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The role of spirituality in South African specialist psychiatric practice and training

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A changed climate for mental health care delivery in South Africa

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Abstract
Objective: Traditional health practice was recently mainstreamed in South Africa by the promulgation of the Traditional Health Practitioners Act, No. 35 of 2004. Due to the extent of integration of mental health in the legal definition of traditional health practice, promulgation of this Act also has significant implications for mental health care delivery. This paper explored the documented interface of traditional health practice with mental health care in South Africa over the past almost 50 years. **Method:** A preliminary overview of health literature was done on formal mental health care and traditional alternatives in South Africa since the 1950's. Important themes were identified as first step in a qualitative approach to identify concepts. **Results:** The search yielded 143 references, between 1958 and 2004, from articles, case reports, scientific letter, theses and chapters in books. A cross section of 56 references was selected for inclusion in this review of the material. **Conclusion:** The documentation on the interface between the two parallel systems contribute to establish a context against which the promulgation of the legislation to formally integrate and regulate African traditional health practice in South Africa can be considered. South African policy makers may now have ensured that a multi-faceted, multi-cultural and multi-cosmological context for health and mental health care delivery has come to pass. To health administrators, though, the inclusion of traditional healers into the formal public health system and mental health may still prove to be too costly to implement.

Key words: Traditional health practice; Mental health care; Collaboration; Changed environment

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Introduction

Traditional African health practice has recently been mainstreamed in South Africa by the promulgation of the Traditional Health Practitioners Act, No. 35 of 2004. This Act has significant importance in the mental health care scenario with reference to the Act's emphasis on mental health in the definition of traditional health practice, namely: ''the performance of a function, activity, process or service that includes the utilization of a traditional medicine or practice with the object: (a) to maintain or restore physical or mental health or function; (b) to diagnose, treat and prevent physical or mental illness; (c) to rehabilitate a person to resume normal functions and (d) to physically and mentally prepare a person for phase of life changes (puberty, adulthood, pregnancy, childbirth and death)''. The purpose of the Traditional Health Practitioners Act, No. 35 of 2004 is to: - establish the Interim Traditional Healers Council of South Africa (as detailed in Chapter 2); - provide for the registration, training and practice of traditional healers (Chapter 3); - serve and protect the interest of the public who use the services of traditional health practitioners (Chapters 4 and 5).

This has taken place against the background of the significant change that has occurred in political, social and personal spheres of life in South Africa since achieving a democratic dispensation in 1994. This included a renewed emphasis on the identification of, and return to African roots, culture and history in all of these spheres. The process is perhaps best represented by the now well-known maxim ''African renaissance'' intended to influence the whole continent in a positive way. Against this background, towards the end of the 1990's Foster, Freeman and Pillay(1997)[1] assembled several chapters on policy issues in mental health, contextualising the history and the change needed in mental health care in South Africa, including a chapter by Bodibe and Sodi on ''Indigenous Healing'' [see ref. 43].

The objectives of this paper are to: - (i) provisionally explore traditional African health practice's interface with formal mental health care delivery in South Africa as documented previously in the South African medical literature; - (ii) find some context to reflect on the current general climate of health and mental health care provision; and – (iii) identify provisional themes as a first step in a qualitative approach to identify and define relevant concepts from the subject literature.

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Method

A provisional health literature search was done to explore the documented interface around "formal" mental health care services and traditional or "indigenous" alternatives in South Africa and Africa, using the search term "complementary therapies and mental health in Africa". The search through the University of the Witwatersrand Health Sciences Library's intranet routinely covered literature sources such as the Cochrane, ABSCO-Host, MD Consult, PubMed and SABINET databases. A recently published work on the historical developments in Africa by Martin Meredith entitled "The State of Africa – A History of Fifty Years of Independence"[2], was referred to as a background canvas of events against which to reflect on historical developments in Africa and South Africa over this period. A cross-section from the retrieved references was selected for inclusion in an initial review of the material. A qualitative analytical approach was followed to identify the main themes from these references as first step in the identification and definition of central concepts.

Results

This explorative search yielded a first round of 190 references to broader African issues, of which 31 pertained to South Africa. Of the 190 references dating from July 1966 to August 2004, the majority were on policy and general issues in Africa (n=51) while the rest were specific to the Nigerian scenario (n=41), Zimbabwe (n=14), Ethiopia (n=8), Tanzania (n=7), Ghana (n=6), Egypt (n=5) Uganda (n=4). The other references were three each on Morocco, Senegal, East Africa and West Africa, two each on Kenya and Botswana and one each on Rwanda, Namibia, Malawi, Zanzibar, Congo, Benin and Central Africa.

Reviewing the 31 references on South Africa from this explorative search, another 112 were identified from their reference lists. A total number of 143 South African references were eventually listed for this preliminary overview, representing reports in the literature from 1958 to 2004 and included articles, case reports, scientific letters, theses, conference papers and chapters in books. [Figure1]

Because of the volume, a cross section of 56 references was included in this initial identification of important themes and are noted in the section below ("Prominent authors"). Those not included for review here are listed alphabetically in Appendix A (n=87).

Prominent authors

Authors that reported on the interface of formal or western "scientific" mental health care services and traditional or "indigenous" alternatives in South Africa [Figure 2.] included:

- 1950's (n=1): Lee (1958);
- 1960's (n=5): Abrahamson et al (1961), Sundkler (1961), Berglund (1967), Fisher & Hurst (1968) and Lee (1969);
- 1970's (n=26): Crouch (1971), Conco (1972), Le Roux (1973)[3], Stott & Brown (1973)[4], Kiernan (1974,1977), Kruger (1974), Manganyi (1974)[5], Cheetham (1975), Hammond-Tooke (1975), Hurst (1975), Pauw (1975), West (1975a, 1975b), Robbertze (1976), Setiloane (1976), Berglund (1976), Bührmann (1977a,[6] 1977b), Ngubane (1977)[7], Schweitzer (1977), Schweitzer & Bührmann (1978), Gumede (1978)[8], Daynes & Mesengi (1978)[9], Editoral South African Medical Journal (1979)[10] and Holdstock (1979);
- 1980's (n=54): Bührmann (1980a[11], 1980b,1981a[12], 1982[13], 1983,1984,1985a,1987), Watts (1980)[14], Cheetham & Griffiths (1980a[15], 1981[16], 1982a[17], 1982b[18]), Cheetham & Rzadkowolski (1980)[19], Griffiths & Cheetham (1982)[20], Thompson (1980), Bührmann & Gqomfa (1981[21], 1982a[22], 1982b[23]), Holdstock (1981), Mkhize HB (1981), Editorial South African Medical Journal (1982), Edwards SD, Borsten et al (1983), Edwards SD, Cheetham et al (1982), Edwards SD, Jainarain et al (1982)[24], Pearce (1982), Thorpe (1982), Edwards SD, Grobbelaar et al (1983a[25], 1983b); Benjamin (1983)[26], Edwards FS (1983)[27], Farrand (1980,1984[28], 1986), Edwards (1985), Bührmann (1985b)[29], Swartz (1985[30], 1987,1989), Swartz et al (1983,1986), Sokhela et al (1984), Snyders (1985), Wessels (1985)[31], Bhana (1984,1986)[32], Edwards SD (1986)[33], Uys (1986), Bodibe (1988), Straker (1988), Choto (1989), Gillis et al (1989)[34], Hammond-Tooke (1989);
- 1990's (n=39): Freeman (1990,1993), Gobodo (1990), Hickson et al (1990), Kottler (1990), Swartz (1991), Theron (1991), Wittstock et al (1991)[35], Freeman & Motsei (1992), Straker (1992), Hirst (1993), Mathabe (1993), Pillay (1993), Robertson & Kottler (1993)[36], Sinha (1993), Stein (1993), Thom et al (1993)[37], Abdool Karim et al (1994), Green (1994), Straker (1994)[38], Crawford (1995)[39], Patel (1995), Pretorius (1995)[40], Dawes (1996), Ensink & Robertson (1996), Hirst et al (1996), Shai-Mohoko (1996)[41], Tshotsho & Strumpher (1996)[42], Beuster (1997),

Figure 1: References on western and traditional mental health practice in sa (n=143)

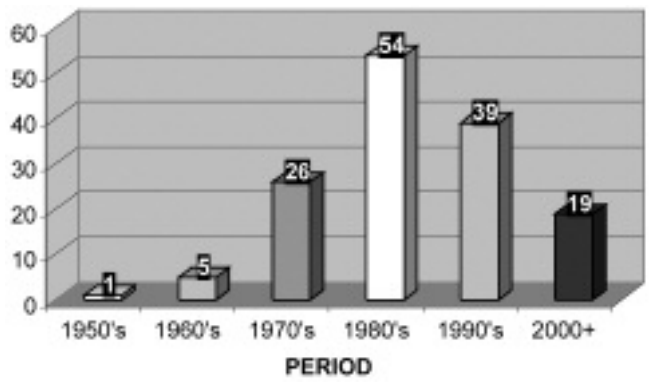
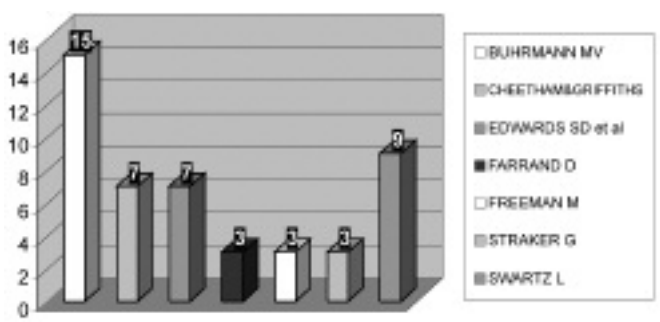


Figure 2: References on western and traditional mental health practice in sa: prominent authors (1967- 2004)



Bodibe C & Sodi T (1997)[43], Levett et al (1997), Mkize DL (1998)[44], Peltzer et al (1998)[45], Swartz (1996, 1998)[46], Butchart (1998), Hewson (1998), Hopa et al (1998), Long & Zietkiewicz (1999);

- 2000 - 2004 (n=19): Nevin (2000), Yen (2000), Gericke et al (2001), Kahn & Kelly (2001), Peu et al (2001)[47], Prinsloo (2001)[48], Mbanga et al (2002)[49], Swartz (2002), Seedat et al (2002), Berg (2001,2003)[50], Ellis (2003)[51], Hugo et al (2003)[52], Koen (2003)[53], Manamela et al (2003)[54], Mkize DL (2003)[55], Yen & Wilbraham (2003a[56],2003b[57]) and Mkize LP & Uys (2004).[58]

General themes and trends

Five thematic categories were identified from the reviewed literature as a first step in the identification and definition of central concepts (Table I).

Population subgroups

Xhosa

Soga JG (1931)[59] and Hammond-Tooke (1937)[60] may have produced some of the earliest authoritative reports on the Xhosa, but Bührmann (and Gqomfa) contributed extensively during the 1980's to contextualize and inform about the Xhosa Group.[6,11,12,13,21,22,23,29]

Zulu

It is beyond the scope of this review to exhaustively explore Ngubane's[7] historical ethnography of health and disease in Nyuswa-Zulu thought and practice, but in this thesis she provided an exposition in different chapters including: - the people and their land; - natural causes of illness; - sorcery; and - the ancestors and illness (Table II). The ancestors, for example, are primarily concerned with the welfare of their descendants. (Also see Cheetham and Griffiths (1980)[15], Edwards SD and co-workers (1983)[25], Wessels (1985)[31], Gumede (1978)[8] and Watts (1980)[14]).

Zionist religious subgroup

Edwards F (1983)[27] reported on the healing and transculturation in Xhosa Zionist practice. She examined categories of illness, diagnostic procedures and therapeutic practices in relation to converging traditional Xhosa and Western Christian frames of reference.

Indian

Bhana (1986)[32] highlighted the fact that most research work on indigenous healers was done in terms of African communities and that very little empirical information is available on Indian indigenous healers in South Africa.

Tswana/Sotho

Shai-Mohoko (1996)[41] noted that regular users of traditional healers amongst the Batswana included educated people such as nurses, teachers, traders and also ministers of religion. Peu et al (2001)[47] conducted a survey exploring the attitude of nurses towards the integration of traditional healers into the primary health care system.

African worldview

Le Roux (1973)[3] explained the ''Bantu'' perspective as that ''nothing happens on the strength of its own dynamics'' and that mental disorganization does not occur naturally. The sufferer's condition is the result of intimidation by some medium. Manganyi (1974)[5] with reference to Senghor[61], argued that the pre-industrial African ontology as the historical ''Black man's philosophy of being and of existence (life)'', is fundamental to a fuller appreciation of his (the ''Black man's'') ideas in the areas of health and disease. Bührmann (1977)[6] also referred to the fact that it is believed that in general, everything animate and inanimate e.g. words, acts, thoughts, dreams, is ''to be charged with some kind of power or force''. Prinsloo (2001)[48] added a more philosophical perspective to the discussion of world-view by considering ''ubuntu'' and applying it to African medicine. Berg (2003)[50] regarded traditional healers as ''highly trained psychotherapists'' while also referring to ''ubuntu'' as depicting humanity and compassion. Mkize DL (2003)[55] saw the way forward to integrate Western and African psychiatry as a system incorporating both approaches based on the core African cultural value of ''ubuntu''.

Table I. Categories of main themes

Population subgroups
Xhosa
Zulu
Zionist religious subgroup
Indian
Tswana/Sotho
African worldview
Trans-, cross- and multi-cultural
Communication: language barrier and interpreter bias
Conflict or synthesis: caught between the two paradigms
Boundaries of normality and abnormality
Application of Western diagnostic categories and interpretation of symptoms
Assignment of labels and resulting stigma
Terminology and definition of concepts
Importance of a cultural formulation
Collaboration and roles
Pathways to care

Table II. Synopsis of the Zulu creation story (Ngubane, 1977)

: "… in the beginning there was uMvelinqangi (the first Being). At some point there was also uNomkuhbulwane or Inkosazane (the Princess). At another, a reed growing on a riverbank burgeoned and gave birth to a man. (No mention is made of a woman in relation to that man.) The people multiplied. uMvelinqangi sent a chameleon (unwabu) to tell them "that they will not die". After some time uMvelinqangi sent a lizard (intulo) to tell them "that they will die". The lizard overtook the chameleon, which had stopped on the way to feed on ubukhwebezane, wild mauve berries. When the chameleon at last arrived with the message that "people will not die", they refused to accept it, and decided to stick with the message already delivered by the lizard. Meanwhile the Inkosazane promoted fertility of the land, the people and the animals. Ideally every year in spring, certain rites should be performed by married woman and maidens to ensure good crops, more cattle and more healthy babies. These rites are directed to Inkosazane. uMvelinqangi is approached only in situations of catastrophe and impending disaster such as extreme drought, in which this case both men and women participate." p47

Trans-, cross- and multi-cultural

Communication: language barrier and interpreter bias

Le Roux (1973)[3] pointed to the clear limitations of diagnosis in psychiatry made through an interpreter, resulting in e.g. the unwarranted diagnosis of schizophrenia. Bührmann (1977)[6] explained the difficulties of the Western-trained psychiatrist in dealing with Xhosa patients as threefold: - the language and the intricacies of its usage; - customs and rituals; and – the ''inapplicability of the Western psychiatric model''. (See also Bührmann (1980)[11] and Cheetham & Griffiths (1982)[18,20]). Daynes and Msengi (1979)[9] highlighted the importance of explaining to the mentally ill Xhosa patient what the causes of the illness are, including ''spiritual disharmony''. Gilles et al (1989)[33] showed that a single home visit, during which instructions about medication were given, almost doubled the compliance rate in Xhosa patients. Benjamin (1983)[26] reported on a project at Sterkfontein Hospital in the early 1980's that incorporated song, dance and drama in a group of Black mentally ill inpatients, in an effort to overcome communication difficulties. Ellis (2003)[51] considered Zulu words that ''might approximate the idea of depression''.

Conflict or synthesis: caught between the two paradigms

Manganyi (1974)[5] explored the question of pre-industrial African ontology still being valid and alluded to the sociological evidence relating to the urbanization and industrialization of Blacks in South Africa at the time. To answer the question, he commented on the recurrence and 'resilience' of traditional views and practices in the areas of health and illness, to be understood as the validity of African ontology (''theory of forces'') and as an organizing principle in the lives of urban Blacks. Cheetham and Griffiths (1980)[15] remarked at the time that for some urbanised/urbanizing groups, a transitional position existed of apparent acceptance of Western methodology but with covert adherence to traditional beliefs, ''…this dichotomy has contributed to the extensive emergence of syncretic religions which combine Christian and traditional beliefs'' ; further ''Under extreme stress, moreover, there is a tendency to revert to traditional beliefs, with concomitant processes and even communication.''. Bührmann writes (1980)[11]: ''My concern is whether we know enough and are sensitive enough to other realities and other states of consciousness to do justice to realities, concepts and views which are different from ours, especially in situations of acute stress when regression to earlier modes of function is normal.''

Boundaries of normality and abnormality

Le Roux (1973)[3] referred to the ''thinness'' and overlapping nature of the dividing line between normal and abnormal thought processes and shades of behaviour whilst Bührmann(1980)[11] stated: ''The diagnostic problem is that the two ('normal primitive beliefs' and paranoid delusions) can run parallel with each other. To distinguish the two, they must be recognized by most members of the cultural group… i.e. when he (the patient) expresses ideas which do not make sense in terms of their cosmology ''.

Application of Western diagnostic categories and interpretation of symptoms

Cheetham and Griffiths (1981)[16] investigated the errors in the diagnosis of schizophrenia in Black and Indian patients and found that schizophrenia was misdiagnosed in 60% of their sample. Edwards et al (1982)[24] reported on a retrospective review of patients with 'classic conversion symptoms'. From the DSM III at the time, they found it clinically useful to refer to conversion disorders in those who subjectively firmly attribute their dysfunction primarily to traditional beliefs, as ''culture-bound syndromes''. Mbanga et al (2002)[49] reported on attitudes and beliefs of Xhosa families towards schizophrenia. They showed that African people mostly regard witchcraft or possession by evil spirits as the cause of schizophrenia. Manamela et al (2003)[54] found that the majority of stable individuals diagnosed with schizophrenia in a supportive community of origin, managed to meet their daily needs.

Assignment of labels and resulting stigma

Le Roux (1973)[3] reported at the time that attitudes towards mental health amongst Blacks ranged from sympathetic understanding to open rejection and even maltreatment and suspicion. Swartz (1998)[46] pointed out that a myth about trans-cultural psychiatry seems to be that mental illness is not recognized as pathological in non-western cultures, or where it does exist, that it is accepted in a non-stigmatized manner. Hugo et al (2003)[52] investigated the attitudes of the general public towards mental illness and concluded that stigma and misinformation regarding mental illness, influenced preferred treatment modality and help-seeking behaviour.

Terminology and definition of concepts

Wittstock et al (1991)[35] reported on a ''mass falling phenomena'' at a Black primary school in Pretoria. He demonstrated that certain culturally driven presentations are difficult to explain with standard diagnostic terminology. Pelzer and colleagues (1998)[45] reported on the ''brain fag'' syndrome first described in West African students in a rural South African Secondary School and suggested as a conclusion to their study, that the ''brain fag'' syndrome is basically a depressive disorder.

Importance of a cultural formulation

Le Roux (1973)[3] stated: ''Culture-related problems abound in cross-cultural psychiatric practice, which therefore necessitates a sound anthropological knowledge of a group concerned.'' According to Manganyi (1974)[5]: ''…the ''witchcraft extravagance'' which characterized many contributions of observers at the time, must be replaced by a relevant and enlightened sociology, anthropology and socio-psychology.'' Bührmann (1977)[6] advised careful inquiry into customs and ceremonies and especially about the neglect of these that will expose areas of concern and guilt.[11,29] Tshotsho and Strumpher (1996)[42] provided important conceptual information about and guidelines on: - cultural taboos and ritual ceremonies; - life caring rituals and rites of passage; and - caring-curing and support systems.

Collaboration and roles

According to Stott & Brown (1973)[4], the African medicine man is regarded as one who honours, placates or exorcises evil. His treatment is often gained from dreams and his diagnostic ability attributed to psychic power granted by ancestral spirits. See also Robinson and Kottler (1993).[36] Bührmann (1977)[6] noted: ''The role of the diviner ('medicine man') must be

acknowledged. Some have an impressive amount of knowledge and wisdom''. Straker (1994)[38] wrote about how little dialogue between African healing practices and Western health practices was actually still taking place at the time. More correspondence included Crawford (1995)[39] and Pretorius (1995)[40], that explained and encouraged the process ''to bridge the gap'' between the different paradigms and healing/treatment practices. Shai-Mahoko (1996)[41] concluded that: - indigenous healers provide measures that prevent certain illnesses; - they ''treat diseases that Western trained health workers, in most cases, fail to treat successfully''; - they prevent social conflicts by ritual cleansing and fortifying of homesteads; and – they put social relations right by performing sacrificial rites for the ancestors. Koen et al's letter (2003)[53] called for a more pro-active stance on the co-operation with ''reputable'' traditional healers as they form a very important part of mental illness health-seeking pathways in the African population. Bodibe and Sodi (1997)[43], urged for integrating past wisdom with modern psychology. Results by Peu et al (2001)[47] indicated that respondents demonstrated a positive attitude towards the integration of community nurses and traditional healers. Yen and Wilbraham (2003)[56,57] mapped the tensions between ''cultural relativism and psychiatric universalism'' and how ''assertion of 'cultural differences' may be used to resist psychiatric power''. Roles were also tracked by Bührmann in an earlier paper ''Xhosa Diviners as Psychotherapists'' (1977b) and by Cheetham and Griffiths' (1982).[17,20] They explored the role of the traditional healers not only as ''psychotherapist'', but rather as being ''priests before healers'' with an intermediary function between the people and the ancestors. ''From the very outset, the traditional healer is directed by the spirit world of the ancestors. His powers arise out of this contact with the spirits – he is expected to have supernatural powers and to use them for healing purposes.''.[17] ''His access to the ancestors also gives him a priestly role and he has the status of a priest in terms of his awareness of the will of the ancestors and the necessity for their propitiation.''[17] Finally: ''The isangoma fulfils a number of roles: (i) as healer, either through divination or provision of 'muti' (medicine); (ii) as the centre of social integration and cohesion; (iii) as seer or diviner; (iv) as the protector of the people, their possessions and their environment, particularly against lightning; and, most importantly (v) as the religious head of the society and mediator between the ancestors (amadlosi) and their descendants, either for love and protection or propitiation for omission of required rites or for contravention of the social code.''[20]

Pathways to care

Pathways to health-care are essentially determined by knowledge and belief systems about the causes of illness. Farrand (1984)[28] described a trend away from total reliance on indigenous healers. However, there was little agreement as to which illnesses fell into which categories. Thom et al (1993)[37] concluded that there is a significant incidence of undetected psychiatric disorders in patients that attended a primary care clinic. Mkize and Uys (2004)[58] explained that the decision to contact a western doctor or a traditional/spiritual healer is influenced by factors such as the seriousness of the illness and the availability of health services, financial implications and the person responsible for the decision.

Discussion

A large body of health literature documented over the past 50 years exists, in which aspects of traditional African health practice's interface with formal mental health care delivery in South Africa. This report is an attempt to provide a preliminary review of a cross section of material yielded by a literature search on the topic. A general observation resulting from a retrospective review of this nature is the change in style and tone of writing over time. In literature from the 1970's and 1980's for example, more racial overtones may be noted, contrary to the more ''politically correct'' reporting and phrasing of more recent reports. (See e.g. references to ''Bantu'', ''Blacks'', ''Black patients'' and ''psychiatric illness'' [3,5,9,11,14,16,25,26,29,33,37])

It can be noted that a relatively large amount of reporting was done on this topic during the 1980's and although largely dominated by white and Western trained authors, essential contributions by African authors were made to the process of documentation. Apart from Ngubane, other African authors (see also Appendix A) include Conco (1972), Manganyi (1974), Setiloane (1976), Gumede (1978), Msengi (1979), Mkhize HB (1981) and Gqomfa with Bührmann (1981,1982a,1982b). With Edwards SD from the Department of Psychology (Univ Natal/Zululand): Majozi E (1982), Makunga NV (1983a, 1983b), Sibaya PT (1983a); Nene LM (1983a,1983b), Kunene ST (1983a), Magwasa AS (1983a). Also: Sokhela (1984), Bodibe (1988), Choto (1989), Joyi M with Gilles (1989); Gobodo (1990), Motsei with Freeman (1992) and Mathabe (1993). Shai-Mohoko (1996), Tshotsho (1996), Bodibe C & Sodi T (1997), Hopa et al (1998), Peu et al (2001), Manamela et al (2003), Mbanga et al (2002), Mkize DL (1998,2003) and Mkize LP (and Uys 2004). The documentation on the interface between the two parallel systems over time contribute to establish a context against which the recent promulgation of the legislation to formally integrate and regulate African traditional health practice in South Africa can now be considered.

A characteristic of African traditional health practice that was often discussed in the literature is the question of whether the work done by traditional healers is religion or psychotherapy. Some psychologists and psycho-analytical writers compared the traditional healer with the Western psychotherapist and probably considered traditional health practice more as psychotherapy than a religion (e.g. Bührmann[6] and Berg[50]). Other authors such as Edwards et al[25] and Griffiths & Cheetham[20]) referred to African cultural beliefs as being religious and spiritual. It was noted during the draft phases of the legislation on traditional health practice in 2001, that in reports submitted to parliament's Arts and Culture Portfolio Committee, representatives of South African traditional healers themselves were defining their role and their knowledge base in terms of a religion.[63] As legislation governing African traditional health practice now exists, an observed gap in the reviewed literature appears to suggest that integration of other cultural traditions (e.g. Muslim, Jewish, Hindu or Christian perspectives) may not have been pursued with the same drive. It may, according to the Constitution, have to follow that other religious and spiritual views of health, within their own particular culture and cosmology, must likewise be examined and considered.

South African policy makers may now have ensured that a

multi-faceted, multi-cultural and multi-cosmological context for health and mental health care delivery has come to pass. To health administrators, though, the inclusion of traditional healers into the formal health and mental health system may still prove to be too costly to implement, especially within the current reality where resources are generally strained by a characteristically low priority allocated to mental health services. As traditional health practice may over time, also become more integrated with public health services, some concern from a health systems perspective can be raised relating to the practical challenges of the possible employment of different categories of spiritual and traditional health workers to the formal health and hospital environment. Caution should also be registered regarding a trend, especially in more remote or rural areas as documented by Odejide et al[64] and Okasha[65], which would rely on traditional health practice to fill the gap as the only providers of at least some form of mental care in the absence of adequate formal health infrastructure.

Conclusion

Considering the documented interface of traditional practice with formal health care in the literature over the past 50 years in the context of the recent legislation on the definition and regulation of traditional practice, it can be contended that no minor adjustment to health care delivery has occurred. Rather, a fundamental change has been effected in the climate and the whole environment in which mental health care now has to be delivered. Continuous discussion and interaction with role-players in this domain may therefore be essential for some time to come, in order to explore the meaning and operational detail of this changed climate for mental health care delivery in South Africa.

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APPENDIX A: REFERENCES ON WESTERN AND TRADITIONAL MENTAL HEALTH PRACTICE IN SOUTH AFRICA FROM LITERATURE SEARCH NOT INCLUDED IN DISCUSSION (n=87)

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