

**HEALING AT THE MARGINS: DISCOURSES OF CULTURE AND
ILLNESS IN PSYCHIATRISTS', PSYCHOLOGISTS' AND INDIGENOUS
HEALERS' TALK ABOUT COLLABORATION**

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ABSTRACT

This dissertation explores discourses about culture and illness in the talk of mental health professionals and indigenous healers. It represents an attempt to situate the issue of indigenous healing in South Africa within a particular strand of critical discourse analytic research. In the context of current deliberations on the value, or otherwise, of indigenous healing in a changing health and specifically *mental* health system, the talk of both mental health practitioners and indigenous healers as they conceptualise “disorder”, and discuss possibilities for collaboration, is chosen as a specific focus for this study. Disputes over what constitutes “disorder” both within mental health, and between mental health and indigenous healing are an important site in which the negotiation of power relations between mental health professionals and indigenous healers is played out.

The results of this study suggest that despite the construction of cogent commendations for the inclusion of indigenous healing in mental health, it remains largely marginalised within talk about mental health practice. While this study reproduces to some extent the marginalisation of indigenous healing discourse, it also examines some of the discursive practices and methodological difficulties implicated in its marginalisation. However, in the context of “cultural pride strategies” associated with talk about an African Renaissance, indigenous healing may also function as a site of assertion of African power and resistance in its construction as an essentially African enterprise. At the same time, it may achieve disciplinary effects consonant with cultural pride strategies, in constructing afflictions in terms of neglect of, or disloyalty to cultural tradition. These results are discussed in terms of the methodological difficulties associated with interviewing and discourse analysis of translated texts, which contributes to difficulties with articulating indigenous healing discourse in a way that challenges the dominant psychiatric discourses implicated in its marginalisation within mental health. It concludes with recommendations for future research which addresses indigenous healing discourse in its own terms, and examines its operation as a disciplinary apparatus in South African society.

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CHAPTER ONE
INTRODUCTION: DISCOURSE ANALYSIS AND MENTAL HEALTH
CARE IN SOUTH AFRICA

Discourse perspectives that connect mental health practices with the cultural-political contexts that produce them are being increasingly employed by South African authors wishing to develop critical analyses and interventions (Levett, Kottler, Burman & Parker, 1997). Many of these analyses have drawn strongly from the work of Michel Foucault, in his analysis of modern culture. Employed within psychology, Foucauldian discourse analysis foregrounds the ways in which the production of knowledge within the discipline is the effect of power struggles over which versions of reality are to be sanctioned (Mills, 1997).

Foucault's theory of productive power, in which power is seen less as an oppressive or repressive force, but rather as operating through discourse to constitute and position people in various ways, is also especially relevant to the study of psychology and psychiatry. The "gaze" of these disciplines impels us to experience ourselves in certain ways as individual subjects and to assume certain "subject positions" (Parker, 1992), in order to be accorded rights (whether as "users", or as agents) to speak or participate in its institutions (Levett *et al.*, 1997).

The emergence of Foucauldian discourse analysis in the post-apartheid South African context is particularly timely, in that the approach provides a framework for examining the structuring effects of language as they are implicated in the continued operation of oppressive exclusionary practices, some of which were previously legislated in segregatory government policy. As Levett *et al.* (1997: 5) assert, "the pervasive notions of self, Other and legitimacy that saturate racist ideas and behaviour will long outlive the dismantling of apartheid". In addition, although the major changes wrought by the onset of democracy have seen the unravelling of oppressive relations of power, they have also resulted in the production of new forms of discourse, whose potential to become inscribed in new regimes of truth requires a continued vigilance (Parker, 1992).

The mental health field is currently the site of a struggle for a “new discursive ordering” (Foster & S. Swartz 1997: 3). This struggle is reflected in the contrasting in much of the contemporary South African literature of terms such as “relational” and “holistic” with “individualist” and “mechanistic”, or “institutional” with “community-based”. In introducing debates on changes in mental health policy, Foster and S. Swartz (1997) argue further that

in South Africa one may characterise the form and content of mental health systems as a struggle between a dominant medical model on the one hand, and two alternative forms (i) Western psychological welfare and (ii) “alternative healing” on the other (p. 7).

Foster and S. Swartz (1997) include two categories in “alternative healing”, those of African indigenous healing and “holistic” healing (e.g. aromatherapy, acupuncture, chiropractics, body therapies etc.), pointing out that consideration of “holistic” healing has been largely omitted from the national debate, whereas African indigenous healing is usually acknowledged as an important issue for discussion. In spite of its topicality, indigenous healing is described as an area in which serious debate is lacking. As will become apparent in the review of the literature, very little has been written about indigenous healing that addresses its position in relation to the dominance of the biomedical health system, while taking into account issues of power and control. In addition, even fewer studies have attended to the different ways in which notions of “culture” are used in accounts of indigenous healing.

The continued social and economic inequalities between racialised groupings in South African society are obvious. With regards to mental health services, the inequalities that continue in spite of the racial integration of facilities and institutions have been more difficult to identify and document (cf. L. Swartz, 1996). The perpetuation of oppressive practices within mental health has been shown to be due in large part to the “racialisation” of madness within psychiatry (L. Swartz, 1989; 1991). Moreover, in addition to racialised inequities S. Swartz (1995) has shown that discrimination in psychiatric classification and treatment has also been both “classed” and “gendered”.

A critical perspective on current developments in mental health may be gained from a brief consideration of its historical backdrop. Foster and S. Swartz (1997) describe the

development of mental health services in South Africa as it is intertwined with a history of colonialism. In their brief historical analysis, they outline the intersection of racist and biomedical discourse on madness in its positioning of Africans as “other”. These representations were part of psychiatric discourse well before the formal establishment of explicit apartheid policy. They argue that the increasing “humanisation” of psychiatric services over time was (and is) not only the result of greater attention to human rights and humane care, but also an extension of more subtle forms of psychological and medical power and surveillance.

Against this background, this dissertation explores discourses about culture in the talk of mental health professionals and indigenous healers. It represents an attempt to situate the issue of indigenous healing in South Africa within a particular strand of critical discourse analytic research (Parker, 1992), in the hope that it will assist in reviving a hitherto stagnant debate. In the context of current deliberations on the value, or otherwise, of indigenous healing in a changing health and specifically *mental* health system, the talk of both mental health practitioners and indigenous healers as they conceptualise “disorder”, and discuss possibilities for collaboration, is chosen as a specific focus for this study. Disputes over what constitutes “madness” within mental health will have major policy implications, and have hitherto been largely overlooked (Foster & S. Swartz, 1997). The conceptualisations of disorder of these particular traditions – specifically psychiatry, psychology, and indigenous healing – are particularly important in that they are central to the distribution of power between mental health professionals and indigenous healers, should they work together.

The psychological and psychiatric disciplines both inform, and are informed by culture. However exact or formal practitioners may wish to be, they already employ culturally available discourses in their talk about patients and indigenous healers (Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995). Contemporary local and continental debates about African identity and African culture are therefore particularly relevant to the issue of indigenous healing, and some attention is devoted to these debates in the present study.

CHAPTER TWO

LITERATURE REVIEW

2.1. INTRODUCTION

Representations of African indigenous healing and healers are intertwined with constructions of African culture and subjectivity. A review of the psychiatric and psychological literature concerning the subject of indigenous healing therefore necessarily entails an examination of the notion of “culture”. This will be crucial in providing a context within which the debate on indigenous healing may be understood. Other work concerning the construction of African subjectivity or “black minds” in psychology and psychiatry will also be considered.

This will be followed by a review of the available literature concerned specifically with relevant policy debates, as well as studies or accounts of indigenous healing. Although predominantly a review of literature applicable to the Southern African context, it will also include reports on work done in other regions.

2.2. “CULTURE”

A criticism that has often been levelled at psychology and psychiatry is that it is “culture-bound” and “culture-blind” (Lonner & Malpass, 1994). Certain authors have been quick to appropriate these criticisms for the South African context (e.g. Biesheuvel, 1987). However, this ignores the long history of writing on culture in South African psychology and psychiatry, which although ostensibly concerned with improving care, also clearly reproduced racist ideas (e.g. Laubscher, 1937, cited in L. Swartz, 1991). Importantly, ideas of culture and the “African mind” developed in such literature found their place in the rhetoric of the apartheid state in its justification of segregatory practices, and persist in psychological accounts written in the 1980s and up to the present. The mid-1980s and

early 1990s saw the proliferation of a body of literature that took up various critiques of mental health care in South Africa. Well-meaning mental health professionals concerned themselves with “cross-cultural” or “transcultural” work in efforts to address the inequalities of mental health provision, but in many cases succeeded only in reproducing racist or depoliticised analyses and solutions to the problem of “culturally appropriate” care. Such studies tended to presume the *a priori* existence of racial or cultural groups and differences (e.g. Van Schoor, 1989; Hickson, Christie & Shmukler, 1990).

However, during this time there was another strand of writing which stimulated a renewed consideration of the social and cultural embeddedness of the mental health disciplines. For example, some writers criticised the “western”, individualist or “bourgeois” underpinnings of psychological theory and practice, and how such practices diverted attention and energy away from social or political action (Anonymous, 1986). Many liberal psychologists and academics strove to demonstrate mental health professionals’ (conscious or unconscious) collusion with, and participation in the prevailing social order, as well as the “cultural encapsulation” of psychological theory (Dawes, 1986; Turton, 1986). Significantly, certain authors working within a growing social constructionist movement argued that an examination of the notion of “culture” itself, as used in mental health literature, and by its practitioners, was integral to unpacking racist or discriminatory practice (L. Swartz, 1989, 1991; Kottler, 1990).

2.2.1 The quandary of relativism vs. universalism

In this section I will not rehearse the *theoretical* debates in anthropology or cultural psychology regarding relativism and universalism (cf. Shweder, 1990), but will focus instead on the dilemmas, particular to the South African context, associated with each position. “Culture” is a highly contested term and cannot be taken to be politically neutral (Foster & S. Swartz, 1997; L. Swartz, 1996). In much of the mental health literature it is used in ways that assume *difference* from the outset, and positions those to whom it refers as “other”. As Kottler (1990) has shown, discourses of cultural difference (associated

with a relativist position) or similarity (associated with a universalist position) as evident in various psychological accounts reproduce ideas that achieve or support differing political ends. Most prominently, the notion of an essential and natural cultural difference between “blacks” and “whites”¹ provided justification for separate (and unequal) treatment in apartheid mental health care. Against this background, the particularly salient point made by both Kottler (1990) and L. Swartz (1996) was that to acknowledge or assert difference in the South African context was to somehow legitimate the existence of ethnicity and therefore to legitimate apartheid. As a consequence, many writers, adopting a universalist approach, would (and still continue to) downplay difference and emphasise the ways in which “we are all the same underneath”. The fact that a “differences” discourse is frequently regarded as politically progressive outside South Africa highlights an important dilemma in South African culture discourse (Kottler, 1990). A notable exception was the work of writers such as Manganyi (1991, cited in L. Swartz, 1996), which emphasised the centrality of black experience and the positive assertion of black identity in providing possibilities for personal and political change. This work appeared during the late 1980s and early 1990s and is significant in that it was a time in which the political importance in South Africa of a universalist view (supportive of non-racialism) of culture was acute (Kottler, 1996).

Situated within a broadly social constructionist framework, the work of Leslie Swartz (1989; 1991) was particularly important in demonstrating how “traditions of racism are woven into the fabric of care” (1991: 240), through the construction in the South African psychiatric literature (and reproduction in clinicians’ talk) of the “otherness” of Africans. It was particularly effective in highlighting the inherent contradictions within psychiatric practice that make it potentially discriminatory, and showing how even practitioners consciously opposed to discriminatory practice reproduced racism in their care of patients. L. Swartz (1991) demonstrated that the problems of a relativist position supportive of segregation could not be solved by a simple repudiation of relativism and a wholehearted embrace of universalism. Sensitive to the ways in which clinicians are torn

¹ It is recognised that these terms are constructions which derive from apartheid ideology, and are offensive. The irony inherent in much post-structuralist or discourse-analytic studies is that problematic or dualistic terms must often be invoked in order for them to be deconstructed (Parker, 1992).

by competing and conflicting discourses, L. Swartz (1991) has made the important point that despite the need for equal treatment of patients, it may at times be necessary to *emphasise* cultural difference in order to secure adequate and appropriate treatment.

More recently, L. Swartz (1996) has noted that there is renewed appreciation in the social sciences for the study of cultural difference within a broadly non-racialist framework. However, his analysis of conditions in contemporary mental health care identifies some new problems foregrounded by the continuing “inclusivist” imperative in psychiatric care. He argues that the current emphasis on equal treatment has silenced or suppressed talk about difference, identity, or racism and even gone towards delegitimising patients’ and practitioners’ experiences of alienation (for an example of the ways in which “inclusivist” rhetoric may function in delegitimising accusations of racism, see Brown, 1997).

The demographics of professionals in the mental health field still largely reflects the distribution of power in the South African population. Psychiatrists and psychologists are still predominantly white, male and English-speaking (L. Swartz, 1998). Inasmuch as this is the case in most institutions, the removal of apartheid and integration of psychiatric care may not necessarily have resulted in better patient care. Ironically, patients may in fact be receiving care of worse quality from professionals who cannot speak their language than when previously confined to segregated wards (L. Swartz, 1998). Furthermore, the moral and political necessity to treat patients equally and to downplay differences presents many dilemmas for professionals attempting to address the problem of care for patients they continue to find difficult to understand (cf. L. Swartz, 1989).

A more general trend in South African academia and in psychology in particular is the call for its “Africanisation” (Anonymous, 1986; Dawes, 1986; 1996; Mangcu, 1998). This is a complex debate which has important resonances with contemporary discourse around the emergence of an “African Renaissance” (e.g. speeches of President Thabo Mbeki, 1999). Arguments for greater understanding of “African epistemologies” as necessary for the relevance of psychology are commonly advanced. While it is

understood to be a laudable and worthwhile enterprise, Dawes (1998) points out that there is a danger of the concept of Africanisation being constructed in essentialist terms so that only “race” and culture are considered. There is the potential that talk about Africanisation will employ “. . . a rhetoric which binds the subjectivities of those inhabiting the African continent seamlessly together, denying that this is a constructive and historically informed exercise” (Dawes, 1998: 6). Thus, Dawes (1998) argues that while the traditional dichotomy that structures the debate (that between African and “western”) is useful and understandably salient in light of our history of colonial oppression, it might also be useful to consider differences between what he calls “modern” and “modernising” societies. These alternative terms are not unproblematic (cf. Mills, 1997), but in effect, Dawes’ (1998) suggestion is an attempt to de-centre the tendency to think of Africanisation as an issue only of race or culture. However, in contrast to Dawes, Appiah (1995) has argued that the assertion of an African identity is important in the forming of, for example, Pan-African alliances, and that despite the recognition that identities are historically constructed, their effectiveness relies on their being seen as natural and real.

2.3. CONSTRUCTIONS OF “AFRICAN MINDS”

In his review of the South African transcultural psychiatric literature published up to the late 1980’s, L. Swartz (1989: 16) identified three “contexts for interpreting mental health and illness”, which are useful for the present review, and still prevalent in the current literature. The first explains manifestations of distress and healing in terms of *inherent characteristics* particular to different South Africans, which make use of concepts such as the “African personality”, world-view, or attitudes. The second seeks to relate phenomena to their broader social context, and the third employs psychological theory in understanding illness and healing. These contexts will be recalled later in the review of the literature concerned specifically with indigenous healing. In this section I would like to pay special attention to the notion of an “African personality”. In the following paragraphs I will seek to draw out both the major methodological problems with concepts

of the “African personality” or world-view, and provide a summary of the ways in which these have been characterised in the literature.

Concepts of the African “personality” or world-view are problematic for a number of reasons. They have usually been used to assert essential differences between Africans and “whites”, most commonly representing African people as “in harmony with nature” and “collectivist”, and in condemning the detrimental effects of “western” culture on the African personality (Bodibe & Sodi, 1997: 187-188). L. Swartz (1989) identifies another common feature of the “African personality” concept in the work of Hammond-Tooke (1975, cited in Swartz, 1989) – the view that Africans are concerned more with “WHY rather than HOW misfortunes occur”. This has great relevance to discussions around indigenous healing, as healers are often portrayed as providing the causal (implied spiritual) narratives most preferred by (or comforting to) Africans, in contrast to the (rational) diagnoses of “western” mental health (e.g. Gillis, Koch & Joyi, 1989).

In addition, making use of theoretical notions of “locus of control”, Africans are often labelled pejoratively as lacking “inner-directedness” and unable or unwilling to acknowledge responsibility for misfortune, attributing it to external agents or causes (e.g. Herbst & Britz, 1986). This deficiency is deemed the cause of “psychic turmoil, which expresses itself in an increasing incidence of psychiatric problems of a psychosomatic nature, as well as anxiety, depression and alcoholic problems” (Henning, 1982, quoted in L. Swartz, 1987: 26). In earlier literature this concept has been employed in arguments that Africans are inherently ill-suited to (or uninterested in) individualistic achievement and intellectual pursuit (L. Swartz, 1989).

In summary, constructions of “African personalities” often portray the realm of the intellect as being essentially unavailable or unimportant to Africans. These representations contribute to evolutionist discourse about the slower progression of Africans from traditional (irrational) belief in witchcraft and the supernatural to the modern (rational) empiricist consideration of life, as compared to Europeans. Importantly, L. Swartz (1989: 21) highlights a lack of attention to the possibility that

“traditional African” concepts of health and illness, rather than being evidence of “evolutionary backwardness”, represent part of a “national pride strategy”, in support of a Black Consciousness ideology.

Thus, although a potentially discriminatory concept, the “African personality” has also been employed by authors associated with Black Consciousness movements attempting to encourage a positive black identity (e.g. Manganyi, 1991, cited in L. Swartz, 1996) and those (more contemporary) authors bemoaning a loss (or lack) of respect for African culture (e.g. Bodibe & Sodi, 1997).

2.4. INDIGENOUS HEALING IN THE MENTAL HEALTH LITERATURE

2.4.1. Introduction

It is curious that while the imperative for collaboration between healers and the formal (mental) health sector has been repeatedly emphasised over the last twenty years, there is little formal collaboration at present, at least in South Africa. The situation is different in several other African countries, in which a number of collaborative programmes are underway, particularly in the field of HIV and AIDS prevention (Green, 1994). Of equal importance is the apparent stalemate in the *discourse* on indigenous healing in the South African literature. Although most articles are overwhelmingly positive about indigenous healing, they tend to be written as if this attitude was not the general view (e.g. Hopa, Simbayi & Du Toit, 1998). In addition, the absence of critical analysis of indigenous healing in the literature contributes to the continued portrayal of indigenous healing practices as mysterious and incomprehensible to outsiders (e.g. Bodibe & Sodi, 1997), and of indigenous healing as an exclusively “black” enterprise (L. Swartz, 1996). L. Swartz (1996) argues that, taken together, these two points suggest that indigenous healing currently functions as a site of resistance for black authors and the positive assertion of African identity.

In the following section, the literature dealing with various aspects of indigenous healing and collaboration will be reviewed, beginning first with broader policy debates, and then leading onto studies or accounts of indigenous healing.

It is necessary to clarify a number of terms. African indigenous healing is by no means a singular phenomenon, although it is often referred to as such. It is characteristically heterogeneous, and comprises a wide and pluralistic range of practitioners and practices (Kleinman, 1988a). Green (1994) nevertheless asserts that in sub-Saharan Africa, the most common distinction made is that between herbalists (*amaxhwele* in Xhosa) and diviner-mediums (*amagqirha* in Xhosa). Typically, herbalists tend to work with the physical material of medicinal plants, while diviners have (additionally) special access to ancestral and other spirits believed to authorise and assist in healing and divination. It is the diviner who is most commonly referred to in the psychological literature on indigenous healing in South Africa, since s/he specialises in oracular and ceremonial practices, which are sometimes regarded as forms of psychological or group/social therapy (Hirst, 1993; Green, 1994). Diviners (as opposed to herbalists), it is assumed, are preferred by people experiencing what may be simplistically termed “psychological” distress. This division of the treatment provided by diviners and herbalists into “psychological”, versus physical care is predicated upon the problematic Cartesian mind-body dualism that plagues much of psychological theory and the mental health literature, and which, it is often argued, is a mode of explanation and experience foreign to African culture (Hirst *et al.*, 1996).

2.4.2. Broad policy issues

The promotion of indigenous healing and collaboration with the (mental) health system is motivated not only by goodwill toward healers and concern for the well-being of patients. There is a diversity of parties and interests that may lie behind efforts to collaborate. For example, co-operation may be motivated by such things as political pressure, social-scientific interest, pragmatic or humanitarian reasons, financial gain, anti-medical

sentiments, or political resistance (Last, 1986, cited in Green, 1994). Korber (1990) has correctly pointed out that the important factors at stake in the South African debate concern the power struggle between systems regarding access to patients and resources, as well as professional controls. Those who promote the legitimacy of healers may be seeking legitimacy themselves, and it is worthwhile to examine what each party involved in the debate on indigenous healers stands to gain or lose (Fassin & Fassin, 1988, cited in Green, 1994).

Descriptions of, or suggestions for, the *nature* of the collaboration practitioners are exhorted to engage in are surprisingly rare in the South African literature. Matters concerning where, or in what setting, collaboration or integration should take place (e.g. on hospital grounds, in ward rounds, as part of a multidisciplinary team, in the healer's sacred hut) are seldom discussed. This absence is notable precisely because such issues concern power relationships between the practitioners.

Various authors have tried to address some of the complexities of defining an appropriate working relationship between indigenous healers and mental health (Green, 1994; Hopa *et al.*, 1998; Kleinman, 1988; Korber, 1990; Kottler, 1988; L. Swartz, 1989). Most distinguish between two approaches, those of "integration" and "collaboration". As Green (1994: 20) argues, albeit from an AIDS prevention and management perspective, "integration" implies, and would entail, "fundamental alteration in both healing systems and in the roles of the respective practitioners, although in practice it is the traditional healer who is expected to change". Green (1994: 20) warns against the extraction of the indigenous healer from his/her social and spiritual functions in the community and his/her subsequent insertion into the medical hierarchy as a "second-rate paramedical worker", arguing that this might disrupt, among other things, a community's capacity to attend to and solve its own social and health problems.

Similarly, some authors have voiced concern over the possibility that proposals for integrating healers into the health system, for example, in the Department of Health's White Paper on the transformation of the health system (Department of Health, 1997)

may represent attempts to incorporate and control indigenous healers within the existing biomedical health system (Korber, 1990; Van Damme & Maseko, 1997). Kottler (1988) has made the important observation that calls for the professionalisation of indigenous healers have come largely from the “dominant elite” (those within mental health and biomedicine), rather than from healers themselves. She argues that such calls have behind them images of indigenous healing as “polluted” and “dirty” (Douglas, 1966, cited in Kottler, 1988). Therefore, proposals that healers professionalise and become subject to the controls of professional bodies, such as the Health Professions Council, or an independent body within indigenous healing, may also reflect attempts by practitioners to change indigenous healing into a less threatening or harmful practice (Kottler, 1988; Kleinman, 1988a). However, professionalised indigenous healers would pose an *economic* threat to the medical profession, since healers would then receive a portion of already scarce state resources (Korber, 1990; Green, 1994).

Chavunduka (1986, cited in Kottler, 1988: 13) regards professionalisation as an important move for “tactical” reasons rather than “pragmatic” ones (e.g. improving their training), since it would “prevent political impotence in the face of the powerful medical system”. But since healers are usually consulted according to their reputation, it is likely that it is the self-proclaimed healers who stand to benefit most from professionalisation.

Van Damme and Maseko (1997) of the Traditional Healing Organisation of Africa suggest that a separate and autonomous Indigenous Health Department be created that could “co-ordinate all future inter health (*sic*) systems co-operation from an early stage, ... have executive powers and a formal role in national health care management and policy making”. However, certain authors, both within and outside of indigenous healing point out that the bureaucratisation of a heterogeneous and pluralistic indigenous healing system would involve fundamental changes to indigenous healing itself (cf. Kottler, 1988; Green, 1994). The simultaneous need to secure governmental power, resources and sanction through the creation of bureaucratic structures, while maintaining the distinctiveness and autonomy of indigenous healing represents an important dilemma in the debate on whether healers should professionalise.

The situation is further complicated by the absence of any unitary representative body for indigenous healers with which the government may consult (Kottler, 1988; Korber, 1990). Relatively recently, however, requirements by local government health departments (for example, in the Northern Province) to negotiate with only one representative structure for healers resulted in the merging of eleven different associations into a single association (Bodibe & Sodi, 1997).

Other recent developments in government have seen parliamentary proposals for the formation of a statutory council that will manage the registration of all qualifying traditional healers and promote training, research, and the creation of a traditional medicine database. Its task will be to develop a code of conduct and maintain discipline in the profession, while facilitating co-operation among traditional healers, the medical profession, and the government (Baleta, 1998; Hess, 1998). Additionally, these proposals include suggestions for the formal division of indigenous healers into four categories: the *inyanga* (traditional doctors or herbalists), the *sangoma* (diviner), birth attendants or midwives, and traditional surgeons who mainly do circumcisions. Interestingly, spiritual healers were not included because their training and accreditation was "unclear" and "ill-defined" (Baleta, 1998: 554).

“Collaboration” on the other hand, implies a working relationship between somewhat equal partners, the form of which would require additional fleshing out. Green (1994) suggests a kind of collaboration in which appropriate referrals are made between healers and their mental health counterparts, and there is a mutual exchange of certain skills and knowledge. Many who advocate this approach also suggest that it would be preferable for each system to practise within its own framework, and for patients to have access to both (Korber, 1990). Such suggestions are usually supported by arguments that emphasise (irreconcilable) differences between indigenous healing and biomedicine or mental health (Korber, 1990; Kottler, 1988). Whether this is indeed the case or not, as L. Swartz (1996) has observed, such a view contributes to justifying a continued lack of understanding of indigenous healing by its mental health counterparts.

The circumstances in other southern African countries may be informative and certain South African authors have tried to draw insights from them (e.g. Freeman, 1988). Korber (1990) reports that in Zimbabwe indigenous healers were legalised in 1981 and organised into the Zimbabwe National Traditional Healers Association (ZINATHA). By 1990 it had established two medical schools and four clinics. Healers are instructed to seek second opinions, and to refer patients to hospitals for certain conditions. In Zimbabwe it has been widely speculated that “neurotic” problems can be treated by healers, whereas “psychotic” problems should be left to the care of “advanced western medicine” (Freeman, 1988).

In Ghana and Zambia healers receive governmental assistance, and are usually the first line of contact for patients. Twumasi and Warren (1986, cited in Korber, 1990) argue that in these countries indigenous healers have been influenced by “western” medicine and are increasingly regarded as an acceptable occupational group. Ghanaian and Zambian doctors regard them as collaborators in contributing to efforts to provide a national health service (Korber, 1990). In the above cases it appears that successful co-operation has taken place only with changes to indigenous healing practice in the form of medical training, and its institutionalisation.

Green (1994: 26) describes what he terms “cultural distance” between indigenous healers and “medically educated Africans and their expatriate advisers” as a factor constraining collaborative programs². Some African government officials may feel that indigenous healers may project images of backwardness, of the primitive, and even of the illegal, and regard healers as a “somewhat embarrassing anachronism”, particularly when dealing with foreign or outside donors (Green, 1994: 30; cf. Bodibe & Sodi, 1997). As a result, Green (1994) argues, governments may oppose official recognition for indigenous healers.

² Notions of “cultural distance” *between Africans* (rather than between Africans and Europeans) are rare in the South African literature. Green’s (1994) point highlights the persistence of apartheid ideology in the tendency for cultural difference (particularly in the debate on indigenous healing in South Africa) to be cast in racial terms.

2.4.3. The case for collaboration

Most of the literature is uncritically positive about the need for some form of collaboration between indigenous healing and mental health (Ensink & Robertson, 1999, are a notable exception). Proponents of collaboration with indigenous healers in the psychological and psychiatric literature appear to employ three broad lines of argument in their rationales for collaboration. These arguments reflect assumptions that affect the ways in which indigenous healing is framed in the various papers and research studies reviewed here.

The first builds a case for collaboration by highlighting statistics, such as the results of Department of Health surveys that suggest that a large proportion (up to 80%) of the population already makes frequent use of indigenous healing (Bodibe & Sodi, 1997), simultaneously with biomedicine, and move between them in ways that do not follow evolutionist predictions, i.e. that the more urbanised Africans become, the more they will make use of biomedicine, leaving behind indigenous healing (Bodibe & Sodi, 1997; Ensink & Robertson, 1999; Hopa *et al.*, 1998). As Ensink and Robertson (1999) point out in relation to psychiatric patients, and Green (1994) argues with regard to AIDS and sexually transmitted diseases, whether indigenous healers are acknowledged by biomedicine or not, in reality they are widely consulted, often in conjunction with, or in preference to, doctors and mental health professionals. As estimated by the Department of Health in 1997, indigenous healers have numerical superiority over their medical counterparts. There are approximately 350 000 healers in comparison with 300 000 medical personnel in South Africa (Bodibe & Sodi, 1997). These statistics do not, however, reflect the heterogeneity of indigenous healing; it is not specified what proportions of these healers are made up of diviners, herbalists or faith healers etc. As a result, a number of authors have commented on the benefits that a sharing of medical knowledge with indigenous healers may have for addressing national health problems such as AIDS. However, these same authors are also quick to point out the danger in such proposals of healers being co-opted into the medical system as lower-status health workers (Green, 1994; Hirst, 1993; Korber, 1990). Foster and S. Swartz (1997) make the

important point that simple piecemeal insertion of indigenous forms of healing into existing biomedical structures tends to undermine their power as distinct explanatory and healing models.

Second, with the current emphasis in the national health strategy on primary health care (Department of Health, 1997), and in light of the shortage of medical and psychiatric personnel in rural areas and in what is often referred to as the “community”, indigenous healers are seen as readily available and accessible complementary practitioners who can provide care for people *before* they come to occupy valuable hospital beds and use expensive resources (Coughlan, 1995). Green (1994: 19) asserts that in most of Africa, traditional healers

are the acknowledged *de facto* primary health care providers in rural areas, and this is not only by default. High concentrations of healers in periurban areas suggests that they are still frequently consulted even when hospitals and clinics are available.

Third, indigenous healers are argued to provide more culturally appropriate and “holistic” care for some African patients where “western” practitioners fail (Bodibe & Sodi, 1997; Green, 1994; Hopa *et al.*, 1998). In addition, healers are depicted as enjoying greater prestige and credibility in health and spiritual matters (Green, 1994; Herbst & Britz, 1986). Admonitory calls feature in a large proportion of the indigenous healing literature, in which “western” (sometimes implied “white”) mental health practitioners are constructed as wholly different and “culturally encapsulated”, and therefore unable to understand either indigenous healing or African people in general (Bodibe & Sodi, 1997). The assertion that indigenous healing is especially effective with African patients is very often made without adequate empirical evidence, and is usually accepted at face value because of its resonance with dominant discourses that idealise African culture (cf. L. Swartz, 1996). As mentioned above, these arguments construct indigenous healing as something exclusively for Africans, and neglect the published literature on the problems of witchcraft (e.g. Evans & Singh, 1991), or the potentially harmful effects of some of its

methods (Dickinson, 1998). Moreover, indigenous healers are commonly represented as being automatically able to understand African patients by virtue of the fact that they are also African, and are thus better suited for their care. In parallel with the debate on Africanisation, such an approach (which focuses predominantly on “culture”) tends to ignore other important factors which may lie behind people’s use of indigenous healing, such as the inaccessibility or inadequacy of existing medical or mental health care (Korber, 1990; Green, 1994).

An important study by Ensink and Robertson (1999), although limited since it is only applicable to the experiences of psychiatric patients, provides an interesting counter to wholehearted proposals for collaboration. In a comparative study of patient and family satisfaction with psychiatric services and indigenous healers, Ensink and Robertson (1999) found that while patients were satisfied with their encounters with herbalists and faith healers, they reported *negative* experiences with diviners. Moreover, they found that patients’ use of “indigenous names” as explanatory categories for the distress did not preclude their being satisfied with psychiatric services. They recommend “further direct study of indigenous healing practices for individuals with mental illness” (Ensink & Robertson, 1999: 40). As will be discussed further in the following section on research into indigenous healing, such “direct” studies are rare.

2.4.4. Studies of indigenous healing and collaboration

The following is a review of studies or accounts of indigenous healing practice, and in certain cases, instances of collaboration with mental health, found in the psychological/psychiatric literature. To begin with, it is interesting to note here that no research with the explicit aim of determining the efficacy (or otherwise) of indigenous healing was found in the literature (except perhaps for Edwards, 1986). As L. Swartz (1996) has commented, much of the literature on indigenous healing contains descriptions, rather than analyses of, indigenous healing processes. It seems clear that conventional outcome-based designs applied to studies of psychotherapy (as have been

suggested by some) might not be wholly appropriate when studying indigenous healing (cf. Korber, 1990). However, despite the fact that such studies would present complex methodological challenges, their absence is conspicuous. L. Swartz (1996) has argued that this has much to do with the construction of indigenous healing as unknowable to outsiders, and a regard for attempts to examine it as evidence of disrespect for African culture (e.g. Hopa *et al.*, 1998).

As mentioned earlier, it would be useful here to recall the three “contexts for interpreting mental health and illness” identified in the literature by L. Swartz (1989), since it is possible to categorise the literature on indigenous healing in a similar way. It would however be an error to think of these as mutually exclusive “contexts”. For example, many accounts that interpret indigenous healing in terms of its social context may also employ notions of the “African personality”.

The African world-view/personality

Most psychological/psychiatric accounts of indigenous healing that employ the concept of the African personality or world-view follow a somewhat similar format. Studies by Herbst and Britz (1986) of collaboration with healers in an “industrial” setting, and of Wittstock, Rozental and Henn (1991) at a primary school, are illustrative. Both reports begin with a rationale for consulting with healers, which often includes some notion of “cultural” appropriateness, as mentioned above. This is followed by an “authoritative overview” or description of African culture and the role played by the indigenous healer in it, usually without any reference to research. In these accounts, African culture is assumed to be static and homogeneous, and Africans are positioned as passively subject to its prescriptions. Neither of these studies attempts to analyse the consultation process, although Herbst and Britz (1986) provide a lengthy and detailed description of the proceedings.

An interesting feature of the above studies is that in both cases the mental health professionals allowed the healers to operate independently. Wittstock *et al.* (1991: 852) even go as far as to state that “the healers’ power and status in the community would be undermined if they were perceived as part of the [mental health] team”. Herbst and Britz (1986: 7) report the decision to call in indigenous healers as a “drastic step” and a “last resort”, while Wittstock *et al.* (1991: 852) considered it a necessary step when “western beliefs and interpretations did not seem adequate”. In both reports, the need for indigenous healers is framed as a solution to a problem of a situation resistant to interrogation by “normal” means. In these accounts, indigenous healers are seen to provide interventions that cater to the superstitious and irrational African mind, which cannot be reached by “western” reasoning.

In a chapter ostensibly addressing policy issues, Bodibe and Sodi (1997) provide a largely polemical “overview” of indigenous healing that mystifies the work and effectiveness of indigenous healers. Far from taking policy debates forward, Bodibe and Sodi (1997) take great pains to spell out the uniqueness and value of the African world-view, and to stress the difference between “contemporary Anglo-American values” and “traditional African values”. A number of “uniquely African” problems are described, which therefore require for their resolution “techniques that are uniquely and pertinently African” (Bodibe & Sodi, 1997: 186). Propitiation ceremonies conducted to appease ancestors and circumcision rites are proffered as the correct solutions, effectively ruling out “western” practitioners from offering any useful interventions. Healers in this account are cast as naturally closer to patients, while “western” practitioners are depicted as ignorant and foolishly cynical.

The solution to this lack of cultural knowledge, as recommended by both Bodibe and Sodi (1997) and Hopa *et al.* (1998: 13), is to “reduce the ignorance, prejudice and suspicion among western and traditional practitioners about their counterparts . . . [through] . . . joint workshops, seminars and/or conferences . . . to encourage the practitioners to learn about each other”. It is implied then that collaboration would

automatically and unproblematically begin to occur if only “we would learn about each other’s cultures”.

Research studies done in other contexts make use of similar notions of culture and are illustrative. Suryani and Jensen (1992) describe efforts at collaboration between psychiatrists and traditional healers in the management of an episode of “mass dissociative disorder” in Bali. Similarly to writers in the South African context, their description of Balinese culture is framed in largely essentialist terms, including relevant aspects of Balinese beliefs and help-seeking habits. The validity of this exposition of Balinese culture (which is then used to make sense of the interventions described later) is unquestioned, presumably because one of the authors of the report appears to be Balinese.

It is particularly relevant that the authors describe this as a “rural” consultation, and an intervention at “community-level”, which seems to necessitate a discussion about issues of definition and open consultation with the “community”, that would likely not have been raised in the clinical/hospital setting. In the hospital setting, the organisation of space underlines the power of psychiatry to define patients’ identities, for example, in locked wards (cf. Rose, 1994). The issue of whether a diagnostic name will be upsetting to a patient is less likely to be considered, and the name is not necessarily given to a patient. It seems that working outside of this setting occasioned greater attention to issues of power, community suspicion, and lay-professional relations than might have been the case in the hospital with an individual. The authors nevertheless reserve the right to define the situation, which they do in psychiatric terms. Interestingly, they conclude by recommending less direct contact between mental health professionals and indigenous healers, in order to minimise conflict over treatment, and avoid attempts to change each other’s practices.

The social context

There are relatively few accounts in the psychological and psychiatric literature that seek to understand indigenous healing within its social and cultural context. The work of Harriet Ngubane (1977) and Manton Hirst (1990; 1993) are significant exceptions, although both are anthropologists and not directly involved in mental health care. Hirst (1993) conducted an ethnographic study of the Xhosa *amagqirha* (diviners), undergoing the training himself. Despite its extravagant claim that “divination is an indigenous form of Freudian psychoanalysis” (1993: 97), Hirst’s study provides some access to understanding indigenous healing symbols and practice on its own terms. It shows due respect for the process by which healers are called by the ancestors, but also allows for explanations that account for social and economic reasons behind initiation into indigenous healing. For example, Hirst (1993) describes how becoming a diviner could be a culturally available means of redressing serious interpersonal difficulties in the family, as well as an entrepreneurial means of earning money outside of formal, low-paying employment. Hirst’s (1993) work is significant in that it enhances the credibility of indigenous healing by translating its key concepts and symbols into formal academic, anthropological language, without compromising its complexity. Although in the final analysis Hirst (1993) asserts the essential similarity between (western) psychoanalysis and divining, his detailed ethnographic accounts prevent the crude collapsing of indigenous healing practices into psychological concepts. Additionally, the detail of Hirst’s (1990; 1993) and Ngubane’s (1977) works on indigenous healing helps to avert the tendency in South African psychiatry to focus on the peculiar and exotic (L. Swartz, 1986).

In one of the few reports of collaboration between indigenous healing and psychiatry, Hirst, Cook and Kahn (1996) apply anthropological and psychological concepts to indigenous healing (in this case the Xhosa *amagqirha* or diviners), situating it within a socio-cultural context, and elaborating meanings around Xhosa symbols and practices, paying special attention to the issue of social relations and somatisation (a psychoanalytic notion). These authors base their arguments on the thesis that with the “Cape Nguni”, the

human body is symbolic of the social body, and therefore “illness and disorder are interpreted among the Cape Nguni as being caused by unresolved conflicts in significant social relationships with kith and kin” (Hirst *et al.*, 1996: 256). They analyse several case studies in this context, broadening interpretations of predominantly somatic symptoms – the somatic mode, they argue, is a common way in which Xhosa-speaking people communicate distress – to acknowledge them as expressive of emotional and particularly social distress.

Their analysis of the case of Ms G is particularly pertinent to the present research in that it is an account of the ways in which both the healers and the psychiatric team conceptualised and made sense of Ms G and her difficulties. As the psychiatric team deliberated over a diagnosis of psychotic illness, diviners were invited to consult with Ms G. Hirst *et al.* (1996) contrast the narrow, “meaningless” interpretation of Ms G’s symptoms as signs of psychiatric illness, with the socially contextualised interpretation offered by the diviners, who explained that Ms G was being tormented by evil spirits (*amafufunyana*) related to her husband’s unfaithfulness, and her failure (due to her Christian beliefs) to perform the requisite traditional rituals connected with her marriage and the birth of her children. Hirst *et al.* (1996) attempt to conceptualise this aetiology of Ms G’s symptoms, which comprised religious or spiritual and somatic elements, in terms of the stresses of social and cultural change.

Significantly, although their concluding plea that “shades” and somatisation be recognised simply as cultural modes for the expression of social conflict represents an important counter to the medicalisation of these expressions, this assertion highlights the complexities of accounting for indigenous healing concepts within psychological or anthropological discourse, particularly when produced for a professional or academic audience. While this account may render indigenous healing concepts accessible to a wider audience, there is also the potential for them to oversimplify these concepts, and therefore trivialise the work of indigenous healers. Hence, the above assertion that shades are “simply” expressive of social conflict may ironically reproduce the marginalisation of indigenous healing.

Psychological theory

There are only a few instances in which authors have applied psychological theory to the task of understanding indigenous healing. Schweitzer (1977) has used phenomenological theory in his account of Xhosa “categories of experience”. He makes many comparisons with “western” forms of healing and experience. Burhmann (1984) is well known for her Jungian approach to indigenous healing rituals and symbols, comparing for example, the *ukuthwasa* initiatory “illness” through which healers are called, to Jung’s theory of individuation.

Comparative studies of indigenous healing

A number of studies may be found in the South African psychiatric/psychological literature that examine African concepts and idioms of distress or illness. Many of these studies also attempt to evaluate the equivalence of these terms with DSM-IV psychiatric categories and what are termed “culture-bound syndromes” (American Psychiatric Association, 1994). The social construction of these categories is to varying extents, acknowledged or ignored by these studies. Most however, reify both the psychiatric categories and African idioms or concepts of distress they attempt to understand and compare (cf. Kleinman, 1988).

Peltzer (1998: 191) has documented the social demographics, concepts of illness, “case load”, and training and specialisation of indigenous healers in the Northern Province, in a largely positivist and biomedically biased account. Thorpe (1982) has studied “psychodiagnostics” in Zionist faith healing. Although he has employed a qualitative methodology, the research is based on universalist assumptions and collapses indigenous idioms and explanatory concepts into psychiatric categories. Mkize’s (1998) review of the literature on *amafufunyana* concludes similarly. Mogale (1999) has argued that the Tswana idiom of distress “*moriti wa letswele*” (literally, “shadow of the breast”) is culturally specific, but in an attempt to integrate “western psychology and the original

experiential world of black patients”, Mogale (1999: 73) has equated it with the DSM-IV category of somatoform pain disorder. The value of these accounts in dispelling ignorance by bringing African terms and concepts into the formal academic arena is debatable. It may be argued that their construction of these idioms of distress as real and invariant objects in effect amounts only to their appropriation into a more “culturally sensitive” biomedical discourse.

Ensink and Robertson (1996) document descriptions by indigenous healers of “indigenous categories of distress”, such as *amafufunyana*, *ukuthwasa* and *isimnyama esikolweni* (thought to be equivalent to brain fog syndrome), to determine whether it would be possible to include them in epidemiological studies. They conclude that although the “categories” studied correspond with aspects of certain DSM-IV psychiatric categories, they are insufficiently clearly defined and are used variously to denote a variety of afflictions or difficulties. In addition, they note that symptoms are neither prioritised nor tightly enough circumscribed in these “categories”.

Importantly, when comparing the ways in which healers in their study made use of idioms of illness with those of patients and their families (cf. Lund, 1994, cited in Ensink & Robertson, 1996; Lund & L. Swartz, 1998), they point out that these categories were employed by healers as relatively discrete, producing accounts that “accentuate ethnospecific features” (Ensink & Robertson, 1996: 162). This finding suggests that the terms or idioms used by indigenous healers are by no means authoritative and cannot be considered to be representative of the experiences or understandings of all Africans. It also highlights the role that healers, and not only medical professionals play in reproducing discourses about illness and social norms.

While contributing to an understanding of Xhosa idioms of distress, Ensink and Robertson (1996) acknowledge that studies such as theirs, which construct categorical representations of distress, may contribute to indiscriminate application of these categories in the name of cultural sensitivity. Significantly, they are not unequivocally

positive about indigenous healing, which they argue, may also be unhelpful in attributing causes of distress to bewitchment, for example.

Understanding the nature of what is known as *amafufunyana*, has been the subject of many psychological and psychiatric studies. It has been compared with the DSM-IV's brief psychotic disorder (Mkize, 1998), and also understood as a form of hysteria or dissociative disorder (Guiness, 1992, cited in Ensink & Robertson, 1996). Lund and L. Swartz (1998) investigated the experiences of Xhosa-speaking schizophrenic patients, and concluded that the term *amafufunyana* is used in complex ways as a diagnostic, explanatory and aetiological concept. Arguing from a social constructionist perspective, they assert that questions of which "diagnosis", whether *amafufunyana* or psychosis, is correct, are irrelevant, since patients employ both terms in understanding their condition. Similarly, consultation with indigenous healers to determine whether something is "cultural" as opposed to "psychiatric", a common way in which the debate is structured, would fall into the same trap of reification.

Ensink and Robertson (1999) conducted a comparative investigation of psychiatric patients' (and their families') experiences of psychiatric services and indigenous healers in Cape Town. Importantly, this study is one of the few that attempts to address the issue of improving communication by demystifying indigenous concepts of illness. The authors also take a more critical approach towards indigenous healing, and warn against naïve endorsement of its practices. Its significant findings were twofold. First, Ensink and Robertson found that patients reported being satisfied with herbalists and faith healers, while having predominantly negative experiences with diviners, who had promised, but were unable to produce, the results patients had paid substantial amounts of money for. Second, as I have previously mentioned, patients expressed less dissatisfaction with psychiatric services than was expected, including those who understood their illness predominantly in terms of indigenous explanatory categories. They conclude that since illness concepts and treatment are not uniformly bound and coherent, "the use of indigenous names does not preclude satisfaction with conventional psychiatric services" (Ensink & Robertson, 1999: 23).

In what appears to be the only study of its kind, Edwards (1986) conducted a standardised comparison of the interviewing, assessment and treatment planning procedures of indigenous healers and clinical psychologists. Although Edwards interviewed his participants, his approach is essentially positivist, and his results compare quantitatively the different practitioners' "interview orientations". Edwards (1986) reports that healers emphasised "supernatural" aspects of the interview, whilst the psychologists emphasised "natural" elements. He also reported significant agreement on diagnosis and treatment choices between the two groups, and perceptions by patients that both types of practitioners were equally helpful. He sets up for analysis two apparently mutually exclusive and oppositional categories – those of the natural and the supernatural.

Edwards (1986: 1275) concludes that these findings confirm that people eclectically embrace both traditional and modern medicine, in addition to re-emphasising the "universal components of psychotherapy shared by both traditional healers and modern health professionals". Unfortunately he does not elaborate on these universals. Edwards then recommends further research to assess the demand for, and implications of greater collaboration. Interestingly, Edwards (1986: 1276) also includes in his recommendations a call for research into the "effect of modernisation, education, economic, socio-cultural and political change on traditional and transitional societies and their related help-seeking behaviour".

2.4.5. Summary

The present review of the literature has not been exhaustive. However, it has highlighted some of the salient features of the current debate. With some exceptions, problematic notions of the African worldview or personality continue to be used by contemporary authors in accounts of indigenous healing. Biomedical universalism in positivist-informed research continues to dominate, and very few authors within mental health are conducting studies of indigenous healing that set out either to critically examine its processes or account for the social or discursive context which produces and sustains it.

Furthermore, those who advocate collaboration with indigenous healers do not set out any practical recommendations for such an endeavour, and make no reference to the possible difficulties inherent in such attempts. With the exception of L. Swartz (1986, 1987, 1996), no specific attention has been paid to the ways in which the construction of cultural difference has structured the current debate on indigenous healing.

Lastly, no studies have been conducted that have examined the implications for collaborative arrangements between mental health and indigenous healing, of the differing illness conceptualisations that practitioners might employ in their attempts to understand and help patients (Foster & S. Swartz, 1997).

2.5. RATIONALE AND AIMS OF THE STUDY

Mental health professionals' diagnoses and conceptualisations of patients' illnesses form an integral part of the practice of psychiatry, and are an important site for the production and reproduction (or subversion) of notions of culture (L. Swartz, 1989). These psychiatric formulations play a role in constructing identities for both patients *and practitioners*, as well as structuring power relations between them (cf. Terre Blanche, 1997). Particularly in the South African context, these effects may depend to a large extent on the way "culture" is constructed in these formulations. Debates over whether an indigenous healing intervention would be "culturally appropriate" in a particular case would invariably involve some kind of negotiation of illness understandings between practitioners. This negotiation may resemble that between psychiatric professionals when deliberating over the significance of "cultural" issues in formulating a more "cultural" understanding of a patient's problems (L. Swartz, 1998). For example, a particular case may be constructed as inscrutable to the understanding of "western" professionals, and amenable only to treatment by indigenous healers. On the other hand, psychiatric conceptualisations may hold greater legitimacy because of their incorporation of universalist aspects of biomedical discourse. Furthermore, a strict biomedical diagnosis

and conceptualisation would position psychologists and “allied” professionals, as well as indigenous healers, with fewer rights to speak and make treatment decisions.

The purpose of the research is to examine discourses, with particular emphasis on discourses about culture and illness, in two distinct but related areas: i) psychiatrists’, psychologists’ and indigenous healers’ conceptualisations of a diagnostically ambiguous case; and ii) these practitioners’ talk about collaborating with each other in dealing with this case. In addition to the specific emphasis in this study on discourses of culture and difference, the reproduction of (or resistance to) power relations and positions in these discourses will also be examined. In so doing, it is hoped that the research will throw light on some of the issues that may arise as mental health workers and indigenous healers attempt to find a practicable arrangement for collaboration.

CHAPTER THREE

METHODOLOGY

3.1. INTRODUCTION AND THEORETICAL BACKGROUND

In this chapter I outline the methods and theoretical approach informing this study. I begin with a brief discussion of discourse analytic approaches in order to provide a theoretical context, and return to this in greater detail in the final section dealing with the analysis of the interviews. I also discuss the construction of the vignettes and interview schedules used, the selection of participants, and some issues related to the need for an interpreter.

3.1.1. Discourse analysis

The methodology employed in this study is largely informed by discourse perspectives which are concerned with the ways in which language constitutes the very things it appears to describe. Accordingly, much of the work of discourse analysis consists in teasing out the systematic construction of objects in language in ways that make them seem both natural and real. Furthermore, *critical* discourse analytic approaches, such as that of Parker (1992) – which operationalises the work of Michel Foucault – attend specifically to the operation of *power* in discourses. Power, in this perspective, relates directly to the ways in which people are produced or positioned as certain kinds of “subjects”, and how this subjectification is effected through dominant, institutionalised knowledges, for example, psychiatric discourse (Levett *et al.*, 1997).

An attempt was made to utilise methods that follow from, and are consistent with, this theoretical approach. Having briefly described this background, I will now discuss these methods, and the reasoning behind their use.

3.2. CONSTRUCTION OF VIGNETTES AND INTERVIEW SCHEDULE

Two vignettes were constructed and presented to the participants. Vignette 1 described details of a “case”, while Vignette 2 described a scenario in a psychiatric hospital, in which an indigenous healer is consulted by mental health practitioners in relation to the case described in Vignette 1. Their construction is discussed in more detail below.

3.2.1. Construction of Vignette 1

Vignette 1

Mr X is a twenty-five year old man living in [name of suburb] who is brought for help by his family. When asked what is happening to him he replies that this is not necessary as you can read his mind. He mentions that he can talk with spirits, whom he can see, but is evasive, and appears confused and preoccupied with something. He says that these spirits are here because there are people in his family who are jealous of him. He complains that he cannot think clearly and worries that he has done something wrong, but believes that a spirit may have entered his body and may be responsible for his actions. His family reports that there has been a change in him over the past few weeks as he spends more time alone than he used to, and is often found to be crying.

The case in Vignette 1 was specifically constructed to elicit talk about culture and difference in relation to an African patient, and owes much to similar vignettes used in research by L. Swartz (1989). It alludes to some of the symptoms of schizophrenic and major depressive disorder, as described in the DSM-IV. Although other diagnostic systems are used in psychiatry, such as the World Health Organisation’s ICD-10, the predominant diagnostic system in use in the training of clinical psychologists in South Africa is the American Psychiatric Association’s DSM-IV (Swartz, 1998), and the symptoms in this vignette were therefore checked according to its diagnostic criteria.

Vignette 1 was designed so that from a psychiatric or mental health perspective, it would not fit unambiguously the diagnostic criteria for any one psychiatric disorder. Diagnostic complexity would invite speculation about aetiology and other details concerning the patient’s history. In practice, cases are often diagnostically complex, and in this sense, care was taken to ensure the vignette was as plausible as possible,

based on my own experience as an intern psychologist in ward rounds. I recognise that the choice of what I have termed a “diagnostically ambiguous” case represents a degree of bias towards psychiatry. No patients fit unproblematically into diagnostic categories, and the practice of diagnosis is an essentially reductive process (Kleinman, 1988a; Good & DelVecchio Good, 1980). However, in practice there are degrees to which psychiatric categories may be said to “fit” with the way patients present, and “cultural issues” are often invoked to explain variations in presentation. A “diagnostically ambiguous” case would therefore facilitate speculation and talk about “cultural issues”. In addition, psychiatric terminology was omitted so that as far as possible, Mr X should not be thought of by the mental health professionals exclusively in psychiatric terms.

The vignette also had to be accessible to the indigenous healers, who may or may not have had knowledge of psychiatric categories, since the healers interviewed had had varying degrees of contact with psychiatry. With this in mind, an attempt was made to include Xhosa idiomatic expressions of distress in the case description. Not only would these expressions improve the vignette’s accessibility, but they represent important aspects of the way in which African psychiatric patients present to mental health services (Ensink & Robertson, 1996). Since patients who come to the attention of mental health professionals often employ terms such as *amafufunyana* or *ukuthwasa* to account for their experiences (cf. Lund & Swartz, 1998; Ensink & Robertson, 1999), the case vignette was also constructed so that symptoms resembled characteristics of *amafufunyana* and *ukuthwasa* (as described by Ensink and Robertson, 1996).

Furthermore, the inclusion of these features would facilitate talk about “cultural relabelling” amongst the mental health professionals (Swartz, 1998), and for example, how what may appear to be a symptom of psychiatric disorder might be a common and “non-pathological” phenomenon in another culture (American Psychiatric Association, 1994). Additionally, the theme of suspicion of jealousy from others was included since it may be read by psychiatric practitioners as suggesting an aspect of paranoia, while being an important part of suspicion of bewitchment, which has been found to be a common explanation given by African psychiatric patients for their difficulties (cf. Ensink & Robertson, 1996). Interestingly, there are frequent

references in the literature to the role of envy or jealousy in writing about “African psychopathology” (e.g. Hirst *et al.*, 1996). In my experience as an intern, it is a common theme for discussion by mental health professionals.

In important respects however, it may be argued that this vignette may not be particularly accessible to the indigenous healers, and this is an issue to which I return in the final chapter. Xhosa idioms for the expression of distress were gleaned from *psychiatric* research, and not checked for linguistic appropriateness. In addition, since the vignette resembles psychiatric referral notes to some extent, it could be argued that it is cast in an unfamiliar (to the healer) psychiatric narrative (Swartz, 1989; Ensink & Robertson, 1996).

Finally, all of the participants were presented with the vignette in written form in English. However, the vignette was translated orally into Xhosa for the indigenous healer by an interpreter with whom I had previously discussed the vignettes. Aspects of the interpretation and some methodological difficulties are discussed below.

Choice of location, age and gender

The choice of Mr X’s suburb was made so that the vignette would likely be read as being about an African person. My having mentioned explicitly that he was African in the vignette might otherwise have prompted the participants to place undue emphasis on this detail. In addition, in my experience, in both ward rounds and case notes practitioners do not usually refer specifically to a patient’s “race” or “culture”, but rather allude to it by referring to the patient’s spoken language, or the area in which the patient lives. That it is possible to do this reminds one that social and geographical divisions in many South African towns and cities continue to exist along “racial” lines.

Mr X’s age of twenty-five, and his gender, were chosen in order to limit the scope of discussion. First, the late adolescent/young adult period is cited as being the average age of onset for most major psychiatric disorders in the DSM-IV (American Psychiatric Association, 1994), and discussion about adolescent issues or those relating to middle or late adulthood was thus avoided. Second, S. Swartz (1995) has

demonstrated that in the history of mental health care in South Africa, the construction of African madness is both strongly “gendered”, as well as “racialised”. While both male and female patients are positioned in very specific ways in psychiatric discourse, according to their gender, there is a long history of discourse that specifically elides femininity with madness (Eagle, Frenkel, Green & Wolman, 1991; Mills, 1997; Showalter, 1987). The complexities of an analysis of the gendered positioning of *female* African psychiatric patients is beyond the scope of this study. I also recognise however, that the separation of gender and “cultural issues” in discursive studies is problematic³.

The interview schedule

The interview schedule for Vignette 1 addressed the following themes (see Appendix A for interview schedule). Participants were asked to:

- discuss diagnoses or to talk about what they thought was happening to Mr X;
- provide an account of how they understood its having come about;
- fill in other details they would have considered likely to be true of Mr X;
- comment on the treatment or care Mr X would receive;
- discuss any possible problems they might foresee in the care of Mr X;
- relate any experiences they had had of dealing with people similar to Mr X in their practice.

Responses to these questions could be examined for the ways in which, firstly, notions of “culture” are used in conceptualising Mr X’s affliction; and secondly, the manner in which such constructions are implicated in the positioning of Mr X, and of the different practitioners, in relation to one another.

³ I do not wish to imply here that constructions of “*male* psychopathology” are somehow gender-free. S. Swartz (1995) has discussed the very significant ways in which males, and specifically “black” males have been positioned in colonial psychiatric discourse.

3.2.2. Construction of Vignette 2

The second vignette described a situation in which mental health practitioners and an indigenous healer are involved in working together in Mr X's care. This vignette was constructed with the purpose of eliciting talk about cultural difference, differences in practice, possibilities for negotiation and conflict, and power relationships in reference to each other and the collaborative situation. The vignette is deliberately open-ended, to facilitate speculation and projection.

Vignette 2

This same Mr X is admitted to the local psychiatric hospital, and seen first by the psychiatric registrar. After examining him, the registrar refers Mr X to the clinical psychologist for psychological assessment. It turns out that there is difficulty in deciding on Mr X's diagnosis, and how best to help him, and it is decided that an indigenous healer should be consulted. An indigenous healer is invited to the next case conference, at which the registrar who admitted Mr X presents his findings. This is followed by a presentation of the assessment results by the clinical psychologist. Some discussion follows, after which Mr X is called into the room for questions. The healer begins performing a divining ritual to identify Mr X's difficulties. Once the healer is finished, Mr X leaves the room and more discussion follows. The indigenous healer is asked to give his/her understanding of the case. There is disagreement about what the healer says, and a debate ensues.

Some authors within indigenous healing have expressed concern over the likely dominance of biomedicine in government proposals for collaboration (Van Damme & Maseko, 1997). In order to facilitate discussion in this regard, this vignette presents a scenario that is biased towards psychiatry in that collaboration takes place in the psychiatric hospital, and an indigenous healer is consulted only after difficulties with establishing a psychiatric diagnosis for Mr X are encountered. Furthermore, the indigenous healer performs the divining ritual during a psychiatric case conference. Case conference or ward round research has demonstrated that, apart from providing opportunities for joint decision-making in the interests of patients, these conferences also provide a site for the reproduction or contesting of professional boundaries and power relations (Swartz, 1989).

As mentioned previously in the literature review, detailed descriptions of close collaboration between healers and mental health professionals are rare, and there are subsequently very few recommendations as to where or how collaboration should take

place. Of course, there are many other situations or settings in which collaboration may occur, but this vignette incorporates the characteristics of some of the reported instances of collaboration in the literature (e.g. Hirst *et al.*, 1996). Postulating such a scenario would facilitate discussion of the kind of disagreements different practitioners might have, and how these might be resolved, within a mental health context. For example, in the psychiatric domain, concerns about power might be particularly salient for indigenous healers.

The interview schedule

The following themes were explored in this part of the interview:

- general thoughts about the vignette;
- responses to the way the case was dealt with (e.g. decision to admit Mr X, to consult the indigenous healer);
- ideas about how the other practitioners might have understood what was happening to Mr X;
- the kinds of disagreements practitioners might have with each other;
- a projected conclusion for the vignette;
- difficulties practitioners might encounter in working together on this case;
- the advantages of working together on this case;
- previous experiences of collaborating with either mental health or indigenous healing.

Responses to these questions would provide more explicit texts of the construction of the different disciplines and their practitioners, and of the relationships between them.

3.3. PARTICIPANTS

Two clinical psychologists and a consultant psychiatrist from a psychiatric hospital in the Eastern Cape participated in the study. All three of these mental health professionals were chosen for their experience in daily contact with patients such as

Mr X. An indigenous healer (*gqirha*) who practised divination was selected from the surrounding area, who had had previous collaborative contact with psychiatric hospital staff. Significantly, as there are no “formal” means of establishing the reputability of indigenous healers, this one was selected on hearsay (snowballing). The last participant was someone who occupied the interfaces between many positions. She had been trained as a nurse and had worked in general hospitals and in primary health clinics, as well as having recently undergone training to become an indigenous healer. She also occupied the position of postgraduate student/academic, and was selected for the insight she might be able to give on her experience in working within both the indigenous healing and biomedical systems. No claim as to the representative nature of the participants used in this study is made, since from a discourse analytic perspective neither the size of the research sample nor the randomness of their selection are relevant. Rather, participants are selected for richness of material (Banister, Burman, Parker, Taylor, & Tindall, 1994).

3.4. PROBLEMS ASSOCIATED WITH THE USE OF AN INTERPRETER

An interpreter was required for the interview with the indigenous healer, who spoke *isiXhosa* and was not fluent in English. The interpreter was selected for having had previous experience in interpreting for a number of other research studies in the Rhodes University psychology department. As I have mentioned above, the interpreter was required to present the vignettes orally to the indigenous healer, and interpreted during the rest of the interview. Prior to the interview, I met with the interpreter to discuss the ways in which the vignette was to be interpreted to the healer and immediately met with some difficulties. We could not be sure, for example, whether there were equivalent terms in Xhosa that would help the healer distinguish the role of a clinical psychologist from that of a psychiatrist. In addition, the interpreter was not involved in the transcription of the interviews, and thus no comparison could be made between the recorded translation, which would no doubt have been influenced by the exigencies of the interview situation, and the healer’s actual words. Although in a discursive study, the “true” intentions of the speaker are irrelevant (Parker, 1992), it must be acknowledged that the transcript that was finally used for this study was the production of the complex and layered interaction between

myself as researcher and both the indigenous healer *and the interpreter* (Bantjes, 1999). I have attempted to address the significance of these difficulties of translation for the analysis in the final chapter.

3.5. RECORDING AND TRANSCRIPTION OF THE INTERVIEWS

All of the interviews were audio-taped, and no notes were taken during the interviews. These audio tapes were then transcribed to obtain a general sense of the interviews, and did not include details such as stresses on certain words, and the lengths of pauses etc. The transcription notation used by Parker (1992) was considered sufficient for the purposes of this study.

The following is a key to the transcription notation used in illustrative extracts in the analysis:

- [] Indicates words inaudible.
- () Indicates words whose accuracy is in doubt.
- . . . Indicates a pause in speech, or that the extract was taken from the middle of a sentence.
- Indicates that intervening speech has been omitted.
- // Indicates words spoken while other is speaking.
- # Indicates points in the interview at which either the indigenous healer or the interpreter are speaking Xhosa.

3.6. ANALYSIS OF THE MATERIAL

Analysis of the transcribed interviews is informed largely by Parker's (1992) approach to discourse analysis. Parker (1992) sets out a number of criteria for distinguishing discourses, which I will summarise here in order to outline the kinds of questions that will be posed to the text in the course of the analysis.

To begin with, Parker (1992: 5) defines discourse as “a system of statements which constructs an object”. Discourses also operate in the positioning of subjects, that is, in producing “particular types of self” (Parker, 1992: 9) which have varying rights to speak within particular discourses. In the construction of these objects, discourses also simultaneously and often implicitly map out a picture of the (social) world and how it works. The cultural “rules” implicit in these ways of organising the world may be identified by a consideration of how the discourses would deal with deviations from, or objections to the terminology used in the discourse. I will, accordingly, identify discourses in terms of their construction of objects (e.g. “culture” or “mental illness”), the positioning of subjects (e.g. the “white” psychologist as “ignorant”), and the kinds of (social) worlds they presuppose and “defend”.

Discourses also refer to other discourses, and in this sense, they are always in dialogue and in conflict with other discourses. As Parker (1992: 13) states, “the contradictions *within* a discourse open up questions about what other discourses are at work”, and it is these contradictions that allow space for *resistance* to dominant meanings. Additionally, a discourse may be said to “fold around” upon itself and comment or reflect on its own way of speaking, in reference to its own contradictions, for example, or to assert how important it is to speak in that way. This allows instances of the discourse, as they appear in other texts (e.g. in debates about education), to be identified (Banister *et al.*, 1994).

The analysis that follows will therefore not be “staged-based”, or attempt to reflect positions in any holistic way, as discourses and subject positions intersect across the texts from the different participants. The discourses will be identified in the body of texts taken together, and their interactions and areas of overlap or contrast will be demonstrated.

Parker (1992) lists three “auxiliary criteria” for identifying discourses which connect discourse analysis with critical practice. That is, they attend to the ways in which discourses may reproduce or subvert institutions, the power relations (and resistance to power relations) these institutions entail, and how discourses may have ideological effects through their connections with other discourses which sanction oppression.

These criteria are of crucial relevance for the present study, as they impinge on relations between the different practitioners in their talk about working together.

There are some methodological difficulties associated with Parker's (1992) approach which must be noted here. These relate to the application of Parker's (1992) discourse analytic approach to the analysis of *interviews*, which represent co-constructed accounts (or generated texts) between the participants and myself as researcher. Parker's (1992) approach deals very effectively with "pre-given" or "finished" texts constructed previously in another communicative event (Kvale, 1996), such as a toothpaste tube (see Banister *et al.*, 1994), and these texts are analysed by Parker as an addressor of the reader. In contrast, the use of texts here which have been generated in the context of an interview situation, has necessitated a greater emphasis in the analysis on subject positioning (e.g. Hollway, 1989). Furthermore, Parker (1992) does not appear to address the interpretative difficulties of relating meanings in interview *excerpts* to the *entire* interview. This tension is reflected in the following analysis in that my reading of individual excerpts has been framed by my reading of the full interview. Moreover, when articulating discourses and their effects, in certain cases I could not find a corresponding interview extract containing all of the illustrative features.

CHAPTER FOUR

ANALYSIS

4.1. INTRODUCTION

In this chapter I attempt to draw out and examine the major discourses relevant to the research question, with reference to illustrative interview material. In the course of this analysis, I will elaborate only certain discourses separately. Other discourses will be discussed primarily in terms of their effects in interaction. For the sake of clarity however, it is necessary to provide a brief description of the discourses “identified” in the talk of the participants. They are as follows:

- *professionalist* – in which “professionals” are constructed and separated from non-professionals in terms of their expertise, commitment to an ethic of service, and their authority to identify (or define) illness and prescribe and supervise a course of corrective action;
- *psychiatric* – in which the objects “mental illness”, its corresponding “patients”, and the myriad diagnostic and therapeutic principles and procedures they require are constructed; predicated on the ontological reality of “mental illness”;
- *psychological* – in which “inner dynamics”, “emotions” and the injunctions to self-reflexivity and self-rectification are constructed;
- *indigenous healing* – in which afflictions such as “*amafufunyana*” and “*ukuthwasa*”, their manifestation in the body, and their roots in the neglect of traditional customs, are constructed.

It must be noted that the identification of discrete discourses is attempted here only for the reader’s convenience, and belies the complex intertwining of multiple discourses throughout texts (Banister *et al.*, 1994). Further, in listing them I do not intend to imply that they are unitary and homogeneous discourses. For example, there are significant

differences between the operations and effects of humanist-informed psychological discourses, and those of psychoanalytically-informed psychological discourses.

“Discourses” identified in other studies, for example “similarities” and “differences” discourses (Kottler, 1990), and “culture-as-therapy” discourse (Wetherell & Potter, 1992) are also evident in the interviews and are relevant to this analysis. A distinction could be made between these uses of the term “discourses”, and Parker’s (1992) definition of “discourses”. While Parker (1992) is concerned with the constitutive effects of discourses and their *connections with institutions*, these “discourses” are more “thematic”, and descriptive of versions of the social world (cf. Mills, 1997).

I will now provide a brief overview of the analysis which follows. The vignettes elicited some of the expected psychiatric/psychological diagnoses and conceptualisations from the mental health professionals. In their discussions about differential diagnosis, there was much talk about psychosis, and to a lesser extent paranoid schizophrenia, affective disorders and anxiety disorders. As hoped for, there was much talk about “cultural issues” in their conceptualisations of the aetiology of Mr X’s problems. As I will demonstrate, the overriding features of this “culture talk” are two apparently contradictory constructions of African culture, both of which emphasise an African “collectivism” or “communalism”. On the one hand, African culture is constructed as highly familial and group-oriented, and therefore also holistic, natural, and hospitable to the mentally ill. On the other, the valuation of conformity and loyalty to ancestral tradition in African culture places strain on individuals, and is therefore also “pathogenic”. Both constructions of African culture are defined in contradistinction to a “western” culture, which is constructed as both harsh and pressurised, and also more “advanced”.

The vignettes elicited discussion from both indigenous healers that contained interesting contrasts and resonances with the talk of the mental health professionals. The academic and professional training of the healer/nurse was evident in the interview, which contains many instances of formal academic discourse. Her responses were also structured along a

diagnostic narrative, reflecting perhaps her medical training. In contrast, the second indigenous healer's response to the vignette and interview was quite unexpected and highlights some important assumptions and shortcomings in the conception and design of this study. These will be discussed in more detail in the final chapter.

I would like to point out here that in drawing contrasts between the talk of the healers and that of the mental health professionals and referring to specific participants I do not wish to attribute these discourses to the intentions of individual speakers. Nor do I wish to reproduce the dichotomy between indigenous healers and psychiatric professionals. However, certain details about speakers (e.g. their profession, gender and "race") are integrally bound up with their positions as users (and subjects) of discourse and are important to the analysis (Parker, 1992).

Note that the interview extracts used below are identified by the position that is "speaking" (e.g. psychologist), and a number (e.g. [1]). Analytical comments in the text will refer to the number associated with the relevant interview extract.

4.2. PROFESSIONALIST DISCOURSE

What I would like to call a "professionalist" discourse provides the central axis around which the talk of the mental health professionals in particular appears to be organised. This discourse has close resonances with what may be termed a "rationalist" discourse (Banister *et al.*, 1994), and it is noticeably absent from the interviews with both indigenous healers. The main feature of professionalist discourse is its sharp division of professionals from non-professionals.

Psychiatrist [1]: Well I mean I would try and negotiate a pragmatic um approach 'cos it's really the patient that's at stake not any of the professionals /hmm/.

Psychiatrist [2]: I'm largely led by the family ok so if the family want to take him to a traditional healer, um you know I'd need to establish what their understanding is, what their expectations are, and if it was reasonable within that I would support it you know.

Psychiatrist [3]: Um . . . but I think when we identify potential sources of harm, wherever it might be, then we'd counsel the subject and their families. But you see we can advise but we can't control, nor should we /ja/, but we can certainly advise

Psychiatrist [4]: The patients need protection from psychologists, psychiatrists, traditional healers.

Psychologist [5]: We as psychologists know, that the [words unclear] so to speak, is very much dependent on what the client wants, what the patient wants So in the end it's gonna be the patient that decides what does the patient want to do. They kind of do anyway /ja/ so. In our profession psychiatric and psychological, the patient comes to us /hmm/, as they do to the healer . . . um but [] we often lose someone 3 or 4 times for 3 or 4 times before they come back and they're ready to /hmm/ then be compliant with the medication.

Psychologist [6]: . . . if there was a debate around a patient who I believed to be in serious difficulties . . . ok this would obviously tend toward more psychiatric issues than . . . but I would object if somebody said that I'll er chuck a few of this and er kill that and everything's gonna be fine, I'd be inclined to say no.

The above excerpts illustrate some of the principal features of professionalist discourse. Professionals are positioned as dedicated to an ethic of service, and to the provision and betterment of care; they are responsible, careful and deliberate in their work, and are indignant about harmful practice, of which they are aware they may also be capable (see psychiatrist [3] and [4], and psychologist [6] above). Furthermore, professionals are identified by their rationality, moderation, and pragmatism, exemplified above in the use of words such as “negotiate”, “realistic” and “reasonable” (psychiatrist [1] and [2]).

The recipients of professional services are referred to as *clients*, whose positioning in professionalist discourse constructs their needs and opinions as being of primary concern to the dedicated professional (psychologist [5]). For example, in the excerpts from the psychiatrist [2] and the psychologist [5], the decision to consult with an indigenous healer is not made unilaterally by professionals, but is allowed to be “patient- or family-driven”. At the same time, professionals in this discourse have the status of *experts*, and their clients, as well as non-professionals, are required to defer to their authority. As such, those people addressed by professionalist discourse feel a strong pressure to obey or be regarded as foolish and imprudent. The excerpt from the psychologist [5] above asserts that patients who insist on disobeying professional wisdom soon “come to their senses” about the need to be “compliant with the medication”. In this excerpt, together with that from the psychiatrist [3], professionals are positioned as paternally and sagely tolerant

and permissive of both the freedom and folly of patients. This positioning casts any expression of resistance from patients to the prescriptions of professionals as unwise and naïve.

As Louw (1988: 76) argues, professional practice is based on a *scientific* body of knowledge and professionals' high level of expertise is highlighted by requirements of stringent training and professional regulation, and consequently, professionals "do not have to argue their validity claims". Importantly, the emphasis on service and skill serves to construct professionals as independent of political interests. Professionals are characterised by their membership of institutions; authority in their areas of expertise, the boundaries of which are carefully negotiated and policed; stringent procedures for their licensing and registration; and a sense of high status (Louw, 1988).

Thus far in my discussion of professionalist discourse, I have focused primarily on the positioning of professionals in relation to the *users* or *recipients* of professional services. In later discussion, I will argue that professionalist discourse positions *indigenous healers*, as non-professionals, as both irrational and potentially dangerous.

4.3. PSYCHIATRY AND "CULTURAL ILLNESS"

In this section, I address the constructions of Mr X's affliction in participants' response to the vignettes, as objects within psychiatric and psychological discourses, and their deployment in arguments for (or against) indigenous healing and psychiatric intervention.

When asked to outline their understanding of Mr X's difficulties, the mental health professionals in particular placed great emphasis on the diagnostic difficulties presented by Mr X. As mentioned above, a number of possible diagnoses were advanced, and were talked about in such a way as to set in opposition the "ordinary run" of psychiatric illness on the one hand, and on the other, something that was unusual, "atypical" and defined by "cultural issues". This "atypical" affliction is constructed in different, sometimes

contradictory ways, that emphasise similarity or difference with “ordinary illness” to varying degrees. The similarities and differences discourses mentioned above are implicated here in the structuring of arguments for or against either indigenous healing or psychiatric intervention, and will be referred to during the course of this discussion. Their interactions in the construction of “cultural illness” are dealt with below.

4.3.1. “Cultural illness” and psychiatry’s universal power

Both psychologists in this study refer to the possibility that Mr X’s affliction is what they term a “cultural illness” (see excerpt from the psychologist [8] below). In their use of the term, the universality of both psychiatric diagnosis and treatment is clearly asserted. First, “cultural illness” is formulated as merely the culturally shaped expression of “known” psychiatric illness:

Psychologist [7]: . . . the thing about cultures is they have different presentations, different illness behaviour if you know what I mean, ok. They articulate it differently. It doesn’t mean that the actual illness is different.

The privileging of “form” over “content” in defining psychiatric illness (cf. Kleinman, 1988) relegates cultural differences to mere embellishments upon the underlying reality of psychiatric illness. Thus, for example, the fact that a person hears voices is given greater diagnostic significance than what those voices are saying. The meaning of the voices may differ “across cultures” since the content is culturally shaped, but the very presence of voices signals pathology (cf. Parker *et al.*, 1995). Significantly, this formulation allows psychiatric professionals to address cultural differences without having to make any substantial alterations to clinical practice. The patient’s own account is deemed largely irrelevant, and diagnosis, for example, becomes the simple reductive “decoding” of atypical symptoms to reveal the universal psychiatric illness (Good & DelVecchio Good, 1980). If the patient’s account can be dismissed, there is no need to develop a subtle understanding of his/her experience.

Alternatively, within what might be crudely termed a cultural relativist approach, “cultural illness” is constructed as an affliction *unique* to African patients (other patients have “ordinary illness”), which is related to anxiety or the stresses of family conflict or other social problems:

Psychologist [8]: . . . you know prognosis depends on diagnosis okay so if this is just a cultural illness, if it’s related to family troubles and being unemployed and stuff like that, as long as there are no heavy substances thrown in then I would say that the prognosis could be quite good /ja/.

Psychologist [9]: I mean we’re talking here about initiation and the diagnosis of *thwasa* I mean /ja/ that you know . . . can cause incredible anxiety /hmm/ in genuine cases that I’ve seen . . .

Psychologist [10]: I mean if you want to know what *thwasa* is it’s usually more of an emotionally based kind of illness . . .

In the excerpt from the psychologist [8] above we see cultural illness constructed as a less severe condition than is “real” mental illness, and therefore has a good prognosis. Additionally, in the excerpts from the psychologist [9, 10] above, *ukuthwasa* is mentioned as an example of this culturally-specific “cultural illness” (cf. Ensink & Robertson, 1996).

Although the construction of an affliction unique to African patients (similar to the definition of “culture-bound syndromes”) may seem to rely on a kind of cultural relativism, in its definition by the mental health professionals as a variation of mental illness, there is a re-affirmation of psychiatric illness as universal. Within the context of psychiatric care, the simultaneous assertion of difference over and above a fundamental similarity helps to position mental health professionals as respectful of cultural difference, while being the exclusive owners of the skills needed in the alleviation of “cultural illness”. An extreme relativism removes psychiatry’s right to speak; this formulation furthers its continued hegemony. The construction of “cultural illness” as a variety of mental illness (whether culturally-specific or culturally-shaped) implies that it can be adequately managed by psychiatric professionals, and does not require the intervention of indigenous healers.

An interesting aspect of the construction of the power of psychiatry is demonstrated in the notion of its ability to effectively “contain” patients through both psychopharmacological means and through “listening to” them. Consider the following extracts:

Psychologist [11]: But, if it is just a cultural thing, he’ll settle very quickly, ok. So the response to treatment is very very different to someone who is psychotic in a schizophrenic sense, ok . . . and if you take a schizophrenic person, someone who is genuinely psychotic and you treat them with antipsychotics, they still take a while to settle down /ja/. Typically these kinds of people, you take them out of the source of their trouble, and um, you contain them, and treat them, and they respond very very quickly /hmm/. Especially when they’re being listened to and heard you know.

Psychologist [12]: I think whatever whatever’s happening to somebody . . . um . . . containment is the first order of business. The degree of the containment depends on the degree of the stress /hmm/ or distress that he’s in. Um . . . the bit about him sort of er spending time alone and crying and stuff like that suggests that he certainly needs to be contained. /hmm/ . . . So the degree of insight often tells you how much they should be contained. No insight, much distress, lots of containment. Um good insight . . . perhaps um with manageable degrees of distress, less containment. You know on the sliding scale of containment probably therapy provides the most gentle degree of containment, when you see somebody, provide that initial contact, and let them go home /hmm/ ok. Now a hospital say in a locked ward, provides the most degree of containment for somebody without any insight, who’s held against their wishes /hmm/. And just very often that holding um is part of the treatment, you know it’s not to remove them from society, it’s a [] to provide them with a bit of structured [] so they feel safe /hmm/ ok . . . Um off the top of my head I would say that whether it’s a cultural illness or not, there’s no doubt that he’s in distress he’s crying, he’s withdrawn, um he’s not coping ok. Um, and I would imagine . . . that there’s a chemical somewhere that’s going to . . . precipitate um his recovery. /hmm/ Ok? Just hasten it along a little bit. However having said that I must say that er if we could do the containment side of things better, if we could provide you know if money was spent on many more psychologists and many more nurses and we had better wards and stuff, then we could probably get away with medicating a lot less /hmm/ a lot of the time because the containment that we could provide would do a lot of that job for us /hmm/, ‘cos that’s what chemicals do, they just contain /hmm/. Um however, everybody is quite prepared to acknowledge these days that psychiatry is a very efficient and cost-effective service /hmm/ in that you get fairly immediate results um they’re getting more fine-tuned the chemicals themselves etc etc.

In the first extract [11], the rapid response to psychiatric treatment is regarded as indicative of a “cultural” as opposed to “genuinely” psychotic condition. Psychiatric treatment is constructed as powerfully efficient in the alleviation of this “cultural thing”. “These kinds of people”, referring to those with “cultural illnesses”, are positioned squarely within the domain of psychiatry, being effectively “settled” by the provision of “containment”, which takes the form of separation from the precipitating stress (“the source of their trouble”), and “being listened to”. Practitioners’ frequent use of the

psychoanalytic notion of containment to describe the work of psychiatric care has been noted elsewhere (L. Swartz, 1989). The concept refers to an aspect of psychotherapy, requiring that therapists be sensitive to a patient's unconscious communication (cf. Casement, 1984) and evokes images of the benign maternal "holding environment" (Winnicott, 1965; Ogden, 1986).

There are a number of interesting features in the construction of "containment" in the second extract (psychologist [12]). First, as the foremost priority of treatment, the degree of containment indicated for the patient depends on his/her levels of insight and distress. This construction has some potentially pernicious effects, in that referring to locked wards and medication as "containing" associates the subduing and managing of patients who "lack insight" with images of benign maternal care. In so doing it obscures the fact that these interventions often involve the removal of patients' rights, for example, in involuntary admissions (cf. L. Swartz, 1989).

Second, there is a contradiction in the way "containment" is subsequently constructed in this extract. On the one hand, the construction of locked wards and chemicals as capable of containing patients, in effect, divorces the notion of containment from its psychotherapeutic roots, and the indispensability of communication and understanding in its provision. Containment therefore, is just as easily and effectively achieved through these physical means, as it is through an intersubjectively negotiated therapeutic understanding. On the other hand, containment achieved through the work of psychologists and nurses, which is necessarily more "psychological", is preferable to that effected through medication ("we could probably get away with medicating a lot less"). While indicative of dissatisfaction with the exclusively medical treatment of patients, the effect of these contradictory assertions is to position mental health professionals as working to the best of their ability under imperfect conditions, in which the expediency of medication and locked wards in the provision of care acquires justification. While the favouring of psychopharmacological treatment may be appropriate or unavoidable, particularly in government psychiatric hospitals in which additional time and personnel are luxuries, the construction of psychiatry as able to efficiently treat and "contain"

people's distress through medication, irrespective of the nature and subjective experience of their afflictions may contribute to the marginalisation of "psychological issues" in psychiatric care (cf. Swartz, 1991). The irony inherent in the *prioritisation* of the psychoanalytic notion of "containment" as the core of psychiatric care, in the excerpt above, is that it ultimately reproduces its own *marginalisation*.

4.3.2. Difference and the ineffectiveness of "western" psychiatry

Relativist formulations of "cultural illness", as constructed within a differences discourse, fit well with arguments for the need for indigenous healers and the ineffectiveness of "western" psychiatry:

Psychologist [13]: . . . If it's not the usual western psychiatric stuff and it is cultural /hmm/ ok, the treatment is something that's a lot more controversial ok. Then you raise questions of whether our idea of psychotherapy or our idea of counselling would be useful to this gentleman /hmm/ ok. My experience leads me to think that it wouldn't /hmm/ ok. Because the way our models of counselling work is that we repackage people individually ok, we come from societies which are extraordinarily individuated /hmm/ ok, our sense of identity um flows from who we are as individuals . . . ok that's certainly not true of (all) cultures.

Psychologist [14]: But it has to be done genuinely. I'm I'm no good at killing goats /hmm/ and it doesn't doesn't work. It means nothing to me and I'm not perceived as having any authority in that field.

Psychologist [15]: Um we each have our area of expertise, and we know a little bit about the others, but we're not necessarily experts /hmm/. So I've already acknowledged that I might know something about medication, but I [] I might know something about ritual and indigenous healing, but I'm not placed to offer that service /hmm/.

In the first extract [13] above, an argument for the ineffectiveness of "conventional" psychiatric treatment for Mr X is advanced, should he be suffering from a "cultural illness". The problem of psychiatry's inefficacy in Mr X's case is framed exclusively as a problem of "cultural" difference. As in various other parts of the interviews, this is achieved through setting the "individualism" of "western" society and the "collectivism" of other cultures (to which I return later) in mutually exclusive opposition.

In the remaining two excerpts from the psychologist [14, 15] above, we see the positioning of different practitioners within boundaries of expertise, which are defined and legitimated in the assertion and appreciation of difference. In particular, cultural difference functions to “naturalise” the division of expertise. For example, who may legitimately practice within each healing system, and which patients may receive treatment from which practitioner is argued on the basis of “genuineness” and “authority”. The fact that the psychologist above is “culturally different” from indigenous healers positions him as incapable of legitimately performing any kind of indigenous healing intervention. The ineffectiveness of “western” practitioners is an aspect of their selves, and not of their methods. That is, although they may learn how to do an indigenous healing ritual, their “cultural difference” would prevent them from performing it “genuinely” and with authority.

The converse implication that indigenous healers have no authority in matters that might fall within the realm of psychiatry is clear. Thus, the criteria for professionalism dictate that an indigenous healer may only lay claim to the position of “expert” as a practitioner who practices within a separate domain, with different methods for different problems. That is, indigenous healers may be experts only in those fields in which psychology or psychiatry do not already have a claim. Thus “cultural difference” functions here as a compelling reason for the clear demarcation of boundaries of expertise and jurisdiction.

Furthermore, in the positioning of indigenous healers, their expertise is confined to “cultural illnesses”, which are by implication suffered only by Africans. In consequence, the naturalising of domains of expertise between mental health professionals and indigenous healers on the basis of cultural difference is in danger of reproducing the old racialised division of care, or more likely, leading to practitioners abnegating responsibility for the “entire” patient. This division of labour in some way also legitimates a lack of serious attention to adapting psychotherapy, or “talking cures” as interventions for African patients (cf. Parker *et al.*, 1995; L. Swartz, 1991).

4.3.3. The “demonology of madness”

The prevalence of talk about psychosis and schizophrenia in the interviews with the mental health professionals is notable, and it is worthwhile here to examine the ways these objects operate in the indigenous healing/culture debate. In characterising the formulation of psychosis within psychoanalytic discourse, Parker *et al.* (1995: 115) speak of the “demonology of madness”. They argue that dominant constructions of psychosis as both frightening and “other” within clinical psychiatric discourse produce genuine feelings of alarm and concern in practitioners. While the prevalence of talk about psychosis and schizophrenia may be attributed to the inclusion of these diagnostic possibilities in the vignette, in some respects, it is also an indication of the position of psychosis as *the* emblematic image of madness, and its status as the *raison d’être* of psychiatry. The psychiatric professionals interviewed here were particularly concerned that “genuine” psychosis not be trivialised or misunderstood, and there was notable emphasis in their talk on diagnosing it correctly.

As a first point, it is useful to note that of particular concern to these professionals was the difficulty of determining whether something is “genuine” mental illness or “just cultural”. In the following excerpt [16] we are warned about the hazard of misinterpreting “real” psychiatric illness as “merely” “cultural belief system”.

Psychiatrist [16]: I would be uncomfortable if active psychopathology, which could be assisted by western-style treatments, is merely written off as cultural belief system, if we missed the depression, if we missed the schizophrenia.

“Cultural belief system” is something false, a red herring that could divert one from the fundamental and more serious business of diagnosing and treating *bona fide* psychopathology. As an initial response from the participant to the diagnostic complexities presented by Mr X, the above extract [16] seems to caution against undue emphasis on “cultural sensitivity”, given the existence of mental illness. In the following extracts we see the seriousness and force of this warning turning on the construction of schizophrenia (as an epitome or extreme case of mental illness) as universal, frightening

and dangerous. This is achieved through formulations that highlight both the hard empirical reality of schizophrenia, and the extreme nature and destructive consequences of psychosis:

Psychologist [17]: And there's no question in my mind you know that er . . . that schizophrenia's a real thing /hmm/, it's it's an absolutely real thing, and er it doesn't it doesn't er resolve. Schizophrenics don't just like suddenly wake up and they're not schizophrenics anymore. If they do they weren't ever schizophrenics.

Psychologist [18]: I've always thought of it as something that's not nice to happen, should be treated as quickly as possible, and um if not treated, if left to linger actually has destructive consequences. And I would like to maintain that no matter what culture the person comes from /hmm/.

Psychologist [19]: Psychotic people you can't really relate to in that sense, because like there might not be an active stressor going on, or the stressor might not (yet) be severe, but the person has broken down and has unravelled completely, and as such you can empathise with his suffering but you can't quite put yourself in his place, because it's just a little bit too far removed /hmm/ ok.

Psychologist [20]: We always, we always say that the proof um comes out in time /hmm/. Ok if you make the correct diagnosis it becomes really apparent over time and likewise if you screw it up, if you make a mistake, um and you incorrectly diagnose the person, that to becomes apparent /hmm/ ok.

As I have mentioned above, Parker *et al.* (1995: 116) have demonstrated how psychoanalytic accounts of madness construct a reality for clinicians that is both “fantastic and frightening”, and makes all the more “other” the experience of those it talks about. This psychiatric language is organised in discourse such that clinicians experience genuine fear and concern for both their own and their patients' safety. The above excerpts from the psychologist [17, 18, 19] produce similar effects. Interestingly, the accentuation in the construction of madness of both its irrefutable reality and severity may be employed in defence of psychiatry, by attacking the romanticism of anti-psychiatric arguments (e.g. Szasz, 1961) that deny the existence of mental illness (cf. Parker *et al.*, 1995).

It seems that seriously entertaining the idea of collaboration with indigenous healers occasions a moral lesson (the excerpt from the psychologist [20] above takes this form) which establishes science and professional standards as safeguards against a naïve anti-psychiatric sentiment, or against charlatanism. The emphasis on psychiatric expertise and

professionalism serves to justify the exclusive rights of mental health professionals to talk about and define human suffering in psychiatric/psychological terms, in the philanthropic and therefore indisputable interests of public safety. There are clear parallels here to the ways in which the proliferation and increasing popularity of “alternative medicine” has been received in medicine and psychiatry (cf. Foster & S. Swartz, 1997).

An important implication of this “reaction” to talk about “cultural issues” and indigenous healing is that it indicates the potential for such debate to challenge psychiatric power and produce depathologising accounts of human suffering. In many of the interviews with the mental health professionals, the “diagnosis” of a “cultural illness” is regarded as preferable to that of schizophrenia, if it can be made, since it is constructed as having a better prognosis. As L. Swartz (1989; 1998) has noted, attempts to conceptualise patients’ problems in “cultural” as opposed to “psychiatric” terms may represent efforts by practitioners to provide an illness narrative with a potentially better outcome. Discursively, these attempts might be understood as re-positioning mental health professionals as effective and necessary healers, in the face of discourses about patients’ problems that threaten to position them in disempowering ways. Various constructions of African culture may be seen to lie behind such attempts, and it is to these that I will now turn.

4.4. AFRICAN CULTURE AS “PATHOGENIC”

African culture is constituted in different ways throughout the talk of the mental health professionals in particular. As I will demonstrate, it is constructed in their talk as both discrete and homogeneous, and as if it were applicable to all Africans. This problematic construction of culture is employed here in discourses that both reproduce and subvert racist discourse. It also appears in accounts that represent attempts, as I have mentioned above, to construct patient narratives with better outcomes, and therefore functions in resisting psychiatric power. In contrast, as an object of psychiatric discourse, African

culture appears as a force in African lives that is decidedly pathogenic. It is to the latter construction of African culture to which I will turn first.

4.4.1. The “cultural stressors” of “collectivism”

The mental health professionals in this study repeatedly employed notions of what they termed “cultural stressors” or “cultural demands”, in reference to African patients. Its frequent appearance in the participants’ talk about African culture and brain fog syndrome, as discussed below, is notable.

The “cross-cultural psychology” literature contains many references to the classification of cultures as either “collectivist” or “individualist” (cf. Lonner & Malpass, 1994). This somewhat problematic and dualistic theoretical lens is often employed in interpreting the comparative behaviour of people from different cultures. African culture is said to be “collectivist” in that the interests of the social group are more highly valued than those of the individual. Such characterisations of African “collectivism” occur in the literature describing the African “worldview” (e.g. Bodibe & Sodi, 1997; Hickson *et al.*, 1990), and these serve to construct a psychological need for Africans to conform, and to be strongly identified with the group. These notions are reproduced here in the talk of the mental health professionals. Consider firstly, the following extract:

Psychologist [21]: . . . Sometimes a stressor is that someone hasn’t been to initiation school /hmm/. That’s another question that would be . . . you know you might ask if you suspected that kind of a problem /hmm/ you know that in itself can be a stressor and is a stress that you see sometimes in that context /hmm/ [] you know. In a sense he’s not responding to, I don’t know, what you would call cultural demands /hmm is this um . . . / and and the whole self-esteem thing that goes with it [] anxiety [] that in a sense . . . must be acted out.

In this excerpt [21], the failure to complete male initiatory rituals is identified as a possible stressor contributing to Mr X’s condition. In this account, culture is reified as a natural, invariant and coercive force, with which Africans must comply, or suffer deleterious psychological consequences. A “cultural illness” may result, if there is failure to respect or conform to the dictates of cultural tradition.

The strength of culture's "pull", and therefore the severity of "cultural stressors" or demands made upon Africans depends on their being "steeped in culture", implying a pure or true culture in which people may be immersed. Furthermore, the existence of a homogeneous culture uncontaminated by the influence of other cultures, as reflected in the "nostalgia for the village square" (Bibeau, 1997: 32), is thought to be more likely in rural, as opposed to urban areas. Consider the following:

Psychologist [22]: . . . He was a very traditional . . . steeped, quite steeped in culture as well, he had a traditional marriage he didn't marry in court [] . He didn't speak any English /oh/ []. So I would say that this cultural influence was very strong for him. (He wasn't very) westernised in (terms of his beliefs). So again that often could increase the chances of that sort of . . . of *thwasa* having a real meaning for him /hmm/.

In both of the above excerpts from the psychologist [21, 22], "cultural stressors" are formulated in such a way as to construct culture as making fundamental ("deep") and irresistible demands upon African people. Culture is something Africans are compelled to obey, not something that they participate in as active agents. There is an evocation in these accounts of caricatured images of Africans as fundamentalist or dogmatic religious devotees. Conversely, by implication, the speaker who uses this term, who is not African, is not dictated to by a "western culture" but is positioned as objective and impartial, a rational participant in society. Wetherell and Potter (1992) have described similar constructions by Pākehā (European) New Zealanders in their talk about Māori culture. Through the formulation of Māori as the "cultural group", it is implied that the Pākehā do not have culture, but rather a "technical, practical outlook . . . the attitudes of the modern world" (Wetherell & Potter, 1992: 135).

In much of the mental health professionals' talk, ideas that African people value conformity more than individuality are set in distinct contrast to images of the modern individual divorced from social responsibility and intent only on the pursuit of individual gain, or growth. In fact, those Africans who pursue individualistic achievement may suffer the *envy* of others – regarded by the psychologist in the following extract as another possible "cultural stressor", with which African people cope poorly.

Psychologist [23]: And they do so [enter into psychotic states], um for reasons of poor adjustment to cultural stressors, so in this case, Mr X might well be suffering because he, as he says, there are people in his family who are jealous of him. Perhaps he's doing well at school and he's suffering the envy of other people. It seems that in [] cultures er. . . nobody likes being envied, but er it seems to have far more devastating consequences /hmm/ in [] cultures when you're not seen to be . . . moving along with the rest of the people, you're a bit ahead of the bunch. There's a little Xhosa proverb that says um. . . "the nail that sticks out must be hammered down", /hmm/ something like that.

Severe psychological consequences are constructed in the above extract [23] as the result of achieving beyond one's "status" and being guilty of excessive individualism, of being somehow exceptional, and therefore suffering the envy of others. It is interesting to note how the reference to a "Xhosa proverb" functions in legitimating this account. The use of a proverb here implies a common sense, shared by most African people, and in so doing it authenticates what is being said. It also positions the speaker as "wise", and as possessing "cultural knowledge".

The reference to academic achievement as provoking the envy of others deserves a more detailed consideration, since there is remarkable potential in this account for legitimating racist arguments that attribute African people's lack of social mobility or failure to succeed in "modern" South African society to "their culture". These issues crystallise in the notion of *brain fag syndrome*, something which both psychologists referred to in their talk about cases they have dealt with in practice.

4.4.2. Brain fag syndrome

Brain fag syndrome is regarded by many as a "culture-bound syndrome", and is reported to be common in Africa where it is thought to afflict secondary school and university students, often just before important examinations (American Psychiatric Association, 1994; Ensink & Robertson, 1996; Bodibe & Sodi, 1997). It comprises somatic and cognitive aspects of anxiety, such as poor concentration and forgetfulness, which students attribute to "thinking too much". It is usually believed to be caused by bewitchment. Guinness (1992, cited in Ensink & Robertson, 1996) argues that this condition could be

the result of the tremendous familial and financial pressure placed on students due to the high value placed on education in African countries, as a route out of poverty.

Both psychologists referred to this syndrome to illustrate some of the issues they deemed relevant to the case of Mr X. One of the psychologists recounted the case of a female patient with a history of scholastic difficulty, presenting with anxiety, headaches, fatigue and aimless wandering, precipitated by repeated failures at school, who was employed, at that time, as a school teacher. She had been to see an indigenous healer, who had “diagnosed” *ukuthwasa* and recommended that she begin training to become a healer, which she subsequently began but had to discontinue due to lack of funds. According to the psychologist, she felt that she would be cured if she could complete her training. In the following excerpt, the aetiology of her condition and recommendations for treatment are discussed:

Psychologist [24]: . . . in assessing her it was just pretty obvious that she wasn't . . . she didn't have great intellectual capacity I mean she failed often at school /hmm/ and she was really functioning in a job that was far too demanding for her. In a sense ja the stresses of the job were bringing on this symptomology. Um and I mean I don't know if you know what brain fog syndrome is /I've heard of it/ ja, ja, 'cos it almost sort of [] the tiredness, the anxiety around work /hmm/ not being able to concentrate Um ja she was put on medication but we also advised her to basically resign [] from teaching 'cos obviously she couldn't cope, and also to continue with the *thwasa* training, 'cos in a sense it had, it may relieve her of that . . . you know academic stress you know.

In the above extract [24], “academic stress” is particularised in the construction of brain fog syndrome, as peculiar (and central) to its aetiology. Removal of the academic stress is thought to alleviate the condition. The recommendation to resign from teaching and to continue with the indigenous healing training is reasonable in the light of the patient's history and beliefs regarding what would be helpful to her, and constitutes what is often regarded as good psychiatric practice in that it takes into account her social context. However, the medicalisation of the patient's difficulties achieved through a diagnosis of brain fog syndrome individualises her problems, locating the source of difficulty within a deficient intellect.

Empirically, “academic factors” may well be associated with brain fog syndrome, and the patient mentioned above may also have been experiencing academic problems. However, the construction of brain fog in the above extract, as an example of “cultural illness”, is emblematic of a very particular construction of African identity. The attribution of the antecedents of brain fog to the very specific stress exacted by academic pursuit and work achievement reproduces notions of African people as being both uninterested in, or ill-equipped for, intellectual pursuit, and ultimately, inherently incapable of coping with the demands of modern life.

The following extract [25] is interesting because it occurs in the context of discussion about the possible disagreements between mental health professionals and indigenous healers, and the hazards of idealising or romanticising indigenous healing when there are “psychiatric issues” involved. These hazards are underlined through an analogy with the difficulties of managing brain fog syndrome:

Psychologist [25]: . . . *if there was a debate around a patient who I believed to be in serious difficulties . . . ok this would obviously tend toward more psychiatric issues than . . . but I would object if somebody said that I'll er chuck a few of this and er kill that and everything's gonna be fine, I'd be inclined to say no . . .* What we get very often is, and this is something [] um . . . what we have is um cases of um kids coming to us who suffer from what's now been called in the literature as “brain fog” syndrome. Ok um and these people again adjustment disorder with perhaps [] psychotic features related to er what happens at school very often um because people are not coping. Ok and there's such a powerful pressure on people to get an education these days . . . it's like a magic ticket to . . . there are clearly a lot of people who are breaking down in school 'cos they simply can't cope. And um we often like to say, we test you see . . . psychologists test and we test and we find out that the IQ is about sort of among the 60's or the 70's or whatever, and we say listen, you're not going to pass. Um . . . what you need to do is find something else to do and er there's just no [words inaudible but to the effect that they wouldn't accept this news] /hmm/.

It is interesting that a patient's refusal to accept a diagnosis of brain fog syndrome (and therewith a prophecy of inevitable failure) is used here to illustrate the naiveté and obstinacy of an indigenous healer in the face of psychiatric problems (see italicised part of the above extract). It is clearly naïve for an indigenous healer to prescribe rituals for “serious difficulties”, as it is irrational for a person to persist at school when the “fact” of low intelligence has been proven. The extract continues:

Psychologist [26]: So we think, go back to school, there'll be so much pressure you'll relapse again, and every time you relapse it will get worse for you /hmm/. But you know, it's not a . . . an appropriate thing to say these days. So there seems to be a lack of understanding around that kind of thing /ja/. You see we grew up in a society where from the moment you're born, you're streamed . . . , everybody finds their little niche. And er you sort of you know aptitude testing, you know it's a much more individuated process, much, much, much more you know. Um and er it's just a totally different developmental process to what seems to be going on in the schools these days . . . totally totally different.

This excerpt [26] then develops into an account that constructs African culture (and its difference from “our”, “western” society), as the source of African people’s difficulties with brain fog syndrome. Its justification for the abject social and economic status of the majority of African people in “western”, individualistic society, by attributing this to the “developmental processes” in African culture, reproduces racist ideological effects.

Tangled within the two extracts above is the implied positioning of African indigenous healers as naïve and unrealistic about their limitations, and therefore incapable of dealing with people who have “serious difficulties”. As will be demonstrated later, the juxtaposition of hard realism with naiveté, and rationality with irrationality appears throughout the interview texts, in the construction of both African culture and the positioning of healers.

In summary, popular (and academic) notions about “collectivism” in African culture merge with psychiatric discourse in the construction of the object “cultural stressors”, with the result that African culture itself becomes constructed as somehow psychologically harmful or pathogenic, in the exertion of its requirements of conformity. On the other hand, the positioning of Africans as backward or inherently deficient, especially in the ability to cope with the demands of modern life, is also bound up with this construction of African culture (in the construction of brain fog syndrome). Africans are therefore positioned as *vulnerable* simultaneously to the stressors of both “tradition” and “modernity”. As I will argue below, this vulnerability is framed by the psychiatric division of normality from abnormality, informed by humanist psychological discourse, that takes as its normative model of health the self-directed, unconflicted and rational individual (e.g. Rogers, 1961). This *fictional* ideal (Hall, 1996) is implicated, within the

language of “psychological integration”, in the positioning of Africans as precariously poised at the margins of “traditional” and “modern” social and technological worlds.

4.5. “CAUGHT BETWEEN CULTURES”

Psychologist [27]: Now the problem is that a lot of um . . . a lot of er . . . [tsk] local people these days um . . . are caught between cultures. /hmm/ And depending on their social class, and depending on um their level of education, they might be incredibly resistant, we find that in the hospital that the patients themselves sometimes can be quite resistant but the nurses as well, incredibly resistant to anything from their own culture, they’ve, they’ve bought into the western psychiatric model completely.

Psychologist [28]: I mean in a sense it’s being caught between two spheres of meaning. Part of . . . in a sense, often part of getting over . . . it depends on what sort of mental illness we’re talking about now but . . . whether it’s emotionally based or (biologically) based [] um part of getting over it is creating some sort of meaning around it or understanding and in a sense what the symptoms mean for one’s life. And er I would imagine if you were caught between . . . two . . . cultural spheres or whatever it can be very confusing to make sense . . . of certain symptoms [] /hmm/. ‘Cos on the one hand you might be required to perform certain rituals or go through certain procedures to . . . traditionally to address (the symptoms) [] so it would obviously create some sort of anxiety /hmm/ []. Just in terms of being able to resolve the situation ‘cos I think I mean a lot of it has to do with faith [] belief that a certain . . . that something’s gonna resolve []. /ja/

Psychiatrist [29]: . . . nurses of the sort of type we’re talking about, um Xhosa, speak the language, from the culture etc, they’re in a very difficult position because they’ve got one foot in each camp really. They’re trained in western style mental health, um and yet their roots are in traditional indigenous er belief systems. And I think it’s really difficult for them to straddle that er belief divide. It’s very . . . er very few of them manage integration of that, and I think expecting them to perform cultural brokering functions when they themselves haven’t really sorted out the . . . the difficulty of incomplete um ascription to certain belief systems I think it’s asking too much.

In the excerpt from the psychologist [27] above, the adoption of the “western psychiatric model” by African patients or even psychiatric professionals (nurses), is constructed as a kind of betrayal of one’s true cultural heritage, a heritage that rightly belongs to African people. The racialised essentialism in this formulation constructs a “true cultural identity” that Africans are forsaking by adopting “western” concepts. Indeed, the expression of this sentiment by African authors within mental health is not uncommon (e.g. Bodibe & Sodi, 1997), and receives powerful backing from popular discourse in current debates about an “African Renaissance” that encourage the renewal of appreciation for African culture, and cast multiple identifications as disloyal (e.g. Mangcu, 1998). An association with

psychoanalytic discourse may also be made here, in the repeated use of the word “resistant”. This usage underlines the power of the psychologist to speak authoritatively about the unconscious (“true”) nature of Africans, which is being denied in this “resistance”.

The second extract above from the psychologist [28] draws from existential-humanist psychotherapeutic discourse (e.g. Rogers, 1961), in a formulation that posits the possibility of estrangement from one’s true identity, resulting in a painful internal “incongruence”. As a result, being “caught between” represents an obstacle to recovery from mental illness, since it evidently hinders the creation of unitary meaning around one’s symptoms. It also renders indigenous healing rituals ineffective, due to a “loss of faith” in their efficacy.

The extract from the psychiatrist [29] was given in response to my suggestion that working with someone who was familiar with both indigenous healing and psychiatric practice (for example, a psychiatric nurse who had some experience with indigenous healing), would be preferable to an indigenous healer *per se* (cf. Green, 1994). In this extract [29], being “caught between cultures” is constructed as a particularly incapacitating experience, being the cause of much psychic *confusion* and emotional turmoil. The pathologising discourse of psychiatry in which changing social and cultural identifications are framed here positions (African) nurses as psychologically “not-whole” (implied by “integration”), and confused and therefore unable to participate meaningfully in the psychiatric team. The contribution that nurses might make to discussion about “cultural issues” is disqualified on this basis. Moreover, defining the pathology of others involves a simultaneous outlining of the boundaries of one’s own psychological health (cf. Parker *et al.*, 1995). The assertions about the incapacity of nurses are framed in a way that implies that the speaker, as (“western”) psychiatric professional, has already “managed integration” or that there is no integration to have to undergo⁴.

⁴ I will not attempt here what would be a complex discussion of the racialised *and gendered* aspects of this pathologising discourse. Nurses, as both African and female (nurses in psychiatric hospitals tend to be female), are further pathologised within male-dominated medical psychiatry. Their positioning here bears a strong resemblance to the way doctor-patient relationships are structured (cf. Parker *et al.*, 1995).

Africans in a post-apartheid South Africa (“these days” – see extract from the psychologist [27] above) are positioned in this discourse as particularly vulnerable to the confusions of social and cultural change. Moreover, in these extracts it is *only* African people who experience (and suffer) the ambiguity of cultural complexity; others, it is implied, live in homogeneous cultural worlds. This construction is interesting when one considers the increasing acceptance within psychological discourses of post-modern notions of social worlds and identities as inherently fragmented (Hall, 1996). That identities are constructed in the intersection of multiple and contradictory cultural and social discourses is not pathologised in, for example, Lacanian-informed psychoanalysis.

The dominance of the discourse which constructs Africans as having difficulty dealing with rapid social change resulting from “modernisation”, and the introduction of “western” culture, is reflected in numerous accounts found in the literature. For example, Ulin (1974, cited in Green, 1994: 32) speculates that indigenous healers may serve the function of “change brokers” in times of rapid social and cultural change, who are able to guide and reassure Africans who are “torn by the conflicting expectations of their changing worlds”. Other authors have framed the difficulties faced by Africans as the result of conflict between “western” concepts and values and traditional ones (Wittstock *et al.*, 1991). Explanations for *amafufunyana* that formulate it as an “idiom to deal with anxieties associated with failure to cope with the changing way of life in colonial and post-colonial society” are another example (Hirst *et al.*, 1996: 274). Lastly, some attempts to deconstruct conceptions of “South African insanity” have also reproduced images of the conflicted African, at the mercy of competing paradigms or discourses (e.g. Long & Zietkiewicz, 1999).

In certain respects, these ways of speaking about Africans parallels those of Pākehā New Zealanders in their talk about the social and psychological malaise accompanying Māoris’ loss of culture as a result of life in “western society” (Wetherell & Potter, 1992). I will take up useful aspects of Wetherell and Potter’s analysis in the following section.

4.6. AFRICAN CULTURE AS THERAPEUTIC

Constructions of the psychologically damaging effects of the abandonment of African culture, or of its clash with modern “western” culture are reproduced in accounts in both the mental health literature (e.g. Hopa *et al.*, 1998; Wittstock *et al.*, 1991) and media (e.g. Mangcu, 1998) that prescribe the therapeutic benefits of African culture as remedy to this *anomie*. The frequently cited concept of *ubuntu* is emblematic of notions of a hospitable and holistic African communalism circulating in popular discourse, that can be found, for example, in debates on African culture in the media (cf. Mangcu, 1998).

As I will argue, in prescriptions by both indigenous healers and mental health professionals in the interviews to “heed the call” of culture, or tradition, we see culture discursively constructed as a buffering force against the stresses and ills of modern society. The formulation here of the plight of culture-less or confused Africans in post-apartheid South Africa parallels that of Wetherell and Potter (1992), who identify what they term a “culture-as-therapy” discourse in the construction of Māori culture in New Zealand. They argue that such a discourse positions Māoris as “non-persons”, searching for structure and secure identity, and in their absence, prone to delinquency and crime (Wetherell & Potter: 131). Culture becomes offered as a remedy for social discontent, and as a solution that “encourages pride in oneself and a self-esteem based on knowledge of difference” (Wetherell & Potter: 132). Importantly, they argue that the de-politicised culture-as-therapy formulation obscures the social and political grievances of Māoris by re-interpreting their plight as psychological malaise. Wetherell and Potter’s (1992) analysis is replete with examples of the way culture-talk functions in an ideological way to depoliticise social issues. This construction has important resonances with developments in the South African context. For example, some have regarded the psychological benefits accruing from a return to Zulu traditions as a potential solution to violence in Kwazulu-Natal (cf. Koch, 1997), while others have proposed the recognition and appropriation of *ubuntu* as a guiding principle for effective governance and “people-centred” development (cf. Mangcu, 1998). Parker (1997) has commented on the disciplinary functions (in the Foucauldian sense) of the concept of *ubuntu*, as it is

currently being used in psychological research and in the South African media, in producing good and responsible African citizens.

4.6.1. Benevolent primitivity

Psychologist [30]: You know we don't have, we don't have the . . . the cultural metaphors um to allow places in society for people that are mentally ill, you know what I mean. Our society's based really on how quickly you can jump up and down, and how many hours you can put into your job, and how much money you can make, it's it's high pressure stuff /hmm/. Industrial age /hmm/. Um information age. But nevertheless, their culture has allowed them to occupy that place where they can be mentally ill, and they can perform some other function as well /hmm/. And I find that fascinating because our culture I mean that would be completely anathema to our culture. You know as soon as you become mentally ill, you're fit for nothing /hmm/, largely speaking, despite our adherence to human rights and stuff like that you know it's not cool to be mentally ill you've got to hide it /ja/ you know what I mean because the consequences are severe. But imagine living in a culture where you could go in and out of psychosis, weird things could happen and there'd be no penalty attached to that.

African culture, in contrast to “western” society, is constructed in the above extract [30] as highly hospitable to those who are mentally ill. According to this account, in African culture the mentally ill are neither stigmatised nor separated from society, in contrast to those in the harsh, unforgiving circumstances of performance-orientated “western” society. In particular, it is implied that the communalism and leisure of the African way of life allows the mentally ill to blend in anonymously and still be productive community members. The romanticised primitivity of African culture functions here in a kind of anti-psychiatric critique of psychiatry's regulation of “western” culture, and its power to divide (and incarcerate) the ill from the non-ill. Lucas and Barrett (1995) demonstrate the centrality of “primitivist” themes in structuring debates on culture and psychopathology, and contrast two recurring images in the literature, a “barbaric”, degenerate primitivism on the one hand, and a harmonious and therapeutic (“Arcadian”) kind on the other. L. Swartz (1998) argues that the “cultural relabelling” of African patients' afflictions may be seen as attempts to substitute the negative primitivism bound to images of madness (cf. Parker *et al.*, 1995), for the positive primitivism of African culture. This construction of the benevolent primitivity of African culture has resonances with the unequivocally favourable constructions of African culture mobilised in arguments for the value of

indigenous healing in mental health care. For example, the southern African Regional Conference on Mental Health Policy held in 1995 concluded with the following resolution:

It is affirmed by this conference that the traditional African worldview and spirituality is highly promotive of mental health as regards its understanding of *ubuntu*, the high value it places on family life and its deep love and respect of children and the elderly. It is affirmed that the authentic practice of traditional African forms of healing is vital to mental health in Africa, its holistic approach to healing has much value for all to learn (quoted in Bodibe & Sodi, 1997: 191).

The emphasis on the therapeutic benefits of the “*traditional* African world-view” in the above quote is striking. The word “traditional” clearly locates the harmonious, respectful, family-oriented, and spiritual/holistic qualities of African culture in the *past*. This construction therefore urges a return to a prior, pristine version of African culture.

4.6.2. Indigenous healing: psychotherapy “for the people”

Psychologist [31]: . . . the patients themselves sometimes can be quite resistant but the nurses as well, incredibly resistant to anything from their own culture, they’ve they’ve bought into the western psychiatric model completely. Whereas those of us that are applying it a little more directly um . . . are quite happy to acknowledge you know /hmm/ that there’s a place um for a more appropriate intervention /hmm/ and we think that these indigenous healers actually provide that, in many ways /hmm/. If you if in your own cultural way you believe um in spirits, and and sacrifice, and all those things, um just in the same way that in our culture we believe um in the individual, and the pursuit of various . . . goals, um and the conflicts that brings . . .

Healer/nurse [32]: . . . but um the interesting thing I find in the music, is that it’s almost like regression therapy that music because the drum beat is very definitely a doom-do-doom which is the cardiac, which is like the cardiac cycle, which is the two closures of the atrial valves and of the ventricles, and even the anklets and stuff that they have to wear around their feet is like this sound of blood flowing, so it’s almost like, and in fact when they talk about it when that *thwasa* in his training state, before the liminal state, is likened to being back in the womb. He’s removed out of society, and put into nature, which is the same as the baby in the womb, and a lot of the symbolism is associated with being in the womb, so this music is perhaps like a form of taking a person back into his foetal state /hmm/, and then in that way they can work out his illness.

Healer/nurse [33]: I don’t think any psychiatrist or psychologist should worry about that, if it is, if the patient has been diagnosed as being called, because they actually get perhaps the best psychotherapy they can in the care of the healer in that situation, where you’re doing dance therapy, you’re doing dream therapy, you’re doing all sorts of things which are

recognised within the . . . you know . . . psychotherapy /ja/. You know, that . . . that world. So there's a lot of focus and love and attention to the person.

In the first extract [31] above (part of which has been discussed before), a rationale for collaborating with indigenous healing in mental health is structured in terms of its “cultural appropriateness”. This is a construction found repeatedly in the literature advocating collaboration with healers (e.g. Bodibe & Sodi, 1997). Interestingly, the speaker, as a psychologist, is positioned in this account as knowing more about patients’ “true (cultural) needs”, which they have disavowed in favour of the “western psychiatric model”, than patients themselves. Furthermore, both psychologists and indigenous healers are positioned in this account as possessing the authority and skill to address the “core dilemmas” or problems of their respective cultures, what Littlewood (1997: 84) has termed “culture healers”. Importantly, Littlewood (1997) argues that this discursive positioning of healers, whether psychiatric or indigenous, as “culture healers” serves to reinforce their influence and maintain their clientele.

The second excerpt [32] from the healer/nurse above describes an aspect of the trainee healer’s initiatory dance ritual. It is remarkable in its invoking of metaphors of “natural” and “deep” bodily processes in constructing indigenous healing processes. The association of the drum beat with the “cardiac cycle”, with reference to the anatomical details of the heart’s “atrial valves” and “ventricles”, links this rhythmical aspect of the ritual with an essential and involuntary biological function. Additionally, the likening of the dance ritual, and the entire process of initiation into healer status, to a return to a foetal state in the womb, valorises regression to a child-like, innocent state as a means to healing. Indigenous healing thus constructed is powerfully legitimated as an ancient, primordial form of healing that is “close to nature” and rooted in the past. It is unsurprising that the primal images used in the construction of indigenous healing have been attractive to some within the field of transpersonal psychology, and the term regression therapy is derived from transpersonal psychological discourse (e.g. Grof & Grof, 1989). To my knowledge, there is as yet no published literature on African indigenous healing within the field of transpersonal psychology in South Africa, but it

has been regarded as an African form of “shamanism”, which is thought to be a worldwide phenomenon (David Edwards, personal communication, 1996).

In the third extract [33] above there is the further use of psychological terms to describe the work of indigenous healers. Dance rituals become “dance *therapy*” and the interpretation of dreams by healers becomes “dream *therapy*”. As I will argue later, the use of psychological terms to characterise aspects of indigenous healing may be read as an attempt to enhance its credibility and that of its proponents.

In summary then, the mobilisation of this conglomeration of eulogistic images of African communalism and Arcadian primitivity (Lucas & Barrett, 1995) in psychiatric practice, in the literature and in the media, has the potential to function in the construction of a powerfully compelling argument for the necessity for collaboration with indigenous healers.

4.7. THE MARGINALISATION OF INDIGENOUS HEALING

In this section I outline some of the contradictions in the construction of indigenous healing, and in the positioning of the relevant practitioners. The imperative to be inclusive appears to structure the talk of all of the participants, including that of the healers (cf. L. Swartz, 1996). All spoke of the value of complementarism in enriching and broadening the scope of both mental health and indigenous healing care.

Psychiatrist [34]: Um the registrar’s consulted with a psychologist, why shouldn’t the registrar consult with an indigenous healer?

Psychiatrist [35]: . . . Let’s say for example that he was depressed, I would try and negotiate that he would continue on a course of antidepressants while he was undergoing indigenous healing. Um so I mean I think I would pragmatically look for complementary, potentially beneficial complementary interventions being used by all parties.

The above extracts [34, 35] are structured by a professionalist discourse, emphasising a “team approach” in which the contributions from different practitioners are accorded equal validity as a matter of pragmatic (and democratic) principle. Professionalist

discourse casts any overt assertion of hierarchical authority as dogmatic and irrational (cf. Billig, Condor, Edwards, Gane, Middleton & Radley, 1988), and both of these extracts position the speaker, in marked contrast, as open-minded, tolerant and non-authoritarian. In the extracts above, the power differentials that necessarily exist between practitioners are effectively played down. As I will demonstrate, in spite of the persuasiveness of these “inclusivist” constructions, indigenous healing and its practitioners occupy a clearly marginal position in relation to mental health, and particularly psychiatry. Some participants were clearly aware of this, and their talk about collaboration reflected a concern with the question of credibility.

I hope to demonstrate further that the subjugation of indigenous healing knowledge within mental health care, and specifically in the context of the psychiatric institution, is sustained largely through the dominance of rationalism. This rationalism is embodied in both psychiatric and professionalist discourses that interact to reinscribe the “otherness” of African indigenous healers. This construction of “otherness” is centralised in images of African intellectual primitivity, which reproduce “African minds” as bound to irrationality and superstition. Another aspect of the marginalisation of indigenous healing is the alternation in some accounts between the minimisation and accentuation of its tangible effects. In those that warn about the potential dangerousness of indigenous healing methods, they are constructed as able to bring about substantive effects. For example:

Psychiatrist [36]: . . . My other concern is um some of the er indigenous healing practices involve potentially toxic um treatments which um you know purging type treatments which er I think can be dangerous . . . physiologically.

Alternatively, the potentially positive effects of indigenous healing are downplayed in accounts of its benefits:

Psychiatrist [37]: My experience is that in the norm, traditional healers are quite good at working . . . of picking up whether there are mental health issues which are beyond them [] /hmm/ . . . I think it's extremely difficult to manage acute psychosis in a traditional healing system.

Psychologist [38]: . . . It seemed that doing his *thwasa* training was going to relieve him of a hell of a lot of anxiety.

Healer/nurse [39]: And by sorting it out in a ritual fashion, then it actually alleviates a lot of that anxiety which is causing that /hmm/ [] that state /hmm/.

Psychologist [40]: . . . to continue with the *thwasa* training, 'cos in a sense it had, it may relieve her of that . . . you know academic stress you know and []. And again it was something she . . . it gave her meaning for her symptoms it was something we could give her . . . meaning that people need . . . I suppose to work with their own symptoms and start curing themselves in a sense /hmm/.

These accounts attribute the effectiveness of indigenous healing to “reducing anxiety” [38, 39] and “providing meaning” [40]. While these results are not undesirable, in the world of psychiatry, they are the peripheral, nonessential aspects of care.

Psychologist [41]: . . . [S]o the debate might be around you know, what are you going to do Mr Healer /hmm/, and er does the goat really have to have it's throat cut you know, 'cos you can imagine, say say . . . I mean just imagine that the healer says right fine, what I'm gonna do, is I'm going to get the whole family onto the ward, I'm gonna get a goat and I'm gonna butcher it here on the grounds /hmm/. I can tell you right now that er, myself I'd probably object, I don't like animals suffering and er other psychologists feel even stronger than I do /hmm/ you know there's no ways . . . there's no ways I would I could be pressed actually I would actually not be able to watch having . . . to watch some screaming animal be butchered /hmm/.

The above extract [41] illustrates the use of extreme examples in the construction of indigenous healers and their work, which serves to further undermine their credibility. The example of the slaughtering of the goat serves to position the speaker as one whose moral sensibilities have been offended. As Billig (1987; cf. Wetherell & Potter, 1992) demonstrates in his discussion of moderation and extremism, moderation is only identified and defined through contrasts with “extreme positions”. Thus, this construction reinforces the positioning of psychiatry as a bastion of rationality, recognised through both its moderation and its indignation at extreme practices.

4.7.1. A refuge of unawareness

Healer/nurse [42]: . . . I would say that this is not something western biomedicine or mental health could really address very well, because if you believe that you're being affected by spirits and witchcraft, then the best person to go and treat . . . to go and sort it out, to do ritual

action to counteract that would be a healer or a specialist who knows how to work with the spiritual world, the spiritual realm /hmm/, in terms of what he understands. In terms of . . . if he understands that either a goat has to be slaughtered or certain medicines have to be applied and that is what . . . that is all he can believe will sort out his problem /hmm/, then that is the only way he will actually get around it because no matter how much you may tank him up with antidepressants or antipsychotics he will still believe /hmm/, that there is this ultimate problem which hasn't been sorted out. And by sorting it out in a ritual fashion, then it actually alleviates a lot of that anxiety which is causing that /hmm/ [] that state /hmm/.

There are interesting discursive features in the above extract [42] in the way that it contrasts the implied aims of therapy found in psychoanalytic discourse, with those in indigenous healing discourse. In psychoanalytic discourse, self-reflexivity (“insight”) is a highly valued therapeutic goal. In the above extract, Mr X’s belief in spirits or bewitchment is framed in a manner similar to the notion of a defence (cf. Malan, 1979), in that it protects him from awareness of some more fundamental issue, presumed to be unconscious. A particular aim of psychoanalytic psychotherapy is to interpret defences and in so doing to expose to the patient the underlying, forbidden or anxiety-provoking reality (Malan, 1979). The rationale that Mr X requires a healer who will work *within* his belief system, without evaluating its helpfulness to his particular circumstances, implies that “insight” (read: “reality”) is not possible or desirable for African patients. This may be expanded in relation again to notions of African primitivity and the construction of African people’s inability to tolerate the anxiety of “culture-less” existence in a culture-as-therapy discourse. Moreover, in this extract Africans are “othered” in that it is implied that they do not participate in the required therapeutic discourses of “self-inspection” and “self-rectification” (Foster & S. Swartz, 1997: 17). These are powerfully entrenched discourses in the context of modern “western” culture. In addition, this recommendation assumes that healers are automatically better able to work in accordance with Mr X’s acculturated (rather than psychological) needs, and neglects the role of healers in structuring and reproducing norms of health and illness that may be undesirable for Mr X.

There is no doubt that this healer/nurse would strongly object to my reading of her statement. However, the constraints of psychiatric discourse, and to a greater extent, the rationality which constitutes it, impels talk which constructs African subjectivity as bound to superstition and not rationality, and the work of healers as non-substantive.

There is also an intimation of resistance to biomedical reductionism in this account, since it elevates the “psychological” above that of the medical, viz. medication won’t work if a person *believes* in a different illness reality.

4.7.2. Positioning of indigenous healers

In the following paragraphs I discuss the implications of the intersection of professionalist and psychiatric discourses for the ways in which indigenous healers are positioned in the debate on collaboration.

Professionalist discourse

Psychiatrist [43]: . . . Indigenous healers have a different perspective on things, well you know a different . . . prioritisation I suppose, and intellectual pursuit is not necessarily one of those. So you know a case conference is, which I mean apart from hopefully arriving at a reasonable diagnostic and management plan, are also essentially largely intellectual pursuits. Traditional healers don’t (go for that) /hmm/. Um I must say and I know that this is on tape, but I . . . my somewhat jaundiced view . . . of what has happened, essentially revolves around money and power /hmm/. Um and that the first sort of fleeting flirtation between mental health and indigenous healing, I think from mental health’s side was twofold. One was how can we broaden our scope of understanding, how could we treat patients better, um and I think there was goodwill in that. I do think that er in my experience, the traditional healing motive for the flirtation was essentially, how do we access the money and the power. And that’s all about medical aid accreditation, um and you know medical funding, reimbursement, that sort of stuff. And I think when that moved onto a different plane, it um the traditional healers stopped coming to the case conferences and [] /hmm/ . . . in principle, I don’t have any problems with um . . . with suppliers, indigenous healers, mental health professionals etc being reimbursed, or competing for the same sort of reimbursement funding, but then we must all play by the same rules /hmm/. We must all be regulated in the same way. Um registered etc, and I’m aware that there have been some problems in the indigenous healing sector, on that count. So I must, I’m somewhat cynical, I think traditional healers saw cooperation as a means to an end, money, status and power /hmm/.

In the above extract [43], professionalist discourse intersects with notions of the “African personality” to position indigenous healers in opposition to mental health professionals. Healers are positioned as uncontrolled, greedy for money and power, individualistic and non-intellectual, and are distinguished from the benevolent, educated “western” professional in pursuit of knowledge and better patient care.

Moreover, since indigenous healers are motivated only by personal gain, rather than the objectives of knowledge or better patient care, they are also potentially dangerous and need to be subjected to restrictions. Significantly, the words “control”, “manage”, “regulate”, and “handle” appear frequently in various other sections of the mental health professionals’ talk, in reference to both healers and patients. For example:

Psychiatrist [44]: So I think carefully managed, indigenous healing could enrich the vocabulary of mental health.

In addition, in the following extract [45] the potential dangerousness of indigenous healers is related to a stubborn, irrational approach to treatment, a construction which has appeared previously in the discussion of brain fog syndrome:

Psychiatrist [45]: So I think my concerns about traditional healing are, ‘cos there’re lots of benefits in indigenous healing, but my concerns are one . . . is that useful chemical or psychological interventions . . . potentially useful ones are not allowed, ok, and my other concern is um some of the er indigenous healing practices involve potentially toxic um treatments which um you know purging type treatments which er I think can be dangerous . . . physiologically.

This obstinacy of indigenous healers manifests in the threat that they might insist on outright rejection of psychiatric treatment in favour of their own methods. Further hazards stem from scientifically untested treatments, which may be physiologically harmful. The emphasis on the physiological or chemical dangers presented by indigenous healing allows this psychiatric professional to speak about a subject on which he is a recognised authority. Thus the psychiatrist is accorded the right, in this discursive position, to judge the suitability or otherwise, of indigenous healing for a particular patient.

As I have mentioned previously, a rational, problem-solving approach is emphasised in the talk of “multidisciplinary” professional teams in particular (cf. Billig *et al.*, 1988). The valuation of a democratic approach in such teams, in which the opinions of all professional members are deemed equally important, casts any competition or pursuit of status for its own sake, or the overt assertion of hierarchical authority as irrational.

It is not difficult to see how conceptualisations of Mr X's distress in biological terms (with the frequent and especial emphasis on schizophrenia as a worst case), and in terms of the demands of efficient and responsible care, would serve to undermine arguments for working together with indigenous healers. If indigenous healers can at best provide only supportive, spiritual care (similar to the marginalisation of psychotherapy in psychiatric practice), but would slow down the process of care, and at worst are ill-motivated and even dangerous, it is best that they keep to themselves.

Psychiatric discourse

In this section I will demonstrate some of the difficulties speakers experience when seeking to employ the language of indigenous healing in its own terms, within psychiatric or biomedical contexts. As one psychologist put it, in reference to the training indigenous healer's initiatory illness (*ukuthwasa*):

Psychologist [46]: Now a lot of people who go through that, are, in my opinion, genuinely mentally ill, ok.

The statement above [46] represents a common belief about indigenous healers, to the extent that some authors have taken pains to refute it (e.g. Schweitzer, 1977). The significant point is that the discursive dominance of rationalism in psychiatric contexts constrains talk about spirits or possession in terms of irrationality and madness, and positions those who employ these ways of speaking as pathological. As Foucault has argued, the construction of the pathological depends on the division of reason from unreason, or rationality from irrationality (1971, cited in Parker *et al.*, 1995). Irrationality, being defined by a loss of the ability to doubt or reflect, is something that requires policing.

As I have mentioned above in the discussion on "cultural relabelling", calls for collaboration with healers may reflect some hope that patients' "pathological" talk about spirits may to some extent be "de-pathologised" through indigenous healers' "sanctioned" talk about spirits. Thus, for example, it is said that healers can provide an

understanding of the patient's "cultural context", so that hearing voices and belief in spirits are not mistakenly construed as signs of psychiatric illness. However, healers who insist on employing indigenous healing discourse, in which, for example, ancestral spirits are given a literal, ontological reality, find themselves positioned within universalist, biomedical psychiatric discourse as superstitious, dogmatic, and therefore ultimately, "mad". This positioning is demonstrated in the excerpt below from the healer/nurse:

Healer/nurse [47]: Oh I see ja they'd probably think I was totally mad [laughs]. I know that's what they would think you know But ja because I know the scepticism of western biomedicine and that's what I'd say for myself because I'm fully conversant with that mode of thought, I mean I was like that myself but, but I mean that's what I've been struck with that many healers are not quite so aware of how little the white the biomedical scientific people actually disbelieve /hmm/. I think they tend to assume that most people believe in the spirits and that we're just slightly different, we do things differently /hmm/. Um you need to actually tell them, no they don't believe in it, they think it's a bit mad, they actually they're quite surprised /hmm/. You know they take it for granted that we all believe in the spirits, but that we just do things differently. Um but I would be very aware that and I would perhaps find it quite difficult to communicate with communicate my ideas /hmm/ with a western healer trained healer if I had suspicions that this man was being called because I think they would probably question my credibility. But I would probably argue from the point that if this man [Mr X] is convinced that he is being bewitched or whatever, the only way you can solve it is to actually give him the remedies and the rituals that he believes are needed /hmm like within his / ja within his cultural context. You know this whole mind over matter business which has got it's empirical sort of logic in it /hmm/. So ja you know not actually having to say, well the spirits are actually getting you [laughs] you know, just rationalising it on sort of like a psychotherapy [] is that you know, if you believe you're gonna be better, you will get better /hmm/.

Although the use of the word "mad" is intended here somewhat in jest, it indicates an awareness of her positioning as indigenous healer within psychiatric discourse. This "awareness" points to the way discourse may "fold around and [reflect] on its own way of speaking" (Parker, 1992: 14). As this healer expressed in the introduction to this study, once she had undergone the training to become a healer, she was regarded with suspicion by colleagues as having become "deluded" or mentally ill. Furthermore, this instance of reflection may point to the pathologising of this healer's discursive positioning "at the margin" of two cultures, constructed as both discrete and different/conflicting. As a "white", educated nursing professional who is also an African indigenous healer, she had been labelled as mentally ill, or as having deserted rationality.

As this particular text [47] illustrates, one way in which to maintain one's credibility, and avoid accusations of "madness" in arguments for indigenous healing intervention is to play down bewitchment or "calling" by literal ancestral or other spirits by "translating" patients' irrational, and therefore pathological, language into more acceptable, and in this case, psychological terms. Paradoxically, while this might contribute to indigenous healers' credibility within the mental health field, it also undermines the distinctiveness of the healer, who is reduced to a kind of "Africanised" psychologist. In the collaborative situation, what this implies is that a healer who may not be able to do this "translation" within a psychiatric context may well be written off as "deluded".

Resistance

Psychologist [48]: This is the kind of scenario that we would have um perhaps in our naiveté a couple of years ago imagined could have happened, /ja/ indigenous healer's coming onto the grounds. I understand in Canada what they've got there with the native Indian population is that they've got in the grounds of the psychiatric hospital, they've got like a wigwam, and they've got a guy sitting in a wigwam you know /ja/. And I mean that's what we thought was gonna happen here that we'd have a . . . we'd have like a like a tame healer who would like er be fully into the way we thought /hmm/ and would love to find out, you know, the kinds of metaphors and things that we do, and would come in here and sit at ward rounds and we'd say what's your opinion and he'd say no this is not for me you keep him /ja/ but that person over there, that's somebody that I can work with, in the way that psychiatrists and psychologists often do that /hmm/. But that hasn't happened at all and I don't know that that's happened at all anywhere in the country /hmm/.

There is a significant instance of resistance in the above account [48]. Although it reproduces the positioning of indigenous healers as dogmatic, unreflective, unwilling to acknowledge their limitations, and therefore incapable of participating in rational collaboration, this account may also be read as ironical. The quaint picture of the native American healer in his wigwam indicates a reflection within psychiatric discourse on its power to dominate indigenous healers in collaborative efforts. The crux of the resistance inherent in this reflection lies in the almost absurd and conspicuous picture of the rural, primitive healer (in a "wigwam") resident in the hospital, and the irony contained in the reference to the "tame healer". The positioning of indigenous healers as "untamed" or "untameable" means that they cannot simply be expected, or made to conform to the conventions of rationalist psychiatric practice. Thus paradoxically, this account subverts

dominant professionalist representations of indigenous healers as merely money- and power-hungry, since it normalises indigenous healers' reluctance to collaborate as legitimate resistance to co-option by psychiatric power.

4.7.3. Positions for mental health professionals

Psychologist [49]: But er you know empirical disciplines like psychiatry is a much much more there's a higher degree of common consensus amongst psychiatrists as to what is good psychiatry, than in psychologists where people have a much more sort of individual . . . non-empirical kind of way of working things out. Um [] empirical disciplines . . . they can be quite snotty about people who don't fit into /hmm/ you know what can be shown or proved or demonstrated etc.

I have up to now been relatively silent on the issue of the relationship between psychological and psychiatric discourses. Psychological discourse, it may be argued, occupies a “middle position” in the debate, and is perhaps more compatible with indigenous healing concepts. This is an opinion expressed both in the literature and by the mental health professionals in this study. The concern in psychological discourse with the “inner” dynamics and particularly the social relations of patients lends support to the view that both theoretically and practically there might be less incongruence between positions offered to psychologists and indigenous healers. The psychologists interviewed spoke of psychiatry being largely unsympathetic to “non-empirical” disciplines, referring to both psychology and indigenous healing (see for example, the extract from the psychologist [49] above). This recalls the long history of clinical psychology's struggle to gain a legitimate, distinctive identity, while achieving some degree of scientific respectability vis-à-vis the medical institution, both internationally and in this country (cf. Louw, 1988; Foster & S. Swartz, 1997; Parker *et al.*, 1995). This continued contest for credibility within a psychiatric context appears to frame much of the talk of the psychologists in particular.

Within many psychiatric hospitals, the *de facto* organisational hierarchy sees medically trained psychiatrists and doctors in managerial and administrative positions, overseeing the work of psychologists (Foster & S. Swartz, 1997). The medically dominated arena of

the psychiatric hospital, in addition to the constraints of limited time and personnel, would appear to discourage the development of more sophisticated and subtle understandings of African patients:

Psychologist [51]: . . . [A]s a psychologist you know in the hospital context that's psychiatrically run we work very much um . . . to put it positively, in support of the doctors but not making the decisions and the doctors' work loads are quite high, so in a sense the aim is to . . . stabilise the patient on medication and then (release him) /hmm/. So it doesn't really give time to go into the intricacies of every /hmm/ case.

The psychologists positioned themselves as working under imperfect conditions, to an extent, against the problems of medical reductionism, while at the same time acknowledging the role and necessity of psychiatric practice.

Psychologist [52]: . . . [T]hese cultural issues often revolve around . . . the bad psychiatrist would say, schizophrenic, load them up with medication, and of course that achieves absolutely nothing /hmm/. And a bad psychologist, would do the equivalent thereof . . . and say um . . . you know schizophrenia's just a label, um it's caused by society's labelling certain behaviours etc etc.

The moderation expressed in the above account [52] may be read as an indication of the difficulties thrown up by the constraints of professionalist and psychiatric discourse, which, as I have argued above in the case of indigenous healers, functions powerfully in disqualifying and excluding talk about indigenous healing in its own terms.

“Cultural issues”, and indigenous healing seem to provoke talk that positions psychological and psychiatric discourses in opposition to one another. As I have already noted, it is interesting that the question of indigenous healing has been framed within the context of debates largely hostile to psychiatric discourse. I read this as an indication of the potential for “cultural issues” and the question of indigenous healing in psychiatry to function as a site of resistance to the dominance of biomedical discourse. Although talk about culture, as we have seen, can be patronising to African patients, it can also provide space for a challenging voice *within* psychiatry. In arguing that practitioners’ “cultural relabelling” of patients may express a hope in its potential to counteract recidivism in psychiatry, L. Swartz (1998) is also making a link between such practices and the articulation of a position of “anti-psychiatric” resistance.

There are some further points to be made about the ambiguous positioning of mental health professionals in relation to indigenous healing in the context of professionalist discourse, and the strong imperative to be simultaneously non-discriminatory and culturally sensitive in practice. Much of the talk of the mental health professionals reflects an uneasy negotiation between a number of subject positions. On the one hand, in recommending caution or greater control in working with indigenous healing, these professionals (and the psychiatrist in particular) could be positioned as obstructive and non-progressive traditionalists; patently racist; the “veterinary psychiatrists” (L. Swartz, 1991: 242) demonised in anti-psychiatric arguments; or in a related way, disrespectful of African culture and insensitive to cultural difference. On the other hand, as I have discussed at length, unduly favourable talk about indigenous healing or deviation from psychiatric discourse may position these practitioners as irrational or eccentric, and therefore unprofessional and incompetent. This seems a difficult balancing act, and the “stalemate” in the discussion around indigenous healing is perhaps understandable in this light.

In the following, final chapter, I will discuss some of the implications of this analysis for the current debate on collaboration between indigenous healing and mental health.

CHAPTER FIVE

DISCUSSION AND CONCLUSIONS

In this chapter I discuss the implications of the foregoing analysis for the contemporary debate on indigenous healing, and address certain reflexive issues and limitations of the study. As I have argued, despite the construction of cogent commendations for the inclusion of indigenous healing in mental health, it remains largely marginalised within talk about mental health practice. Admittedly, this study *reproduces* this marginalisation through the scarcity of analytical comments which address indigenous healing discourse, and particularly the interview with the indigenous healer. This interview proceeded in a manner which was in certain respects largely unanticipated, and was difficult to include in the main part of the analysis, for reasons I discuss below. It foregrounds specific problems of language difference and discourse analytic methodology, and I will reflect on these in the course of this discussion.

5.1. “OTHERING” AND LANGUAGE DIFFERENCE

Psychologist [53]: . . . I've just come to the conclusion that what we do is completely different you know We seem to be such a vast um difference.

Mental health professionals' construction of indigenous healing, and the corresponding “African mind” or psychology it supposedly addresses, as fundamentally *different*, produces problematic effects. As I have argued in the analysis, this construction of difference is largely determined by psychological and psychiatric discourses of “African minds” and African culture that, similarly to the production of colonial knowledge, are produced in relation to the “West”, and in terms of how they differ from the “West” (Mills, 1997). These colonial discourses are strikingly reproduced in the talk of the mental health professionals who participated in this study. In colonial accounts Africans are constructed not as individuals, but in terms of an undifferentiated, homogeneous mass, existing on a different time scale (exemplified in notions of primitivity) (Mills,

1997). In addition, the language of “stress” and coping encountered in conceptualisations of Mr X’s affliction (as the result of “cultural stressors”) contributes to the construction of the “African mind”, as an object of psychological knowledge, as essentially fragile and vulnerable to social change, and in this sense different to the “western mind”. Lastly, the rationalist underpinnings of mental health practice serve further to position African indigenous healing as a contradictory or negative discourse in relation to rational, empirical “western” psychiatry.

Understanding indigenous healing and the cultural forms it draws from and sustains would be immeasurably assisted by fluency in the language that constructs them. The construction of difference is exacerbated by the obvious difficulties posed by the majority of mental health professionals’ inability to speak any African languages. As a commentary on the interviews as a whole, the absence of any reference to this issue in participants’ talk, matching that in the indigenous healing literature, is striking. Collaboration with indigenous healing is advanced as a panacea for the “cultural inappropriateness” of mental health care for African patients. However, the undue focus on “*cultural* differences” as the reason behind the ineffectiveness of “western” psychiatric treatment obscures a critical lack of attention to the issue of *language* difference between patient and practitioner. Adequate communication is not only desirable, but essential to the realisation of mental health care. As has been noted by L. Swartz (1989; 1996; 1998), and particularly Drennan (1999), the silence about language issues in South African psychiatry belies its centrality in the complex institutional and power dynamics that impede change and integration in daily psychiatric practice. Therefore, although the debate on indigenous healing may represent important moves toward more equitable service, any discussion pertaining to it tends to foreground and prioritise “cultural issues”, diverting attention away from the more immediate concern of being able to communicate acceptably with patients.

As I have already mentioned, ironically, the marginalisation of indigenous healing is to some extent reproduced in this study, in its silence about the indigenous healer. I discuss the difficulty of analysing this encounter with the healer and offer some thoughts on its

significance in the following paragraphs. In providing some context I resort to interview extracts, as well as observations and notes about the interview process written immediately after the interview, and this account therefore takes a somewhat ethnographic form.

I had initially assumed that I would be able to locate an indigenous healer who was both fluent in English, and had a basic familiarity with the “language” and procedures in psychiatric hospitals. The healer who agreed to participate in this study had had previous collaborative contact with the local psychiatric hospital, but did not speak English at all, necessitating the enlistment of an interpreter. The interpreter made the initial contact with the healer, briefly explaining the purpose of the study. The interview took place later in the healer’s “sacred hut” in which she usually consults with her “clients”. Upon beginning the interview, it seemed as if she had been under the impression that I had come for a consultation. I began to explain about the research and the vignettes, to which she stated that she would only comment if I had seen this patient myself so that she could divine the problem and its cause. It became apparent to me that she had been under the impression that I was from the local psychiatric hospital and that I had come to consult her about a patient there. After some clarification of my intentions, which unfortunately was not recorded on tape, the following comments were made by the healer and interpreter in response to my request to present her with the first vignette (Mr X)⁵:

Healer & interpreter [54]: If this was really a case that was existing, and if er the patient was around, and they would bring that patient I would look at that case, and see what’s bothering the person, because that’s one other way that I’m really using, to look at the patient and see what’s wrong with the patient /hmm/. [long pause] # If you had seen this person, then we would be able to look into that person, and tell you without seeing the person that this is happening, this is what is happening with this patient, and because you have seen how the person looks, how the person reacts, how the person is, then you would be able to say ja, I’ve seen these things so you are right, but unfortunately that’s not the case /ja/. # Ja because it’s easy to tell what is happening with the person, the person that is sick, especially when you have seen that person, so that you could agree and say, this is the case, if it’s not then it’s not. But if you have not seen then it’s difficult. Actually I could look into it, but unfortunately you wouldn’t be able to say if that’s the case or not, because you haven’t seen the person /ja/.

⁵ Note that the hashes (#) in the extracts refer to instances of conversation between the healer and the interpreter in Xhosa, and these were neither transcribed, nor translated directly.

In this extract [54], the healer expresses an initial reluctance to engage with the case vignette, since if Mr X is not “real”, I will not be able to corroborate her utterances. This is a significant aspect of the *ukuvumisa* (literally, “to agree”) divination “method”, in which a relative consults the healer in the absence of the person in question, and must agree or disagree with the explanations offered by the healer (Hirst, 1993).

To navigate this miscommunication, I then moved on to other parts of the interview and only later returned to the vignette. Imagining that she might also be anxious that my intention was to test or evaluate her, I explained that I was only interested in hearing her opinions about Mr X. She subsequently agreed to hear the vignette. In the following extract, the healer offers some comments on the case vignette of Mr X:

Healer & interpreter [55]: # Ja what usually happens is as you were saying that in this case this person is . . . crying, you wouldn't say the person has something wrong with the heart, which is what the doctors usually say, but we think that what happens is that, that person has what they call is um . . . that person has a guilty conscience sometimes, and it comes up and talks, and it comes from the heart, because when one does something wrong, or when something is wrong with that person, it comes from the heart and it goes up to the mind /hmm/. So it's not really the heart that's wrong, which in many cases doctors say, this person has a heart problem.

JY [56]: And would you have a name for what's wrong with this person, is there a name for it?

Healer & interpreter [57]: # The . . . I'm trying to get the right word for *umbilini*, cos I can feel that (we're not really saying) [] /nerves?/ but I think it's when you feel like you . . . you know, I think it's nervous system that goes wrong, it's like you have nerves you know, ja. And then she says this nervous illness that we have, doesn't stay as it is. But what happens is that it becomes wind inside *umoya*?/ Ja *umoya*. # Then it's the stomach /ja/. Ja. Then it's the stomach that has a problem, so that problem is in the stomach /ok, ja/. # Then it goes to his head, # then his head you know it's like, it gets puzzled, as if there's something wrong, # then when that person is thinking, he cannot say clearly what am I thinking, because something's wrong with the head, # it's the . . . I think the . . . what is this . . . it's the nerves really, it's the . . . the nervous system that really gets tight and gets painful, ja. # Then it makes that person, as we can look into it, we say as blacks (*amaXhosa*), that he can get scared of something that he doesn't see, he gets scared of what is not there /hmm/, because of the system, the nervous system that is painful then that's making him think wrong /hmm/, it's puzzling him. # Then from the head it goes and stay here at the back [points to back of his head and neck]. Actually what she's saying is what is happening with that person, the actual patient that you are talking about /hmm/, she says that's what is happening with the patient. # The blacks (*amaXhosa*) would say # she has something between the . . . at the back, just at the centre of the back, and it comes up in front /hmm/, and then she would feel like something is sticking her inside /hmm/. # Ja this is what is happening it's like a feeling because the patient dreams of these things, and the patient sees these things, although no-one else can see them, so that's what really happens with this patient, he sees the wrong things that are not there, but only he can see them /hmm/. # When your blood is light in Xhosa I

mean it's like you . . . you have not done all the rituals you have done [or] must have done, so your blood is light. # If your family would have liked to make *ligqira*, # everything is just here for you, actually everything is . . . nothing is hidden, nothing gets hidden from you, in other words, it's easy for you to see things that are not seen by other people /oh . . . oh/. # And then it makes you . . . it makes things [] in your mind, because your mind is full up with other things that other people cannot see /hmm/.

The interpreter was not involved in the transcription of the interview, and I was unable to discuss with him in much detail his own impressions of how the interview had proceeded. As a result, a consideration of the subtleties of translation between Xhosa and English, although complex and important, has been omitted. I am unable to determine, for example, exactly how the interpreter described the research objectives to the healer, or whether he found it difficult to translate the healer's divinations into English. The above exchange represents a complex and elusive text which is to some extent difficult to analyse discursively, firstly, without having re-translated the audio-tapes before transcribing them, and secondly, without fluency in Xhosa or some awareness of the extract's cultural or historical connotations. As a study by Hirst (1993) suggests, the meanings of utterances in a Xhosa *ukuvumisa* divination are not easily translatable into English.

It is interesting however, to note that in the above extract [57], while talking about Mr X, the healer began to experience the somatic manifestations of *umbilini* in her own body, and to speak of Mr X as a "real" person. The healer's experiencing first-hand of a person's affliction is a common characteristic of healers' divinations (Hirst, 1993). The significance of the apparently involuntary conflation of the fictional case vignette with a real person is difficult to interpret without further contextual knowledge. However, in reading this extract it is possible to speak, rather simplistically, of an indigenous healing discourse that constructs *umbilini* as an affliction experienced in a primarily somatic mode, which is caused by neglect of required rituals.

5.1.1. Positioning in the interview

I will discuss here the possible ways in which both myself and the healer were positioned in this interview.

Healer & interpreter [58]: # There's no difference as such. # As long as they are going to give enough space to do what you want to do, # not unless it's a person that can um . . . a person that can't move /ja/, then you could go and see that person even if he []. # Cos we blacks (*amaXhosa*) we usually do that when the person cannot move, then they usually come and take you so that you could go to where the person is, and do a *vumisa*, er in that place.

Healer & interpreter [59]: # Ja she's heard that there [healer laughs and speaks] are patients, people that have come to see her, so she's been panicking all the time /oh/ [healer laughs and speaks] [] . . . and they've come to see her /oh/ ja because she always sees when one is coming. She could feel it in her body that a certain person is coming /oh/ with this problem, but now she's been keeping things up until we finish /oh/, and she says for the time that we've taken she's really been, not been herself most of the time, because she's been feeling that she must have been doing something else /oh/ and she thinks that it will be fifty rands. # This is painful in you, as one who is asking all these things you know, when you ask of a certain case, then you sort of transfer yourself in that case, so you feel all those things /hmm/, so that's why it's painful.

Although, as I have stated, I was largely unable to determine how the interpreter had translated both the healer's and my words, I was able to discern in my transcription of the first extract [58] above that the interpreter had translated *amaXhosa* (literally “the Xhosa people”) as “we blacks”. While the healer's use of the term “*amaXhosa*” constructs a difference between us based on an “ethnic” identity, the translation as it stands constructs us as *racially* different. I am consequently positioned in this extract as an outsider to the knowledge of indigenous healing that all “blacks” share.

The second extract [59] is part of what was relayed to me as I was ending the interview, in response to the question of how much our consultation would cost. It contains two features that are of interest. First, the bodily sensations and experiences that announced the arrival of new “clients” are constructed here as involuntary and as something inflicted upon her from an outside source. Second, in reflecting on this extract, I am aware of being positioned as having wasted her time, keeping her from the more immediate and pressing concerns of healing people, and as having caused her unnecessary pain for a frivolous cause.

Significantly, the translation in both of these extracts [58, 59] positions the interpreter as part of, and insider to the knowledge of indigenous healing, evident in the shifting of pronouns in the last sentence of the second extract (“she” becomes “you”, to refer to himself). Both of these extracts demonstrate how the power of an interviewer may be subverted, in the Foucauldian sense, and how power operates in unpredictable ways in interviews (Ribbens, 1989).

Although the indigenous healer’s response to my request to present the vignette to her may largely have been due to a misunderstanding stemming from the complications of translation, it also alludes to resistance on the part of the healer to being positioned through this exchange as a compliant research participant. My impression that she thought that I had come from the local psychiatric hospital to consult her about a patient is perhaps significant. If this is accurate, I was a representative to her of two powerful institutions, that of the university and of psychiatry (the interpreter had introduced me as a psychology student doing research), and I had approached her, despite all intentions to the contrary, in these terms. In addition, the significance of the usage of “we blacks” in my positioning as an “outsider” suggests an association of the power of psychiatry with “race”, and a resistance to it based on “blackness”.

In terms of analysing the text, in being unable to speak the language of the indigenous healer, I could approach the text only as an “outsider”, and the associations and connotations of the text that Parker and Burman (1993) suggest are important to the analysis were not immediately available to me. As Parker, Levett, Kottler and Burman (1997: 200) have observed, the fact that discourse analysis in South Africa is employed almost exclusively in the medium of English represents a serious obstacle to engagement with the workings of culture and power, since such an endeavour demands attention to the “variety of linguistic resources that people draw upon to make sense of themselves and others”. Although it is possible to produce discursive analyses of translated texts, the social, historical and cultural allusions in these discourses may be harder to elaborate.

Particularly in

communities with a colonial history . . . where part of the resistance is a pride in local languages and categories of identity . . . the complexities of experience are not readily tapped through direct questioning or interviews translated into English or other European languages associated with modernity systems of knowledge (Levett, Kottler, Walaza, Mabena, Leon & Ngqakayi-Motaung, 1997: 126).

There is an extent to which the healer's response was difficult to anticipate in the design of the study. As I mentioned previously, in spite of efforts to ensure the content of the vignette was as accessible as possible to the healer, it seems the vignette itself, as a form of text, was not immediately accessible for the healer to interpret. And, the hindrance of both my inability to speak Xhosa, and my feeling of having intruded kept me from exploring further the healer's thoughts about the interview process.

5.2. VALIDITY

In this section, I discuss issues related to validity, beginning with an attempt to account for the way my perspective as researcher may have influenced the conception and design of the research, the data collected, and the interpretations reached in it. I want to emphasise that the reading produced in this dissertation is my response to the interview texts, and that the discourses I have identified are constructions in themselves. This is not, in any sense, a confession of flawed objectivity, but a reflexive engagement with the various subjectivities implicated in the research process (Hollway, 1989).

5.2.1. Conception, design and interpretation

First, my choice of a critical discourse analytic approach for the study of collaboration with indigenous healing was motivated by my experiences as a "psychologist-in-training". I have been confronted on numerous occasions in my practical training in psychiatric or medical institutions by professionals' power to define people's identities.

These experiences have brought me into contact with the contradictions inherent in both the desire to “help”, and how this “help” may lock people who receive it into disciplinary psychological apparatuses that reproduce oppressive power relations. I am aware, in many cases, of having reproduced in my own reports and presentations for case conferences, discourses that have potentially individualising or even racist effects (e.g. in my case conceptualisations). These issues are intensified by the intertwining of the imperative to “help”, with the requirements of training, in which disciplinary/institutional progress is evaluated in terms of one’s ability to apply psychological discourses to both “patients” and to oneself (cf. S. Swartz, 1999). Within the institutions in which I have been trained and evaluated, I have been aware of being positioned, both as a trainee and as a patient in psychotherapy, in ways that made it difficult for me to define or understand myself in alternative ways.

As a result, in producing this study I am aligning myself with attempts at articulating instances of resistance to the power of psychology and psychiatry as dividing practices to produce pathological “cultural” (or “racial”) identities. As a result, my “alienation” within indigenous healing discourse was ironic. The production of knowledge about “race” and culture in South African psychiatry both informs and is fed by developments in a larger, socio-political context. In my meagre experience as a practitioner, I have been sympathetic to the dilemmas posed by this “larger context” amidst the daily necessity to perform interventions that directly affect the lives of people. Suspicious of comfortable and apparently morally compelling formulations to respect cultural differences, or to be non-discriminatory, I have sought to produce an account that highlights the new dilemmas for practice thrown up by cultural-political developments, in the context of indigenous healing.

5.2.2. The participants

In this section I attempt to outline some points arising from a consideration of the interviews as texts which were co-constructed between myself and the participants, and

in particular, my positioning in these texts in relation to the participants (cf. Hollway, 1989). Although I am unable to substantiate the following comments with reference to specific interview material, I will briefly outline my impressions of some of the ways I was positioned in these interviews. In the interactions with the mental health professionals, I was positioned as: a “westerner” (who shared the practitioners’ culture and values); as a colleague (who shared and understood the difficulties of psychiatric practice); and as a naïve and inexperienced trainee (who needed to be warned about the dangers of being overly idealistic). In the interview with the healer/anthropologist, I was acutely aware of being positioned primarily as a psychologist, who would be scrutinising her words for evidence of pathology, occasioning, on her part, talk about indigenous healing that incorporated notions from psychological discourse, and talk which explained and justified indigenous healing concepts in a rational way. As I have argued, this rendered her talk “manageable” in an academic register in a way that the healer’s talk was not. Lastly, as I have mentioned above, I seem to have been positioned in the interview with the healer and interpreter as an “outsider”, as both “racially” different (and therefore ignorant) and as sceptical psychiatric professional or student (who would be scrutinising her practice in order to discredit it). In reflecting on my positioning, I present here an excerpt from the notes I wrote immediately following the interview with the indigenous healer:

Tough going. Felt that I had somehow behaved inappropriately, and invaded without respect, a world whose significance and power I didn’t know how to interact with, or acknowledge. Felt that I had somehow offended this woman, who was more interested in doing, and healing, than talking, speculating, or offering opinions (although, as I said before, she could have been inhibited for other reasons). Felt like a blundering oaf. Frustrating that I couldn’t speak the language, stilted the interview. Felt lost, as if I were missing the keys to the proper approach, that I could in fact offend without being aware.

As a reflection on the interview, this account attests to my positioning as an ignorant “buffoon”. In it, I am positioned as an outsider to a separate world whose rules I have inadvertently transgressed, producing the required emotional response of guilt. Numerous (particularly feminist) researchers have written about the difficulties of research with participants who are “other” to the researcher, “racially” or otherwise (e.g. Edwards, 1996; Russell, 1996; De la Rey, 1997). These authors foreground the politics of

“representing the other” and importantly, deconstruct the notion that researchers and participants must be as similar as possible in order to produce valid research, provided that the effects of difference are engaged with.

My positioning in relation to the participants reflects the flexibility of power relations, which may shift unexpectedly in interviews (Ribbens, 1989). For although I occupied an ostensibly powerful position as a representative of “white” psychiatry/academia in the interview with the healer and interpreter, I found myself positioned as ignorant, different, and ultimately without power. This is consistent with a Foucauldian conception of power, in which “power is not conceived of as a unidimensional quality that is possessed or lacked” (Banister *et al.*, 1994: 68), but as shifting between varying positions within the possibilities provided in discourse.

5.2.3. Validation, accountability and ethics

Kvale (1996) refers to three “communities of validation”, to which qualitative research studies may be accountable, namely the participants, the general public and the theoretical or research community. Ethical principles held by new paradigm qualitative research approaches (e.g. feminist and “participatory” research) generally emphasise accountability to participants, and consequently, research “results” – as truths emergent from a particular context – are usually fed back to participants in attempts to include them in the final production of knowledge (Henwood & Pidgeon, 1994). While this study could have been improved by an exchange of readings and reactions between myself and the participants, this would not be conducted with the aim of getting to participants’ “true” meanings, as it is perhaps in more “realist” approaches (e.g. phenomenological or ethnographic studies). Discursive studies, such as the present one, will produce interpretations that are suspicious of, and potentially hostile to participants’ meanings (Parker, 1992), and in this sense, their validity and accountability do not depend on “being true” to these meanings. At the same time, my power as analyst to impose meaning on other people’s words must also be acknowledged, and I emphasise that the

reading produced in this study is one of a number of possible readings (Parker & Burman, 1993). While this acknowledgement does not invalidate the study, it does point to the importance of accounting for the reasons that may have led me to privilege certain interpretations over others, as I have attempted in the reflexive analysis above (Banister *et al.*, 1994).

Since the primary “community of validation” at which this study is aimed is a predominantly academic and professional audience, its validity must be evaluated according to the body of meta-theory and methodological paradigm that informs it (Kvale, 1996).

5.3. CONCLUSIONS

The production of knowledge concerning African culture in psychiatry is usually seen as an expression of benign motives aimed at improving understanding of other cultures, appreciating difference, and thereby optimising care. As Wetherell and Potter (1992) point out, culture-talk (as opposed to talk about “race”) positions those who engage in it as tolerant, open-minded, appreciative of diversity, and progressive. However, as I have arguably demonstrated, psychiatric discourses on culture focus implicitly on the “black” (and not “white”) patient, and reinforce constructions of difference and “otherness”. Thus, although attention to “cultural issues” in mental health is ostensibly motivated by liberal values of equal access and fairness, the individualising effects of psychiatric practice and some forms of psychological discourse promote a “culturalism” that plays a part in the surveillance function of the state (Foster & S. Swartz, 1997; Parker *et al.*, 1995). However, psychological knowledges produced about the “African mind” and indigenous healing may function in contradictory ways to both extend the surveillance of the discipline (cf. Butchart, 1997), *and* as a platform for resistance to psychiatric power, for example, in psychological notions framing “cultural illness” as treatable by “containment”, versus constructions of “cultural illness” as amenable only to indigenous healing interventions. As I have argued in this study, despite constructions of the power

of scientifically validated psychiatry as universal, in the treatment of Africans, this power is disavowed. In this regard, psychiatry is constructed as *fundamentally ineffective* in treating certain “African afflictions” or in providing therapeutic “illness narratives” for Africans, while indigenous healing methods are constructed as pre-eminently suitable for these afflictions (notably “cultural illness” and for example, *ukuthwasa*) and can act upon Africans in ways that “western” psychiatry cannot.

This brief study has highlighted the ways in which the interests and power/knowledge struggles between the psychiatric and psychological professions are implicated in the issue of collaborating with indigenous healing. The all-encompassing and persuasive *inclusivist* rhetoric characteristic of the literature on indigenous healing, and reproduced here in the talk of the participants, obscures the fault lines dividing domains of expertise both *within* mental health (between psychiatrists and psychologists) and *between* mental health and indigenous healing. The prominence of “professionalist discourse” in the talk of the mental health professionals is an indication of the way the debate on collaboration serves to show up professional interests, and the policing of domains of expertise, to which indigenous healing presents a potential challenge.

Furthermore, while this study reproduces to some extent the marginalisation of indigenous healing discourse, it has also examined some of the discursive practices and methodological difficulties implicated in its marginalisation. It is nevertheless possible to glean, from my brief analysis, the following points about indigenous healing discourse. In the context of “cultural pride strategies” associated with talk about an African Renaissance (and initiatives to preserve “indigenous knowledge”: cf. Wynberg, 1998), indigenous healing can function as a site of assertion of African power and resistance in both mental health professionals’ and indigenous healers’ constructions of it as an essentially African enterprise (cf. L. Swartz, 1996). At the same time, it may also achieve disciplinary effects consonant with cultural pride strategies, in constructing afflictions in terms of neglect of, or disloyalty to, cultural tradition. Despite its marginalisation in modernity mental health, indigenous healing may function as a dominant discourse in

relation to other discourses defined in opposition to it (cf. Parker, 1992), producing effects which may also be potentially oppressive.

Finally, I have focused in this study on the constructions of culture and “pathology” in material from different sources (the different practitioners), and attempted to explore the implications of these constructions for the power relations between mental health and indigenous healing discourses. The study has highlighted two important issues for the current debate on indigenous healing. First, without knowledge of the language in which indigenous healers and Africans construct indigenous healing, it will be difficult to articulate indigenous healing discourse in a way that challenges the dominant psychiatric discourses implicated in its marginalisation within mental health. Second, a more detailed exposition of the disciplinary apparatuses of indigenous healing discourse in itself, and their operation in South African society would be important. The experience of conducting this research has led me to conclude that, while a discourse analytic approach is crucial to unpacking modernity discourses about “African culture” or tradition, the conspicuous lack of attention to discourse analysis in languages other than English represents a significant obstacle to developing critical accounts of the processes of culture and power in a heterogeneous South African society.

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APPENDICES

APPENDIX A: INTERVIEW THEMES

Vignette 1

- How would you understand or explain what is happening to Mr X (what might your likely diagnosis be)?
- How might Mr X's difficulties have come about?
- If you were to make up a story about this man, what other information (e.g. background, presentation, or anything else at all) would you think likely to be true of him?
- What kind of care or treatment plan might he receive?
- What problems, if any, could you foresee in dealing with this patient?
- Tell me about any previous experience you have had of dealing with cases like this.

Vignette 2

- What are your thoughts on the proceedings/situation described here?
- What do you think about the decisions that were taken for
 - Mr X to be admitted?
 - an indigenous healer to be consulted?
- How might the psychologist/psychiatrist/healer have understood what is happening to Mr X?
- In what respects might there have been disagreements
 - between the healer and other members of the team?
 - between the psychiatrist and the psychologist?
- Describe how you think this situation would most likely reach a conclusion.
- If you were the healer/psychologist/psychiatrist in this case, what difficulties, if any, would you experience in working together (with the other two) in relation to Mr X?

- If you were the healer/psychologist/psychiatrist in this case, what advantages, if any, would there be in working together (with the other two) in relation to Mr X?
- In your view, what factors (if any) represent the greatest obstacles to working together?
- Tell me about any experiences you've had in working together (with healers, psychologists etc.).

APPENDIX B: CONSENT FORM

I, _____ hereby agree to participate in the proposed research project, subject to the following conditions:

1. My participation is **voluntary**, and should I feel uncomfortable at any point during the research, I am free to discontinue my involvement, as well as request that any record of my participation be deleted.
2. My participation is **anonymous**. Any identifying information will be changed or removed in the research report.
3. The interview will be audio-taped and transcribed, according to conditions stated in the separate Psychology Department permission form.
4. I will be given feedback on the research, and be able to read the research report, should I require it.

SIGNED

DATE