A) in the transcripts and the research report. Tapes and transcripts of the interview were only accessible to my supervisor and I. The interview recordings and transcriptions will be kept in a locked cupboard at the university for a period of three years, thereafter they will be destroyed. Participants will be notified regarding the results of the study in the form of a one page summary sheet which will be made available on request. Participants were informed that they are welcome to contact me or my supervisor with regards to any further queries or questions. The contact details appeared on the informed consent sheet which participants were requested to keep when they were asked to sign the informed consent forms. Two informed consent forms[5] were given to all participants before the interview. The consent forms were presented with the informed consent cover letter. The first form required consent for the interview to be administered and the second form required consent for the interview to be recorded. These were collected from the participant before the interview. It was noted that that the research may be presented at a local or international conference and published in a journal and/or book chapter. There were no foreseeable benefits or risks in participating in this study and this was clarified for participants in the information sheets and consent forms.

2.10 Self-reflexivity

Reflexivity is often seen as a method of validity in qualitative research. Researchers are encouraged to be aware of the manner in which their personal histories can influence their listening (of participants) and writing (Pillow, 2003). If reflexivity is utilized in the research

[5] See Appendices B and C

process, more 'accurate' and 'valid' research will be produced. Reflexivity can in a way legitimize the research (Pillow, 2003).

Therefore with regards to the present research, the study aims to explore Muslim general practitioners perceptions of mental illness. It is however, important to note that I am an Indian Muslim and thus my views, beliefs, background, past experience and perceptions can influence the research process. It was thus imperative that I was continually aware of my position in this study and should be able to view all writing and listening reflexively. Furthermore, I attempted to respect participants own religious beliefs and I was aware of not imposing any expectations or my views on the participants. Although participants were all Muslim, they may have different spiritual as well as religious beliefs and hence I tried to remain neutral and not let it interfere with the interview process. I also abstained from giving my own opinion however this may nevertheless raise concerns of bias. I also refrained from probing and asking too many questions as I feared that questions would stem from my own biases and motives and may thus influence participants' responses. However, as a clinical psychology student, I may have focused on addressing issues related to psychology in the community. In addition, the interpretation and analyses of data were not distorted and I was consciously aware of the factors that could influence the research process.

2.11 Conclusion

The motivation for the study was discussed together with its possible contributory role in further research. A qualitative study, with a semi-structured interview, was carried out by complying with all of the ethical procedures. A qualitative design was used as it proved useful in obtaining in-depth information to explore the perceptions of Muslim GP's with regards to mental illness and the role of religion in these perceptions. The sample was discussed together with the method that was utilized in obtaining the sample. GP's Due to the fact that I am an Indian Muslim, I may have had certain biases which have been noted. This study was relevant and can contribute to current and future understanding and knowledge. The results that were obtained will be discussed in the next chapter.

Chapter 3: Results

3.1 Introduction

Braun and Clark's (2006) method of thematic content analysis was used to analyse the data. The analysis resulted in eight themes, namely GP's understanding of mental illness; aetiology of mental illness as understood by GP's; culture and mental illness; the assimilated identity; Islamic beliefs and values regarding mental illness; GP's beliefs regarding spiritual illness; collaboration and referral to other healthcare professionals and influential factors affecting GP's. The results for each of these themes, as well as their subthemes are presented below.

3.2 GP's understanding of mental illness

GP's provided various definitions of a mental illness. Four of the participants (D, E, H and J) were of the opinion that mental illness can be defined as anything affecting **"mental well-being"**; disturbing **"the psyche"** or an **"illness that affects the mind"** (Participant H). Two participants (A and C) defined it in terms of the conditions that are considered to fall under mental illness, namely depression, anxiety, bi-polar disorders, psychosis, dementia, delirium and schizophrenia. Participant G defined mental illness as **"anything that impairs their behaviour, their general, general ideas of life, basically day to day functioning, it impairs their day to day functioning".** In relation to this, Participant F explained mental illness **as "limiting or debilitating, where it affects a person's cognitive function; his ability to concentrate, to work, to sleep".** However, Participant B explained mental illness as **"someone who is psychotic"** whereas Participant I considered mental illness in terms of the DSM-IV-TR classification.

3.3 Aetiology of mental illness as understood by GP's

The majority of GP's (seven of the ten interviewed) attributed mental illness to stressful lifestyles, relationships and factors related to work and finance. This is highlighted by **Participant A** as she states that it's **"our lifestyles of today, if I look at it things are so hard for our patients; work wise, marriages, financial. I think running up and down, things are just busy, it's a very busy, tough world out there. And it is contributing to our patient's mental status".** Participant G agreed that **"stresses in life"** often lead to patient's

depression and their relationship status can be a precipitating factor. Participant D also concurred and mentioned that **"it's the lifestyle that they lead and then sometimes it's the environmental factors".** Participant H described environmental factors in terms of home environments' and social circumstances which included marital status (divorced/widowed), difficulties in relationships with spouses and children as well the lack of employment.

According to Participant E, **"there are very few which are environmentally related"** and like stress disorders, they result from exposure. He thus acknowledged that environmental factors do have a role in mental illness but attributed mental illness mainly to an **"organic basis"** and to a **"genetic predisposition, they built in inborn errors, probably of metabolism, probably of genetic aberrations".** He continued to explain that disorders such as schizophrenia and obsessive-compulsive tend to have a genetic basis **"where the patient has no control over their disease, they didn't ask for it, it is not due to the environment, it's something that is just built in and will manifest at some stage in the life".** Similarly, Participant F also attributed mental illness to one's **"genetic predisposition"** but it is only one of the factors that could contribute to a mental condition. He noted that environmental factors such as, family dynamics, the transformation of society and people's lifestyle choices are further influential factors. He further stated that **"we are in an age now where what we have to deal with is overachiever's syndrome***".*

Additionally, Participant J was of the opinion that there are **"various causes that can give you mental illness".** Participant I supported this by stating that it **"depends on the circumstances"** but mentioned that a **"chemical imbalance"** as well as a **"medical problem for instance low thyroid can give you depression, high thyroid can give you mania**". Participant B differed entirely from the rest of the participants and stated that **"people of the lower social economical population would have more mental disorders than the more affluent people".**

3.4 Culture and mental illness

Participants discussed the role of culture in terms of mental illness and the following sub-themes arose, namely, the aspect of secrecy and concealment; stigma and somatisation.

3. 4.1 Secrecy and concealment

All of the GP's were of the opinion that patients are unwilling to disclose their symptoms and that mental illness is often hidden. Participant F discussed mental illness as being an area that both patients and the Indian community **"shy away from".** Participant J similarly stated that **"Indian people shy away from mental illness and try and cover it up".** She also found that **"Indians as a whole"** tend to **"hide the thing"** and not specifically Muslims. Participant D postulated that **"the Muslim person still, I still feel, that they wouldn't easily tell you that she is mentally deranged if she is mentally deranged. And they would still keep it aside, and I think the same goes for the other Indians as well".**

This was further substantiated by Participant E who reported that **"Indian patients in general and patients tend to hide mental illnesses, families tend to hide it, parents tend to hide it, and they try to seek outside resources before they consult anybody"**. Participant I similarly claimed that the **"family will hide it"** if any of their family members suffered from a mental condition. Participant I supported this by stating **"they don't accept that they mad, they don't accept that they have a problem, seriously, they don't accept it, because a majority of the time they won't even do anything about it especially amongst our Indians, not Muslims per se but Indians themselves, they would rather suffer, or the family would hide it and if the person has a problem they will leave it alone".**

Additionally, Participant B and C respectively expressed that **"among the Muslims you have to force it out"** as **"Muslims are very secretive".** In support of this, Participant E reported that **"Muslims by and large, Indians by and large, Muslims specifically are very reluctant to vent and open their hearts to strangers and Indians in general we tend to be more orthodox and more closed".** Participant H highlighted that **"Muslim females were just a bit more conservative and would be more hesitant to disclose and you would have to tease it out from them. You know, kind of like fish it out from them".** Participant B agreed that Muslim women **"don't want to like discuss it in full".**

Participant A noted that culture plays an influential role in patient's disclosure of symptoms. She gave the example of 'Indian housewives' as well as a Black patient who both had difficulty in disclosing to their family that they are suffering from depression. Additionally, Participant F posits that due to our cultural background, illness and disabilities were kept

hidden and treatment was not sought for people with conditions like, for example, Down syndrome or cerebral palsy. Thus **"initially in our community it** (mental illness) **was probably something that was hidden".** Furthermore, Participant G was of the opinion that "**I think Muslims are a bit more oblivious to what is happening around them, we tend to, to, to push it under the carpets, so to speak. It happens with other population groups with certain other conditions as well but I think with mental illness we are worse off than everybody else in our understanding about it".** He further indicated that **"patients' understanding is very limiting because of the population group they come from or the religious background they come from".** Hence **"a Muslim patient won't disclose everything, they always keep something behind".**

3.4.2 Stigma

The majority of participants (seven of the ten) specifically stated that mental illness is an area that is considered to be taboo; and stigma is attached to mental conditions by society. To elaborate Participant G stated that, **"it is because if you have a mental illness people look at you like, generally in lay man's terms, you cuckoo, off the bend, so to speak; you, you, taken out in society like you, you are different from everybody else. When people have mental illness, people look at them differently, I mean across the board I think mental illness is looked at like something which is taboo and because you you have, you have some chemical disorder in your brain or whatever there is, they look at you and say 'no, you don't belong in society' so to speak".** In addition, Participant G was of the opinion that mental illness is often wrongly understood and he thus felt that **"even doctors look at people with mental illness differently".** He elaborated that **"younger doctors are a bit more ok with mental illness"** than **"older doctors"** as mental illness was not heard of in the past. Participant C also posited that **"with our Indian population; it's a misconception of how they interpret depression. In the old days if you said a patient has depression, they would say the patient is cuckoo's".** Participant A stated that patients feel that **"everyone is going to think I'm mad. That's the word they use, 'mad' ".**

In support of this, Participant J claimed that **"if you have a mental illness it's almost as if there is a little bit of a stigma attached, there is something wrong with you mentally".** She further said that **"society I think is not quite accepting of that as such. So when it is a mental illness, it's like the mother would feel ashamed to say my daughter has got**

bipolar. You understand. So there is a little bit, not a little bit, there is quite a bit of stigma attached to it". Participant F also confirmed that mental conditions were hidden due to the stigma that existed initially in the community. However although he acknowledged that perceptions have begun to shift, he was of the opinion that stigma continues to be an influential factor in both patients and GP's perceptions. Participant H also emphasized that people are either not aware of psychological/mental conditions or they deny it. She hence related that parents deny that their children may have a psychological problem and thus increased awareness of mental conditions is needed in the community.

Participant C further mentioned that **"people are anti-mental illness".** Participant A concurred that patients are often embarrassed to take antidepressants due to the stigma of having a mental condition. Additionally, Participant C postulated that she **"feel(s) that Indian population look at it as a weakness**". She supported this by saying that **"Indian people will say, like, if you say I'm feeling depressed they'd say something is wrong with you".** This also affects their treatment as **"you tell them you are depressed and you need to go onto an anti-depressants for 6 months, and most of them would say no, we don't want it".**

3.4.3 Somatisation

The majority of GP's (9 of the 10) acknowledged that patients present with somatic complaints. Participant E proposed that GP's would need to **"read the signs"** as patients **"disguise their presentation"**. All of the GP's reported that although depression was the most common condition; patients don't present with depression, **"they won't come and say I am depressed"** (Participant I). Participant C supported this notion and claimed that patients come in expressing that **"my stomach is sore, my head is sore, I'm not sleeping. They won't say I am depressed".** Thus, patients **"tend to present with physical symptoms"** (Participant E) and would thus have complaints of feeling **"run down, can't concentrate on the work, loss of appetite"** (Participant B). **"A lot of them complain about headaches for no reason"** (Participant F), **"decrease appetite, they have insomnia, loss of interest in things that they normally do, what they would love doing – they normally do; withdrawal from family and social life as well."** (Participant G). Thus patients **"will complain of somatic symptoms even though the real complaints may be non somatic"** (Participant E).

Additionally, Participant D confirmed that patients **"complain about a stomach ache or you know, a gynaecological disorder, whereas there is nothing".**

A large number of participants (7 of 10) reported that the main problem patients present with is their changes in sleep, appetite, energy and mood. Participant F elaborated that **"If somebody comes to you, he won't say 'you know doctor, I'm just feeling down' he'll say 'doctor, I've just got no energy' and he'll come to you and say, 'doctor, I've just been having trouble sleeping' or he'll report to you that 'I'm not enjoying work anymore' and 'I'm not enjoying my kids anymore".** Participant A concurred as she reported that her patients express difficulty and state **"I'm not sleeping at night, I'm not eating, I'm feeling low, and I'm feeling moody".**

Three participants (A, G & H) postulated that patients often present with symptoms that are **"very vague".** Participant H elaborated that patients often complain of having **"pain in my neck, pain in my back and multiple symptoms".** Participant G confirmed that patients **"would present with organic symptoms"** but that their **"symptoms are just different".** Participant I also alluded to somatisation as he found that when one cannot find a reason for the symptoms, the symptoms may be due to the stress of a non-medically related problem for example, a patients financial situation.

3.5 The assimilated identity

All of the participants noted that culture or religion or both factors have an influential role in GP's, patients, and the community's perceptions of mental and spiritual illness. Religion and culture would thus form the backbone of one's identity. GP's and patients identities are therefore multifaceted as it incorporates the Indian heritage, Islamic faith as well as one's South African nationality. This was best supported by Participant E who acknowledged that **"we have drawn a lot, we come from India and we brought a lot of Indian culture with us even though we have a Muslim religion, so the Islamic faith is very specific whereas Indian culture is drawn from the areas that our forefathers came from**". Participant G was of a similar opinion, regarding the belief system of mental and spiritual illness, as he stated **"I think it's more religious than cultural. It's a combination of both, I mean if you take us Indians for example, I mean, if you take our ideas as Muslim and Indian there is a lot of Indian ways in us. Like if you compare us to the Hindu population itself, as Muslims, we**

have lots of Hindu traditions in us, compared to... So I would think it's a combination of both".

Participant I agreed with this but also felt that **"there is not so much cultural left there so it has simmered down quite a bit, but some cultural things are there, the overlap from India and where else they coming from, but it's not as much as it was before, old people still reinforce it, the newer generation don't really look at cultural, the religious yeah, whatever is still there, will perpetuate, and will continue from there."** However, Participant F posited that culture was more influential than religion and hence stated that **"culture plays a big role"** as **"in some cultures you can't be depressed... in some cultures I think it is spoken about more openly. In others it's probably suppressed."** He further mentioned that **"we get caught up between religion and culture. From a cultural point of view definitely especially from an Indo-Pak mentality, a lot of it we have sort of kept hidden away".**

Additionally, the influential role of one's background and upbringing in the understanding of mental illness was discussed which reinforced the importance of noting one's heritage. This is demonstrated by Participant E who acknowledged that **"we tend to draw on our heritage, and I suppose a lot of our influences are built into our systems, so you tend to react accordingly, and I think I acknowledge that I am Indian, I do have Indian tendencies so a lot of that would impact on my behaviour. But I'm not acutely aware of it as such; I would like to believe that I am not influenced, but I know that everything we do is influenced by our upbringing".** Participant D emphasized the importance of one's background, but on the other hand felt that she was not influenced by any cultural factors, and only by religious factors. On the contrary, Participant H reported that the classification of mental and spiritual illness is **"more cultural. I think a lot has to do with culture. A lot has to do with a person's upbringing. How much culture has actually been inculcated into them. I don't think it is totally religiously based. No".** Participant A was also of the opinion that one's culture has a greater influence than one's religion as **"people's cultures actually influence what they do a lot".** She lastly added that it's **"our South African culture"** that is not open to the idea of mental illness.

3.6 Islamic beliefs and values regarding mental illness

The role that religion plays regarding perceptions of mental illness, in GP's practices as well as among their patients, was brought to light by participants. The interviews revealed the importance of prayer, having faith (imaan), believing the will of God (Taqdeer/predestination) and using religion as a coping mechanism and hence a mode of treatment.

3.6.1 The Islamic perspective regarding mental illness

The majority of participants (n=8) agreed that mental illness is acknowledged by Islam but society and the Indian community/population have a negative perception of mental illness. Participant C substantiated this by stating that **"Islamically it's not that there isn't mental illness, there is. It's just that generally with our Indian population; it's a misconception of how they interpret depression. Indian people will say, like, if you say I'm feeling depressed they'd say something is wrong with you"**. Participant J said that **"Islam accepts that it is in an illness"** when asked about the Islamic view regarding mental illness. Similarly, Participant H doesn't **"think that Islam per se, stigmatizes mental illness".** Participant A was of the opinion that **"Islam contributes in a positive way, I think Islam actually deals with it very well".** Participant A further mentioned that being Muslim provides support, understanding and prevention of harmful conditions like alcoholism.

On the contrary, Participant G seemed ambivalent about Islam's perspective regarding mental illness. He stated **"I think Islam itself doesn't believe in mental illness. I'm not sure about it but, I mean, there is, there is certain dua's you can get for depression and stuff like that. There is some Islamic connotation to depression".** Participant I also stated that **"I don't know what's the Islamic concept of mental illness**". However, Participant B was of the opinion that **"being Indian Muslim your perception is, you don't get really severe mental problems amongst Indians as such, there wasn't but now of course there is an increase. You know people, being a Muslim; I don't think there is much difference you know".**

However Participant E differed in opinion and believed that as **"scientists you cannot base your diagnosis on religious ethos".** He however acknowledged that even though religion does not play an influential role in his understanding; **"it does impact on your**

understanding, or your perception or management of any kind of mental illness because mental illness presents in an abstract form". In addition, **"As far as religion is concerned, it would depend on the perspective, a lot of people tend to see it positively and the community sees it negatively".**

3.6.2 Faith (Imaan)

The firm belief in Allah and having faith that the Almighty is the provider, curer and giver of all good and bad was highlighted by 50% of the Participants (A, B, C, D, I). Participant B posited that Muslims **"perceptions of illness would be different If you believe that Allah is a giver and Allah is a taker; as Muslims you are supposed to believe it and be able to cope much better with our Imaan and believe and turn everything to Allah and must pray to Allah and you must ask for Allah's help, and you don't have to go ; and not let it become a serious illness".** Furthermore, he stated that **"because as Muslims we have a lot of Imaan and believe that a lot of things are from Allah so I think Muslims take it a little bit better although it depends on the Imaan, I'm not saying some people never got Imaan, but it depends what the level of your Imaan is and how much deen you know, so if you know a little more deen and if you believe in Allah then I suppose you can cope with things much better".** He thus felt that Muslims will be able to cope better as **"with Muslims our Imaan is supposed to be much stronger so, of course, when you talking about mental illness you are born mentally defected, then that's different that's from Allah. When you talk about mental illness when its brought by the person themselves (like depression, anxiety, all that) then of course, being Muslim and having Imaan we are supposed to cope with it better than the other groups. I mean we are supposed to but unfortunately we don't".** Participant D also alluded to the importance of believing in Allah and being **"answerable to Allah one day".** She further emphasized the importance of a **"good Islamic lifestyle"** and mentioned that **"if you really think Islamically then you won't think like that. You will always come back and say; you know 'there is something that I'm not doing right in my life that I've got to think that these things are coming on me".** Participant I felt that the **"person's beliefs"** play a role in the understanding of mental illness and the person may believe "**all illnesses are from Allah Ta'allah and the thing is Allah Ta'allah causes certain things to happen".** Participant A also found that having faith helps Muslims to deal with illnesses in a positive way.

3.6.3 Predestination (Taqdeer)

A number of participants (n = 5) (B, C, D E, I) expressed that fate or predestination played an important role in the accepting and understanding of all illnesses. Thus one's belief that it was Allah's will helps patients to make sense of their illnesses. Participant C articulated that **"we might experience difficulties or like I mentioned: trials, tribulations, deaths, losses; these are mainly just part of tests and they are part of your destiny or taqdeer and I think it's also a way of us turning to God to ask Him for help and say 'help me through whatever you have put for me as this is just a test' ".** Participant D also acknowledged that at times one has to believe **"that it's just matter of taqdeer. You've always got, you know, Allah's put it out for me, fate, taqdeer".** In conjunction with this, Participant E mentioned that Muslims specifically tend to **"to accept God's will and that in itself is part of the management and acceptance, tolerance, and reputation of denial, helps towards relieving the problems, so Islam does teach that more so than other religions and the Islamic community, Muslims in general tend to have greater belief in that perspective unlike the other groups; so we are taught and fed, and nurtured in that sense, it makes it a lot more easy, and that in itself, religion itself is part of the psychological management of mental illnesses".**

3.6.4 Incorporating religion into treatment

Although participants did not rely solely on religion, it was still seen that in fact, religion does play a role in GP's perceptions as well as in their understanding of mental illness. All of the participants acknowledged religion as an influential factor but differed in whether they would recommend religious practices to their patients.

Participant A stated that 50% of her understanding of mental illness is influenced by her being Muslim as **"I use everything I know to try and guide my patients. So definitely, it does influence my way, in general, my way of treating my patients".** Additionally, she **"would recommend that patients pray a lot and do lots of zikr and lift up their hands and ask Allah. I always say to the most depressed patients, I always say: "at a time when you are feeling your lowest and it feels even like you have no hope, to sit down on your pray mat and say, everyone else around you is praying for you and somehow or other Allah will hear someone and answer their prayer. My religion does influence my way of treating".**

With regards to possible treatment, Participant B stated that **"If there is a slight problem, you tell them to turn to Allah and if they're not reading the Namaz then tell them to read the Namaz, do this. But otherwise, medication wise there is nothing that is Islamic or non-Islamic of course. So as far as the deen (religion) is concerned, from an Islamic point of view, tell the person, you ask him how is he with his deen. If he's paban or regular with his deen, salaah, fine then you tell him to continue with this and then you help him with medication and if he's not then you tell him this thing".** Participant I similarly reported that **"whatever patient I see, whether it's a physical illness, mental illness, you have to tell all of them to turn towards Allah Ta'allah, give out sadaqah and read two rakaats nafl namaaz to sort the problem initially and whatever else we can sort out medically we will"** .Participant C also said that **"there's also Du'aas in the Quran and that to help with if you feeling depressed".** Participant J agrees that **"in Islam you must make Duaa for the patient, good for the patient".**

Furthermore, Participant F viewed mental illness like any other medical condition and being Muslim has a moderate influence on him. However, he believed that **"there is a fair amount of doctors that will tell you to use religion as part of treatment, there is no doubt about it".** However, in terms of treatment, he acknowledged that there are **"certain duaa's that you can read, I don't use them specifically. I leave it and defer it to the patient because I can't pass judgment. Some people, they are very spiritual and religious and they prefer using all of that, others are different; others don't want to hear about it".** Participant G similarly mentioned that are duas for depression but did not elaborate if he recommends them to patients**.** Participant H also supported this and said **"I never used ah… you know, my, my beliefs as my guide, forcing it onto my patients or whatever, I used to just use the treatment that I knew and that we were taught".** She however did take religion into consideration and would not give patients **"something that is going to be against their religion".**

3.7 GP's beliefs regarding spiritual illness: Understanding aetiology and treatment.

Participants discussed spiritual illness in terms of its existence, characteristics as well as possible treatment if such an illness does occur. The majority of participants (8 of 10) believed overall that spiritual illness exists and there is a place for it. Participant J

characterized spiritual illness by reporting that patients **"do not fit into any mental illness as we would know it; don't fit into particular boxes and the usual behaviour is quite weird and quite different from your usual mental illnesses".** Correspondingly**,** Participant I characterized a spiritual illness as **"a result of something that's not explained by medicine and there is no medical cause".** Participant E had a more scientific approach and hence felt **"as a scientist obviously one cannot subscribe to that, one needs to find a basis for it".** He thus proposed that **"when there is an absence of scientific objective evidence then it's easier to label it as a spiritual illness".**

Alternatively, Participant F believed **"if you haven't experienced it you'll think its fantasy. But if you have seen it either somebody in your family or somebody close to you has been through something like that then you will be able to relate better to it. So my personal view is, yes. I think that those kind of things do exist"**. Participant H also believes **"that there are spiritual illnesses. This is from like personal experiences**". Similarly, Participant F also felt that **"it's only when you have seen it that that you can relate to it".**

Participants' (n = 4) also relied on religion in their understanding of spiritual illnesses. Participant J mentioned **"if you look at Rasool (S.A.W), it is said that Jadu exists, so if the Rasool (S.A.W), says that it existed then we have to believe that it does exist".** Participant B similarly said **"You have to believe because it happened to Nabi (S.A.W)".** Participant D further said that the **"Quran says that it's got a remedy for it, so you have to believe in that as well".** Additionally, she thinks that **"most of them (GP's) don't believe in it, but I do, if I don't then I'm not a Musilmaan".** Participant C also reported **"Islamically the Quran does state that you can have spiritual illness".**

On the other hand, Participant G expressed that **"maybe, in Islam there is such a thing as Jadu but I'm very sceptical about it, in our population, for example, any mental illness is regarded that someone did something to you, you know, I think these superstitions need to come out of us".** Both Participant B and D also suggested that **"jealousy"** is considered to be the main contributing factor in the development of a spiritual illness and specifically the reason jaadu is done. Participant G had a corresponding opinion and reported that with **"a lot of psychiatric illnesses people do believe that it's because of witchcraft and nothing else**" Participant B also agreed with this notion and claimed that **"for some people the first**

thing they think about is Jadu". Additionally, Participant I likewise stated that **"Islamically you have that reaction where you think something is wrong with the person they attribute it to black magic and jaadu, it exists, but it's not the cause of all problems; it's the same thing with jinn's and that, they do trouble people, and they do give them the symptoms of mental illness where they see things, and they talk funny, and they can be manic, or hypo-mania we talking medically speaking, in the mean time the guy has a jinn, but not every mental illness is caused by jinn or so, so there's an overlap between the two".**

Participant A was ambivalent with regards to spiritual illness and mentioned that **"I do believe that they can exist. I do. But that's where I believe that you sit down and you pray to God and you ask him for help".** She further stated that "**I haven't seen it personally"** but patients often report of being affected by evil eye. She also attributes this to culture; **"They say religious but it's actually very cultural".** Participant G also confirmed that it's a combination of both of religion and culture that impact on patients' belief systems regarding spiritual illness. Witchcraft is common in both the Black population and in Islam. Participant B reiterated this view as he reported that jaadu is **"very rife in the Muslim community"** but occurs with Hindu's and Tamils as well.

Participants (n =5) discussed the difficulty of determining if it is a spiritual illness as symptoms **"are so common, overlapping that it's difficult initially to see"** (Participant B). Participant H mentioned that patients' don't often complain of spiritual symptoms as **"I think that maybe when they come to a doctor, they probably felt stupid to say that; because I'm the doctor and we don't go and tell a doctor that there was witchcraft done to us and evil eye".** This was further expanded by Participant B who provided an example to illustrate this: **"one girl came with severe stomach pains and I couldn't say spiritual but once you have exhausted the medical route then you can say go; she went to a maulana and maulana cured her so it's spiritual".** Participants F and J also related examples of incidents whereby medical treatment was exhausted and it was concluded that a spiritual illness existed.

In addition, all of the participants agreed that patients would first need to be medically examined before claiming that a spiritual illness exists. This was demonstrated by Participant D who confirmed that **"you have to do a full, good medical check-up and then**

rule out" and only if you cannot find any medical reason and the person is still **"mentally unwell"** then she would suggest they **"consult a Maulana".** Hence, Participant C stated **"Treat them medically first and advise them that perhaps they need to also seek spiritual help".** Similarly, Participant B stated that one needs to "**rule out medical this thing problems and what medical problems are sorted out or medically you sort of exhausted every avenue and then the only thing left is to try spiritually".**

3. 8 Collaboration and referral to other healthcare professionals

In order for patients' to receive holistic care, collaboration and referral to other healthcare professionals may be an important avenue to consider. The GP's also made reference to this.

3.8.1 Traditional healers

Seventy percent of the participants acknowledged the important role that traditional healers and specifically "maulanas" play in helping patients who are ill. However, all of the participants were not in favour of sangomas as their treatment could be harmful to the patient; but, maulanas were seen as harmless and could lift patients' moods. Participant F reported that **"some people will go to a traditional healer before they come to a doctor".** However, **"your Maulana - your doctor and your traditional healer they become, almost the centre of conflict for a lot of families".** In addition, Participant F felt that traditional healers/maulanas have important roles to play if they can **"dissect which ones need to go to a psychologist, which ones need to get medical therapy, then he almost does like a screening job for you".** Participant J also felt that traditional healers "**do play a role"** as **"often the patient would often feel that it is Jadoo; they have been bewitched".** Participant H also concurred that traditional healers do have a vital role to play and they should not be ignored as the **"country is so multi-ethnic"**.

Although Participant F acknowledged that seeing a maulana and receiving treatment in the form of water or thavees (amulet) is "**good for the patient because the patient has some sort of positivity about their illness";** he would not refer patients to traditional healers but would encourage collaboration. Participant B agreed that collaboration would benefit as **"both of us can help the patient in whatever capacity it will make life easy for the patient".** Participant D also agreed that joint concurrent treatment and **"cooperation"** can

help the patient and an Aamil **"would read on the water and give you a thavees to wear"** which will benefit the patient. Participant F reported **"I'd never say to someone go and get a thavees first because I think in our society and our forefathers if someone showed signs of any mental problems before, the first thing they would do is probably take them to a Maulana".** He however speculated that **"if and when they do exist, I'm definitely not in a position to help, I'd definitely refer**". Participant H reported that if patients **"feel that they need to go to a traditional healer then they are welcome to go. I won't specifically recommend going to a traditional healer. I guess it's not in our protocol".**

Participant I stated that he would refer to a traditional healer, be it an Aamil or Hakeem **"as long as it's not ripping the people off then its fine"** and provided the **"the patient has benefit in the end, then why not".** Participant D mentioned **"If I just don't find anything, then I would sometimes say: 'go and see, you know speak to the Maulana, or find a solution that way.' But I, I won't. Or tell them to read something from you know Ayatul-kursi or the 3 Quls or things like that to read and blow on themselves because it's there so I do believe in it completely".** Participant B mentioned **"Sometimes you have to tell them look ok you can do traditional treatment and you can do medical treatment concurrently".** Participant C also said that she would refer patients **"if we find that there is no progress with the patient even though they've seen the psychologist and the psychiatrists and they are on treatment"**.

However, two participants were not in favour of traditional healers. Participant E reported that he **"would not refer patients to traditional healers for medical management obviously that would be contrary to my training".** He was hence not in favour of traditional healers **"with in South Africa who have no formal training, who have no knowledge, who are practicing medical relief but have no insight or knowledge"** and would refer to **"scientific, more registered people and you also have a medical legal injunction".** Similarly, Participant G felt that traditional healers **"sometimes they don't understand what pathology the patient presents with. And sometimes, their modes of treatment can be helpful but sometimes more harmful to a patient".** He further said that **"it becomes difficult to treat them at the end of the day because they only listen to one aspect of it and not everything else**". Additionally, Participant A also reported that she felt that a traditional healer **"doesn't work for me"** but she respects it as patients **"grew up with certain of those beliefs".**

3.8.2 Psychologists and psychiatrists

All of the participants agreed that they would refer to both psychologists and psychiatrists. However, the reason of referral at times differed slightly. Hence the severity of the condition determined who GP's referred to first. It was thus noted that for serious illness, for example, schizophrenia and bi-polar; participants preferred to refer to psychiatrists as medication is often needed when dealing with these major illnesses and **"they are more difficult to control"** (Participant J). Participant E highlighted that due to psychiatric illnesses not being his speciality; he refers patients to psychiatrists as **"initial diagnosis has to be totally spot on and accurate".**

In addition, Participant A prefers to refer to a psychologist first because she feels **"that a therapist is more equipped to deal with their issues"**. She acknowledged that she will refer patients' who have serious difficulties to a psychiatrist and those who need to be started on medication. Nevertheless with that said, she reported **"I hardly use a psychiatrist. I think I referred once to a psychiatrist."** Participant J and B also felt that if they were in the position to treat them, then they would do so without referring to a psychiatrist.

It was also highlighted that often patients are reluctant to see both a psychiatrist and a psychologist. This was demonstrated by Participant I who reported that **"not many actually go to a psychologist or a psychiatrist to get it sorted out unless it really affects life and it affects the rest of the family and then the family get them to a psychiatrist"** Participant H concurred with this notion and stated **"not many of them are very acceptable to the fact for going to see a psychologist. No, It's very hard. They would take the medication and I call them back for a review and sometimes these patients don't come back for a review"**. Thus Participant H and G both confirmed that the decision to consult with a psychologist was left with the patient. Participant G reported that **"If they come to me and they say, look I don't want to see a psychologist, I'll say whatever makes you happy".** Participant H confirmed this and mentioned that she recommends that her patients **"see a psychologist, but I can't force you to see one ".**

However, patients prefer talking to their GP as they feel comfortable and at times they **"would walk into the room and from the first moment they would start talking about**

everything else that is related to their homes and the underlying cause, but won't even tell you why, the reason that actually brought them there. Sometimes they are just there to talk" (Participant H). Participant D also claimed that her patients find her approachable and hence disclose their problems to her. In relation to Participant H claiming that patients' feel comfortable talking to their GP's, Participant B differed and felt that patients perhaps feel **"you can't tell your GP everything. But if you go to a psychologist or psychiatrist, someone completely new to you and you will open up more as you know these people don't know me too well so they won't laugh at me".** On the contrary, Participant E posited that some patients find it difficult to speak to a psychologist as he/she is a stranger and hence **"wouldn't want to talk about issues that they feel would not be confidential, would not be kept confidential".**

Furthermore, Participant H reported that although patients **"total mood changes when they are leaving my rooms just from talking to them"** she mentioned that she **"can't be the doctor and psychologist in helping them; they need to go to somebody who is an expert in that field"** and hence thinks a psychologist plays a vital role. She thus recommends therapy for her patients and often explains the role of the psychologist to her patients. However, although therapy is recommended and often suggested by the GP's, patients perceptions of psychologists remain ambivalent. Participant A alluded to the fact that seeing a psychologist might be shameful and it's thus difficult for people to say that they are in therapy. She promotes therapy and often relates her personal experience with going for therapy to her patients. She thus relates that **"I always tell my patients you can't just take the pills, it won't solve the problem, you need to go for therapy; for me therapy is very important".**

Furthermore, Participant D also felt that not many patients were sent to a psychologist in the **"old days, (as) they didn't know about it"** but now referrals occur more often. According to Participant B, the attitude towards mental illness and psychologists is slowing changing. He reported that previously it was unheard of to go and see a psychologist as **"if you tell them to see a psychiatrist or a psychologist they already probably think 'what does this doctor think, I'm mad"** but nowadays there are many psychologists in the community and they are used more often. Participant F was also of the opinion that **"people are becoming aware of it"** and that perceptions have changed. He reported that

"When I started the practice it was hard to find one. So in these ten years there has definitely been a mindset change". Furthermore, Participant G reported that **"before psychologists weren't looked at as important in communities for example. But I think today, they play a vital role. Very, very important role".**

However, all of the participants concurred that psychology plays an important role in the community due to the social and economic problems that people face such as stress, divorce, abuse, unemployment etc.

Participant F reported that **"almost 50% of the time you find that there is a stress element to it whether it's work, home, relationship, finance, family"** and thus **"most of the time that gives them anxiety".** He thus posits that people have realised that a psychologist can help them with their problems and psychology also plays a role in domestic disputes in the form of marriage counselling. Participant C concurred that **"stresses can originate from how we live our lives and psychologists can assist with how the patient can deal with problems that they are facing"**. Participant G also reported that divorce and abuse have increased and hence psychotherapy will be beneficial.

3.9 Influential factors affecting GP's.

Participants discussed the role of medical training and their experience as an influential factor. Thus the number of years GP's practised for as well as the comparison between older and younger GP's were briefly highlighted. Furthermore, GP's limitations were briefly looked at.

3.9.1 GP's medical training and experience

All of the participants concurred that their medical training had a predominant influence on their way of practising. This is demonstrated by Participant H who stated **"I think we are taught to go by the book and everything we do is done by the book so that's how we encounter our patients".** Two participants emphasized that the training has altered their perceptions regarding mental illness. This was best described by Participant G who stated **"I think if you asked me that twenty years ago what is mental illness I would look at it and say 'I think it's just someone being crazy'. But I mean with the training that you have and things like that you are able to pick up on it earlier and you are able to understand it much better".** Furthermore, Participant C agreed with this and reported that **"Well I think I have**

changed my perception of mental illness by being educated. So it's more that with education you realize that there are other things".

Further substantiation was highlighted by Participant A who reported that 40-50% of her understanding of mental illness is due to the training she has received. Participant F valued his training and further mentioned that he would prefer **"going to university again and spending more time doing, what you call it, understanding mental illness during my internship or something else. 'Cause definitely there is an influence, there is no doubt".** Participant E also accentuated that his training has influenced him completely **"because before training, before knowledge, before reading the books one has a lay mans perspective of mental illness which is very, very erroneous by far and large and your training opens doors for you; and you tend to have a deeper understanding of what's going on; your behaviour patterns are not influenced as much by tradition or religious bias or other aspects of your perception. So your training does influence you totally".**

Together with the importance of training, the vital issue of GP's experience was also highlighted. A large number of participants (n=9) postulated that the experience the GP had in terms of the number of years GP's have been consulting for, played an influential role in the understanding, diagnosis and treatment of mental illness. Participant H stated **"I think the more patients you see the more you become open to understanding mental illnesses"**. Both Participant J and D agreed that medical training, further education and experience provide one with a richer understanding of mental illness. Participant G emphasized that the GP's experience is vital as **"I think experience as a general practitioner makes a big difference because if you are able to recognize it earlier you can pick up on it earlier and you can deal with it. But I mean if you are not experienced in that way, of probing into the patient and being a bit more caring to the patient, I don't think you will pick up on mental illness in the patient".** Participant E claimed that the GP's would be influenced by the number of **"years of exposure to the community".** In support of this, Participant F agreed that the training also limited GP's as due to the hospital set-up they were not exposed to out-patients and thus at first exposure to less severe mental illness, like anxiety, was limited. Hence the more patients GP's seen assisted in their understanding and awareness

of mental illness. Participant A thus felt that **"it's more experience of what you have dealt with, than years I think".**

In addition, four of the participants were of the opinion that the age of the GP played a role in the understanding of mental illness. Participant G claimed that **"younger doctors are a bit more ok with mental illness"** compared to older doctors. In relation to this, Participant C posited **"your older doctors will say no depression is you just a weak person. Whereas perhaps the younger doctors do feel that it is a condition that needs to be treated"**. Furthermore, Participant A proposed that **"the older doctors have a different view, the younger doctors are more open".** She further related that the **"older generation are still where they are. They don't get it. They just think like, 'life is tough and you just have to deal with it and finish'".** Thus she postulated that older doctors are more rigid and hence favour medication over therapy whereas the younger doctors will consider alternative treatment and are more open to the idea of psychologists.

3.9.2 Time constraints

Five of the participants also mentioned briefly that time constraints prevent GP's from providing patients with more space to discuss emotional issues and hence referral to a psychologist is recommended. According to Participant F, GP's do not have the time to discuss issues as consultation is usually only 10 minutes. Participant G agreed that **"It's difficult to sit with them, because, I mean, they need, some of them they need, need, need long, their consultations, are quite tedious and, I mean, when you look at it time wise, its time consuming. So I mean, if you refer them to a person that has the time to deal with them and deal with their issue, it's easier in that way. So you rather refer them to somebody who is more trained in that aspect".** Participant E also reiterated that with some conditions, like PTSD, patients' need ongoing care and time to discuss their anxieties and **"very often in a GP practice one doesn't have the time**". He thus suggests that patients need to **"be spoken to, needs to vent and it would be possibly better for them to be handled by a psychologist who allows that kind of allotment".** Participant J also confirmed that she **"would refer to a psychologist because I don't have the time to often sit with the patient for half an hour to an hour to talk to the patient".**

3.10 Conclusion

Thematic content analysis was used in order to identify the themes of the data collected. The results obtained were presented in this chapter and will be discussed in great depth in the next chapter.

Chapter 4: Discussion

4.1 Introduction

In this chapter the results presented in Chapter 3 will be discussed. The findings of the analyses will be discussed in reference to possible explanations found in previous literature. The discussion will follow the sequence of the results using the eight themes as headings.

4.2 GP's understanding of mental illness

Six of the ten of participants understood mental illness as any condition that affects one's daily functioning and mental well-being. Three of the ten partcipants provided an intellectual understanding of mental illness, based on their medical exposure and training and hence defined it in terms of the disorders (i.e. depression, anxiety, bi-polar, schizophrenia etc.) that are considered to fall under the classification of a mental illness. Only one older participant provided a very limited understanding equating mental illness with only psychosis. According to Adewuya and Oguntade (2007) GP's tend to see patients who have minor illnesses in their practice, however in their medical training they mostly encounter psychotic patients in the hospital setting. Fernando et al., (2010) have also posited that perhaps medical students are exposed to patients with severe illnesses in their training years which have led to their stigmatizing attitudes. This may help to understand the participant's definition of mental illness as a person that is "psychotic".

Additionally, the lack of training regarding mental illness amongst GP's was noted as a problem and hence it could be a reason as to why the older GP's had limited understanding of mental illnesses as their psychiatric training was conducted many years ago and for a very short period of time. In this regard, the same participant also enquired if depression falls under mental illness. It thus reflects that older GP's may not be aware and knowledgeable regarding the extent of mental illness and its consequences. Such limited understanding is dangerous to the patient and enhances stigma in the community if primary caregivers are unaware of what a mental illness is, what comprises a mental condition and subsequently how to treat it. Patients with less severe illnesses may not be identified and hence will not receive treatment. Undetected mental illness is detrimental to the patient and will be discussed further at a later stage.

A number of participants also preferred to prescribe medication when patients present with symptoms of depression and anxiety. This once again indicates that hasty treatment may be sought due to a lack of awareness on how to effectively manage patients with mental illness. Thus this related to GP's limited training and the need for more awareness regarding mental illness as well as educational interventions.

It thus appeared that as a whole, participants understanding of mental illness were based on the DSM or ICD classification. GP's also understood mental illness predominantly from a biomedical approach. Their explanations however did not reflect a clear and comprehensive understanding of what comprises of a mental illness and they remained close to their area of familiarity. There were however a few GP's who were of the younger generation, who had a more open minded and broad understanding regarding mental illness. These younger participants also viewed mental illness from a bio-psychosocial perspective. All of the participants mentioned depression and anxiety as common mental illnesses that face the community.

4.3 Aetiology and perceptions of mental illness as understood by GP's

Medical doctors in a study conducted in Nigeria (n=312) exploring doctors attitudes and understandings of people with mental illness revealed that the most common cause, identified by GP's, was substance abuse (Adewuya & Oguntade, 2007). The second frequent cause was reported to be social factors and specifically stress (personal, financial or marital) (Adewuya & Oguntade, 2007; Hugo et al., 2003). This correlated with participants in the current study's belief that stress and lifestyle had a major influence in the development of mental conditions, like anxiety, depression and stress disorders. The majority of GP's/participants in the current study attributed mental illness to stress and the hectic lifestyles of today. They elaborated that due to financial pressures both parents often work and hence family time is limited. Marital conflicts as well as one's marital status (divorce, widow) have a serious impact on patients' well-being. This correlated with East Asian women's opinion that they have become mentally ill due to the extremely stressful lifestyles they lead where they are expected to work, take care of children and do household chores (Chiu, Ganesan, Clark, & Morrow, 2005). Furthermore, marital conflict and relationship with in-laws have also been exacerbating factors that have led to their mental health deteriorating (Chiu et al., 2005). The busy western lifestyle in Canada led to a lack of family

time and no social support from neighbours and friends. This was compared to their lifestyles back in India where the community helped each other but they reported that in Canada, no one helps as everyone is too busy. It was further stated by woman in the study that the stress of Canadian lifestyle had a severe effect on women's illness in comparison to their lifestyle in India (Chiu et al., 2005). This concurred with participants views, in the current study, that "today's lifestyles" leave one with no room for extended family, neighbours and friends and hence the western type of living affects people negatively. Furthermore, in line of the above study it may be highlighted that similarly amongst the Lenasian Indian community, times have also changed. Previously, Indian women remained at home to look after the children whereas now both parents work and this contributes to the stressful lifestyle as indicated by participants. Women also have more household responsibilities and hence face greater amounts of stress. Therefore social and environmental factors play a pivotal role in the development of mental illnesses according to participants. Furthermore, some participants' pointed that depression and anxiety are very common amongst "Indian housewives" and Muslim/Indian woman. On the other hand, physical and medical causes of mental illness were also discussed as well as co-morbid conditions and organic causes that may contribute to one developing a mental illness, for example, a thyroid condition. Both older and younger GP's took into account the role of social, environmental and organic causes of mental illness.

4.4 Culture and mental illness

Culture plays a vital role in the understanding of mental illness and in the attitudes and stigma that is attached to it (Razali, Aminah, & Khan, 2002) by GP's, patients and the community as a whole. Perceptions of mental illness are often influenced by cultural expectations and norms. Religion may also be incorporated into one's culture as Islamic injunctions influence "all aspects of a person's life and is a fundamental part of culture" (Rashidi & Rajaram, Culture care conflicts among Asian-Islamic immigrant women in US hospitals, 2001, p. 56).

4.4.1 Secrecy and concealment

All of the participants in this study mentioned the tendency of their patients to keep mental illness a secret from their families and community at large. Patients were even reluctant to disclose their mental status to their GP's and the tendency to hide illness amongst the

Indian/Muslim community was a common occurrence. This concurs with Chiu et al. (2005) as a female South Asian woman reported that "We have never told anyone. No one tells anything about their illness to others. They all keep it secret, and this is family secret" (p. 642). An East Asian woman further stated "We do not want our friends to know my mental condition because it's not good to let people know about it" (Chiu et al., 2005, p. 642).

Participants, in the current study, were of the opinion that Indian/Muslim people are hesitant to disclose their symptoms and many participants mentioned that it is often observed amongst the female population. Indian/Muslim patients were said to be very secretive. A study conducted with British Indian female patients revealed that patients often did not tell their GP's all their complaints (Jacob, Bhugra, Lloyd, & Hann, 1998). Thus individuals who did not disclose all their symptoms were unlikely to be correctly diagnosed by the GP (Jacob et al., 1998; Pill et al., 2001).

It has also been reported that there is a significant problem of non-detection by GP's or primary care settings and hence many patients are either undiagnosed or misdiagnosed (Hugo et al., 2003). The findings of the study revealed that common mental disorders are not identified by the GP (Jacob et al., 1998). This may be due to patient perceptions differing from GP's in the sense that patients are unaware that depression is a medical condition that requires treatment (Jacob et al., 1998). Hence patients' do not disclose their depressive symptoms to GP's (Jacob et al., 1998) and similarly participants in the current study claimed that they needed to probe or force it out of their patients. Additionally, doctors may believe that mental illness is managed within the family in Asian communities (Greenwood, Hussain, Burns, & Raphael, 2000; Pill et al., 2001). A similar finding was revealed in the current study as a few participants mentioned that amongst the Indian/Muslim population, people tend to rely on their extended families for support. Hence parents, aunties, uncles and grandparents may serve as a support system during times of sadness and depression.

Based on the above findings, it is evident that a relationship exists between concealment of mental illness and the stigma attached to it.

4.4.2 Stigma

According to the World Health Organization (2001) stigma against people with mental illness is the most serious challenge that people face. Stigma is also considered to be the

greatest obstacle in improving the quality of life of the patient (Imran & Haider, 2007). Most of the participants acknowledged that mental illness is often stigmatized amongst the Indian-Muslim community of Lenasia, South Africa. However, research has revealed that stigma towards mental illness also occurs in the rural areas of South Africa, amongst the African population, and specifically in Limpopo where a study was conducted to explore the experiences of caregivers of individuals with mental illness (Mavundla, Toth, & Mphelane, 2009). A study conducted in Cape Town, South Africa to determine the attitudes and knowledge of the general South African public (n=667) toward mental illness revealed that there is still ignorance and stigma with regards to mental illness (Hugo et al., 2003). A participant, in the current study, emphasized that the stigma attached to mental illness is "even worse in the Lenasia community" (Participant G).

According to Cinnirella and Loewenthal (1999) stigma continues to exist in communities regarding mental illness and consequently some participants expressed fear of being labelled depressed and losing their community reputation. Black and Muslim participants explained that mental illness is considered taboo and the family reputation is of utmost importance (Cinnirella & Loewenthal, 1999).

According to Mavundla et al. (2009) mental illness is often classified "under the umbrella of madness" (p. 363). A large number of participants, in the current study, indicated that mental illness is often understood as being "cuckoo" or "mad" in layman's terms. Participants mentioned that people with mental illness are frequently labelled and to some extent even taken out of society. Derogatory terms such as these are harmful to not only the patient but the community at large as it portrays mental illness in a distasteful manner.

Furthermore, a recent study conducted in Jamaica to examine mental illness stigma reported that a focus group participant (N=127, 16 focus groups) stated that "people don't treat people with a mental illness as though they were a normal human person, they stigmatize them that they are mad man" (Arthur et al., 2010, p. 253). Participants in the current study also mentioned the embarrassment that families face when a member has a mental condition. Mental illness is often disguised as a medical illness (diabetes, hypertension etc.) which is more acceptable as it carries less stigma (Loganathan & Murthy, 2011). Parents may also disguise their children's condition as behavioural problems in order

to prevent relatives from finding out (Greenwood et al., 2000). Thus, the term 'psychiatric' seems to have a negative connotation and hence parents will not disclose that their child is receiving psychiatric treatment due to the stigma attached to it (Greenwood et al., 2000).

According to Loganathan and Murthy (2011) mentally ill patients often remain unmarried (Loganathan & Murthy, 2011). Relatives of mental ill patients were also worried that people might not want to marry into their family if they know they have a family member who is mentally ill (Shibre, et al., 2001). In traditional Indian society, mental illness will be concealed from a prospective husband as it is likely that a marriage proposal will be withdrawn if it is known that the woman suffers from a mental illness (Loganathan & Murthy, 2011). There is also a high risk of divorce or separation if it is later discovered that the spouse suffers from a mental illness. Thus psychiatric treatment is also not frequently sought as it might reduce marriage prospects (Greenwood et al., 2000).

Additionally, together with other factors, the fear of stigmatization may prevent people from seeking help (Hugo et al., 2003). Due to misinformation and a lack of knowledge, people with mental disorders are often perceived as dangerous, unpredictable and thus undergo the greatest stigma (Adewuya & Oguntade, 2007; Hugo et al., 2003; Imran & Haider, 2007). Subsequently social rejection, abuse and isolation are a result of misinformation, lack of education and resources addressing mistruths, fear and suspicions surrounding the mentally ill (Hugo et al., 2003). Similarly participants in the current study have voiced that their patients and community members in Lenasia also have a lack of information with regards to mental illness which contributes to the stigma attached to it. Therefore participants in the current study expressed that increased awareness and campaigns are needed in the Lenasian community with regards to mental illness and the potential stigma that patients face. Similarly, Mavundla et al. (2009) also recommended that educational programmes are needed to inform members of the community with regards to the causes of mental illness, coping methods, importance of counselling and medication as well as discussions about the cultural conceptualizations of mental illness.

According to Hugo (2001) health professionals tend to have a more negative perception of the outcome of mental illness and thus are more pessimistic regarding the rate of long-term prognosis of patients with a mental illness. Medical professionals thus had more negative

attitudes regarding mental illness than those of the public (Hugo, 2001). This is further supported by research conducted in Pakistan (Imran & Haider, 2007; Naeem et al., 2006) who claimed that doctors and medical undergraduates hold stigmatizing attitudes towards patients with mental illnesses. This was further supported in the study conducted by Dixon et al., (2008) which revealed that medical undergraduates, in the UK, have less favourable responses to mentally ill patients. Therefore GP's may also have stereotypical perceptions of people with mental illness which is perhaps due to the influence of the community. This concurs to one participant, in the current study, who was of the opinion that "even doctors look at people with mental illness differently".

In terms of doctors relying on personal experience, it was found that Nigerian doctors had less social distance towards mentally ill patients if they had experienced a family member with mental illness (Adewuya & Oguntade, 2007). Furthermore, medical students' negative attitudes towards mental illness were reduced if they had personal experience or if someone around them had a mental illness (Dixon et al., 2008). However, there also appeared to be social stigma attached to mentally illness by doctors as 92% of Nigerian doctors would not hire a formal mental patient to take care of their children nor would they (80.8%) marry someone with a mental illness (Adewuya & Oguntade, 2007). A significant proportion of Nigerian doctors would not treat a former mentally ill patient in the same manner as another person and 47.8% felt that mentally ill patients were not as trustworthy as the average citizen (Adewuya & Oguntade, 2007). Hence, it seems that mentally ill patients are not socially accepted in society even by medically trained doctors. This is supported by the result that 61.4% of doctors have a high social distance towards the mentally ill (Adewuya & Oguntade, 2007). Interestingly doctors did not differ from the public in their social distance towards mentally ill people (Adewuya & Oguntade, 2007).

Sri Lankan doctors and medical undergraduates tend to consider certain patients blameworthy for their illness (Fernando et al., 2010). They were of the opinion that schizophrenic patients were personally to blame for their illness and should "pull themselves together" (Fernando et al., 2010, p. 737). One participant, in the current study who had been practising for 30 years, mentioned that mental illness can be "brought by the person itself like depression, anxiety". It thus highlighted that older GP's may lack understanding of mental illnesses and thus have more negative views to patients. Other

participants acknowledged that older GP's may be more rigid in their views and lack awareness of mental illness and the treatment available. According to one participant, the older generation might still have the perception that "life is tough and you just have to deal with it and finish".

Medical professionals have a vital role in diminishing stigma and thus stigmatizing attitudes held by them not only impede treatment but also worsen discrimination towards mentally ill persons in the community (Fernando et al., 2010). Based on the above findings, it is evident that stigmatization of mental illness is a serious problem in many Asian/Indian populations. Thus Lenasia is also one community whereby mental illness is considered taboo and stigma is still known to affect both doctors and community members' attitudes and behaviours.

4.4.3 Somatisation

Somatisation is "defined as a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings to attribute them to physical illness and to seek medical help for them" (Ali, Radwan, & Al-Shihabi, 2008, p. 111). Participants in this study expressed that patients would often present with pain related complaints, such as headaches, backaches, abdominal pain etc but that symptoms are not due to a medical condition but an underlying emotional distress. According to Cape and McCulloch (1999) GP's do not often identify psychological problems that patients may be suffering from due to patients presenting with physical symptoms and failing to mention emotional problems. Thus patients frequently somatise, that is, they deny the significance of psychological distress (Cape & McCulloch, Patients' reasons for not presenting emotional problems in general practice consultations, 1999).

According to researchers (Ali et al., 2008; Reid et al., 2001) somatisation (which is used synonymously with the term 'medically unexplained symptoms') in the form of physical symptoms are frequently presented in modern practice and are difficult to manage. Jackson et al. (1999) reports that approximately 25% to 33% of physical symptoms remain unexplained. Medically unexplained symptoms or somatic symptoms frustrate GP's leading to GP's having a negative attitude towards such patients (Ali et al., 2008). Thus treatment and patient care suffers with GP's being the primary system of care that patients call upon when they experience disabling symptoms. Participants, in this study, reported that often

multiple symptoms are present which do not have an organic basis. Ali et al. (2008) have concurred that symptoms do not represent organic conditions but patients fail to accept this result.

Thus the majority of GP's in a study (n=147) conducted to determine the attitudes of GP's towards somatic or medically unexplained symptoms (MUS) agreed that patients with MUS are difficult to treat. More than half of the GP's (57%) agreed that personality factors have a contributory role (Ali et al., 2008; Reid et al., 2001). Thus it can be postulated that a link exists between physical symptoms and psychiatric disorders and it is essential for GP's to consider both factors when deciding on appropriate treatment (Ali et al., 2008).

In addition, patients with depressive and anxiety symptoms frequently present in primary care. This concurs with participants in the current study as they all were of the opinion that depression, mood disorders and anxiety were the most common disorders that affected patients. Furthermore Jackson et al. (1999) and Pill et al. (2001) posited that these disorders are often undetected because "patients typically present in primary care settings with somatic rather than emotional complaints" (p. 135) but may have an underlying psychiatric disorder. It was reported that emotional disorders were seen as trivial by most people and needed to be managed either by oneself or with the help of one's family and friends. However, physical complaints were deemed appropriate to be presented to the doctor; but emotional complaints were not (Pill et al., 2001). This correlated once again with participant's belief that patients present with physical symptoms and won't come in stating that they are depressed. Participants, in this study, postulated that patients are often embarrassed to discuss emotional symptoms due to the stigma attached with being depressed. Participants also mentioned that stigma is to such an extent that often wives will not be able to tell their husbands that they are depressed.

According to researchers (Greenwood et al., 2000; Wilson & MacCarthy, 1994) Asian patients may not be referred for psychiatric care as they are prone to somatise psychological problems and consequently mental illnesses are not identified and diagnosed. This is due to emotional symptoms being stigmatized amongst Asian communities. However it is noted that mental disorders can exacerbate physical symptoms and increase the

possibility of presenting to a GP or health care provider with multiple or unexplained symptoms (Jackson et al., 1999).

4.5 The assimilated identity

"Indians" are said to be a diverse group in terms of religion, culture and language (Jacob et al., 1998). According to Wig (1999) India is a country that consists of spiritual traditions which incorporates many religions, including Islam, Hinduism, Buddhism, Sikhism and Jainism. Thus people are often brought up with traditional beliefs but also partake of the Western educational system (Wig, 1999). Hence Wig (1999) posits that the medical physician remains Indian at heart even though they may view the world from a Western perspective. One participant, in the current study, was of a similar opinion as expressed that although he would like to believe that his culture doesn't influence him, he still has "Indian tendencies that would impact on my behaviour". Wig (1999) further mentions that one's upbringing controls one's understanding of the concept religion. Additionally, he suggests that mental health professionals need to accept both spiritual values as well as science in order to understand and help the individual (Wig, 1999). This correlates with a few participants in the study who mentioned that religion, culture and one's upbringing influenced their beliefs and understanding of mental illness.

According to Chiu et al. (2005) spirituality, culture and health beliefs are shown to determine whether people seek professional or non-professional help. Hence "spiritual dimensions of culture are among the most important factors that structure human experience, beliefs, values, behaviour, and illness patterns" (Chiu et al., 2005, p. 632). Most of the participants, in this study, were of the opinion that culture has a greater influence than religion in the understanding of spiritual illness, but often it is the combination of both culture and religion that contributes to their patients understanding of spiritual and mental illness. It was therefore postulated that culture has a vital contribution to such beliefs.

According to researchers (Chiu et al., 2005) spirituality and culture both play an important role in the lives of woman with mental illness. They conducted a study with 30 immigrant woman with diagnoses of severe mental illness from East and South Asia. South Asian participants were from Indian origin whereas East Asian woman were Chinese but from different countries of origin (Chiu et al., 2005). Mental illness was described as a "bad spirit

residing in me" (Chiu et al., 2005, p. 645) and hence traditional healing practices was often used. Furthermore, another woman believed that "if we practice the religion, then illness will not come near 'and further explained, 'when body and soul are together like friends no disease comes" (Chiu et al., 2005, p. 645). Thus cultural beliefs were at the forefront of women's understandings of mental illness. Additionally, woman also turned towards God and their religion for relief (Chiu et al., 2005).

A study was conducted in the UK with 24 Asian in-patients and carers from various religious groups; however participants were predominantly Muslim (75%) (Greenwood, Hussain, Burns, & Raphael, 2000). It was revealed that although participants were Asian (originated from the Indian sub-continent), they were also British and furthermore they also possessed a religious identity (Greenwood et al., 2000). Thus participants considered their culture, nationality and religion as important factors that comprise their identity. Similarly participants in the current study took into consideration their (and their patients) assimilated identity of being Indian, Muslim and South African. A related study was also conducted in Canada to examine the differences between South and East Asian women regarding mental illness choices (cf. Chiu et al., 2005). Greenwood et al. (2000) found the complexity of the Asian identity as a questionable and intriguing concept. Hence it often poses to be difficult to divide the proportion that culture or religion have as an influential role in people's perceptions. This was evident in the current study as participants were also uncertain whether culture or religion played a larger role and it was posited that one's heritage, background and religious beliefs are all crucial factors to consider. Thus it was important to differentiate that the study focused on Muslim GP's from Indo-pak ancestry as Muslim GP's from a different country of origin may hold different beliefs, practices, and traditions with regards to the perception and understanding of mental illness in their context.

4.6 Islamic beliefs and values regarding mental illness

Islamic beliefs and practices form part of the daily life of a Muslim (Rashidi & Rajaram, Culture care conflicts among Asian-Islamic immigrant women in US hospitals, 2001) and hence religion permeates all aspects of one's life. The first pillar of Islam entails the belief in Allah and his Prophets and the acceptance of Muhammad (pbuh) as the last prophet of God (Carter & Rashidi, 2003; Rashidi & Rajaram, Culture care conflicts among Asian-Islamic

immigrant women in US hospitals, 2001). Thus belief and faith form the core of an individual's values. Participants noted the influence that Islam has on their patients as well as on their own personal beliefs. Having strong faith (imaan) and believing in the will of Allah (preordainment/predestination) during times of adversity was shown to be core beliefs of the Muslim person. Both GP's and patients may resort to a religious interpretation of symptoms and thus participants may draw on their Islamic beliefs when treating patients. Therefore the incorporation of religion into treatment was a further sub-theme that was explored. Islamic beliefs and values overlap into all aspects of life and hence it will be suitable to discuss the Islamic perspective regarding mental illness together with the three remaining sub-themes (faith, predestination, incorporating religion into treatment).

A number of participants in the current study acknowledged that Islam recognizes mental illness and does not portray mental illness negatively. Islamic injunctions as stipulated in the Qur'an and Hadith make mention of the mentally ill patient in terms of them not having to perform certain compulsory acts, such as fasting and salaah (five daily prayers) if they are medically or mentally unfit to do so (Rashidi & Rajaram, Culture care conflicts among Asian-Islamic immigrant women in US hospitals, 2001). However, during sickness or good health, Muslims should turn to God to seek help or express gratitude and should not lose faith in the mercy of Allah (al-Qarni, 2003). Thus both good and bad are from Allah and should be accepted.

According to one participant in the current study, wrong doing or sin may make a person feel bad and this could lead to him feeling low or depressed. He thus thinks that prayer and turning to God for assistance would help patients feel better. Leavey (2010) is of a similar opinion as he postulates from the research he conducted with Christian clergy that if people engaged in sinful lifestyles, they may feel guilty which may subsequently cause mental illness. Hence Christian participants in his study reported that sin could cause a variety of things and there exists a relationship between sin and poor health (Leavey, 2010). It was similarly noted by the participant that if a person prays and asks for forgiveness of his sins, he may feel well and this will lessen one's depressive feelings.

Participants in the current study also acknowledged religious practices that are available during times of depression or any illness such as, dua (supplication), zikr (meditation) and salaah (ritual prayer and second pillar of Islam). According to Carter and Rashidi (2003) meditation and prayers have been used to promote and enhance emotional experiences as well as establish a connection with God. Additionally, prayer purifies the mind, heart and soul and provides people with a source of hope, courage, patience and confidence (Carter & Rashidi, 2003, p. 405). The third pillar of Islam, fasting, is considered to cleanse the body, mind and soul and thereby bring the self to peace (Carter & Rashidi, 2003). Fasting is also a reminder to take care of the less fortunate and poor and it also reduces greed and promotes self-control (Carter & Rashidi, 2003). Fasting also assists in both physical and mental well-being (Carter & Rashidi, 2003).

Additionally, religion is said to have many positive psychological effects and hence patients who are more religiously inclined tend to experience less psychological morbidity when stressful life events occur (Razali et al., 2002). Furthermore, the five daily prayers are reported to be included in the therapeutic process as it is a way of meditation that encourages relaxation and well-being (Razali et al., 2002). According to Greenwood et al. (2000) patients' religious beliefs and prayers appear to be very helpful as in-patients in mental care facilities report that they meditate and perform the required rituals despite the inconvenient circumstances. Furthermore, caregivers also felt that the cure comes from God (Allah) and that doctors and medication are merely messengers who are sent from God alone (Greenwood et al., 2000).

There has thus been debate regarding the relationship of religion to mental health (Koenig & Larson, 2001; Amer & Hood, 2008). Considerable research conducted by Koenig and Larson (2001) has reported that the role religion plays varies in different countries. Previous research in the USA found that a large percentage of Americans (83%) found comfort in their religion when they are stressed (Koenig & Larson, 2001). In contrast, in northern European countries, religion was not considered to be as important with many participants not resorting to religion as a coping mechanism. Islam is a way of life and thus participants in the current study expressed that both GP's and patients may resort to religion as a means of coping with illness. Thus prayers are performed by the patient and GP's may also pray for the recovery of their patients. Indeed having faith, praying and asking God for assistance

provided patients with a source of comfort, strength and hope. Participants in this study also related that praying is good for the patient. Koenig and Larson (2001) also provided studies that showed both positive and negative associations between religion and mental health. It was however noted that religious beliefs are related to feelings of hope, purpose, meaning, positive affect, happiness and higher morale (Koenig & Larson, 2001; Amer & Hood, 2008). Prayer was highlighted as the preferred method to obtain guidance and strength to deal with mental illness (Shibre, et al., 2001).

Furthermore, Koenig and Larson (2001) were of the opinion that patients can use their religion as a means of coping with illness and felt that religion could be a protective factor in the development of certain conditions, like depression. They found that depression was lower and resolved quicker among the more religious (Koenig & Larson, 2001). Additionally, they reported that depressed patients who received religious interventions recovered faster than those who didn't or than those who received a secular intervention (Koenig & Larson, 2001). In the current study, a participant emphasized that if an individual has imaan (faith/belief) he will unlikely suffer from severe depression as he will turn to Allah for assistance and relief and will therefore cope better. A third of participants in the study conducted by Cinnirella and Loewenthal (1999) also concurred that religion played a causal role in depression. The Muslim group further attributed depression to a lack of faith and prayers and thus felt that religious practices such as praying could be useful to treat depression and schizophrenia (Cinnirella & Loewenthal, 1999).

Further positive associations entail that a significant relationship between religious involvement and social support exist. Thus an increase in the amount and quality of social support and its impact on mental health is highlighted with religious involvement. Furthermore, greater and similar religiousness of partners predicted increased marital happiness and stability (Koenig & Larson, 2001). Koenig and Larson (2001) after conducting comprehensive research have thus concluded that religious involvement is often associated with positive outcomes such as greater well-being, social support and less depression, anxiety and substance abuse. Amer and Hood (2008) have also concurred that studies have noted the reduced rate of depression, suicide, anxiety, substance use, delinquent behaviours; and the increase of social support and marital satisfaction in relation to religious involvement. A few participants in the current study also concurred that due to the Muslim

community's religious beliefs and teachings that Islam prescribes, Muslims may find it easier to deal with issues and may therefore not to resort to alcohol or drug abuse. Islam thus assists people by prohibiting harmful acts like alcohol. Furthermore, a participant was of the opinion that by being Muslim, it makes it "easy for us... helps us" as the religions restrictions or commandments may ward off harm and subsequently depression. Islam was thus seen in a positive light as it assisted the patients and their ability to cope with difficult situations.

Koenig and Larson (2001) also found that psychiatrists are unaware of how to deal with religious or spiritual issues that arise in clinical practice and thus tread cautiously. Additionally, they report that religion is a personal issue and hence patients may feel that their doctor won't understand their beliefs (Koenig & Larson, 2001). A number of participants, in this study, noted that they respect patient's beliefs even if they differ from their own beliefs. Participants also noted that they were not always sure of the patient religiousness and hence were cautious in providing religious advice whereas some participants would offer religious advice to their patients. Koenig and Larson (2001) considered it useful for psychiatrists to address patients' religious beliefs once rapport has been established as it often opens up areas that need to be addressed as well as the discovery of healthy beliefs that are part of the patients' culture or bizarre beliefs that may be part of the patients' illness. Participants in the current study also concurred that once rapport has been established, patients find it easier to discuss personal issues and GP's also may feel more comfortable in giving religious advice. Participants further reported that GP's are also consulted for non-medically related problems, like marital problems, and the reason is that patient's trust their GP's and have an established relationship with them. Thus GP's are valued and held in a high esteem by their patients.

According to Cinnirella and Loewenthal (1999) patients preferred GP's who were of the same religion as they could recommend prayers that would assist in treating the ailment. Participants in the current study acknowledged that some patients, who were more religiously inclined, may appreciate GP's religious advice to pray and to read certain duas (supplications) and this may be beneficial for the patient as "religion itself is part of the psychological management of mental illnesses" (participant E). Thus a few participants were of the opinion that patients may find it easier to relate to GP's who were of the same race

and religion. However, one participant as concerned that patients may not feel the same way when it comes to psychologists as this may threaten confidentiality.

Western beliefs systems differ from that of Islamic belief systems and since Islam is a way of life that influences all areas of an individual's life, it is imperative for healthcare providers to have insight of Islamic concepts and practices. Thus the understanding and acceptance of religious practices when treating patients is of paramount importance.

4.7 GP's beliefs regarding spiritual illness: Understanding aetiology and treatment.

According to Razali et al. (2002), the DSM-IV has started to acknowledge the role of religious and spiritual problems by the inclusion of V codes and thus it is recommended that doctors should also consider religious or spiritual facets of their patients' lives. Eight of the ten participants in this study acknowledged that spiritual illness exists and patients often discuss their experiences with their GP's of being affected by such illnesses. Spiritual illness in this study was described as something that is "unnatural", "non-medical", "no scientific basis" or "not explained by medicine".

Participants, in the current study, thus believed in the existence of spiritual illnesses but the aetiology of such illnesses appeared to be a contentious area. Hence participants relied on their personal exposure, Islamic beliefs, or cultural injunctions that community members ascribe to.

Participants in the current study also reported that often personal experience or exposure to spiritual types of illness makes it more believable and understandable. A few participants related their own experience of a family member being inflicted with a spiritual illness as they felt that "it's only when you have seen it, that you can relate to it". Participants also provided examples of patients who after medical treatment were still sick and were therefore deemed to be affected by a spiritual illness.

A significant proportion of doctors (50%) in Nigeria believe in the supernatural causation of mental illness and hence cultural beliefs are not only prominent but are considered to form part of the aetiology of mental illness (Adewuya & Oguntade, 2007). According to Adewuya and Oguntade (2007) a major cause of mental illness, in Nigeria, was considered to be

supernatural factors, specifically evil spirit, witchcraft and sorcery. Similarly, spiritual illness, in this study, was understood to mean symptoms that were beyond medical classifications and was thus somewhat supernatural, that is, jadoo (witchcraft), nazr (evil eye) and jinn (spirits). Four participants acknowledged that amongst the Black African population, this is also very common and thus spiritual illness and traditional healing form part of the "South African culture". One participant was sceptical regarding it but commented that community members often think they have been affected by a spiritual illness before considering other possibilities. It was reported in a recent study that members of the black African community, in South Africa, often attribute mental health problems to cultural causes, such as witchcraft or the ancestors, rather than genetic or biological causes (Campbell-Hall, et al., 2010). Previous studies have also acknowledged the existence of witchcraft, evil eye and spirit possession amongst the Indian and/or Muslim population and the subsequent belief that mental illness is a cause of such spiritual afflictions (cf: (Ally & Laher, 2008; Ally, 2008; Laher & Khan, Exploring the influence of Islam on the percepion of mental illness of voluneers in a Johannesburg communit-based organisation, 2011; Padayachee, 2010).

The belief in supernatural causes of illness or supernatural conditions is not only restricted to one specific culture or religion. According to Leavey (2010) the involvement of the supernatural in illnesses is a belief that is sustained in many societies. Thus spirit or demonic possession, and bewitchment can be part of either a cultural or religious practice (Leavey, 2010). Mavundla et al. (2009) also posit that amongst members of the rural community in South Africa, witchcraft is attributed as a cause of mental illness. Furthermore, in Ethiopia prevalent beliefs exist regarding bewitchment, demonic possessions, evil spirits and evil eye and the role they play in mental illnesses (Shibre, et al., 2001). Two Asian patients in the UK also acknowledged that Jadoo (black magic) and nazr (evil eye) could be possible explanations of a mental illness but felt that it was more common in the Indian sub-continent than in the UK (Greenwood et al., 2000).

GP's, in this study, noted that Indians and Muslims of Indo-Pak origin often believe in supernatural illnesses and hence traditional treatment is sought from such conditions. Thus Muslims of Indo-Pak origin share similar beliefs to Hindu's due to the assimilation of cultures and traditions. Thus Muslims and Hindus origin has led to both religions having very similar beliefs with regards to supernatural causation and

According to participants in this study, mental illness is not equated with spiritual illness but was seen as a separate entity. It was noted that it can be very difficult at times to distinguish between a mental and spiritual illness but doctors per se did not think that they were one and the same thing.

However, participants in this study highlighted that the community and patients are of the view that “mental illness is looked at as total jadoo” (participant G). Thus patients find it difficult to accept that a family member may have a mental illness and will instead only consider that “somebody has done something to me” or “because the persons eye is on you”. Therefore psychiatric treatment is not considered to be a treatment option as patients and family members would rather seek spiritual treatment due to believing that the ailment is due to supernatural factors and not due to a psychiatric condition. This may hence demonstrate that stigma is attached to psychiatry and mental illness amongst the community.

Hence, one participant in this study mentioned that even though she does not subscribe to supernatural beliefs and causation of illness, she respects patient’s beliefs and won’t debate with them. She found that patients feel good knowing that their doctor respects their beliefs. Hence, the GP needs to be aware of illnesses that might be understood by patients as a spiritual condition and respect patients beliefs irrespective if it contrasts their own personal beliefs. Razali et al. (2002) concurred that therapists will also not challenge patient’s beliefs as they aim to establish good rapport with patients and strengthen the therapeutic relationship. It is thus vital to understand the patient’s cultural and religious beliefs (Razali et al., 2002).

South Africa as a rainbow nation has a variety of cultures and religions. African belief systems incorporate spiritual understandings into causation of symptoms such as due to ancestors, bewitchment and rituals (Campbell et al., 2010; Sorsdahl et al., 2009). Thus illnesses are subject to interpretation. Hence health professionals will need to have adequate knowledge regarding the cultural norms of the community in which they are practicing in. Failure to do so might be detrimental to the patient who has a different explanatory model of illness (Campbell et al., 2010). Thus healthcare practitioners need to be culturally competent, that is, they need to be aware of the various cultural groups and

their attitudes, beliefs and practices when diagnosing and treating illnesses (Haarmans, 2004). Islam is a way of life for Muslims and it is thus important for healthcare practitioners to understand Muslims traditions and practices in order to deliver appropriate culture care to Muslims (Rashidi & Rajaram, 2001).

Furthermore in order to ensure that patients receive culturally-based treatment health professionals need to be aware and understand the beliefs of the community (Laher & Khan, Exploring the influence of Islam on the percepion of mental illness of voluneers in a Johannesburg communit-based organisation, 2011) in order to prevent incorrect diagnosis and insensitive treatment. Patients may also feel more comfortable to be treated by a professional who understands and has knowledge of their culture and/or religion (Laher & Khan, Exploring the influence of Islam on the percepion of mental illness of voluneers in a Johannesburg communit-based organisation, 2011). Patients also tend to trust practitioners who are of the same religious background (Koenig & Larson, 2001). In the study of Cinnirella and Loewenthal (1999) the majority of participants (92%) also felt that they would be able to relate better to a healthcare professional/GP that was of the same religious or cultural belief due to shared understanding. Hence in this study, a participant noted that patients often express their spiritual problems possibly due to shared cultural and religious understanding between GP and patients. However, due to medical professionals often not understanding cultural or religious belief systems, patients prefer to consult with traditional healers who are considered to be experts in this area (Sorsdahl et al., 2009). Recent studies (cf: (Bulbulia, 2011; Ismail, 2010; Laher & Khan, 2011) conducted in South Africa have also recommended and advocated the need for more culturally competent healthcare professionals as not only will quality care be provided but healthcare professionals will also gain a deeper understanding of mental illness in the community.

Additionally, when medical care is insufficient, religious healing comes into play and may contribute to the understanding of illness by transforming patients suffering (Leavey, 2010). Similarly, participants, in the current study, reported that once all medical treatment was exhausted, religious treatment may be sought by patients. A number of participants found it appropriate for patients to seek spiritual help if it would benefit them.

4.8 Collaboration and referral to other healthcare professionals

It was ascertained that spiritual illnesses are common occurrences in the Muslim community. However, it is important to note that the Muslim community of Lenasia form part of the South African culture at large. Thus South African belief systems recognize the cultural beliefs of both the Black, Muslim and Indian population with regards to culture-bound disorders and traditional modes of treatment. Hence the term traditional healer was used loosely by participants to refer to sangomas when discussing the Black population and referred to specifically maulanas or aamil's when examining the Indian-Muslim population.

4.8.1 Traditional healers

Traditional healers were considered by participants to be included in the multi-ethnicity of the South African culture and population. It was previously reported that there was an estimate of 200 000 healers in South Africa (Abdool & Ziqubu-Page, 2004). Thus traditional practitioners seem to outnumber Western-trained mental health practitioners (Meissner, 2004). Hence it was acknowledged by participants that in addition to medical professionals being consulted, traditional healers, like maulanas (Muslim clergy) and sangomas were consulted by patients regularly. This is congruent with South Africa where a significant proportion of people who suffer from mental health problems often consult with traditional healers (Campbell-Hall et al., 2010).

Several earlier studies (cf: Freeman, Lee, & Vivian, 1994; Mbanag, Niehaus, & Mzamo, 2002; Nattrass, 2005) have demonstrated that alternative practitioners, in South Africa, may play an important role by offering culturally-based treatment. According to Sorsdahl, Stein and Flisher (2010) traditional healers in South Africa, are consulted for a range of conditions including mental disorders. Previous research revealed that traditional healers were consulted amongst approximately 50% of patients with a mental disorder (Ensink & Robertson, 1999; Freeman et al., 1994). According to Russinova, Wewiorski, and Cash (2002) 50% of people resort to religious/spiritual activities when faced with a serious mental illness. Findings in studies conducted elsewhere in Africa, found that in Nigeria, 26% of mentally ill patients consult with a traditional healer before mental health services (Abiodun, 1995).

According to Sorsdahl et al. (2009) alternative practitioners were described as a traditional healer, spiritual or religious advisor (e.g. minister, priest, or rabbi), or any other healer (Sorsdahl et al., 2009). Participants in the current study understood traditional healers in terms of the culture they fall into, that is, Indian Muslims would consult with a maulana, aamil or Hakeem whereas the black population would prefer to consult with a sangoma. Some of the participants acknowledged that patients consult with a traditional healer either first, before seeking western-based medical treatment or when medical treatment seems to exhaust all options and the patient has not recovered or responded to treatment. Religious and spiritual advisors were found to be consulted more regularly when people are faced with mental health concerns (Appiah-Poka, Laugharne, Mensah, Osei, & Burns, 2004; Sorsdahl et al., 2009).

Traditional healing methods are used concurrently with western medicine by Asian woman in Canada (Chiu et al., 2005). This is supported by participants, in this study, who mentioned that often both modes of treatment are used by patients. Furthermore, woman made mention of their desire to use Ayurvedic or herbal medicine that was traditionally used in India (Chiu et al., 2005). Thus Asian woman integrated their religion or traditional treatments in their daily healing practices. Furthermore, almost all of the women in the above mentioned study reported that spirituality and religious practices provided them with mental strength (Chiu et al., 2005). Previous research has also suggested that spirituality plays a vital role with regards to mental illness in a multicultural context (cf: (George, Larson, Koenig, & McCullough, 2000; Greasley, Chiu, & Gartland, 2001; Winkelman, 2001). An elderly female participant, in this study, reported that Indian traditional forms of healing are still prescribed amongst Indians, she provided an example of badaam milk (almond milk) being used when one is feeling down or paak (cooked ginger combined with clarified butter and nuts) given to women after childbirth and during postpartum depression. The participant also stated that she too would recommend certain foods to patients.

Furthermore, Sorsdahl et al. (2009) claimed that traditional healers, religious and spiritual advisors are sought amongst community members for advice. It was also noted by two participants that in conjunction with treatment that the traditional healer (maulana) provides, he also assists patients with regards to their psychosocial problems, such as family difficulties, divorce, marital issues and hence provides counselling from a religious

perspective. According to Campbell-Hall et al. (2010) the traditional practitioner provides psychosocial support and assists the person with conflicts in his/her life. They also provide counselling and psychological support to common problems (Campbell-Hal et al., 2010). Thus they play a noteworthy role as community member's value their advice (Sorsdahl et al., 2009).

It was noted by participants that collaboration and referral are important aspects that need to be carefully looked at in relation to traditional healers. According to Sorsdahl et al., (2009) South Africa has limited psychiatric care and thus it may be beneficial to work with traditional healers. Campbell et al. (2010) also acknowledge that there is a treatment gap for mental disorders in South Africa. Hence the incorporation of traditional healers or religious clergy may help South Africa move forward in the management of mental illness as they are knowledgeable about cultural norms (Sorsdahl et al., 2009).

Some participants (n=7), in the present study, were of the opinion that referral and collaboration can take place whereas others (n=3) differed and preferred to treat patients solely from a western medical model. On the other hand, half of the participants (n= 5), in the current study, proposed collective/dual treatment as it would benefit the patient. Hopa, Simbaya and du Toit, (1998) reported that western systems of care and traditional healers prefer the option of collaboration which still allows each practitioner to remain autonomous but co-operate through mutual referral. Xhosa psychiatric nurses were of the opinion that dual psychiatric and traditional treatments would benefit patients (Kahn & Kelly, 2001). Likewise South African Muslim faith healers (maulana/aamil) were also in favour with collaborating with medical practitioners as they reflected that illness can consist of medical, psychological and /or spiritual elements (Ally & Laher, South African Muslim faith healers perceptions of mental illness: Understanding, aetiology and treatment, 2008). Nevertheless it was postulated that traditional healers are more eager for reciprocal collaboration than western practitioners (Campbell-Hall, et al., 2010). This was also observed in the current study where three participants were not in favour of referral or collaboration with traditional healers as they are not medically or scientifically trained. Thus one participant clearly stated that traditional healers without scientific training cannot be referred to. This was supported by previous research (Wreford, 2005) who reported that western health practitioners believe that traditional practitioners need to be educated and hence they refer

patients to western systems of health care and psychiatric care instead of untrained traditional healers (Campbell-Hal et al., 2010; Wreford, 2005).

Participants also pointed out that Muslim traditional healers like maulanas tend to be harmless as they did not prescribe medication. Patients are given water to drink which has been prayed on and thavees which are harmless. However, some participants stipulated that the African traditional healer can pose a danger to the patient as often herbal medication is prescribed and this can be harmful. According to Campbell-Hall et al. (2010) community members found that African traditional medicine (herbal) often made them worse and did not help.

Hence, a number of participants also reported that they are less likely to refer to traditional healers and definitely won't refer to a sangoma. They will however not stop patients from seeing spiritual healers. This concurs with Campbell-Hall et al. (2010) whom reported that health workers did not prevent consultation with traditional practitioners but were also unlikely to refer to them. It was suggested that alternate forms of healthcare are often more accessible to patients than Western modes of treatment (Sorsdahl et al., 2009) as it is often cheaper and they provide an "alternative culturally embedded system of healing" (Campbell-Hall et al., 2010, p. 611).

4.8.2 Psychologists and psychiatrists

All of the participants agreed that they would refer patients to psychiatrists if the need arose. Thus it was dependent on an individual basis and the severity of the diagnosis. Participants however did highlight a significant factor of patients being reluctant to see psychiatrists and psychologists; and would prefer to see their GP and be given medication. In the study conducted by Hugo et al. (2003) as discussed above, it was revealed that the majority of the general South African public (n=492, 77.6%) viewed psychotherapy as the best treatment option. Psychiatrists were not considered as one of the treatment options but 54.5% of participants (n=345) would consult their GP (Hugo et al., 2003). Furthermore, a number of participants, in this study, expressed that although psychiatrists are considered, they very rarely refer to them. Psychologists are preferred at times as participants felt that often patients just need a space to talk. Furthermore a referral to psychiatrist was considered to be less effective as it was suggested that that psychiatrists may be better

equipped to deal with severely ill patients and psychotic patients and are less skilled in treating patients with non-psychotic illnesses (Ali et al., 2008).

Additionally, participants mentioned that there still may be stigma associated with seeing a psychologist or psychiatrist amongst Indian-Muslim patients in the community. According to Stones (1996) stigma or the 'social risk' is a key reason that individuals avoid consulting with mental-health professionals. Furthermore, cultural expectations that one should handle emotional difficulties without professional help may also contribute to participant's view of patients being reluctant to visits psychologists and psychiatrists (Fernando et al., 2010). Participants in this study acknowledged that patients may feel ashamed to let people know that they are in therapy as seeing a psychologist or psychiatrist is equated with madness.

A further factor that may prevent patients from seeking help is the concern of confidentiality. Due to the stigma associated with mental illness, a participant postulated that even though the psychologist may be a stranger, patients may feel that issues will not be kept confidential. Another participant posited that due to confidentiality concerns, a psychologist might be a more suitable treatment choice than speaking to a GP as he/she will be a stranger but on the other hand, patients might find it difficult to discuss personal issues with a stranger. In summary, despite changes from the old days it appears that patients are still ambivalent with regards to psychotherapy and consulting psychiatrists and hence will rather avoid consulting with these professionals than be shamed. A future possibility that might break the ice may centre on the inclusion of religion in psychotherapy with Muslim patients (cf: Razali et al., 2002).

4.9 Influential factors affecting GP's.

Participants discussed the influence of their medical training and experience as practitioners in detecting mental illness. Limitations surrounding treatment were also briefly highlighted and it was noted that time constraints affect GP's ability to provide patients with emotional care.

4.9.1 GP's medical training and experience

All of the participants claimed that their medical training had the most influence on them. Furthermore it was noted that prior to training they were not knowledgeable about mental illness and may have ascribed to a cultural viewpoint. However opinions that in South Africa,

doctors' psychiatric training is limited and two participants wished more time was spent on learning about psychiatric conditions and common mental illness during their undergraduate and internship years. According to research conducted on undergraduate medical students (n=70) in the UK, it was found that medical student's attitudes towards psychiatry and mental illness became more positive once they received training during the course of the their undergraduate study (Baxter, Singh, Standen, & Duggan, 2001). However their attitudes declined once they were in their final year of study and hence their positive attitude towards psychiatry was temporary. In a later study, it was found that Sri Lankan medical students demonstrated more negative attitudes towards mental illness than doctors (Fernando et al., 2010). Hence there seems to be a need for more psychiatric training in the undergraduate curriculum. On the contrary, Dixon et al. (2008) posited that despite general clinical and psychiatric training, students had negative attitudes towards mentally ill patients. Forty five percent of the students aspired to practice as GP's but their views regarding mentally ill patients did not alter (Dixon et al., 2008). This is in contrast to previous research which suggested that with training, attitudes towards mental illness will change (Dixon et al., 2008).

Furthermore, participants expressed that their training was based in a hospital setting and hence they were only exposed to severely ill patients and did not consult with patients who had less severe illnesses. Thus, when common mental illness is presented in GP practice, GP's may not be aware of it and subsequently may not be in the position to recognise and treat it.

Furthermore, some participants felt that older doctors were more entrenched in their cultural beliefs and did not have sufficient exposure to mental illness despite having a greater amount of experience. Thus older GP's may fail to recognise mental illnesses, like depression and anxiety, as serious conditions. This may also be due to "olden day" perceptions of mental illness. Once again, the older doctors did not receive comprehensive psychiatric training and two older participants acknowledged that further training and awareness is desperately needed in the community. Hence it was mentioned that continuous professional development (CPD) is essential for doctors. Additionally, one participant mentioned that seminars held by community clinics also very beneficial in

educating both the doctors as well as the community members wither regards to different aspects of mental illness.

Stigmatizing attitudes is found across cultures and hence medical education is capable of reducing stigma (Fernando et al., 2010). A large number of studies (Adewuya & Oguntade, 2007; Ali et al., 2008; Dixon et al., 2008; Fernando et al., 2010; Imran & Haider, 2007) have been conducted to determine doctors and medical undergraduates attitudes towards people with mental illness and subsequent recommendations have been to include further exposure to mentally ill patients as well as provide more psychiatric training to undergraduate students.

4.9.2 Time constraints

Participants in the current study claimed that consultations with patients are very short due to the quantity of patients they need to see per day. Hence they do not have time to discuss emotional issues that arise. According to Cinnirella and Loewenthal (1999) GP's were perceived as being too busy to talk to patients and assist them with stressful life events. Patients in that study thus felt that GP's had no time to listen to personal problems and were not good listeners (Cinnirella & Loewenthal, 1999). Similarly Cape and Mcculloch (1999) reported that patients (48%) may experience difficulty in presenting their emotional problems to their GP as they feel that GP's do not have the time to listen or be interested. Both GP's and patients experience dissatisfaction with consultation time and discussion of emotional difficulties leads to longer consultations which is unsuitable (Cape & McCulloch, Patients' reasons for not presenting emotional problems in general practice consultations, 1999). Furthermore, patients (39%) were of the opinion that there is nothing the GP could do to help with their emotional problems and once again both doctors and patients doubt the doctors' competency in dealing with psychological problems (Cape & McCulloch, Patients' reasons for not presenting emotional problems in general practice consultations, 1999). Participants in the current study also expressed GP's limitations in providing psychological care and although they would try their best, they felt it would be best to refer patients to a professional psychologist.

4.10 Conclusion

General practitioners seemed to understand mental illness in terms of a medical model. However the aetiology of mental illness was understood broadly to include socioeconomic, financial, social factors and lifestyle problems together with medical conditions by most practitioners. GP's also acknowledged the important role culture plays with regards to their own as well as the community's perception of mental illness. Based on the findings it was evident that stigma towards mental illness coloured all of the results. Thus stigma may be considered to be a huge problem in the Lenasian community with both GP's and patients having a lack of knowledge regarding mental illness.

As a result secrecy around mental illness was shown to be a problem amongst the community and patients concealed their symptoms due to the stigma attached to mental illness. A further consequence of stigma was the somatisation of symptoms to reflect a physical illness rather than a mental illness.

Furthermore, GP's reported that a "fine line" exists between religion and culture. Hence GP's and patients were influenced by their religion and culture. It was highlighted that due to assimilation of Hindu and Muslim culture, many traditional beliefs regarding mental illness were still apparent. Thus cultural beliefs of nazr, jinn and jadoo dominated the Lenasian community's view of mental illness.

Both religion and culture were deemed to be pivotal in the understanding of perceptions as well the stigma attached to not only mental illness but also to the treatment of mental conditions. It was revealed that psychologist and psychiatrists were rarely consulted even though community perceptions towards these professionals have advanced in the last decade.

A further contributing factor that was highlighted was the misconception amongst patients who equated mental illness with spiritual illness. Thus cultural explanations regarding the causes of mental illness is often provided which points to misinformation amongst community members. GP's acknowledged the existence of spiritual illnesses but expressed that they were in no position to treat such conditions. Hence traditional healing was considered an option. GP's were divided in the role that traditional healers play in the

community but acknowledged that patients would inevitably consult with them and hence they should be recognized.

The influence that religion, Islam specifically, played in the understanding and treatment of mental illness was shown to be significant. Thus Islamic beliefs were touched on and GP's recognized that religious dimensions exist in the understanding of mental illness. As a result both GP's and their patients found value in having faith, praying and believing in the will of God.

Although GP's did not have negative attitudes towards mental illness, the lack of awareness, education, exposure, training and knowledge proved to be significant factors that may adversely affect the holistic treatment of the patients. Participants also pointed out that time constraints factors may influence their ability to provide effective care and treatment of patients with mental illness. GP's also acknowledge that older and younger doctors may have different views with regards to mental illness as their training differed and older doctors may be influenced by their culture and upbringing. To conclude, participants expressed the importance of community awareness regarding mental illness in the form of educational interventions aimed at both enhancing GP's and the general public's knowledge, with the hope of diminishing stigma. In the chapter to follow, limitations and implications of the study will be reviewed and thereafter suggestions for future research directions will be made.

Chapter 5: Limitations, Implications & Recommendations

5.1 Introduction

The study aimed to explore perceptions of mental illness among Muslim GP's of Indo-Pak ancestry who are practising in Lenasia, Johannesburg. Specifically, the study sought to determine if religion, particularly Islam, had any influence on these perceptions. As with all studies, this study had several limitations which will be outlined followed by the implications of the findings. Lastly, recommendations for future research will be explored.

5.2 Limitations

This study has several limitations which will de discussed in terms of conceptual limitations and methodological limitations.

5.2.1 Conceptual Limitations

Since the study aimed to explore Muslim GP's perception of mental illness, it was essential to comprehensively discuss and explain religious concepts and principles. The study also specifically focused on Muslim GP's who were from Indo-Pak ancestry. Hence, one was required to look at the Indian culture and religion of Hinduism which has contributed to the current South African Indian-Muslim identity. However, literature regarding Hinduism, its texts and Hindu psychology was very limited. Similarly, it was difficult to obtain academic sources which discussed Islamic psychology and the Islamic perspective regarding mental illness. The Quran and hadith are available as primary texts however it is essential that such texts are translated and interpreted by Islamic scholars as misinterpretation by layman will provide an artificial understanding. Thus translations of Islamic and Hindu texts were not readily available and are not easily accessible to the West.

Furthermore, no specific theory or model was used in this research due to the reliance of religious theologians and the Islamic faith as the core concept in the study and hence the theory was located in the Islamic and Hindu paradigm.

There is however no universal definition of spiritual illnesses and what comprises a spiritual illness. It may however be considered to fall under the DSM IV TR section on culture bound syndromes but it is not included. Furthermore, the West understood somatisation to mean "medically unexplained symptoms" "(MUS) whereas MUS appears to be understood by GP's to indicate symptoms that are not medically understood and are hence considered to be symptoms of a spiritual illness as they are unnatural. Hence GP's did not distinguish somatic symptoms from symptoms considered to be part of a spiritual illness.

Additionally, the results of the study clearly demonstrated the enmeshment of culture and religion in the Lenasian community and hence participants also experienced some difficulty in identifying which factor carried the most weight in their patient's perceptions. Lastly, there have been no studies examining these factors in the Lenasian community.

5.2.2 Methodological implications

The study aimed at exploring GP's perceptions of mental illness and thus it seemed fit to employ a qualitative study in order to obtain more depth and understanding. The researcher aimed to obtain the perspective of the GP's and thus semi-structured interviews were used to allow for probing and more open ended questions.

However in qualitative research, the researcher is part of the study and hence cannot be completely objective and value free (Struwig & Stead, 2001). Thus my biases and beliefs are an integral part of the research which cannot be ignored. Additionally, being an Indian and a Muslim, my personal opinions and values may have influenced the interviews and hence the results. I may have thus focused on aspects which I deemed interesting. Hence on reflection, a journal noting down my views and experiences would have been useful in order to minimise my subjectivity and bias.

In terms of the sample, the sample size was appropriate for the purpose of the study and due to time constraints could not have been larger. However, a large sample may have reflected different opinions and been beneficial in adding to the various perspectives that other GP's may have had. The sample may be seen as a limitation as although I attempted to obtain both recently qualified and established GP's, prior experienced obtained by GP's differed and thus GP's who were more exposed to mentally ill patients in hospital settings had different perceptions than those who only worked in private practice since qualifying.

Furthermore, GP's were of different ages and hence perceptions differed between the younger and older GP's. However, the fact that GP's were practising for varying amounts of time may be seen as a positive as it highlighted different perceptions across generations. A further factor that needs to be taken into account with regards to the sample is that some GP's were more religiously inclined than others whereas some were more aware of cultural norms.

In terms of the interviews, it was very difficult to obtain interviews with GP's as they found the length of the interview problematic as it interfered with their working hours. Time constraints were thus a crucial limitation to the study. Thus interviews were not as long as I would have liked them to be and a few GP's rushed to complete the interview and thus comprehensive information could not be obtained.

Although confidentiality was maintained, complete anonymity was not as face to face interviews were conducted. However pseudonyms were used to maintain confidentiality. It was also noted that although all of the GP's agreed to be audio recorded, once the audio recorder was switched off, they were more open and honest. A number of GP's revealed personal experiences regarding mental illness and mentioned that issues like substance abuse are common in the community but are considered taboo and hence not spoken off. Thus there is a possibility that some participants may have held back or censored their responses. Similarly some GP's also tended to withhold information which in some way correlates with the findings that the community is unwilling to discuss and disclose mental illness due to stigma. This further demonstrates that GP's had difficulty in trusting that confidentiality will be maintained and hence were reluctant to voice their beliefs while being audio recorded.

A number of participants (n=4) were also unable or unwilling to answer a few questions regarding how mental illness is conceptualized in different religions and cultures; the Islamic perspective regarding mental illness; western understanding of mental illness as well as the difference between a mental, psychological and spiritual illness and this may have affected the results.

Furthermore, the study was conducted in only one Indian-Muslim community in Johannesburg; therefore the findings of the study are not a true reflection of all Indian-

Muslim GP's in the country. The GP's were also all from Indo-pak ancestry and as such the findings in this study may not be generalized to all GP's.

Lastly, Islamic terminology and reference to Islamic practices was used throughout the study and this may be confusing to a reader who is not familiar with the religion, practices and beliefs. English translations were provided to accommodate for this. However it is possible that such brief explanations and the inability to explain the Islamic faith comprehensively due to time constraints may make it difficult for a reader, with no knowledge of the Islamic faith, to fully understand the study.

5.3 Implications

The findings of this study in context with past research have significant implications to GP's as well as other healthcare professionals. Furthermore, Lenasian community members who are the patients of GP's will also be affected by GP's perceptions.

Moving forward, GP's practising in the Lenasian community should continue to be aware of the tendency of the population to hold negative perceptions of mental illness and to therefore consequently conceal symptoms, somatise and neglect their emotional statuses. As noted by research (cf: Bentzen, et al., 1991; Dixon et al., 2008; Fernando et al., 2010) GP's are in a pivotal position as primary caregivers to help the community and they should thus be encouraged to play an active role in furthering their own education as well as educating the public regarding mental illness and the deeply rooted stigma attached to it.

GP's should thus take note of their own stigmatizing attitudes as well as those of the society in which they live in. Thus training and continuous professional development is essential in educating and combating myths, stigma and false beliefs. Efforts should be made to address stigma by hosting anti-stigma campaigns and seminars educating medical professionals and the public regarding mental illness. Thus the study may be useful in providing a reference to the research that may be conducted in the future from a South African context which will now be discussed below.

Likewise, care should be taken with regards to other healthcare professionals' role in managing mentally ill patients. Thus collaboration with traditional healers is an important area that needs further attention in order to provide holistic care to patients. GP's should

also encourage patients to consult with psychologists in order to minimize the gap between physical and psychiatric illnesses as well as prevent social/societal stigmatization of consulting with psychologists and psychiatrists.

GP's are also unsure of how to approach religious and spiritual issues with their patients and hence tread cautiously. Furthermore, research may be conducted in terms of looking at spiritual illness as a category of illness in Western classification systems such as the DSM. Indians, Muslims, Hindu's as well the African population believe in supernatural causation of illness and hence spiritual illness as well traditional healing form an important part of a large proportion of the African population.

5.4 Recommendations for future research

In continuation from this study, future research may also concentrate specifically on the perceptions of Lenasian community members, from Indo-Pak ancestry, regarding mental illness and a comparison study may be conducted. However, since the role of culture was shown to be pivotal in this sample, future research may also include investigating perceptions of mental illness in a sample of participants that were Muslim but not from Indo-Pak ancestry or alternatively non-Muslims who are from Indo-pak ancestry. Thus comparisons will assist in identifying common issues and/or differences and help to expand the literature base regarding mental illness and the role that religion and culture play in fostering positive or negative attitudes.

Since the study was limited to GP's of Indo-pak ancestry, the findings could not be generalized to indicate the perceptions of all GP's, hence future research could focus on investigating the attitudes of GP's, as well as other healthcare professionals, towards mental illness from different religious and racial backgrounds in other areas of the country.

Based from the results, it was established that often patients use concurrent treatment when they are ill, hence prayers, traditional healing together with Western medicine are used. Thus this study also adds to the literature regarding traditional healing and spiritual illness in South Africa and opens the pathway for further exploration regarding the diverse cultural beliefs that exist.

Additionally, future studies may be conducted amongst traditional healers and GP's with the aim of identifying each practitioner's role in the treatment of the patient and opening pathways for communication and collaboration.

The results of this study clearly demonstrated the lack of community awareness and education in some parts of South Africa regarding mental illness. Thus future studies would benefit from addressing stigma in different areas of South Africa. Therefore there is a need for research to clarify what the harmful consequences of stigmatizing attitudes are for psychiatric patients in South Africa. Therefore, a further recommendation may include psychoeducation and workshops for traditional healers, Islamic scholars, GP's, psychiatrists and psychologists in order to gain better understanding of mental illness in the community from different perspectives in order to avert the stigma attached to it. Additionally, psychiatric patients experience with healthcare professionals would highlight the impact of both positive and negative care.

The findings in this study highlight the need for GP's to take into account the influence of religious beliefs among their more religious clientele. Hence, healthcare professionals need to become more culturally competent and be aware of the diversity of the South African population in order to provide holistic care.

Since there has been a gap in research regarding the role that the religion plays in mental health and well-being in South Africa, future research may address religious involvement and mental health by having a larger sample consisting of community members with different religious beliefs in order to achieve a more diverse understanding of the role that one's faith plays. Focus groups would be useful in this regard. Furthermore, quantitative research could also be conducted as that would allow for larger samples. Thus quantitative research may be beneficial in developing indicators to determine what people believe constitutes a mental illness or a spiritual illness and may be administered broadly which could support or refute previous studies conducted.

Islam is a way of life and hence Muslims incorporate their religion into every aspect of their lives. However academic literature regarding Islamic perceptions of physical and mental illness is not common and thus the study adds to the body of literature both locally and internationally. It also encourages researchers to conduct further research in this area.

Additionally, Islamic and Hindu psychology are unfamiliar terms and attention could be drawn in increasing knowledge and awareness of the importance of managing patients from a religious perspective. Thus research could be conducted to explore whether a religious paradigm may be included into western mainstream psychology in order to develop culturally competent diagnosis and treatment.

5.5 Conclusion

This study focused on Muslim GP's perceptions of mental illness that were from Indo-pak ancestry. General practitioners are considered the first point of entry when seeking healthcare from a variety of ailments. Thus their attitudes are of paramount importance. It was ascertained that religion and culture are important and influential factors that contribute to both GP's and their patients understanding of mental illness. Hence, both factors may influence the treatment sought and the management of the patient may include concurrent treatment from both a Western medical perspective as well as from a cultural-religious perspective. The impact of religion was significant as Muslim patients were prone to include prayers when affected with any illness. Thus the Islamic faith and the belief in God's will was imperative to many patients, however, GP's treaded cautiously in providing patients with religious advice.

GP's considered the causes of mental illness to stem from medical reasons; however they acknowledged the inclusion of spiritual illness and the difficulty in distinguishing spiritual illness from a psychiatric illness. Thus referral and collaboration with traditional healers was debatable with GP's differing in their beliefs. Importantly, stigma was identified as a common problem amongst the Lenasian community and amongst patients from Indo-Pak ancestry. Stigma hence included the hesitancy of patients to disclose emotional symptoms to their GP, the tendency to present with somatic complaints and a tendency to conceal mental illness from family and community members. The role of psychology in such communities were also looked at and although there has been an increase of awareness and referral to psychologists, a large portion of the community is still apprehensive in consulting with psychologists as the they fear being labelled and stigmatized. GP's limited experience in dealing with mental illness is also an area which can be improved.

Based on the results of the study, it was recommended that future research may be conducted with Lenasian community members from Indo-pak ancestry; other healthcare professional's attitudes towards mental illness as well as GP's from different religious and racial backgrounds. Future studies could also focus on addressing stigma, consequences of stigma, traditional healing and the role of religion in mental health. Additionally, research regarding the exploration of Islamic perceptions of physical and mental illness as well as Islamic and Hindu psychology may be conducted as there are gaps in these areas.

It is thus hoped that this research has added to the knowledge and awareness regarding mental illness in the Lenasian community and as a result, it will be used to dissipate the negative perceptions associated with mental illness amongst GP's and the community at large.

6. Reference list

Abdool, K., & Ziqubu-Page, T. (2004). Bridging the Gap: Potential for a health care partnership between African traditional healers and biomedical personnel in South Africa. *South African Medical Association.* Available at: www.samedical.org.

Abiodun, O. (1995). Pathways to mental health care in Nigeria. *Psychiatric Services, 45*, 823-826.

Adewuya, A., & Oguntade, A. (2007). Doctors' attitude towards people with mental illness in Western Nigeria. *Social Psychiatry and Psychiatric Epidemiology, 42*, 931-936.

Ali, A. (2000). *The Meanings of the illustrious Qur'an.* Delhi: Milat Book Centre.

Ali, N. H., Radwan, M., & Al-Shihabi, F. A. (2008). Attitudes of general practitioners towards cause and management of patients with medically unexplained symptoms; capital health district, Kuwait. *Kuwait Medical Journal, 40*, 111-115.

Alias, A. (2010, December 21). *An Islamic redefinition of psychology*. Retrieved December 31, 2010, from Islam and Psychology: http://blogs.iium.edu.my/alizi/2010/12/21/an-islamic-redefinition-of-psychology/#more-1303

Al-Issa, I. (2000). *Al-Junun: Mental illnessin the Islamic world.* Connecticut: International Universities.

Ally, Y. (2008). Cultural perceptions of psychological disturbances: The folklore beliefs of South African Muslim and Hindu community members. *Unpublished MA dissertation: University of the Witwatersrand*, Johannesburg.

Ally, Y., & Laher, S. (2008). South African Muslim faith healers perceptions of mental illness: Understanding, aetiology and treatment. *International Journal of Religion and Mental Health, 47*, 45-56.

Al-Qarni, A. A. (2003). *Don't be sad.* Riyadh: International Islamic Publishing House.

Amer, M. M., & Hood, J. R. (2008). Special issue: Part II. Islamic religiosity: Measures and mental health. *Journal of Muslim Mental Health, 3*, 1-5.

Appiah-Poka, J., Laugharne, R., Mensah, E., Osei, Y., & Burns, T. (2004). Previous help sought by patients presenting to mental health services in Kumasi, Ghana. *Social Psychiatry Psychiatric Epidemiology, 39*, 208-211.

Arthur, C. F., Hickling, F. W., Robertson-Hickling, H., Haynes-Robinson, T., Abel, W., & Whitley, R. (2010). "Mad, sick, head nuh good": Mental illness stigma in Jamaican communities. *Transcultural Psychiatry, 47*, 252-75.

Ashy, M. (1999). Health and illness from an Islamic perspective. *Journal of Religion and Mental Health, 38*, 241-257.

American Psychological Association. (n.d.). *Diagnostic and Statistical Manual of Mental Disorders*. Retrieved January 21, 2012, from www.psych.org: http://www.psych.org/MainMenu/Research/DSMIV.aspx

Baxter, H., Singh, S. P., Standen, P., & Duggan, C. (2001). The attitudes of 'tomorrow's doctors' towards mental illness and psychiarty: Changes during the final undergraduate year. *Medical Education, 35*, 381-383.

Bentzen, B., Brigdes-Web, C., Carmichael, L., Ceitlen, J., Feinbloom, R., Metcalf, D., et al. (1991). The role of the family practitioner/family physician in helath care sytems: A statement from WONCA. *WONCA International Classification Committee.* WONCA.

Bhugra, D. (2006). Severe mental illness across cultures. *Acta Psychiatra Scandinavia, 429*, 17-23.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Brems, C. (2001). *Basic skills in psychotherapy and counselling.* Belmont: Wadsworth.

Bulbulia, T. (2011). Islamic perceptions of mental illness amongst South African Muslim psychiatrists. *Unpublished Honours dissertation* . University of the Witwatersrand, Johannesburg.

Byrnes, R. (1996). *South Africa*. Retrieved February 12, 2011, from countrystudies.us: http://countrystudies.us/south-africa/52.htm

Campbell-Hall, V., Petersen, I., Bhana, I., Mjadu, S., Hosegood, V., & Flisher, A. J. (2010). Collaboration between traditional practitioners and primary health care staff in South Africa: developing a workable partnership for community mental health services. *Transcultural Psychiatry, 47*, 610-28.

Cape, J. (2001). How general practice patients with emotional problems presenting with somatic or psychological symptoms explain their improvement. *British Journal of General Practice, 51*, 724-729.

Cape, J., & McCulloch, Y. (1999). Patients' reasons for not presenting emotional problems in general practice consultations. *British Journal of General Practice, 49*, 875-879.

Carter, D. J., & Rashidi, A. (2003). Theoretical model of psychotherpay: Eastern Asina-Islamic women with mental illness. *Health Care for Women International, 24*, 399-413.

Chiu, L., Ganesan, S., Clark, N., & Morrow, M. (2005). Spirituality and treatment choices by South and East Asian women with serious mental illness. *Transcultural Psychiatry, 42*, 630-656.

Cinnirella, M., & Loewenthal, K. (1999). Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study. *British Journal of Medical Psychology, 72*, 505-524.

Cornelissen, R. M., Misra, G., & Varma, S. (n.d). *Introduction to foundations of Indian psychology*. Retrieved March 05, 2011, from Indian Psychology Institute: http://ipi.org.in/texts/matthijs/fip-introduction.php

Dalal, A. (2010). A journey back to the roots: Psychology in India. In M. Cornelisson, G. Misra, & S. Verma (Eds.), *Foundations of Indian Psychology.* New Delhi: Pearson.

Dalal, A., & Misra, G. (2010). The core and context of Indian psychology. *Psychology Developing Societies, 22*, 121-155.

Deuraseh, N., & Abu Talib, M. (2005). Mental health in Islamic medical tradition. *International Medical Journal, 4*, 76-79.

Deveugele, M., Derese, A., & De Maeseneer, J. (2002). Is GP–patient communication related to their perceptions of illness severity, coping and social support? *Social Science and Medicine, 55*, 1245-1253.

Dixon, R. P., Roberts, L. M., Lawrie, S., Jones, L. A., & Humphrey, M. S. (2008). Medical students' attitudes to psychiatric illness in primary care. *Medical Education, 42*, 1080-1087.

Dunn, E. (1986). *The adventures of Ibn Battuta, a Muslim traveler of the fourteenth century.* University of California Press.

Fernando, S. M., Deane, F. P., & McLeod, H. J. (2010). Sri Lankan doctors' and medical undergraduates' attitudes towards mental illness. *Social Psychiatry and Psychiatric Epidemiology, 45*, 733-739.

Fernando, S., Deane, F., & McLeod, H. (2010). Sri Lankan doctors' and medical undergraduates' attitudes towards mental illness. *Social Psychiatry Epidemiology, 45*, 733-739.

George, L. K., Larson, D. B., Koenig, H. G., & McCullough, M. E. (2000). Spirituality and health: What we know, what we need to know. *Journal of Social and Clinical Psychology, 19*, 102-116.

Gielen, U., Fish, J., & Draguns, J. (2004). *Handbook of culture, therapy, and healing.* Retrieved April 11, 2011, from http://books.google.co.za/books?hl=en&lr=lang_en&id=nfNr_sukZkwC&oi=fnd&pg=PA293&dq=Sinha+AND.+hinduism+and+mental+illness&ots=tM-CqRBdWr&sig=O3u5Q4BzVt0X-nUXg9co1eB16Qg#v=onepage&q=ayurveda&f=false

Greasley, P., Chiu, L. F., & Gartland, M. (2001). The concept of spiritual care in mental health nursing. *Journal of Advanced Nursing, 33*, 629-637.

Greenwood, N., Hussain, F., Burns, T., & Raphael, F. (2000). Asian in-patient and carer views of mental health care. Asian views of mental health care. *Journal of Mental Health, 9*, 397-408.

Haarmans, M. (2004). *A review of cultural competence: Definitions, key components, standards and selected trainings.* Toronto: Centre for Addiction and Mental Health.

Haque, A. (2004). Psychology from Islamic perspective: Contributions of early Muslim scholars and challenges to contemporary Muslim psychologists. *Journal of Religion and Health, 43*, 357-377.

Hindu Existence. (2011, January 29). *Increasing Muslim population in India will create severe persecution*. Retrieved January 21, 2012, from hinduexistence.wordpress.com:

http://hinduexistence.wordpress.com/tag/increasing-muslim-population-in-india-will-create-severe-persecution/

Hopa, M., Simbaya, L., & du Toit, C. D. (1998). Perceptions on integration of traditional and Western healing in the new South Africa. *South African Journal of Psychology , 28*, 8-15.

Hugo, C. J., Boshoff, D. E., & Traut, A. (2003). Community attitudes toward and knowledge of mental illness in South Africa. *Social Psychiatry Psychiatic Epidemiology , 38*, 715-719.

Imran, N., & Haider, I. I. (2007). The stigmatization of psychiatric illness: What Attitudes do medical students and family physicians hold towards people with mental illness? *Pakistan Journal of Medical Science, 23*, 318-322.

IPI. (n.d.). *What is Indian Psychology*. Retrieved March 05, 2011, from Indian Psychology Institute: http://ipi.org.in/second/whatisip.php

Ismail, Z. (2010). Muslim psychologists perceptions of mental illness. *Unpublished Honours dissertation*, University of the Witwatersrand, Johannesburg.

Jackson, J. L., Kroenke, K., & Chamberlain, J. (1999). Effects of physician awareness of symptom-related expectations and mental disorders. *Archaic Family Medicine, 8*, 135-142.

Jacob, K. S., Bhugra, D., Lloyd, K. R., & Hann, A. H. (1998). Common mental disorders, explanatory models and consultation behaviour among Indian women living in the UK. *Journal of the Royal Society of Medicine, 91*, 66-71.

Jain, R. (2010, January 12). *Are we exporting western definitions of mental illness to the rest of the world?* Retrieved January 17, 2010, from Integral Options Cafe: http://integral-options.blogspot.com/2010/02/are-we-exporting-western-definitions-of.html

Kahn, M., & Kelly, K. (2001). Cultural tensions in psychiatric nursing:Managing the interface between Western mental health care and Xhosa traditional healing in South Africa. *Transcultural Psychiatry, 38*, 35-50.

Karim, S., Saeed, K., Rana, M., Mubbashar, M., & Jenkins, R. (2004). Pakistan mental health country profile. *International Review of Psychiatry, 16*, 83-92.

Khalili, S., Murken, S., Reich, K., Shah, A., & Vahabzadeh, A. (2002). Religion and mental health in cultural perspective: Observations and reflections after the first international congress on religion and mental health, Tehran, 16-19 April 2001. *The International Journal for the Psychology of Religion*, *12*, 217-237.

Koenig, H., & Larson, D. (2001). Religion and mental health: Evidence for an association. *International Review of Psychiatry, 13*, 67-78.

Laher, S., & Khan, S. (2011). Exploring the influence of Islam on the percepion of mental illness of voluneers in a Johannesburg community-based organisation. *Psychology in Developing Societies, 23,* 63-84.

Leavey, G. (2010). The appreciation of the spiritual in mental illness: A qualitative study of beliefs among clergy in the UK. *Transcultural Psychiatry, 47*, 571-590.

Loganathan, S., & Murthy, R. S. (2011). Living with schizophrenia in India: Gender perspectives. *Transcultural Psychiatry, 48*, 569-584.

Mavundla, T. R., Toth, F., & Mphelane, M. L. (2009). Caregiver experience in mental illness: A perspective from a rural community in South Africa. *International Journal of Mental Health Nursing, 18*, 357-367.

Meissner, O. (2004). The traditional healer as part of the primary health care team? *South African Medical Journal, 94*, 901-902.

Meyer, W., Moore, C., & Viljoen, H. (2003). *Personology: From individual to ecosystem (3rd ed.).* Cape Town: Heinemann.

Mukherjee, R., Fialho, A., Wijetunge, A., Checinski, K., & Surgenor, T. (2002). The stigmatisation of psychiatric illness: The attitudes of medical students and doctors in a London teaching hospital. *Psychiatric Bulletin, 26*, 178-181.

Murthy. (2009b). Contemporary relevance of Hinduism to mental health. (A. Sharma, Ed.) *Spirituality and Mental Health*, 111-135.

Murthy. (2009a). Hinduism and Mental Health: Chapter 9. In P. Verhagen, H. Van Praag, J. Lopez-Ibor Jr, J. Cox, & D. Moussaoui, *Religion and Psychiatry: Beyond Boundaries.* Chichester: Wiley-Blackwell.

Naeem, F., Ayub, M., & Jayed, Z. (2006). Stigma and psychiatric illness: A survey of attitude of medical students and doctor in Lahore, Pakistan. *Journal of Ayub Medical College Abbottabad, 18*, 46-49.

Ng, C. (1997). The stigma of mental illness in Asian cultures. *Australian and New Zealand Journal of Psychiatry, 31*, 382-392.

Padayachee, P. (2010). Hindu psychologists perceptions of mental illness. *Unpublished MA dissertation: University of the Witwatersrand,* Johannesburg.

Pies, R. (2010, January 12). *Are we exporting western definitions of mental illness to the rest of the world?* . Retrieved January 17, 2011, from Integral Options Cafe: http://integral-options.blogspot.com/2010/02/are-we-exporting-western-definitions-of.html

Pill, R., Prior, L., & Wood, F. (2001). Lay attitudes to professional consultations for common mental disorder: A sociological perspective. *British Medical Bulletin, 57*, 207-19.

Pillow, W. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *Qualitative Studies in Education, 16*, 175-196.

Rashidi, A., & Rajaram, S. (2001). Culture care conflicts among Asian-Islamic immigrant women in US hospitals. *Holistic Nuring Practice, 16*, 55-64.

Rassool, G. (2000). The crescent and Islam, Healing, nursing and the spiritual dimension. Some considerations towards an understanding of the Islamic perspectives on caring. *Journal of Advanced Nursing, 32*, 1476-1484.

Razali, S. M., Aminah, K., & Khan, U. A. (2002). Religious–cultural psychotherapy in the management of anxiety patients. *Transcultural Psychiatry, 39*, 130-136.

Reid, S., Whooley, D., Crayford, T., & Hotopf, M. (2001). Medically unexplained symptoms-GPs' attitides towards their cause and management. *Family Practice, 18*, 519-523.

Russinova, A., Wewiorski, N. J., & Cash, D. (2002). Use of alternative health care practice by persons with serious mental illness: Perceived benefits. *American Journal of Public Health, 92*, 1600-1604.

Sadock, B., & Sadock, V. (2007). *Kaplan & Sadock's synopsis of Psychiatry: Behavioural sciences/clinical psychiatry (10th ed.).* Philadelphia: Lippincott Williams & Williams.

Satorius, N. (2007). Stigma and mental health. *The Lancet, 370*, 859-878.

Shanti, A. (2002). Psychology: need for a paradigm change. *National Conference on Yoga and Indian Approaches to Psychology. http://ipi.org.in/texts/nsip/nsip-full/shantiauluck.php.* Pondicherry: Indian Psychology Institute.

Shibre, T., Negash, A., Kullgren, G., Kebede, D., Alem, A., Fekadu, A., et al. (2001). Perception of stigma among family members of individuals with schizophrenia and major affective disorders in rural Ethiopia. *Social Psychiatry Psychiatric Epidemiology, 36*, 299-303.

Sinha, D. (1990). Concept of psycho-social well-being: Western and Indian perspectives. *NIMHANS Journal , 8*, 1-11.

Sorsdahl, K., Stein, D. J., Grimsrud, A., Seedat, S., Flisher, A. J., Williams, D. R., et al. (2009). Traditional healers in the treatment of common mental disorders in South Africa. *The Journal of Nervous and Mental Disease, 197*, 434-41.

Sorsdahl, K., Stein, D., & Flisher, A. J. (2010). Traditional healer attitudes and beliefs regarding referral of the mentally ill to Western doctors in South Africa. *Transcultural Psychiatry, 47*, 591-609.

Spiro, A. (2005). Najar or Bhut-Evil eye or ghost affliction: Gujarati views about illness causation. *Anthropology and Medicine, 12*, 61-73.

Stones, C. R. (1996). Attitudes toward psychology, psychiatry and mental illness in the central Eastern Cape of South Africa. *South African Journal of Psychology, 26*, 221-225.

Struwig, F., & Stead, G. (2001). *Planning, designing and reporting research.* Cape Town: Maskew Miller Longman.

Sue, D., Sue, D., & Sue, S. (2006). *Understanding abnormal behaviour (8th ed.).* Boston: Houghton Mifflin.

Tibi, S. (2006). Al-Razi and Islamic medicine in the 9th century. *Journal of the Royal Society of Medicine, 99*, 206-207.

van den Brink-Muinen, A., Verhaak, P., Bensing, J., Bahrs, O., Deveugele, M., Gask, L., et al. (2000). Doctor–patient communication in different European health care systems: Relevance and performance from the patients' perspective. *Patient Education and Counseling, 39*, 115-127.

Verhaak, P. (1993). Analysis of referrals of mental health problems by general practitioners. *British Journal of General Practice, May*, 203-208.

Watters, E. (2010). *Crazy Like Us: The Globalization of the American Psyche .* New York: Free Press.

Wenar, C., & Kerig, P. (2006). *Developmental Psychopathology: From infancy through adolescence (5th ed.).* Boston: McGraw-Hill.

WHO. (2001). *The world health report 2001 – mental health: New understanding, new hope.* Geneva: WHO.

Wig, N. N. (1999). Mental health and spiritual values.A view from the East. *International Review of Psychiatry, 11*, 92-96.

Winkelman, M. (2001). Alternative and traditional medicine approaches for substance abuse programs: A shamanic perspective. *International Journal of Drug Policy, 12*, 337-351.

Wirth, M. (n.d.). *Re-discovered! -- Indian Psychology*. Retrieved March 5, 2011, from Indian Psychology Institute: http://ipi.org.in/texts/btw/btw-second-maria3.html

Wreford, J. (2005). Missing each other: Problems and potential for collaborative efforts between biomedicine and traditional medicine in South Africa. *Social Dynamics, 31*, 55-8.

Appendix A: Subject Information Sheet



School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg, South Africa

Tel: (011) 717-4500 Fax: (011) 717-4559

Assalamualykum

My name is Zaakiyah Mohamed. I am currently doing my Masters degree in psychology at the University of the Witwatersrand. As part of my studies I am required to conduct a research project. My research intends focussing on Muslim general practitioners perceptions of mental illness. I would like to invite you to participate in my study. Participation is voluntary and will involve an interview of approximately 45 minutes to one hour. All information will be treated confidentially. Even though the interviews will be tape-recorded, only my supervisor and I will have access to the tapes and both the tapes and the transcripts of the tapes will be kept in a locked cupboard at the university for three years and destroyed thereafter. You are free to answer only the questions you feel comfortable with and to withdraw any information you provide at any time with no consequence. There are no benefits or risks associated with participation in this study. Your anonymity will be ensured in that no identifying information about you will be revealed in my report or subsequent publications. You will be referred to by a pseudonym, e.g. participant A or participant B.

If you have any further queries or you would like to know the overall results of the study, please feel free to contact me. A summary of the study and the results should be available on request approximately six months after the interview. My contact details appear in the signature below. Thank you for taking the time to read this. Your participation will be highly appreciated.

Kind Regards

_____ _____

Zaakiyah Mohamed

082 303 5006

zaakiyahkaloo@gmail.com

Sumaya Laher

011 717 4532

sumaya.laher@wits.ac.za

Appendix B: Consent Form (Interview)

I, _____ hereby consent to being interviewed by Zaakiyah Mohamed, for her study exploring the perceptions of mental illness amongst Muslim general practitioners. I understand that:

- Participation is strictly voluntary.
- I do not have to answer all the questions should I choose not to.
- I am free to withdraw from the study at anytime.
- My identity as well as any information I reveal will be confidential.
- I will be referred to by a pseudonym in the research report and any subsequent presentations or publications.
- There are no benefits or risks associated with the study.
- The results of the study will be reported in the form of a research report for the partial completion of the degree, Masters in Clinical Psychology.
- The use of direct quotations from the interview may be used in the research report but it will not be possible to identify you from the quotes as pseudonyms will be used.
- The research may also be presented at a local/international conference and published in a journal and/or book chapter.

Signature_____

Date_____

Appendix C: Consent Form (Recording)

I, _____ give my consent for my interview with Zaakiyah Mohamed to be recorded for her study exploring the perceptions of mental illness amongst Muslim general practitioners. I understand that:

- The recordings will be confidential and only Zaakiyah and her supervisor will have access to them.
- Throughout the study, I will be referred to by a pseudonym (Participant A or Participant B, etc) and no identifying information will be revealed.
- After the study has been completed the tapes will be kept in a locked cupboard at the university for three years and destroyed thereafter.
- Tapes are kept primarily to facilitate the research being presented or published.

Signature_____

Date_____

Appendix D: Interview Schedule

Introduction

Assalamualykum

I'm Zaakiyah. We spoke on the phone. I would like to thank you for agreeing to participate in my study. With your permission I am going to record the interview but 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 kept at the university in a locked cupboard for three years. This is primarily to facilitate the publication of the study. After three years they will be destroyed. Although I know who you are, confidentiality will be maintained by not disclosing any information that is of a personal nature in the report. I will assign a pseudonym to your information in the report, for example, Participant A or Respondent B.

I would like to remind you that you have the right to withdraw from the study at any time during the interview. You also have the right to refrain from answering any question/s 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. You may e-mail or phone me if you would like to receive this. The feedback will be available approximately 6 months after the collection of the data. My contact details are on this information sheet.

Before beginning the interview I will need you to read through the information sheet. It just details what we have just spoken about. If you are in agreement with this, please sign these two consent forms (See Appendix B & C). These forms just confirm that you are aware of everything that we have discussed concerning confidentiality, feedback and privacy.

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

Questions:

Contextual questions

1. How long have you been practising as a GP?
2. What kinds of patients do you consult with? (also their demographic characteristics especially population group, gender, cultural affiliation)
3. And in terms of their problems/pathologies? (Remind practitioner that they should not compromise their clients' confidentiality).
4. Are patients from a specific racial and/or religious group?
5. Before working here, where else did you consult (ever since internship)?

General practitioners perceptions of mental illness

6. As a general practitioner, what is your definition of a mental illness?
7. What percentage of patients would you say present with mental illness?
8. What are the most common types of mental illness that patients present with? What are the commonest symptoms?
9. Is there a difference in symptoms amongst various religious and population groups?
10. As a general practitioner, what would you attribute mental illness to?

Religion and Culture

11. How does Islam conceptualise illness and mental illness?
12. Do you think this is similar to how mental illness is conceptualised in other religions/ cultures? Please elaborate.
13. How congruent is this with a Western understanding of mental illness?
14. How do western views of mental illness differ from Islamic views?
15. Are there traditional vs. contemporary views regarding mental illness among general practitioners? Yes/No. And does experience have an influence on these perceptions?
16. How much of your understanding of mental illness is influenced by you being Muslim?
17. How much of your understanding of mental illness is influenced by you being Indian?

18. How much of your understanding of mental illness is influenced by the community and patient's perceptions?
19. How much of your understanding of mental illness is influenced by your training?
20. Do culture and religion play a role in patient's disclosure of symptoms?
21. Do patients often present with somatised symptoms? Yes/no. Please elaborate.

Treatment of mental illness

22. How do you manage patients who do present with psychiatric/psychological symptoms?
23. Is there anything specific in Islam around the treatment of mental illness that you are aware of? If yes, do you use these treatments?
24. What is your understanding of traditional healing?
25. What is the role of the traditional healer?
26. Would you refer patients to traditional healers? If yes, when would you refer?
27. Would you refer to other professionals?
28. Who would you refer to?
29. What role does psychology play in Muslim communities?
30. What is your opinion on collaboration with traditional healers?

Spiritual illness

31. What are your personal beliefs regarding spiritual illness? (Prompt with: do they exist, what typically characterises spiritual illnesses like the evil eye/ witchcraft/ spirit possession? What experiences have you had with them, the impact of them on the person etc.)
32. Can it be said that there is a distinction between mental/psychological illness and spiritual illness? Please elaborate.
33. What characterizes a spiritual illness? (if a spiritual illness does exist)
34. Are these aspects religious or cultural?
35. How do you think a person can be relieved of these symptoms?
36. How do you handle patients who present at your practice with these symptoms?
37. Do you have any further comments, or would you like to add any other information that you feel we have not discussed?