

Differences between Western and African models of psychiatric illness

A case study

G. M. Behr, C. W. Allwood

African and Western illness models differ dramatically. The overwhelming majority of black psychiatric patients are exposed to both Western psychiatry and traditional healing and somehow have to integrate the different approaches to causation and management of their problem. This case study compared the assessment of four psychiatric inpatients by a traditional healer with that of the psychiatrists. The study attempted to describe the similarities and differences in respect of method of assessment and causation, treatment and prognosis of the affliction. These preliminary findings seemed to indicate that the differences were far more significant than the similarities.

S Afr Med J 1995; 85: 580-584.

In South Africa two major models of illness causation are prevalent. There is the Western (biomedical) model which ascribes illness to chance, heredity or lifestyle, and the traditional African model which explains all events in terms of God, ancestors, pollution and witchcraft.¹

South African traditional healers (THs), such as diviners, herbalists and faith healers, use the latter model both diagnostically and therapeutically, although they may well differentiate natural from supernatural causation.^{2,3} THs are widely consulted by both urban and rural black South Africans of all classes.⁴⁻⁶ Furthermore it has been suggested that consultation of THs for psychological disturbance is higher than for somatic/physical ailments.⁷ A survey conducted among certified patients at Sterkfontein Hospital (G. M. Behr — unpublished research) revealed that fully 75% had consulted a TH at some point in their illness and 67% indicated that they intended to continue to do so in future.

If one considers these figures and the relative ratios of TH to population (1:500)⁴ against doctor to population (between 1:100 000 and 1:150 000 in some South African rural areas),⁸

Department of Psychiatry, University of the Witwatersrand, Johannesburg

G. M. Behr, M.B. B.C.H., Registrar

C. W. Allwood, M.D. (PSYCH.)

it is clear that the vast majority of 'healing' in our society is done by THs.

Our society is in transition and for most black South Africans this means having to integrate the Western world view and, specifically, the Western model of illness causation into their own world view. For many, a mystical causation is ascribed to mental illness even if, as often happens, a dual diagnosis^{8,9,10} is accepted, i.e. assessment and treatment by both Western and traditional medicine.

Efficacy of THs

Very little research has been done into the efficacy of traditional healing¹ and this has been described mostly in anthropological and psychological terms.^{5,11-13} Despite this, it seems likely that the large numbers of people who attend THs do so because there is some perceived benefit. Besides the medicinal properties which some of the traditional remedies may possess (Watt and Breyer-Brandwijk in Hammond Tooke¹ suggest that only 5% do), much emphasis has been placed on the fact that THs explain the meaning¹ of the disease, and answer questions like 'why me?'^{14,15} and 'by whom?' — a form of 'psychotherapy'.

Psychiatrists in South Africa are increasingly seeing psychiatric problems which, until recently, were probably seen only by THs. It is also proposed that THs be included in the health service, and Littlewood¹⁶ suggests that the discipline of clinical anthropology be developed to address these problems. Currently, however, it seems appropriate and important for psychiatry to try to understand how South African THs perceive psychiatric illness.

Objectives

This study is an attempt to describe a TH's assessment of psychiatric patients and to illustrate themes. The issues examined include: (i) method of assessment; (ii) formulation of the patient's problem and its management; (iii) assessment of severity and prognosis; (iv) attitude toward psychiatric treatment.

Methods

The research took the form of a case study of a TH who assessed four psychiatric inpatients at Sterkfontein Hospital, a psychiatric hospital. The sample was chosen from patients who were sufficiently recovered to give consent. All had been treated and observed in hospital for at least 1 month. The psychiatric diagnoses had been made according to *DSM-III-R* criteria. The assessment was conducted behind a one-way mirror, with G.M.B. observing. Each assessment lasted 20 - 30 minutes and the TH was then interviewed about the illness, its cause, severity and prognosis, and her treatment plan and her attitude to psychiatric treatment of that patient. Translation was undertaken by two nursing sisters, one of whom is herself a qualified TH.

Results

Case 1

A 44-year-old Zulu woman had a diagnosis of bipolar mood disorder. She presented with classic manic features and responded well to treatment. At the time of assessment by the TH, the patient was not psychotic and her mood was only marginally elevated.

TH assessment

The patient's complaints were noted as being physical ('distended stomach', 'wheezy chest', 'headaches') but the TH asserted that these were caused by the patient's ancestors who had also repeatedly caused her to become mentally ill. She said that her mental illness was not an 'inborn thing'. The 'dollars' (bones, shells, domino pieces and other items thrown by the TH) had shown her that the patient's ancestors had chosen her to do their work and that she had to train (*thwasa*) to be an *isangoma* (TH) herself. She informed the patient, who knew only that her mother had left her, that her mother had, in fact, died. Because the patient was unaware of her mother's whereabouts or the location of the grave (this was, in fact, true), she was distant from her ancestors and possessed by an evil spirit. Once she had located her ancestor's graves, she had first to perform certain duties to awaken her ancestors so that she could then undergo *thwasa*. The TH asserted that once the patient had undergone *thwasa*, she would no longer require treatment. The value of Western psychiatric treatment was seen to be containment of symptoms until training was completed.

Case 2

A 59-year-old Tswana woman had a diagnosis of chronic schizophrenia. She had had an acute relapse (probably due to non-compliance) and presented with mainly negative features of schizophrenia.

At the time of the TH's assessment the patient was not psychotic but had negative symptoms of schizophrenia with poverty of thought, blunted affect and poor self-care.

TH assessment

The patient had been chosen by two of her ancestors to do their work at an early age. The patient had ignored these calls and her ancestors had turned away from her, allowing evil spirits to enter. These were of two kinds, *izilwane* and *amafufunyane*. *Izilwane* are evil creatures which force the person to do bad things and cause people to hate them. *Amafufunyane* is possession by evil spirits which cause 'madness' and disturbed behaviour. These have to be cleansed far from any home because of the risk of contaminating others. These evil spirits had manifested as physical ailments: tired heart, swollen feet, unendurable pain in the side and falling without having tripped, which could lead to epilepsy. At a certain point she could easily have been helped, and had consulted many *isangoma* who had just given her beads instead of purifying her. To start at the beginning would cost a lot and even if this were done, one would still have to struggle with the physical problems. The

TH said that she should just be maintained on psychiatric treatment. The 'dollars' showed that the patient would die within weeks or months. This was said to the researcher but not to the patient, and as far as is known did not happen.

Case 3

A 30-year-old Tswana man had a diagnosis of bipolar mood disorder and his current presentation was with severe mania. His response to treatment had been very slow and at the time of the interview he was still intrusive with mildly elevated mood and delusions.

TH assessment

The TH said that this had nothing to do with witchcraft. His problem was lifelong and a consequence of poor parenting, which had led to his abusing alcohol and cannabis at a young age; this had aggravated the problem. His condition had also been worsened by his being poisoned by a friend with whom he was competing at work. (The psychiatrists had no collateral evidence to confirm this.) The TH felt his condition would never improve beyond what had already been achieved. She felt he would relapse very soon and that there was little value in ongoing psychiatric care. She felt she could give him traditional medicine to calm him down but little else. Although the patient asserted that he was a TH, she told him clearly that this was not so and that he could never be one because his ancestors were too weak.

Case 4

A 24-year-old Swazi man was referred to Sterkfontein from a general hospital where he had been medically stabilised following a head injury 2 weeks previously. He had undergone computed tomography which had shown a resolving cortical haemorrhage. He had become very aggressive and confused and was therefore referred to the hospital. He recovered well on haloperidol and at the time of interview his behaviour was appropriate, he had insight and was performing well at occupational therapy. A diagnosis was made of organic mental syndrome not otherwise specified.

TH assessment

The TH said that this man's family used to believe in the ancestors and do their work, and that one of the patient's ancestors (after whom he was named) had been a TH. However, the family had ceased to do this work. Furthermore, the patient had left home to come to Johannesburg without telling anyone and without asking his ancestors' permission. These factors had led some people at home to bewitch him so that he lost his ancestors' protection and had an accident which caused his mental illness. (The TH mentioned the accident without having any prior knowledge or evidence of it.) She said that he would have another accident and relapse if he did not go home, trace all his elderly living relatives and do his ancestors' work at his birthplace. She said that if he did this he would not get sick again and that he would need psychiatric treatment only until he did this.

Discussion

This study is limited in that it examines only one TH. Most sources agree that the variation in style between different healers is very significant. Information which can be generalised must be gathered in studies of larger numbers of THs and their assessments of the same patient.

Understanding the nuances of what is being communicated is very important in this type of research. Consequently, the use of a translator had obvious drawbacks and reading the transcribed interviews brought home to the author the inadequacy of this process. (That this is the means by which most patients who speak only an African language have a psychiatric diagnosis made, is an issue which needs to be addressed.)

Comparison of method of assessment

In all the TH's assessments she threw the 'dollars'. Although she noted physical symptoms reported by the patient, she made no attempt to elicit psychological symptoms. Neither did she take into account the patients' observed mental state in her assessment.

She elicited certain information by asking the patient to confirm or deny her statements, which were occasionally startlingly accurate despite the lack of evidence (e.g. her first question to patient 3, whose delusions were all concerned with wealth, was, 'Why are you so concerned about money?'). She also had no way of knowing that patient 4 had had an accident.

In the community, the presence of the family and their reactions to the statements may give the TH some diagnostic clues. Clearly that influence was minimised in this context.

Formulation of the problem

The interpretation of reported symptoms

Both patients 1 and 2 were noted by the TH to have extensive physical problems but these were attributed to the same mystical cause as their mental illness, i.e. psyche and soma reflecting a single underlying problem. Neither had been noted by the doctor to have any medical problem, but this phenomenon is consistent with the tendency of black patients to express psychological problems in terms of somatic complaints, as well as the indivisibility of psyche and soma in the traditional African illness model.

Causation

In cases 1, 2 and 4, the TH gave a 'mystical' causation for the illness. In case 3 (bipolar mood disorder) the TH did not invoke any 'mystical' causation but two 'natural' causes (substance abuse and poisoning) and a psychosocial factor (poor upbringing). This was paradoxical because the causative factors listed by the TH are frequently cited in psychiatry, but we had no evidence to support these in this particular patient. Meaningful comparisons could be made, though, because the causative factors are in the vocabulary of psychiatry. This contrasts with the views of some authors^{17,18} who feel that the diagnostic paradigm is so different that valid comparisons cannot be made between psychiatrists' and THs' diagnoses.

Patient 4 was assessed as having organic mental syndrome not otherwise specified with a confusional state directly related to his head injury. The TH felt that the 'accident' was the direct cause of his problem but that this had been allowed to happen because his disrespect for his ancestors had led to the withdrawal of their protection and his bewitchment.

Therefore, although the assessments were similar, the TH had also provided the reason for his 'accident'. In all cases the TH provided the meaning of the illness — the 'why me?' and 'by whom?' — citing mainly neglect of ancestors and interpersonal conflict.

The TH's assessment of cases 1 and 2 differed radically from the psychiatric assessment in that biological factors were excluded. No similarities were noted in the TH's assessment of the two patients diagnosed as having bipolar disorder. Buhrmann¹² cites five illness categories used by a Xhosa TH. Three of these terms were used by the TH to describe the patients in this study and the descriptions of these afflictions (*amafulunyane*, bewitchment and *thwasa*) were similar in both studies. Attempts have been made to describe the phenomenology of folk categories of illness,^{1,7,12,19,20} but the South African examples have not been well elaborated. This study group was too small to help in this regard.

Concepts of causation were described by Wessels³ and Hammond-Tooke¹ and these correlated very well with those put forward by the TH in this study. The findings of this study contradict the assertion by some South African authors^{3,4} that a clear definition of 'natural' illness exists among THs and that biomedical treatment is considered appropriate for this group of patients.

Assessment of severity and prognosis

The TH considered major psychiatric problems to be well within the scope of her ability. This is not in keeping with the findings of other authors^{7,10,11} that THs confine themselves to treating neurotic or psychosocial problems.

In cases 1 and 4 the TH predicted total remission once the patients had fulfilled obligations to the ancestors, at which point they would no longer require psychiatric treatment. The psychiatric assessment of their prognosis depended on their continuing psychiatric treatment for control, but a 'cure' seemed unlikely.

In patient 2 the TH predicted imminent death (from the configuration of the 'dollars'), but saw the irreversibility of the patient's problem as due partly to her not having enough money for the treatment. It was not clear (to the authors) whether her prognosis would have changed if she had had enough money.

Patient 3 (bipolar) was expected by the psychiatrist to have a prognosis at least as good as patient 1 (bipolar), yet the TH felt he would get no better than he was at present, and that his condition would probably worsen.

Patients 2 and 3 received a poorer prognosis than 1 and 4. The former were also the only two to have disturbed thought and behaviour at the time of the interview. Although the assessment was ostensibly by means of the 'dollars', this may have influenced her assessment.

In terms of overall severity and prognosis, both our assessment and that of the TH saw patient 2 as the most

serious case. However, it was difficult to isolate criteria or indicators common to both assessments which determined this. Furthermore, little congruence with regard to indicators of prognosis emerged in respect of cases 1, 3 and 4. It seems, therefore, that there may be very little overlap in the assessment of high-risk groups.

Attitude toward psychiatric treatment

In all cases the value of psychiatric treatment was seen by the TH to be containment of the illness. The TH felt that once the underlying cause had been addressed (in patients 1 and 4 particularly) psychiatric treatment would no longer be necessary. If the psychiatrists' assessment is correct and that of the TH wrong then such patients are likely to relapse as a consequence of the advice of their TH. However, she made a point of encouraging all the subjects to continue taking their medication at this point.

Conclusions

What emerges very clearly from this limited study is that the differences between traditional African and Western assessments of psychiatric patients are much more marked than the similarities. This has significant implications for the two-thirds or more of our psychiatric patients who consult a TH. These people are caught between two worlds, two views of their problem, its causation and its management. This TH did not feel that these were mutually exclusive, but pointed out that other THs do. Many patients would probably seize the opportunity to stop taking drugs; this would most probably result in early relapse.

What is more difficult to comment upon is the positive effect of an alternative explanatory and therapeutic model for psychiatric patients. The persistence of traditional healing, despite the availability of Western medicine, probably implies that it fulfils some need. This 'efficacy', however, is difficult to measure, though this would be very desirable.¹⁵

Although there are probably advantages to unifying traditional and Western psychiatric care, we may have to conclude, as Ben-Tovim does in the light of his experience in Botswana,¹⁵ that the two systems are best left to function independently. The efforts of health workers and planners should be directed at fostering mutual respect and facilitating patients' utilisation of both systems.

The authors would like to thank Professor W. D. Hammond-Tooke for his invaluable assistance and advice. Nursing sisters Miriam Molefe, Constance Mojapelo and especially Sindiswa Nkosi were instrumental in carrying out the research and aiding our understanding. We express our gratitude to Ms Joanne Stein for clarifying methodological issues, and our most sincere thanks to the traditional healer, Thoko Qekeni, whose participation was motivated purely by the desire to further our understanding of traditional healing.

REFERENCES

1. Hammond-Tooke WD. *Rituals and Medicines*. Johannesburg: AD Donker, 1989.
2. Nkosi SA. The utilisation of mental health education of families of psychiatric patients on traditional health practice versus Western psychiatric treatment. Submitted to Rand Afrikaans University for M.Cur. degree, 1991.
3. Wessels WH. Cultural psychiatry: theory and practice. *CME* 1985; 3(12): 23-26.

4. Abdoool Karim SS, Ziqubu-Page T, Arendse R. Bridging the gap: potential for a health care partnership between African traditional healers and biomedical personnel in South Africa. *S Afr Med J* 1994; **84**(12): Insert.
5. Edwards SD. Traditional and modern medicine in South Africa: a research study. *Soc Sci Med* 1986; **22**: 1273-1276.
6. Farrand D. Is a combined Western and traditional health service for black patients desirable? *S Afr Med J* 1984; **66**: 779-780.
7. Mohmann AA, Richeport M, Marriott BM, Canino GJ, Rubio-Stipe M, Bird H. Spiritism in Puerto Rico. *Br J Psychiatry* 1990; **156**: 328-335.
8. Rispel L, Behr G. *Health Indicators: Policy Implications*. Johannesburg: Centre for Health Policy, University of Witwatersrand, 1992.
9. Cheetham RWS, Griffiths JA. Changing patterns of psychiatry in South Africa. *S Afr Med J* 1980; **56**: 166-168.
10. Hirst MM. The Healer's Act: Cape Nguni diviners in the townships of Grahamstown. Ph.D. thesis, Rhodes University, 1990.
11. Kleinman A, Sung LH. Why do indigenous practitioners successfully heal? *Soc Sci Med* 1979; **13B**: 7-26.
12. Buhrmann MV. *Living in Two Worlds*. Pretoria: Human and Rousseau, 1984.
13. Holdstock TL. Indigenous healing in South Africa: a neglected potential. *South African Journal of Psychology* 1979; **9**: 118-124.
14. Daynes G, Msengi NP. Why am I ill? Who made me ill? The relevance of Western psychiatry in Transkei. *S Afr Med J* 1979; **56**: 307-308.
15. Ben-Tovim DI. *Development Psychiatry*. London: Tavistock Publications, 1987.
16. Littlewood R. From categories to contexts: a decade of the 'new cross-cultural psychiatry'. *Br J Psychiatry* 1990; **56**: 308-327.
17. Kiernan JP. Is the witchdoctor medically competent? *S Afr Med J* 1977; **53**: 1072-1073.
18. Littlewood R, Lipsedge M. *Aliens and Alienists. Ethnic Minorities and Psychiatry*. 2nd ed. London: Unwin Hyman, 1989.
19. Robertson BA, Kottler A. Cultural issues in the assessment of Xhosa children and adolescents. *S Afr Med J* 1993; **83**: 207-208.
20. Beiser M, Ravel J, Collomb H, Engelhoff C. Assessing psychiatric disorder amongst the Serer of Senegal. *J Nerv Ment Dis* 1972; **154**: 141-151.

Accepted 15 Feb 1995.
