Perceptions of psychological distress and treatment among the Ovambo in Northern Namibia: A multiple method study

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PERCEPTIONS OF PSYCHOLOGICAL DISTRESS AND TREATMENT AMONG
THE OVAMBO IN NORTHERN NAMIBIA: A MULTIPLE METHOD STUDY

By

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A DISSERTATION

Presented to the faculty of
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The biomedical model of psychiatric care and psychological distress has dominated the Western world’s approaches to psychological treatment (Wampold, 2001; 2007). Moreover, psychology has, historically, been exported wholesale beyond its Western base of development. Such exportation lends itself to the overshadowing of local psychologies in favor of dominant, universal psychology. Imposition of Western theory is further true in applied psychology insofar as how clinical practice and mental illness are defined. This study intended to understand the nature of psychological distress and treatment in a non-Western context – the Ovambo people of Northern Namibia. Little is known about the perceptions of mental illness in this context. A two-phase qualitative design was used to explore Ovambo beliefs about and experiences of mental illness and its treatment. The first ethnographic phase ($N = 22$) was analyzed in two portions – one thematic analysis for general Ovambo participants and a second for practitioners. Six themes, (a) Where Madness Comes From: Witches, Sickness, and Other Explanations, (b) *Omananamwengu* and *Eemwengu*, (c) The Role of Families and Communities for *Omananamwengu* and Distress, (d) Witchdoctors, Frauds, and *Odudu*, (e) Counseling, Medicine, and Religion as means for Healing, and (f) Seeking Care: Decisions Based on Belief and Need, for the general Ovambo were identified, and four themes were identified in the data from practitioners, (a) Mental Health Services in the North, (b)
Traditional Beliefs and Healing, (c) Explaining Mental Illness through Modern and Traditional Lenses, and (d) Integration of Treatment Modalities. An ethnographically contextualized multiple case-study followed in which four cases were sampled to understand experiences of mental illness beliefs identified in the ethnographic phase. Four cross-case themes emerged: (a) Symptoms of Mental Illness, (b) Marginalization and *Omananamwengu*, (c) Family Roles in Treatment, and (d) Belief in Treatment. The results describe culturally-pertinent psychological symptoms and the perceptions of treatment within Ovambo culture. Understanding beliefs about mental illness in Ovambo culture may help shape integration of tradition and Westernized psychological practice in meaningful and helpful ways. These results also add to the growing international literature base in Counseling Psychology and highlight the need for attention to within-culture perspectives of mental health.
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Chapter 1

INTRODUCTION

Psychology, and its practice, has seen an expansion beyond Western borders and grown globally over the last several decades (Gerstein, Heppner, Ægisdóttir, Leung, & Norsworthy, 2009; Moodley, Gielen, & Wu, 2013; Tseng, 2007). However, applied psychologists have cautioned against the “wholesale exportation of Western models” (Heppner, Leong, & Chiao, 2008, p. 79) to parts of the world where Western ways of being are less relevant. This cautionary statement reflects what, in indigenous and cultural models of psychology, theorists have long advocated against – the use of mainstream psychology, both theoretically and methodologically, beyond the confines of the Western populace among whom psychological principles were built (Bartholomew & Brown, 2012; Cole, 1996; Kim, Park, & Park, 2000; Pe-Pua, 2006; Shweder, 1999).

Beyond mainstream psychology, some psychologists have abandoned the comfort of quantitative experiments and embraced culture as a significant impact on psychological experiences. Beatrice and John Whiting, for example, developed their Psychocultural Model of development (1975; 1978), in which context is placed at the center point of an individual’s developmental experiences and constructed, psychological meaning systems. It would follow, within their theoretical perspective and those of others that consider psychology within cultures (e.g., Cole, 1996; Shweder, 1999), that the meaning systems used to understand mental illness, a psychological experience, are also influenced by cultural contexts, meanings, and systems. Heppner and colleagues wrote that psychologists have an obligation “to support the identification, development, and evaluation of indigenous models of helping as potentially equally valid ways of healing”
(2008, p. 79). The aim of the current research, which falls within the scope of culturally-specific psychological research, is to explore what cultural factors exist and influence the meaning, experience, and treatment of mental illness in a specific context – the Ovambo tribe in Northern Namibia.

As recently as 2005, the Republic of Namibia has noted, through its Ministry of Health and Social Services, that mental health services within Namibia lag behind those found in other countries (Republic of Namibia Ministry of Health and Social Services [MHSS], 2005). Despite this paucity of services for people in Namibia, symptoms of psychological distress are not absent (e.g., Feinstein, 2002; Haidula, Shino, Plattner, & Feinstein, 2003; Ruiz-Casares, 2010; Ruiz-Casares, Thombs, & Rousseau, 2009; Shifona, Poggenpoel, & Myburgh, 2006). A lack of evidence regarding states of psychological well-being in an international context (i.e., Namibia) lends itself to a call for greater research. Moreover, the lack of research fails to promote local definitions of distress in Namibia, despite theoretical calls to emphasize cultural context and uniqueness in understanding symptoms (Tseng, 2007). Northern Namibia, home to a high concentration of the country’s population and the majority of the Ovambo tribe (Hishongwa, 1992; Tvedten, 2004), therefore, offers an excellent context in which psychologists can avoid ‘wholesale’ Western theory and, instead, foster more meaningful, indigenous knowledge.

**Purpose**

Given the absence of literature exploring the meaning and nature of mental illness among the Ovambo and the utility of Western models of psychological care in a non-Western, neo-colonial setting, the purpose of this multiple method, qualitative study is two-fold. First, an ethnographic approach will be used with the intention of understanding
and exploring the existing systems, both indigenous and Westernized, of mental health care existing as well as the meanings ascribed to mental illness among the Ovambo. Second, an embedded, ethnographically contextualized multiple case study will be utilized to more deeply understand the lived experiences of people who have endured psychological distress as defined within the Ovambo, culturally-grounded conceptualizations of mental illness that flow from the ethnographic phase. Thus, the purpose of the study is to better know the cultural system and perceptions of mental illness and understand the lived experience of distress within the culture. Because little quantitative data exists to understand mental illness and symptom manifestation in Namibia (Haidula et al., 2003; Ruiz-Casaares, 2010; Ruiz-Casares et al., 2009), qualitative methods offer the most apt approach to accomplishing the purpose of this study.

**Indigenous Psychology & Mental Health**

Complex understandings of indigenous values as they are embedded within culturally relevant psychological understandings have risen as psychology has continued to internationalize. Chinese (e.g., Hwang, 2009; Leung & Chen, 2009; Yang, 2000; 2006), Filipino (e.g., Pe-Pua, 2006), American Indian, (e.g., Duran, 2006; Duran, Firehammer, & Gonzalez, 2008; Gone, 2010), and, in a more general sense, Latino (e.g., Comas-Diaz, 2006), among multiple others, psychologies have been fostered through rigorous, within-cultural studies and theoretical conceptualizations. Within these theoretical frameworks, mental health is considered within the culture at hand instead of having Western paradigms of mental illness imposed. Nearly 30 years ago, Lagmay asserted that Filipino psychological interventions have benefited from “modification into
the local ways” (1984, p. 40), and others have fostered culturally bound and culturally appropriate administration standards of assessment in the Philippines (Enriquez & Guanzon-Lapeña, 1985). In addition, O’Donnell (2012) made an effort to provide a primer for global mental health in which she highlighted the burgeoning organizations, resources, and projects being conducted, globally, to call greater attention to positive human functioning and mental health. Such specific theoretical conceptualizations should not avoid African cultures.

The idea that culture plays a role in psychological healing is not entirely new. Rather, the contextual model, proposed by Frank and Frank (1991) and discussed in more depth by others (Scheel & Conoley, 2012; Wampold, 2001), has long contended that the avenue of psychological healing must be a culturally agreed upon method for it to be effective. With this in mind, one can consider the modality of change in dominant United States culture to be psychopharmacology, psychotherapy, and counseling (Wampold, 2001; 2007). Collins and Arthur (2010) have expanded from this perspective in their proposed ‘culture-infused model’ of counseling in that they argue the working alliance between a therapist and client cannot develop without infusion of clients’ cultures into the therapeutic process. By infusion, Western counseling is adapted to a form that is culturally acceptable, in theory, for non-Western clients. Sue and Sue (2008) likened the Western psychotherapist to a Shaman in some cultures in that both represent a facilitator of healing with specific purposes (e.g., decrease of symptoms of mental illness). They went on to hold true that the healing ability of such agents of change (i.e., Shaman or therapist) is dependent upon perceptions of credibility (Sue & Sue, 2008). Therefore, one can contend that a Western trained psychotherapist, whose skill set is entrenched in
universalist understandings, may lack true credibility and trust in being an agent of change in contexts with distinct histories of healing.

Other cultures have intuitively fostered their own means of intervening with psychological symptoms, and any means of treatment in places like the Philippines, China, and Namibia become more meaningful and agreeable if they are appropriately anchored to local beliefs. Some researchers have developed a literature base for such awareness in parts of Southern Africa (detailed in Chapter 2), but further research specific to the Ovambo is needed in order to better understand how a symptom is known to be a symptom, how a healer is known as credible, and how symptoms are cared for.

**Namibian Context**

Though the Namibian context remains unclear regarding specific cultural traditions related to mental health, the country, and the Ovambo people, have a rich cultural history closely tied to oppression and struggle. Ovambo culture, and the Namibian context as a whole, endured rapid cultural changes as a function of colonialism from the late 19th century through the late 20th century (Hayes, Silvester, Wallace, & Hartman, 1998). Namibia first became a European colony when Germany claimed the region as German Southwest Africa in 1884. However, Germany lost control of the region when its troops fell to South African and British forces fighting in German Southwest Africa during World War I (Clarence-Smith & Moorsom, 1975; Cooper, 1991). In South Africa, the Nationalist party came to power in 1948, leading to the imposition of the party’s apartheid policies which implemented vast racially discriminating policies throughout what was then Southwest Africa (Clarence-Smith & Moorsom, 1975; Cooper, 1991). During this colonial period, Blacks in Namibia were
sequestered into ‘homelands,’ and among these imposed homelands was Ovamboland (Hayes, Silvester, Wallace, & Hartman, 1998). In addition, Black Namibians during colonial rule were put into forced labor, endured famines (particularly in northern Namibia), and suffered perpetual poverty (Hayes et al., 1998). Such subjugation became normative in Namibia for many years, particularly in the North (Bartholomew, 2012).

With an aim to end apartheid, the Southwest Africa People’s Organization (SWAPO) was born in northern Namibia (Ovamboland). In addition to diplomatic endeavors via the United Nations, SWAPO launched its military wing, People’s Liberation Army of Namibia (PLAN), in 1966 to seek an end to apartheid. What ensued was a long, drawn-out guerilla war, which was fought most fervently in northern Namibia, leaving lasting psychological imprints of warfare and oppression among the Ovambo (Bartholomew, 2012). It was not until 1990 that South Africa recognized the futility of its continued oppression of Namibia, and SWAPO, through both diplomacy and military action, secured the independence of their homeland.

**HIV/AIDS Prevalence**

Beyond government funding allocated to mental health and the task of stabilizing multiple facets of a new democracy post-colonialism, Namibia also faces current social and health concerns. In particular, the rates of HIV/AIDS in Namibia have been among the highest around the world; however, these rates have seen marked decreases in the last decade (UNAIDS, 2012). Estimates of the number of cases of HIV/AIDS in Namibia are as high as 204,000 people, 7% of whom are under 15 and 58% of whom are women (MHSS, 2008). Some efforts have been successful, but HIV/AIDS remains a prominent concern in Namibia and one that is not irrelevant to the potential mental health needs of
the Ovambo people. The burden of this illness influences community development and the allocation of various resources, which has been observed in rural Namibian areas (Hitchcock & Babchuk, 2011).

Psychologists and other mental health practitioners are often included in the conversation of HIV/AIDS prevention in developing countries, as Ruiz-Casares (2010) demonstrated in drawing attention to the mental health of children who have become heads of houses as a result of AIDS related death. Moreover, Brown, Sorrell, and Raffaelli (2005) found evidence to suggest that the promulgation of the HIV/AIDS epidemic in Namibia is largely tied to existing norms of masculinity and the belief that an Ovambo man can stand against the disease. Thus, it is clear that the Namibian HIV/AIDS epidemic, which has not avoided influence from Ovambo cultural beliefs and norms, has the potential to influence the psychological experience of the Ovambo. HIV/AIDS prominence also further emphasizes the need for greater understanding of the perceptions of mental illness and general psychological needs in Namibia.

**Kinship**

Kin relationships are exceptionally important ties within the Ovambo context (Brown, 2011; 2013; Brown & Bartholomew, 2013; Tvedten, 2004). With respect to apartheid, Bartholomew (2012) found evidence to suggest that kinship ties were often torn during decolonization; however, this was a focal point of reconciliation efforts after South African rule was ousted. Kinship is mentioned as pivotal facet of Ovambo culture because mental health in regionally similar African countries (e.g., South Africa and Botswana), family and community are thought to be components of an individual’s
healing process. Thus, mental illness may be approached similarly among the Ovambo—with the individual being treated within the context of the many.

Kinship, in Ovambo culture, is matrilineal (Brown, 2011; Lebert, 2005; Tönjes, 1996). This implies that the transmission of kin relationship occurs within the scope of mothers in nuclear families. Such an orientation to the transmission of kin has implications with regards to who is caring for various biologically, and non-biologically (Brown, 2011; Brown, 2013), related individuals in Ovambo culture. Because of matrilineal decent, inheritance of family relationships and goods (e.g., cattle and homes) pass within relationships that can be followed back to a matriarch (Lebert, 2005). Moreover, children are thought to belong to their mother’s family, implying that a mother’s direct kin share in the responsibility for caring for her children (Brown, 2011). Regarding mental health, this may influence who makes decisions when a specific person is suffering from a given psychological condition. A member of an Ovambo family would not contribute to the decisions for mental health services for an individual from his paternal biological relations; however, this person could be significantly involved in any help seeking decisions made by a maternally linked family member. Following a matrilineal kinship link frames how psychological distress is treated and addressed within a specific Ovambo cultural practice.

**Current Research**

This study makes use of a multiple-method, qualitative approach. The methods to be used are ethnography and ethnographically contextualized multiple-case study. An ethnographic approach facilitates closer attention to cultural processes and local ways of being (O’Reilly, 2012). This method also offers a context in which multiple-case studies
can be embedded and better understood, which prevents the interpretation of mental illness within the theoretical conceptualizations of Western psychology. Using this multiple-method approach offers a means of integrating cultural knowledge and individual ways of being that further focuses on the psychological construct of study. Traditionally, psychologists accomplish this via large sample sizes, quantitative measures, and assumptions of generalizability, but asserting universality in the definition, experience, and treatment of mental illness is avoided here by using methods that highlight the nature of these phenomena in the Ovambo context. Below, the operational definitions and research questions guiding this study are outlined.

**Operational Definitions**

**Psychological distress/discomfort & symptom presence.** Psychological distress, psychological discomfort, and symptom presence (as well as other synonymous variations) will be used in this study to describe the presence of disturbing psychological experiences that manifest for an individual. Historically, Western psychologists have opted to understand psychological distress within the system promoted by the American Psychiatric Association and found in the Diagnostic and Statistics Manual of Mental Disorders (e.g., American Psychiatric Association, 2000). However, cultural context is pivotal in understanding how symptoms are meaningful and manifest uniquely among diverse groups of people (Tseng, 2007). This study, being inductive in nature, will focus on those symptoms that emerge in the ethnographic data as meaningful within Ovambo culture, but psychological distress, psychological discomfort, and symptom presence will be used to describe these culturally relevant disturbances.
**Mental health.** Mental health is a broad and encompassing term to be used in this study to describe psychological functionality. It is not representative of the absence of psychological distress; rather, as Hayes, Strosahl, and Wilson (2012) indicated in their Acceptance and Commitment Therapy, “it is *psychologically healthy* to have unpleasant thoughts and feelings as well as pleasant ones” (p. 23). Hayes and colleagues (2012) went on to state that psychological flexibility is representative of mental health. A psychologically healthy person encounters suffering but is able to adapt to the manifestation of distress. Therefore, this study conceptualizes mental health as a state of adaptability. A person who possesses mental health is one who is able to function and adapt in the face of distress. Mental illness, therefore, is the inability to adapt to the development of distress, which has much to do with cultural perceptions of malfunction (Berry, Poortinga, Breuglemans, Chasiotis, & Sam, 2011).

**Western paradigms of treatment.** Western paradigms of treatment are defined as those psychological interventions that have developed from Western theory. Specifically, these modalities of psychological care include individual therapy that manifests in the form of Western trained counselors, psychologists, or psychiatrists. This could include individual counseling, group counseling, psychiatric care, or other such interventions that are not directly attentive to culture as a central process in the experience of psychological distress and its treatment. To guide this study, psychotherapy, as a predominant means of symptom resolution in Western practice, a definition offered by Wampold will be used:

> Psychotherapy is a primarily interpersonal treatment that is based on psychological principles and involves a trained therapist and a client who
has a mental disorder, problem, or complaint; it is intended by the therapist to be remedial for the client’s disorder, problem, or complaint; and it is adapted or individualized for the particular client and his or her disorder, problem or complaint. (2001, p. 3).

Elsewhere, Wampold (2007) asserted, within the common factors framework, that psychotherapy works within the “context of human interaction between the therapist and patient,” (p. 861); however, others promote more standardization and medical models of psychotherapy (Wampold, 2001). All such treatments will be referred to as Western models.

**Indigenous healing.** Greenfield defined indigenous psychology as a psychological lens in which the “prime [focus] of study is the subject’s creation of meaning systems, particularly systems that are shared or normative within a defined cultural group” (2000, p. 225). This definition of indigenous psychology gives way to the understanding of indigenous healing used in this study. Indigenous healing, therefore, is understood as those systems of caring for the individual that are normative within the defined cultural group (i.e., the Ovambo). This study will focus on those aspects of indigenous healing that are pertinent to psychological states. Such treatments are distinct from psychotherapy and Western models of care. Wampold suggested that “treatments based on…indigenous peoples’ cultural beliefs about mental health and behavior…may be efficacious” (2001, p. 3) but are not based on psychological principles. These ways of promoting change certainly carry similarity in their goals, including changing beliefs, remoralizing clients, and fostering hope, but the nature of psychotherapy and indigenous healing are inherently different in their underlying principles (Wampold, 2007).
Research Questions

Given the inductive process of this qualitative research, no hypotheses are made in order to avoid introducing biases of assumption into the analyses. The following research questions are offered as guides to achieve the purpose of this research:

1. **Research Question 1:** Among the Ovambo, what are the cultural perceptions of ill mental health and how is mental illness treated?
   - **Sub-question:** How is mental illness defined by members of the Ovambo tribe, including healers, medical & psychological professionals (including social workers), and non-healing members of the culture?
   - **Sub-question:** What meanings are ascribed, among the Ovambo, to a person’s experience of mental illness?
   - **Sub-question:** What are considered acceptable and appropriate means of alleviating these symptoms of distress?
   - **Sub-question:** In what ways does a person’s experience of mental illness affect their place within the Ovambo community and within kinship relationships?

2. **Research Question 2:** What is the utility of Western paradigms of psychological care among the Ovambo?
   - **Sub-question:** What resources are available in Northern Namibia and used by Ovambo people?
3. **Research Question 3:** What is the utility, content, and process of indigenous approaches to healing mental illness in Northern Namibia?

   - **Sub-question:** How do the Ovambo decide between indigenous and Western care?

4. **Research Question 4:** What is the lived experience of those Ovambo people who have endured psychological distress and have been treated by indigenous or Western modalities?

   - **Sub-question:** In what ways has this experience of living with and being treated for distress influenced their experiences of the self within the Ovambo context?
   
   - **Sub-question:** How do people living with distress become aware of this?
   
   - **Sub-question:** How do such people know themselves to have received effective care?
Chapter 2

LITERATURE REVIEW

Given that psychology is inherently bound to (Gone, 2011) and co-constructive with (Shweder, 1999) culture, the application of psychological theory with regards to people’s well-being must be considered as variable across contexts, including Africa. However, the tradition of mental health care has been perpetuated as an avenue of well-being promotion within the value-systems held by dominant, Western cultures (Gone, 2010; Kleinman, 1986; Moodley & Stewart, 2010; Moodley & Sutherland, 2010), or what has been more recently referred to as WEIRD (Western, Educated, Industrialized, Rich, Democratic) cultures (Heinrech, Heine, & Norenzayan, 2010). Mental health care, therefore, lags behind in many parts of the world where its utility is incongruent with cultural values of groups of people and where people have fostered differential definitions of mental illness in and of itself. Theoretical disparities and emerging areas of care and need are certainly true of many African countries (e.g., Amer, 2013; Bojuwoye & Mogaji, 2013; Cooper & Nicholas, 2013; Kadari & Bennani, 2013; Kpanake & Ndoye, 2013; Mwiti & James, 2013). For example, as the World Health Organization has brought attention to its ‘Millennium Development Goals,’ many researchers have noted the continued underrepresentation of mental health in governments’ budgetary discussions as well as an evident continued lack of available care (e.g., Bhana, Petersen, Baillie, Flisher, & MHaPP, 2010; Kakuma et al., 2010; Leach, Akhurst, & Basson, 2003; Skeen, Lund, Klientjes, Flisher, & MHaPP, 2010; Yen & Wilbraham, 2003a; Yen & Wilbraham, 2003b). The common goal of this systematic research in Southern African contexts is to understand what impedes psychological care as well as the processes by which
psychological intervention can become culturally meaningful in a way that attends to
unique symptomatic experiences and avoids pathologization of culturally normative
behavior.

The aim of this literature review is to explore the theoretical discussions and
empirical findings to understand unique perceptions of mental illness in African contexts,
existing Western systems of care and impediments to attainment therein, the unique
systems of healing across cultures, and the potential for useful integration of approaches.

An emphasis on traditional and indigenous healing should not, however, be taken as an
tempt to exoticize non-Western treatments but, instead, as a way of appreciating
Afrocentric realities within global psychological theory (Moll, 2002). In addition, though
this study aims to understand the indigenous nature and culturally-bound practices of
Ovambo Namibian mental health, the scope of this literature review will extend beyond
Namibian borders and into Southern African countries. The paucity of Namibian mental
health research necessitates attention to how Western and indigenous mental health care
paradigms have fared in regionally similar countries and cultures. For this review,
Southern Africa will be defined using the United Nations macro-geographical region
designations, which includes these countries: Botswana, Lesotho, Namibia, South Africa,
and Swaziland (United Nations, 2013). Furthermore, this review will use terms such as
mental health, psychological well-being, psychological discomfort, and psychological
distress to characterize times of symptom manifestation, within behavioral and
psychological realms, that occur for an individual person. Psychotherapy and psychiatric
intervention will be considered as the Westernized approaches to symptom alleviation,
whereas traditional healing and indigenous healing are defined as culturally bound and contextually relevant theories and practices.

Symptoms of distress may appear intelligible from one group to the next and similar biological patterns that are related to behavioral indicators of psychological discomfort may appear across groups, but embracing this as universality represents the pitfall of mainstream psychology (Kim & Park, 2000) and a reductionist philosophy of psychology. This concept extrapolates to the nature of care for symptoms of distress within their contexts; that is, how people heal themselves has the propensity to be informed by cultural belief systems. Frank and Frank (1991), who authored the contextual model for psychotherapy, argued that psychotherapy works only when it is an agreed upon avenue to changing some experience in a person’s life that both the healer, who is recognized by the person as a promoter of well-being, and the person agree upon. Being an agreed upon avenue to change requires a sense of social acceptance in that psychotherapy, in the United States for example, is agreeable because it is a socially understood system through which psychological discomfort is reduced or resolved (Frank & Frank, 1991). As the applied psychological fields continue to grow internationally, we have an ever-growing responsibility to expand conceptualizations of what constitutes mental illness and how diverse peoples construct avenues to the alleviation of discomfort.

**Mental Health in the South: Oppression & Indigenous Perspectives**

Mental health is thought to encompass the meanings associated with an experience of those symptoms of psychological discomfort – meanings which may be different across groups (Tseng, 2007). Biological disruptions may also promote symptoms of ill psychological being; however, the intentional use of ‘mental health’ is
meant to stretch perspectives beyond a reduced worldview of psychological distress by focusing more on those aspects and symptoms of mental illness that derail well-being within specific contexts. Tseng (2007) has provided the most apt theory to understand this abstract concept of culturally grounded understandings of ill, and positive, mental health. He offered 6 ways of thinking about mental health and culturally grounded symptoms: pathogenic, pathoselective, pathoplastic, pathoelaboration, pathofacilitating, and pathoreactive. Within each of these, one can begin to conceptualize how, specifically, facets of culture interact with psychological well-being in a way that incites or ascribes meaning to pathological ways of existing. Psychologists would benefit, therefore, by immersing themselves in the cultural histories and customs in a way that actively integrates unique perspectives into theory construction and applied intervention.

**Colonialism & Implications for Psychology in Southern Africa**

Unique cultural systems impart different understandings of what actually is *mental illness*. Such differential experiences in Africa, and elsewhere, require consideration of the historical nature of psychological perceptions in diverse settings and post-colonial realities in order to more meaningfully understand diverse mental healths.

Histories of oppression in sub-Saharan Africa, including the long-ranging grip of apartheid, have made lasting impacts on psychologies in these contexts. In South Africa, the home of apartheid, psychology and psychotherapy became tools to preserve the interests of the White, Afrikaans minority at the deficit of the majority Black groups (Cooper & Nicholas, 2013). Systems of care, therefore, were embedded in environments of imposition and racially charged dichotomizations, resulting in counseling and psychotherapy having “reflected [its] racially based origins” (Cooper & Nicholas, 2013,
Much of how mental health in African contexts has been conceptualized by researchers is grounded in what has been characterized as the ‘African Personality’ (Yen & Wilbraham, 2003b) – yet another relic of discriminatory perceptions fostered by minority, yet power-majority, White-European colonizers. The ‘African Personality’ relates to a discriminatory assumption of primitivity in African cultures that may be ascribed because of reliance upon collectivistic practices and technological advances not in-step with European colonial forces (Yen & Wilbraham, 2003b). Interactions between African and Europeans in colonial Africa hinged upon the nature of subordination and oppression, leading to the “psychological sciences grappling with management of the ‘primitivity’ of the ‘African personality,’” (Yen & Wilbraham, 2003b, p. 564). They went on to argue that some clinicians and other members of South African culture perceive Western psychiatric care as hegemony and diametrically opposed to true cultural heritage of African people (Yen & Wilbraham, 2003b). Such colonially imposed perceptions of the African ‘psyche’ contribute to a subordinate understanding of the marginalized across social institutions, including health care.

Assumptions of primitivity and discriminatory origins of psychology in the South shaped systems of psychological and psychiatric treatment. Some colonially ruled countries saw the indigenous populations labeled as insane and committed to segregated, Western-modeled asylums (Leach et al., 2003). Mandated commitment in this context further exhibits the nature of psychological oppression Africans have faced when forced to integrate with Western derived understandings of mental illness. Moreover, the messages of colonialism are hard for the oppressed not to integrate into their own ways of being (e.g., Bartholomew, 2012; Naidoo & Rajab, 2005) and often undermine
psychological well-being among the oppressed throughout Africa (Peltzer, 1998). Psychologists have suggested that oppression and oppressive labels can lead to internalization of selfhood as negative (e.g., Prilleltensky & Gonick, 1996) and even destroy the identities of the marginalized (e.g., Moshman, 2011). If one is considered primitive and one’s cultural practices are labeled as such, then it would lead logically that one’s experience of oppression and subsequent negative self-perception would skew the cultural definitions of maladaptive psychological symptoms. That is, the oppressed is pushed from her or his culture because it is ascribed primitivity and associated, meaningful behaviors are left to asylums. One can wonder, therefore, if the integration of the self as negative that occurs via colonialism (Fanon, 1963; Prilleltensky & Gonick, 1996) contributes to the oppressed not seeing the potential efficacy of or need for mental health care.

Perceptions of Mental Health in Southern African Contexts

Elsewhere, Bojuwoye and Sodi (2010) have highlighted similar findings and theory in that non-Western, or non-WEIRD, contexts exist with their own ideas of health and well-being that lead to incongruence with Western conceptualizations of care. More specifically, what constitutes mental illness in Western cultures is not necessarily mental illness in another part of the world (Bojuwoye & Sodi, 2010). As a result of incongruent value systems (i.e., Western, often medicalized, models of psychotherapy and diversity within African contexts), we see higher rates of non-Western populations preferring to ameliorate health concerns via traditional healing (for example, see Kahn & Kelly, 2001). The history of South Africa, for example, has shown that a significant majority of Africans within the country default to seeking care from traditional healers (Kahn &
Kelly, 2001), and this is not drastically different for mental health (Berg, 2003). Hewson (1998) suggested that this is additionally rooted in a sense of interconnectedness that flows in much of African psychological experiences. *ubuntu*, as a way of being and cornerstone of African philosophical understanding, reflects this perfectly – people exist through others (Gade, 2011). This philosophical perspective manifests in the importance given to social and kin relationships, which, for example, is readily observable among the Namibian Ovambo (Brown, 2011). Healing can, potentially, occur within social and kin relationships as, in this context, a person’s “extended family or community takes part in an individual’s healing through shared diagnosis of the problem and treatment” (Mwiti & James, 2013, p. 77). Feeling a sense of disconnection, itself, can lead to the manifestation of mental illness (Hewson, 1998). *Ubuntu*, according to Edwards, Makunga, Ngcobo, and Dhlomo (2004), is concerned with optimal human functioning within the community and is, therefore, linked to mental health. Clearly, values in Southern Africa place a person within her or his social relationships, which play a central role in how a person experiences and alleviates distress. The role of social relationships as a facet of psychological change, though not foreign in modern psychological theory, reinforces the need to better understand how distress occurs and is treated in unique contexts with their own cultural value systems.

Ancestor reverence represents another central component of African philosophy pertinent to counseling (Bojuwoye, 2013). It provides a means of connecting to one’s deceased kin in, what can be described as, a spiritual manner. Xhosa ancestor reverence is also particularly relevant in avoiding pathological language in some illness experiences (Berg, 2003). In this culture, times of distress, including unsettling dreams, bodily
disruptions, and some illnesses, are often attributed to one’s interaction with ancestors (Berg, 2003; Bührmann, 1981). In African philosophy, ancestors are not worshiped, but a piece of them never leaves despite death, and this is respected (Bowker, 1996). The rituals and experiences surrounding ancestor reverence, such as dreams in which ancestors are prominent and ritualistic gatherings that call for attention to one’s kin, are exceptionally psychological in nature (Berg, 2003). Loss of protection from one’s ancestor has been noted in Namibia as an explanation for the onset of psychological disorders (Vranckx, 1999). Moreover, the perception that a person has angered his or her ancestors has been offered, as an etiological source of psychosis (Mzimkulu & Simbayi, 2006). Xhosa traditional healers, when considering the cause of psychosis, turn their attention, primarily, to the question of the psychosis being incited by witchcraft or angered ancestors (Mzimkulu & Simbayi, 2006). The primacy of angered ancestors and disharmony in these contexts exemplifies the cultural meaningfulness of psychological well-being in African ways of knowing and being.

Perceptions of distress. Experiences of distress are also differentially characterized. Within southern Africa, many indigenous healers work “from a health versus psychopathology mindset” (Mwiti & James, 2013, p. 76), which also suggests an emphasis on preventative care. Moreover, emphasizing health versus psychopathology in understanding mental illness implies the value of a holistic mindset (i.e., ill physicality affects one’s mind). An alternative explanation of this nature leads to differential ways of understanding what occurs when a person experiences mental illness.

Idowu (1985) wrote of different types of psychological illness in Africa: non-supernatural, supernatural, and god-caused. The supernatural and god-caused theories of
‘disease’ are abstracted and faith-based in that they exist within belief systems and outside of scientific cause and effect explanations (Idowu, 1985). Consistent with this, the Himba in Namibia associate psychological distress with supernatural forces (Vranckx, 1999). In the Caprivi region of Northern Namibia, mental illness is explained by traditions such as witchcraft (Thomas, 2007) rather than being defined as pathological like they may in the West. Interestingly, Thomas’ participants reported that, for many Caprivi, being bewitched “offered a form of hope that the illness was manageable” (2007, p. 282). Similarly, witchcraft and bewitchment in Botswana are thought as disturbances in social and interpersonal relationships (Sabone, 2009). These experiences are fraught with emotional vulnerability, which, rather than being automatically pathologized, are thought as learning experiences (Sabone, 2009). An alternatively positive conceptualization, similar to hope that manifests in witchcraft explanations in Caprivi, indicates a way of being that accepts times of distress as moments on which a person can construct greater understanding. Moreover, these experiences of psychological illness, or what Idowu (1985) characterized as supernatural illness, represents “an existential belief or metaphysical article of faith” (p. 81) for Africans. Such a conceptualization reinforces the need to embrace diverse phenomenologies of distress in which the perceptions of distress are entrenched in existing belief systems and avoid medicalizing psychological concerns.

Not only is the source of distress unique in this context, but apparent, symptomatic behaviors themselves may carry unique meanings. In South Africa, the concept of thwasa, or possession, among indigenous groups represents a sense of contact to one’s ancestors and the call to be an igqira, or a diviner (Mzimkulu & Simbayi, 2006;
Yen & Wilbraham, 2003b). Possession in the west would certainly be seen outside of the norm, whether that be by dominant spiritual tradition or diagnostic impression of secular mental health. *Thwasa* becomes meaningful in a person’s life and not something to be pathologized (Mzimkulu & Simbayi, 2006), as was recognized by a psychologist interviewed by Yen and Wilbraham (2003b). What is meaningful, and distinctive, about *thwasa* is the content of the possession (Yen & Wilbraham, 2003a). Ascribing pathology to the structure of possession (e.g., hearing voices) reflects a universal diagnosis and ignores the content – what the possession conveys to the possessed person is culturally meaningful and informative (Yen & Wilbraham, 2003a). In Botswana, possession is seen as a learning experience in that it provides greater insight into a person’s place in the world (Sabone, 2009). Possession in the west often leads to diagnoses of schizophrenia or other psychotic disorders; however, Sorsdahl, Flisher, Wilson, and Stein (2010) noted that many of their participants (traditional healers) in Mpumulunga, South Africa did not see schizophrenia as an illness at all. Instead, the traditional healers, who had been presented with vignettes of Western-defined mental illness cases, described the conditions of the people in the vignettes in terms of witchcraft, spirit possession, life stressors, and substance abuse (Sorsdahl et al., 2010).

The culturally-bound nature of *thwasa*, and similar experiences, as a call to heal rather than a state of possession, does not exclude the manifestation of states of mental illness. Robertson (2006), for example, noted South African Zulu states of mental illness including *amafufunyane* (possession by evil spirits), *ukuphambana* (madness), *isinyama esikolweni* (bewitchment in schools), and *ukuphaphazela* (state of fearfulness). These states of mental illness are rooted in Zulu beliefs. For example, *amafufunyane* is thought
to be “contracted when soil and ants from graves are mixed…and ingested” (Cooper & Nicholas, 2013, p. 66). Culturally developed meaning systems provide a context of knowing what is and what is not abnormal.

Other cultural factors are significant as well, as McCall and Resick (2003) suggested in their inability to uncover some diagnostic indicators of posttraumatic stress disorder (PTSD) among Kalahari Ju/'hoansi. The researchers attempted to verify Western symptoms of the disorder, but in the absence of some evidence (e.g., avoidance symptoms), they argued that their findings might reflect the reality that Ju/'hoansi values are prohibitive of people meeting avoidant-like PTSD symptoms (McCall & Resick, 2003). Avoidance of distress, therefore, is thought to be outside of the norm in Ju/'hoansi culture. Similarly, some practitioners working with non-Western clients may relegate “cultural differences to mere embellishments upon the underlying reality of psychiatric abnormality,” (Yen & Wilbraham, 2003a, p. 551). Such conceptualizations lend themselves to inattention to cultural disorder; that is, participants (practicing South African psychologists) reported believing cultural illnesses require merely simplistic treatment (Yen & Wilbraham, 2003a). Ascribing ‘simplicity’ to cultural beliefs relevant to mental illness situates distinct value systems in which Western models of disorder are imposed on non-Western peoples. Multiplicity of culture is vast in Africa, and one can readily observe difference in Western and African characterizations of abnormal and ill.

Alongside culturally unique perceptions of mental illness are realities of how African people perceive the Western lens of mental illness. Leach and colleagues (2003), for example, pointed out that Blacks in South Africa may have an automatic apprehension toward Western definitions of psychological distress, as such definitions
are often reminiscent of periods of oppression fueled by psychological marginalization. Sidandi, Mambwe, Zoric, Vanvaria, Vanvaria, and Laryea (1999) suggested that belief systems in Botswana indicate that mental illness manifests as a function of the influence of bad spirits and the evil doings of one’s enemies. Similarly, Xhosa individuals enduring mental illness often question if such experiences are the function of angered ancestral spirits that have withdrawn their protection from the individual due to failures to perform ancestral rituals or the commission of an immoral act (Mzimkulu & Simbayi, 2006). In these ways, cultural traditions and belief systems are made prominent in conceptualizing people’s mental illness, revealing the importance of contextually based understandings of the lived experiences of psychological discomfort. Using witchcraft as a way of explaining mental illness is similar to what Trimble (2010) discussed as magical thinking in Native American mental health. Both witchcraft and magical thinking represent diversified ways of processing the symptom manifestations as well as conveying the belief that such mystical processes can manipulate lives.

Within Southern African cultures, philosophical assumptions of the world (e.g., *ubuntu* and ancestor reverence) are significant in psychological understanding. To avoid situating those within conceptualizations of mental health in these contexts would represent little more than continued psychological imperialism. Moreover, the need to embrace alternative ways of being extends beyond philosophy and into the phenomenological conceptualizations of a given symptom. Psychosis or possession means something entirely different in the Xhosa and Zulu contexts as it does in WEIRD cultures. These meanings, or cultural content (Yen & Wilbraham, 2003a), is what psychologists, on the international stage, can better attend to. Doing so encourages the
field to re-conceptualize theories of distress in a way that embraces the unique
experiences of peoples in places such as Southern Africa.

**Evidence of Western-Defined Distress in Southern Africa**

Although cultural sensitivity and attention in understanding the conceptualizations
of mental illness are entirely appropriate, researchers have also developed a literature
indicating the nature of Western-based, diagnostically categorized understandings of
psychological disorder and distress in Southern Africa. Across Africa as a whole, mental
illness accounts for 5% of the burden of illness (WHO, 2008). In addition, the Namibian
government estimates that roughly 2-3% of its population suffers from serious mental
illness (MHSS, 2005). Ruiz-Casares and colleagues (2009), for example, found evidence
of measurable symptoms of depression among orphaned children in Namibia. Similarly,
high prevalence of substance abuse and psychosocial distress, including suicidality and
hopelessness, has been substantiated among Namibian adolescents (Page, Dennis,
Lindsay, & Merrill, 2011). Researchers have also translated the General Health
Questionnaire (GHQ) into the Oshiwambo language and successfully identified
symptoms of distress among the Namibian Ovambo (Haidula et al., 2003). Symptoms of
depression, which are thought to be the result of difficult interpersonal relationships and
stressful live events, have also been noted in women in a peri-urban context in Namibia
(Shifona et al., 2006). Elsewhere, Feinstein (2002) discussed the strong potential for
Western-understood post-traumatic symptoms to manifest among Namibians given the
civil strife endured by many of the population throughout apartheid and decolonization.
Additionally, he discussed prevalent rates of HIV/AIDS and domestic violence and the
reality that each of these, within a Western-originated framework of mental health, is
highly impactful on the psychological well-being of Namibians (Feinstein, 2002).

Elsewhere, evidence indicates that domestic violence experienced by women living in Northern Namibia significantly contributes to psychological dysfunction and impaired self-esteem for the victims of this violence (Nangola & Peltzer, 2003). These results show that some symptoms of psychological distress, defined through a Western lens, are present in Southern Africa. Rates of mental illness and distress in Namibia and Southern Africa may be less known, but disorders such as Major Depressive Disorder and Schizophrenia are present in 7% and .3%-.7% of the population, respectively (American Psychiatric Association, 2013). Therefore, psychologists, without the imposition of universal standards, can certainly consider what role Western-informed practice, when culturally adapted, may have within such contexts.

**Treatment Modalities in Southern African Contexts**

**Western Influences & Theories of Change**

Colonial rule not only brought systematic social oppression, but it also saw the imposition of Western-European means of healing (Sima & West, 2005) in Southern Africa. With the dichotomization of European and indigenous peoples as the way of living in colonially ruled countries, the WEIRD (Heinrech et al., 2010) ways of healing were ascribed more status than traditional treatments. What resulted is the prominence of Western psychiatric and psychological paradigms as funded (although, often underfunded) means of treating distress. Moreover, this implies that what becomes worthy of treatment is defined using a Western lens. Around the world, one can easily observe the influence of Western, applied psychological theory (Moodley et al., 2013), and this is no different in African contexts. South of the Sahara (Mwiti & James, 2013)
and in South Africa (Cooper & Nicholas, 2013; Leach et al., 2003), Western interventions have influenced theory and training, which has run the risk of pushing aside belief in culturally traditional treatments. In Botswana, for example, Sidandi and colleagues (1999) indicated that Western models of psychological treatment have begun to eclipse traditional healing despite little evidence indicating the efficacy of Western treatments in Sub-Saharan Africa (Mwiti & James, 2013) and specific countries, like South Africa (Cooper & Nichols, 2013) and Namibia (MHSS, 2005). If a group is forced away from their cultural beliefs with regards to what is culturally understood to be an effective treatment for an identifiable problem (contextual model; Frank & Frank, 1991), foreign means of psychological intervention may not carry cultural meaning and could, therefore, being ineffective.

Remnants of colonial rule or not, the systems of Westernized psychology in Southern Africa offer insight into the landscape of mental illness and psychological treatment in the region. Psychological distress is not absent in this part of the world, but research shows it remains a low priority in Southern African countries (Bird, Omar, Doku, Lund, Nserek, Mwanza, & MHaPP, 2011), underfunded (WHO, 2006), highly stigmatized (Kakuma et al., 2010), and poorly integrated with primary health care (Bhana et al., 2010). Moreover, most psychological care in some parts of Southern Africa is largely hospital based (Kahn & Kelly, 2001). Underfunding walks hand in hand, in some sub-Saharan countries, with the lack of adequate governmental policy to attend to the psychological needs through Western treatments (Bhana et al., 2010), which are more likely to be funded given their scientific accessibility. Accompanying poorly budgeted systems of care is the fact that many people in underdeveloped areas cannot afford the
fiscal cost of Western care (Bojuwore & Sodi, 2010). These realities of available, systematic, and Western treatment are potentially reflective of incongruent perspectives but are also indicative of the lesser degree of importance afforded to mental health care in some African contexts (Bird et al., 2011).

Limitations aside, most southern African countries have established, Westernized modalities of psychological training and practice, which do have relevance within the context (Leach et al., 2003; van der Westhuysen, 1996; Watson & Fouche, 2007). Universities in South Africa, Botswana, and Namibia all offer mental health relevant degrees ranging from doctoral and masters level training in counseling or clinical psychology to psychiatric nurse training (e.g., Cooper & Nicholas, 2013; Leach et al., 2003; Mwiti & James, 2013; Sidandi et al., 1999). Cooper and Nicholas (2013) made note of the internationally informed history of psychotherapeutic theory in South Africa; that is, they suggested that no one theory dominates treatment. However, those that have risen to prominence have been transported from the West. Mwiti and James (2013) asserted that, in sub-Saharan countries, “the person-centered approach has gained popularity because of the client-therapist relationship as the basis for change and qualities of the therapeutic relationship,” (p. 75) which are compatible with existing African value systems. One theory of psychotherapy, out of South Africa, that approaches this compatibility is the family therapy for schizophrenia offered by Kriztinger, Swartz, Mall, and Asmal (2011). Stockton, Nitza, and Bhusumane (2010), Plattner and Moagi-Gulubane (2010), Sidandi and colleagues (1999) have reflected upon similar developments within therapeutic training and systems of psychotherapy in Botswana. These researchers argue that Western models of psychological care have continued to rise
to prominence in training and in practice (Sidandi et al., 1999; Stockton et al., 2010) and offer ideas as to how such training can be offered in a place where few psychologists live (Plattner & Moagi-Gulubane, 2010). If the few trained and registered psychologists are socialized into a field through a Western lens, it follows that their practice, built upon theories constructed from interaction with primarily white, European groups, would retain a foreign orientation.

Western psychological practice does, however, encourage attention to culture. Sue and Sue (2008) proposed a model of multicultural competence in which clinicians are called to develop knowledge of other cultures with whom they may clinically interact, awareness of one’s own cultural biases, and sets of skills that are appropriately used for intervention. More recently and in a paradigmatic shift away from historical conceptualizations of multicultural competence, Hook, Davis, Owen, Worthington, and Utsey (2013) encouraged psychologists to consider their cultural humility. Cultural humility is conceptualized as a facet of psychologists’ openness to culturally diverse clients and is a component of psychologists’ multicultural orientation, or their attention to the salience of culture in clients’ distress (Owen, Tao, Leach, & Rodolfa, 2011). Training in Western models would ideally include development of awareness, knowledge, and openness regarding diverse. This perspective is particularly useful in settings like Southern Africa; however, a conceptual gap exists in that cultural groups in Southern Africa may not exhibit symptoms, or define them, in ways that are more intelligible to Western trained practitioners. In this way, a sense of cultural competence could remain week and unfulfilled.
**Help-seeking and barriers with the Western-care paradigm.** Patterns of help seeking behaviors within Western systems of care are also worth further consideration. Evidence from other indigenous cultures around the world provide greater insight into various groups’ hesitancies toward seeking Western ways of alleviating psychological discomfort. Research from Australia has suggested that indigenous groups in the country (i.e., Aboriginal tribes) are reluctant to seek psychiatric or psychological care within Western models (Eley et al., 2007). Chinese psychological services, that have developed with the introduction of Western ideas of intervention, have become more readily available and have seen an increase in the frequency of service provision since the 1950s (Chang, Tong, Shi, & Zeng, 2005). However, much of this evidence of increased provision of services appears to come from significantly larger, urban settings, such as Shanghai (Chang et al., 2005).

Flisher, de Beer, and Bokhorst (2002) found that female students at a large university in South Africa were more likely to seek psychotherapeutic services at the university counseling center than were men. Research from South Africa has shown much evidence indicative of communal values that marginalize those experiencing symptoms of mental illness (e.g., Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003; Lupunwana, Simbayi, & Elkonin, 1999). Not only are unique cultural beliefs used to understand the manifestation of mental illness but, it is evident that such values significantly influence the perceptions of those suffering distress. Stigma, as mentioned earlier, is also prominently associated to mental illness in many southern African countries (Kakuma et al., 2012), and some cultures use explanations like being bewitched as a means of avoiding the stigma of psychological discomfort (e.g., Thomas, 2007).
Ascribed stigma certainly has the potential to influence willingness to seek care. Moreover, some cultural social styles may be incongruent with Western therapeutic process, as Vranckx (1999) noted that people in Namibia might “question the wisdom of these clinicians who ask so many questions” (p. 42). Others have historically questioned whether or not the way Western social science asks questions is intuitive within African contexts (e.g., Harkness & Super, 1977). Given the difficulty in measuring variables and testing various concepts in African cultures (Harkness & Super, 1977), it is plausible that the wisdom and intellectual questioning prominent in Westernized psychotherapy may be a poor fit for African ways of thinking about psychology. These represent very realistic barriers to the effectiveness of psychological treatment around the globe, but researchers and practitioners can engage in means of encouraging treatment while maintaining cultural sensitivity.

**Systems of mental health care in Namibia.** Although Namibia has grown with respects to its institutionalized mental health care systems, the difficulties applied psychology endures in an underfunded country are also evident and situated in a context that yearns for greater understanding of psychological needs and treatments. Namibians have endured numerous significant traumas as a whole (Clarence-Smith & Moorsom, 1975; Cooper, 1991; Hayes, Silvester, Wallace, & Hartman, 1998). Some of these experiences, including the civil war for decolonization, have been considered with respect to their potential implications for psychological well-being (Bartholomew, 2012). Although this study focused on the experience of liberation, some of the findings in the qualitative data implicated mental illness within Namibia was, in part, a function of enduring colonial rule and the process of decolonization.
However, little is known of the reality of mental health in Namibia. Feinstein (2002) recommended attention to trauma, HIV/AIDS, and domestic violence when considering Namibian mental health, but he offered little concrete data regarding rates of psychological illness. Ruiz-Casares and her colleagues (2009) found some symptoms of depression among orphaned children, but more comprehensive data (both qualitative and quantitative) is needed to truly understand the needs within the country. Contextual factors and historical experiences in Namibia, therefore, have facilitated conditions in which some people may experience chronic or temporary symptoms of mental illness.

Understanding these needs is complicated further by the realities of mental health as a social institution in Namibia. The Mental Health Policy, published by the Ministry of Health and Social Services, suggests that very little is known of the psychological needs within the county but recognizes that there is a need for greater awareness (MHSS, 2005). Moreover, this document represents mere guidelines and suggestions. Namibian mental health remains legally regulated by a health act from apartheid-run South Africa penned in the 1970s, and to date, no budgetary funds are allocated to mental health in the country. As of 2005, the World Health Organization has pointed to lack of available services in Namibia as well. They have shown statistics indicating Namibia has 2 psychiatrists per 100,000 citizens and 6 psychologists and 6 social workers per 100,000 citizens. With this underwhelming research base, future work is necessary. Primarily, future research in Namibia could benefit by exploring both the perceptions of mental illness within the country as well as the processes by which people are currently alleviating culture-bound syndromes. Moreover, kinship relationships are exceptionally important among many Namibian tribes (e.g., Brown, 2011; Ruiz-Casares, 2010; Tönjes,
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1996; Tvedten, 2004). With this in mind, one can hypothesize that similar systems of indigenous care exist within tribes and communities in Namibia as they do elsewhere in Southern Africa. For mental health concerns to be given more attention here, this research is necessary.

**Indigenous Healing**

Although historical precedent has set the stage for Western psychiatric paradigms to dominate the psychological landscape in Southern Africa, such imposed systems do not overshadow the reality that cultures naturally develop their own systems to cope with and treat diseases and illnesses (Mariarch, 2003). Training models in the south, according to Watson and Fouche (2007), have “an over-reliance on white, Western, Protestant theories,” (p. 155) which facilitates disconnection between training, practice, and care provided to non-white communities. Use of non-contextually developed models of treatment and intervention, though they may be well organized as Western systems of care in South Africa and Botswana, risk overshadowing existing, local theories of healing. Sidandi et al. (1999) suggest that some may believe traditional healing is irreplaceable in that psychiatric medication can ameliorate symptoms whereas indigenous forms of care heal the person. Although these culturally-specific theories of change are useful and, often the preferred means of care, colonial institutions have, historically, outlawed such care in parts of Southern Africa (e.g., South Africa Health Act of 1974). The cultural nature of such care threatened the colonial powers and these means of care were removed.

However, people have continued to seek healing, for many reasons, from traditional healers. In places like South Africa, some have estimated as many as 80% of
the population have sought traditional healing, for some sort of ailment, during their lifetimes (Kahn & Kelly, 2001). Peltzer, Mngqundaniso, and Petros (2006) found that, among those treated by traditional healers for any reason, 14% are seeking to alleviate psychological distress. Additionally, Peltzer and colleagues (2006) asserted that 22.5% of those seeking traditional healing cope with ancestral problems and an additional 21% endure spiritual illness. The efficacy and preference for traditional help-seeking care cannot be divorced from cultural traditions and value systems. Indigenous care in Africa is often more holistic and preventative in nature (Mwiti & James, 2013), which implies it deviates distinctly from reductionist, Westernized models of mental illness. Idowu (1985) suggested that treatment of such mental illness in African contexts can be seen as “full or partial disintegration of individuals, involving not only their emotional or body states but their images of themselves and their relationship to their group” (p. 79). Mental illness, therefore, is part of a system of the individual who, according to ways of being informed by ubuntu and kinship ties, exists through and with others in a given community. Moreover, “traditional practitioners provide culturally appropriate care which is linked to indigenous explanatory models of illness held by many South Africans” (Campbell-Hall et al., 2010, p. 612). As such, the role of kin and social relationships has been documented as a central component of African indigenous healing (Mpofu, Peltzer, & Bojuwoye, 2011). Modalities of care must be culturally relevant. Frank and Frank (1991) argued that the reason psychotherapy works, within the perspective of their contextual model, is because it is a culturally agreed upon theory of change and way of improving well-being. In places that do not promulgate the same explanatory model or sense of agreement upon the utility of Western psychotherapy, other explanations exist.
Much has been written about the traditional systems of care and healing in Southern Africa (e.g., Campbell-Hall et al., 2010; Kahn & Kelly, 2001; Sidandi et al., 1999; Yen & Wilbraham, 2003a; Yen & Wilbraham, 2003b). Kahn and Kelly (2001), for example, outlined the systems of traditional healing within the Xhosa culture in South Africa. Yen and Wilbraham (2003b) also provided insight into indigenous healing among this group as they discussed practitioners reactions to thwasa, or the experience of possession that leads one to becoming a traditional healer (specifically, a diviner).

According to Kahn and Kelly (2001), three types of indigenous healers exist in Xhosa culture: (a) amaggira (diviners), (b) ixhwele (herbalists), and (c) umthandazeli (faith healers). The authors indicated that amaggira and umthandazeli are sought to alleviate psychological concerns. Amaggira do so by using “supernatural powers to explain misfortune and offer guidance on appeasing the shades [or spirits]” (Kahn & Kelly, 2001, p. 38). Such healing often occurs within community and family contexts. Umthandazeli are perceived by the Xhosa as ‘clairvoyant’ and as possessing great healing powers. The ixhwele provide herbal remedies for disease, and although Kahn and Kelly (2001) pointed to amaggira and umthandazeli as the primary healers, holistic approaches in indigenous African healing (Idowu, 1985; Mwiti & James, 2013) suggests that herbal remedies may be a component of psychological care as well. These healers as facilitators of change (i.e., growth of psychological well-being) are representative of who Xhosa people believe to be experts. Although psychologists can accompany such care for some people, attention to these specific peoples as healers cannot be ignored.

Researchers and theorists have also portrayed the processes by which indigenous healers in Southern Africa practice their crafts. Interestingly, and congruent with ubuntu
and an emphasis on interconnectedness, many traditional approaches include the community and the family of the individual being healed (for examples, Berg, 2003; Campbell-Hall et al., 2010; Hewson, 1998; Iwodu, 1985; Sidandi et al., 1999). Campbell-Hall and colleagues (2010) stated specifically, in South Africa, that the traditional healer “provides psychosocial support as well as highlighting areas of conflict in a person’s life” (p. 612). Mzimkulu and Simbayi (2006) provided a more detailed description, developed through a qualitative study of Xhosa traditional healers, regarding the process by which a Xhosa healer treats psychosis. They wrote that treatment begins with an attention to the development of the condition – specifically, whether the disorder is a result of angered ancestors or witchcraft. The traditional healer then asks her or his own ancestors for guidance prior to beginning a cleansing process with the person experiencing mental illness. The authors wrote that “cleansing treatment focuses on the head, stomach and whole body through gabhisa ngentloko (induced vomiting through the nose), gabhisa (induced vomiting through the mouth), futhisa (steaming in herbs), and peyita (a laxative herb mixture used to cleanse the stomach)” (Mzimkulu & Simbayi, 2006, p. 425). This treatment reflects the belief that mental illness, among Xhosa healers, is thought to manifest in a normally functioning person and can be effectively treated through such cleansing (Mzimkulu & Simbayi, 2006). In these portrayals of Xhosa healing, one can see the permeation of African philosophy and a holistic approach to mental health that avoids over-pathologization and emphasizes overall instillation of well-being.

These indigenous treatments in Southern Africa are being provided within the perspectives that are relevant to the cultural actors themselves. Their conceptual understandings of mental illness and treatment, both by traditional practitioners and
within communities, are embraced instead of outlawed or ascribed lesser status as they may be through a Western, (neo-)colonial psychological lens. Such portrayals of Xhosa healing reflect not only the permeation of African philosophy and ways of life, but they also emphasize the avoidance of over-pathologizing mental illness and, instead, focus on the instillation of holistic well-being.

**Integration of Western Approaches & Culturally Relevant Care**

Given contrasting conceptualizations of the amelioration of mental illness across contexts, and certainly across Southern African countries, the question of integration is natural. When Western psychiatric modalities promote categorical diagnoses and avenues of intervention clash with local belief systems and preferences for treatment, psychologists can responsibly seek to understand how local understandings of change can be embedded within existing interventions. Central behind the push for integration is the thought of fluidity between treatment modalities (i.e., indigenous healing and Western psychological approaches). In South Africa, for example, people switch back-and-forth between types of treatment for physical health dependent upon which is perceived to be most efficacious (Lewando Hundt, Stuttaford, & Ngoma, 2004). Alternating to find effective treatments, or the fluid movement between the differential forms of care, could be equally as true for mental health. Farooqi (2006), presenting evidence from a culturally distinct group, found that Pakistanis, especially men, are open to multiple forms of treatment in order to assuage symptoms of mental illness. Similar fluidity may occur in Namibia and other Southern African countries where Western and indigenous practice cohabitate. Statistics indicate high percentages of Africans in this region first resort to traditional healing (Kahn & Kelly, 2001); thus, promoting the dialogue between
Western practitioners and traditional healers could facilitate an encompassing, beneficial avenue of care. Fluidity further implies that the divergent forms of care can co-exist, collaborate, and respectfully refer in productive ways that focus on the well-being of those enduring distress instead of over-valuing one treatment versus the other.

Numerous examples of such integration exist around the globe. James, Noel, Favorite, and Jean (2012), for example, described a program in which Western mental health care providers assisted in the training of lay mental health workers in post-earthquake Haiti. This program, the Lay Mental Health Worker Project or Soulaje Lespri Moun, integrates within-culture representatives who can navigate local value and belief systems while connecting them to Western paradigms of distress. Elsewhere, person-centered therapy, a major Western theory of change, has been shaped for clinical use in Brazil (Freire, Koller, Piason, & da Silva, 2005). Mutual augmentation of traditional and Western treatments have also been called for among indigenous people in China (Leung & Chen, 2009; So, 2005), with Asian groups in the United States (Leong & Lee, 2006), with indigenous groups in Canada (e.g., Duran, 2006; Lavalle & Poole, 2010), and with Latino/a populations in the United States (Comas-Diaz, 2006). Such approaches to integration promote the goal of incorporating the values held by these diverse groups within the intervention strategies of Western clinical work. Thus, the framework of psychotherapy is intelligible to Western trainers and trainees, yet the content therein better matches the experiences and values of the groups being served with the aim of fostering treatment acceptability. What is also significant is the reality that indigenous ideas, from across cultures, are regaining prominence in various social contexts, and
therefore, many diverse clients are seeking the type of psychological care that is culturally attentive and inclusive of indigenous practices (Moodley & Sutherland, 2010).

Integration has also been called for in Southern Africa. Meissner (2004) posed the question of integrating traditional healing into primary care in South Africa. Integration was further explored, qualitatively, by Campbell-Hall and colleagues (2010) with specific attention to mental health. This study showed that several people seek both types of care (Western and indigenous) in order to alleviate symptoms of psychological distress. Merging these approaches, given that people seek both, is only natural. The authors noted, however, that there is a genuine need for better development of evidenced-based models as to how this integration can occur. Theoretically, integration is a sensible approach to alleviating distress, but numerous studies and theorists continue to assert that various challenges exist that halt progress in this regard. Fluidity in movement between Western care and indigenous treatments presents problems in adherence (Campbell-Hall et al., 2010), which conveys the need to find better means, supported by evidence within diverse communities, to promote mutual and integrated practices.

**Challenges of Integration**

Several challenges face the marriage of indigenous healing and Western psychological practice. Bojuwuye and Sodi (2010) called attention to several issues that represent challenges to integration, including epistemological congruency between the practicing parties, attitudinal differences, and the need for greater research on indigenous practices. Primary among the challenges of integration is acceptance of treatments by both parties. That is, Western practitioners accepting the validity of traditional treatment and traditional healers accepting Western practice. Campbell-Hall and colleagues (2010)
suggested that South African indigenous healers were open to integrating their approaches with Western psychologists and psychiatrists; however, this sentiment was poorly reciprocated. Similarly, Kahn and Kelly (2001) found several South African Xhosa psychiatric nurses to be skeptical of the validity of traditional healing; however, Mahape and Peltzer (1998) found that some psychiatric nurses in South Africa favored collaboration with traditional healers. Divergence in these perspectives continues to push existing social institutions (e.g., primary care and mental health care on the politico-national level) outside of the realm of cultural relevance. Instead, psychology remains reduced to a bio-medical model that perpetuates singular problem orientations without maintaining a sense of cultural agreeability. In so doing, psychological practice in Southern Africa risks continuing as an under-sought form of care or prevention because it fails to embrace and become congruent with the cultural values and practices of the people it seeks to help. Forcing somebody into a culturally irrelevant avenue of care has the potential for failure. Moreover, supporting Western psychological practice only risks potential decrease in the number of traditional healers whereas including these practitioners within the purview of genuine psychological care legitimizes their approaches and helps better serve a population for whom this type of care is appropriate and meaningful.

Conclusion

The perceptions of mental illness and the means by which these experiences are treated have unique features in Southern Africa. The literature provided expresses the value of situating mental health, psychological well-being, psychological distress, and psychological treatment within cultural perspectives in order to help bolster congruency
between cultural agents and those providing treatment. Psychologists, as the field continues to internationalize and gain greater attention in places like Southern Africa, can do better to focus on the cultural content (Yen & Wilbraham, 2003a) and phenomenological meanings of symptoms rather than their apparent, surface level appearance. Moving beyond surface level structures of symptomatic expression allows theorists and practitioners to recognize experiences like thwasa have meaning within contexts and that treatment of such experiences as ‘symptomatic’ would be insensitive and inappropriate. Such a movement may also encourage greater attention to the efficacy of various psychological treatments in African contexts, as much of the literature reviewed here does not address treatment efficacy. However, histories of oppression and imposed and underfunded systems of health care have left Southern African theories of change and theories of mental health underdeveloped.

A great deal of attention has also been given to the integration of psychological care and indigenous healing in these contexts. Congruence of indigenous healing within African community values relates to what Bracken (2001) has pointed to as the difficulty that some people from such cultures endure with one-on-one counseling experiences. Considering traditional healing within accepted means of treatment can, ideally, facilitate help seeking for mental illness while not imposing a disagreeable theory of how change occurs. Africans already utilize both forms of care (Campbell-Hall et al., 2010). With people fluidly navigating both systems of psychological treatment, it would be sensible that Western paradigms grow toward respecting traditional healers. Indigenous healers do appear to have an appreciation for the role of Western theories of psychological distress, but such respect is not reciprocated (Kahn & Kelly, 2001) despite both parties aiming
toward the same ultimate goal – distress alleviation. Moreover, augmenting mental health care via integration promotes the validity of indigenous treatments within socio-institutional systems (e.g., health care systems) in Southern Africa that continue to rely upon Western models imposed during colonialism. Integration is not any easy path, however, as Western trained practitioners may remain blinded by the limitations of white, European psychological theories.

Psychologists can further learn from the extended importance of kinship within African contexts. Many of the articles discussed in this review expressed the nature of indigenous healing being grounded in families and communities in so much as relatives and neighbors may engage in the treatment process itself. Engaging communities and kin to make treatments more effective could encourage mental health care to extend beyond hospitals and academia and, instead involve communities while embracing concepts like ubuntu and ancestor reverence as philosophical world views pertinent to mental health. This type of work requires a re-conceptualization of mental health and interventions by Western psychologists. Mental health can come to be alternative understood as the possession of psychological adaptability defined by the appropriate cultural content. In such a way, individuals’ psychological well-being is not defined by foreign theories of illness but is grounded in relevant contexts.
Chapter 3
RESEARCH DESIGN & METHODOLOGY

The study of culture and psychological processes is intimately tied to the methodologies we adopt. Traditional methods in psychology have often overlooked attending to culture as it intersects psychological experience and have, instead, emphasized those methods which seek universality and truth by reducing psychological experience to a common denominator (Bartholomew & Brown, 2012; Berry, Poortinga, Segall, & Dasen, 1992; Cole, 1996; Ægisdóttir, Gerstein, & Çinarbas, 2008; Gardiner & Kosmitzki, 2004; Jahoda & Krewer, 1997; Kim, 1995; Matsumoto, 2001; Merenda, 1994; Pe-Pua, 2006; Shweder, 1999; Yau-Fai Ho, 1994). However, qualitative methods allow researchers to avoid this reductionist approach and instead emphasize rich and thick descriptions of lived experiences as they occur (Creswell, 2013). Ægisdóttir and colleagues (2008) called attention to the need for cultural relevance in the variables and psychological content being studied, specifically, within counseling psychology. Their review of prominent, cross-cultural research helped to draw greater focus to suiting appropriate methods to cultural studies in counseling psychology instead of continued use of culturally mismatched avenues of inquiry. In part, the purpose of this study is to disassociate from universally imposed definitions of mental health, well-being, psychological distress, and treatment for mental illness. As such, reduction of Ovambo mental health to quantified behaviors would fail to address the reality of the experiences of psychological discomfort within this context.

In order to address the purpose of this study (i.e., developing a deep and rich understanding of mental health systems and experiences within Ovambo culture), a
multiple method qualitative design will be used. This design, which will consist of an initial ethnographic phase and a second ethnographically contextualized case study phase, provides a comprehensive and methodologically rich avenue to understand mental health and psychological distress among the Ovambo in Northern Namibia. Using a qualitative approach is also attentive to diverse ways of knowing and being in Namibia, which has been contended as an important methodological issue when conducting psychological research in African contexts (Nsameneng & Dawes, 1998).

**Ethnographic Research**

Ethnography provides researchers with a means of understanding a specific aspect of culture (Creswell, 2013; O’Reilly, 2012). Moreover, the epistemological assumptions of ethnography recognize “the irreducibility of human experience” (O’Reilly, 2012, p. 25); therefore, the confining quantification of human experiences, like mental illness and positive well-being, may result in limited findings. Qualitative ethnography exemplifies an approach in which a researcher can grasp the breadth of human experiences within its contexts. Approaching a construct in this manner allows for a depth of cultural understanding that can be particularly relevant to psychological research. In this study, the aspect of culture being ethnographically examined is mental health among the Ovambo in northern Namibia. The purpose supposes that culture and mental health are inextricably linked to one another and understanding mental health requires a deeper exploration into the cultural norms and values surrounding psychological distress. Ethnographers studying cultural health systems recognize that illness is “constituted by a process of social construction, amenable to sociological description and analysis” (Bloor, 2007, p. 180). Mental health is no differently socio-culturally constructed (Gerstein et al.,
2009; Gone, 2011; Kleinman, 1986), implying that the epistemology of ethnography fits well with this study.

The ultimate purpose of any ethnography is cultural understanding (Creswell, 2013; O’Reilly, 2012). Bourdieu and Wacquant (1992) advocated for an emphasis on studying everyday cultural practices as they relate to theory. Foley (2002) later wrote that researchers studying cultural lives through ethnography base their knowledge of a phenomenon “in the everyday cultural practices of the subjects” (p. 476). As such, researchers only come to know the construct being studied as it manifests specifically within a culture. Systems and descriptions of mental health, as the construct that binds the ethnographic phase of this study, can only be understood as its perceptions manifest within the routine cultural practices of Ovambo culture. This assumption invokes the epistemological assertion that descriptions and states of mental illness only manifest within the culture in which they are constructed. Therefore, the daily practices of culture as they relate to mental health are key to understanding the concept.

Using ethnography to better understand cultural processes in counseling psychology is not a new idea. Suzuki et al. (2005) have previously outlined the effectiveness, and challenges, of ethnographic approaches for counseling psychological research within diverse contexts. Specifically, they stated that, through using ethnography, counseling psychologists are well-equipped to explore relevant psychological experience in “complex environments…where the boundaries of communities are often difficult to determine” (Suzuki et al., 2005, p. 213). The method is well-suited to expanding culturally-relative understandings of mental health.
Many different types of ethnography have been tailored to questions that researchers have intended to answer through interactive, focused field work employing qualitative and quantitative methods within ethnographic epistemology (Atkinson, Coffey, Delamont, Lofland, & Lofland, 2007; O’Reilly, 2012). Creswell (2013), for example, discussed critical and realistic ethnographies as approaches that are politically driven (critical ethnography) versus objective (realistic ethnography). Elsewhere, ethnographic theorists have insinuated that differing worldviews, or epistemologies driving ethnographic research, fosters unique ethnographies, resulting in philosophical integrations of inquiries such as phenomenology and ethnography (Maso, 2007).

Therefore, all ethnographies call for focus on specific, emerging concepts in a culture by providing a lens through which the cultural experiences are interpreted.

Regardless of the specific type, ethnography is an inductive research process (O’Reilly, 2012). In anthropology, Peacock (1986) described the inductive processes of ethnographic research as a means of exploring a given topic but the ways in which this topic is focused upon are not pre-determined. However, O’Reilly (2012) argued that ethnography is not simplistically inductive; that is, a researcher does not decide to observe a community without any directionality or some idea of how to proceed with the methodology. She, instead, described the *iterative-inductive* process of ethnography that is “fluid and flexible” (O’Reilly, 2012, p. 27) but remains directional and purposeful in the designs and field methods. This requires intentional preparation and planning as it relates to the topic being studied as well as the place. Researchers using ethnography must be flexible in their approach. The inductive process allows knowledge of the concept to unfold within the setting (Creswell, 2013).
To begin this *iterative-inductive* process (O’Reilly, 2012), researchers must find access to the site or cultural group being studied in an ethnography. Engaging oneself this way requires the collaboration with key informants or community gate keepers (Creswell, 2013). These key informants, who may also become participants in the study, provide an opportunity for the researcher to build rapport and identify with the cultural group being studied. Classifying participants or respondents as informers is also meant to convey a sense of empowerment for the person providing insight into the object of study (Heyl, 2007). Heyl (2007) stated this is facilitated by the interviewer respectfully and intently listening to the experiences the informant wishes to express. Moreover, these key informants allow researchers to access other community members who can be observed and interviewed to illuminate the construct being studied within the culture. Informants, therefore, lead to the broader community and insights a researcher seeks. However, in this study, what ethnographers typically refer to as informants or gate keepers will be thought of as co-researchers. This idea flows from Moustakas’ (1994) phenomenological approach and recognizes the expertise of informants bring to the research process. Being outside of the Ovambo culture, I will rely on the expertise of my participants and will consider them co-researchers as I collaborate with them on exploring mental health among the Ovambo.

Researchers using ethnographic methods further the inductive process by focusing on researcher observations and individual interviews within the cultural context and unifying construct being studied (Creswell, 2013; Emerson, Fretz, & Shaw, 2007; Heyl, 2007; O’Reilly, 2012). Qualitative research often involves in-depth interviews of participants as this avenue of data collection provides rich understandings of personal
experiences (Creswell, 2013), and ethnography is no different in seeking this depth of knowledge (O’Reilly, 2012; Emerson et al., 2007). However, in ethnography, participant interviews can be both formal (i.e., time set aside for structured, unstructured, or semi-structured [see Creswell, 2013]) interviews, or participant interviews can be conducted during field observations (Emerson et al., 2007). Interviewing while observing participants does not imply a lack of rigor in the method; rather, this process facilitates researchers’ engagement in participants’ lived experiences. A researcher, while immersed in participants’ daily lives, can ask questions as they present themselves, which allows for the inductive research process to unfold and facilitates the researcher’s ability to focus on understanding people within their context. Were a researcher to avoid combining interviews with observations, one might fail to grasp the reality of the construct being studied within the context and even impose the researcher’s own biases by only allowing purely theoretical (i.e., absent of contextual consideration) research questions to guide to data collection.

Ethnographic research cannot be conducted from afar nor can a researcher ever be truly transcended or disconnected from the culture of study (Foley, 2002). That is to say, researchers have attempted to become objective observers of culture to provide a blank-slate approach to analysis, but this is impossible as researchers are inherently prone to write from culturally derived positions (Foley, 2002). Elsewhere, theorists have cautioned against the perception that a qualitative researcher can simply stand above existent cultural biases that impact how qualitative data is analyzed (Creswell, 2013). Critical ethnography provides an approach to understanding culturally-bound phenomena without removing the researcher as a cultural being within the context of analysis (Creswell,
This approach, however, is not the only ethnographic typology that encourages attention to and immersion in culturally informed ways of being. Without some sort of cultural immersion, rich understanding of the construct of study and the cultural group could not come to fruition.

To understand the role of a researcher’s cultural biases and self-perceptions in relation to the culture being ethnographically studied, Foley (2002) discussed the multiple definitions associated to the process of reflexivity. Reflexivity is a broad process which, in a simplistic sense, is a means for an ethnographer to consider his or her position in connection to a context being studied. Although rooted in critical ethnography (Foley, 2002), the concept rings true for much of qualitative research – we can never truly transcend our individual perspectives as researchers because they inherently shape our interpretive processes. Ethnographers, historically, subscribed to the idea that culture can be observed from above and objectively; however, as Spencer (2007) pointed out in a discourse on postmodernism in ethnography, all researchers’ interpretations are informed by their own somewhere, or cultural context. Therefore, an ethnographic researcher must maintain awareness of biases during data collection and analysis.

These elements of ethnography are integrated through the choices the ethnographer makes, and ultimately, lead to an analytic process (Cortazzi, 2007; Emerson et al., 2007) through which a cultural-portrait can be depicted (Creswell, 2013). Within the narratives given via interviews in ethnography, researchers are provided with a glimpse into the life stories of their participants. In these life stories, the reality of one’s cultural context manifests through participants’ respective recollections of their lived experiences which is, in turn, analyzed by the ‘consumer’ (Plummer, 2007). Cortazzi
(2007) stated that ethnographers should analyze narratives within interviews, or the expressions of life stories, to focus on “the meaning of experience, voice, [and] human qualities on personal or professional dimensions” (p. 385) to convey such stories. Lives and contexts are crucial to ethnographic understanding.

Field notes taken by the researcher augment these findings. Researchers can interject their observations and experiences to better frame ethnographic findings in context (Emerson et al., 2007). Van Maanen (1988) described multiple styles of writing field notes, including impressionist tales, in which field notes are organized around striking stories significant to the cultural group and the specific construct being emphasized in the ethnographic exploration. Within this style of writing, researchers can depict the key lived experiences to provide more depth of understanding in the analytic process. Therefore, narrative analysis and reliance upon field notes developed during fieldwork impart great cultural knowledge in order to piece together a contextualized picture of the chosen lived experience being studied. The lives of participants, who are the producers of their cultural stories, in conjunction with contexts and the interpretations made by a researcher, lead to the production of ethnographic analyses.

**Ethnographically Contextualized Case Study**

Ethnographically Contextualized Case Study provides a means of case study analysis with a culturally informed ethnography providing the backdrop for analysis (Gone & Alcántara, 2010). That is, the psychological findings of a given case must be interpreted in conjunction with the idea that psychology is constructed within cultural traditions. Gone & Alcántara (2010), for example, offered a discussion of a Native American woman’s mental health within the context of her tribal heritage. Her tribe
possesses and propagates a set of cultural values and belief systems that influence her construction of her mental health, and these values provide deeper insight to the findings of her case. Clearly, analyzing this participant’s experience as it related to her cultural values provided more depth of understanding into her unique experiences.

Gone and Alcántara (2010) also stated that psychological expressions of culture cannot be understood without some practical cultural knowledge. Therefore, this method relies upon a researcher’s ability to balance two forms of data: “(a) original interview material from single respondents concerning some facet of psychological experience that affords careful and substantive interpretive analysis, and (b) an existing ethnographic record that furnishes details of the historical and cultural context from which interview responses are expressed” (Gone & Alcántara, 2010, p. 159). Integration of these two forms of data, one individually derived and one culturally derived, allows researchers to encapsulate a psychological experience within a cultural perspective. Such an approach allows for researchers to grasp the particular and situational of the given concept, which is ideologically significant in case study research (Yin, 1994). Epistemologically, this approach implies that psychological experience cannot be divorced from the culture in which it manifests; therefore, ethnographic research is the first step forward.

Although the ethnographically contextualized case study method espouses a qualitative means of connecting culture and psychological experience, little guidance is given regarding how this is accomplished. Gone and Alcántara (2010) failed to lay out tangible guidelines for researchers to connect individual interview data to ethnographic contexts. For this study, an ethnographically contextualized case study approach will be merged with the procedures and epistemology of the multiple-case study design (Stake,
2006) because multiple cases of psychological distress among the Ovambo will be considered in-depth. Moreover, merging approaches allows for Stake’s (2006) multiple-case study analysis to provide the underlying structure upon which ethnographic understanding of Ovambo mental health will be built.

**Multiple-Case Study Design**

Multiple-case study research is meant to provide deeper insight into a specific and shared lived experience (Creswell, 2013; Stake, 2006). Each case consists of its own unique experiences significant to the phenomena (or what Stake [2006] refers to as the *quintain*); however, the individual cases are bound by the same phenomenon. In this study, each case will consist of those individuals who are experiencing a culturally identified symptom, or set of symptoms, of psychological distress and members of their contexts (e.g., kin relations and their healers). Individual cases provide the opportunity for distinct insight into the lived experience of psychological distress among the Ovambo. However, by emphasizing a multiple-case study approach, unique experiences across a spectrum of mental illness can be implemented in order to provide a more informative analysis of indigenous mental health among the Ovambo that could not otherwise be developed.

Stake (2006) argued that among the decisions central to the use of a multiple-case study approach is the emphasis of individual case uniqueness with respect to the quintain (i.e., phenomenon) or giving great weight to a cross-case analysis. Because the current study aims to develop a deeper understanding of unique experiences of psychological distress within the Ovambo context, the emphasis within multiple-case study will be in the cross-case analysis. However, cross-case analysis implies multiple levels of analysis
(Stake, 2006). First, a researcher analyzes the individual content of each case (which can, theoretically, include 1 or more participants) of participants, or cases. Second, the research then considers the commonalities across these cases to facilitate an inclusive analysis. An inclusive analysis across cases does not decry the unique nature of each case; rather, it amalgamates the uniqueness of these cases. What is considered the more important philosophical avenue of knowing is the one in which these commonalities are brought to light. In this study, that implies what is more worthy of knowing is the commonalities, or themes across the unique cases. Uncovering the themes of psychological distress among the Ovambo will provide a more complete understanding of how psychological distress is experienced in Northern Namibia.

Although amalgamating data across cases to develop themes within the multiple-case study design is central to this research, Stake (2006) also suggested that “individual cases will often not be organized around the multicase research question” (p. 9). Confining individual cases to the multi-case research questions has the potential to overlook the uniqueness of each case, but Stake (2006) does caution researchers about the balance of a ‘local orientation’ (i.e., emphasizing individual cases) versus consideration of the ties that bind cases to one another. The current study is no different in considering this balance. That is, each case will not be of those individuals experiencing the same set of psychological symptoms. Rather, their unifying construct will be the history of culturally described symptoms of distress and treatment. The local orientation toward individual experience will be balanced with the shared Ovambo cultural meanings for distress and care.
Ultimately, multiple-case study research allows researchers to study unique features of cases that are inherently bound to their contexts (Creswell, 2013; Stake, 2006) – an idea that is further entrenched in the ethnographically contextualized case study method (Gone & Alcántara, 2010). Stake (2006) recommends that 4-10 participants within such unique contexts provide the information to be analyzed in the multiple-case study. Data from a sample of this size will provide depth of understanding of mental illness among the participants, and combining this method with the ethnographically contextualized case study method provides a means by which this data will be tied to the ethnographic data developed in the first phase of the study. The goal of the case study phase is to use a culturally informed method (i.e., Gone & Alcántara, 2010) to bind individual cases (Creswell, 2013; Stake, 2006) to contextually understood perceptions of mental health. A culturally focused research progression such as this is best suited for the questions of this study in that what will be emphasized is how Ovambo people experience mental illness and treat this within the cultural context of Northern Namibia.

Setting

Namibia is home to just over 2 million people (United Nations, 2010), nearly half of whom belong to the Ovambo tribe. Although Khomas, the region which houses Windhoek (Namibia’s capital), is the single-most populated region of the country, the four regions that make up what was historically ‘Ovamboland’ (Ohangwena, Oshikoto, Omusati, and Oshana) is the most densely populated area in Namibia. Ohangwena itself is the second largest region in the country and is the starting site of this study. As recently as 1992, shortly after independence, roughly 70% of Namibia’s population had lived in the North (Hishongwa, 1992); however, this number has steadily decreased with the
urbanization of Namibia (Tvedten, 2004). Figure 1 provides a map with the population of Namibia by region.

Economic stability providers further concern within the Ovambo context. Lower socioeconomic status has been shown to be linked to higher rates of mental illness (e.g., Hudson, 2005). Ovambo culture has historically hinged upon an agro-pastoral, subsistence based structure (Salokoski, 2006; Tönjes, 1996). Namibia as a whole, however, has faced a great deal of poverty, according to the Republic of Namibia’s Central Bureau of Statistics (CBN, 2007). The level of poverty only increases in rural areas in the country, including the north (CBN, 2007). Such pervasive poverty has led to a great deal of migration from the north, and other rural regions, to more industrialized parts of the country – particularly Windhoek and Walvis Bay which offer more work and employment (Tvedten, 2004). Poverty still persists, and as Tvedten (2004) noted, the recent increase in internal migration in Namibia has been the result of many people leaving the North (Ovamboland). In addition, unemployment and underemployment in Namibia have progressively worsened within the regressing global economy (Kanyenze & Lapeyere, 2012). In the Northeastern, rural region of Namibia where poverty is prominent, Ruiz-Casares et al. (2009) found empirical evidence of depression among Namibian children. Although the researchers did not distinctly link poverty, rurality, and mental health, the reality remains that rural areas of Namibia which experience poverty and unemployment may have unique mental health concerns.

Aside from these important contextual and social factors significant to northern Namibia, Ovambo culture and the Namibian context as a whole also endured rapid cultural changes as a function of colonialism from the late 19th century through the late
20th century (Hayes et al., 1998). Moreover, the North was the site of most violence and warfare during decolonization.

This study was completed in Northern Namibia in what was, during colonial rule, named Ovamboland but is now referred to simply as the North. In accordance with ethnographic methods (Creswell, 2013; Emerson et al., 2007; O’Reilly, 2012), I lived in the community, particularly with an Ovambo family on their homestead during the collection and initial analysis of qualitative data. The homestead, which contains multiple huts, two concrete houses, and a cooking area all surrounded by a fence made of tall logs, is located in Eenhana, a village in the north. Although this will be the beginning point of my research, the ethnographic and case study phases required travel to other villages in northern Namibia.

**Participants**

Participants in this study were recruited in multiple phases. Participants consisted of Ovambo tribes-people in the North of Namibia, a traditional healer, and Western-trained practitioners (one of whom is a White Namibian). The initial understanding of cultural perceptions and customs related to mental health and psychological distress gleaned from these participants led to purposeful sampling using maximum variation sampling to interview those Ovambo individuals, as well as their families, who have experienced psychological distress. Participant selection was facilitated by my engagement with the community by living in a village in Northern Namibia, Eenhana, prior to, during, and after data collection for this study. Living in the North with a family allowed me to build rapport with gatekeepers and potential co-researchers in the
community alongside the use of the proper cultural channels for gaining research approval (e.g., support from the Ohangwena regional council).

Interviews were conducted in English or Oshikwanyama, an Ovambo dialect used in northern Namibia. Because I am not fluent in Oshikwanyama, interviews conducted in this language were interpreted by a single interpreter. The interpreter for this study is a 25-year old male who holds a bachelor’s degree and has lived the bulk of his life in Northern Namibia. His awareness of people in the village helped clarify some sampling processes, but he was uninvolved in data collection beyond helping to schedule interviews and interpret them when necessary.

**Ethnographic phase participants**

In the initial ethnographic phase, participants consisted of 22 Ovambo men \( (n = 4) \) and women \( (n = 18) \) who ranged in age from 22 to 57. In addition, I engaged in several informal conversations regarding mental health with people in the North, and the notes taken from these conversations is also used as data in this phase. This sample of formal participants is split into two sub-samples: General Ovambo participants \( (n = 14) \) and Practitioners, both Western-trained \( (n = 7) \) and traditional \( (n = 1) \). General Ovambo participants were purposefully selected based on the following criteria: (a) the ability to express a definition of mental illness, (b) familiarity with treatment systems for psychological distress in Northern Namibia, (c) have lived a significant amount of time in Northern Namibia, and (d) be 19 years of age or older. Individuals currently experiencing invasive psychological distress were excluded from this phase.

Given these specific guidelines, the General Ovambo sub-sample was purposefully selected using maximum variation sampling. Maximum variation sampling
guides researchers to select those individuals who have each experienced the central phenomenon of study but possess diverse perspectives (Creswell, 2013). In this study, the unifying concept was having experience with attitudes toward mental health within Ovambo culture. Incorporating diverse perspectives held by various members of the Ovambo cultural group led to a greater understanding of beliefs about treatment as well as the ways in which people conceptualize the onset of mental illness. Focusing on diversity in beliefs and perspectives allowed for unique and fresh ideas about mental illness to emerge during the inductive ethnographic process.

Interviews with the General Ovambo participants \( (n = 14) \) co-occurred with identification of and interviewing those individuals in Northern Namibia who address and treat mental health disturbances among the Ovambo \( (n = 8) \). These participants were sampled through snow-ball sampling in mental health services agencies and through community contacts. I interviewed seven mental health counselors and one traditional healer. Though they inherently have unique training experiences and view the treatment process differently, incorporating both of these samples allowed for the emergence of an understanding of mental health care that aligned to the perspectives raised by the General Ovambo participants. Practitioner participants were of adult age, had received appropriate training in Western or traditional treatment, and was able to articulate their beliefs about the onset and course of mental illness.

**Case study phase**

The participants in the case study phase were Ovambo men who have previously endured experiences of mental illness described in the ethnographic phase as well as their caregivers and kinship relations. Including individuals and their families in the cases
facilitated greater attention to the role kinship networks have in Ovambo culture. Symptoms within the Ovambo context were understood by ongoing analysis of the ethnographic data. Understanding these symptoms supported the snow-ball sampling used to select individuals who had endured mental illness and their families. Moreover, the community members, healers, and practitioners in the ethnographic phase were a primary source for consultation with respect to sampling cases. That is, each was asked if they knew an individual who had been treated, and if so, these individuals were given my contact information if they were inclined to participate. The inclusion criteria guiding the sampling for this phase is: (a) having a history of experiencing or caring for somebody with psychological distress as defined in the ethnographic phase, (b) seeking or having sought treatment for this psychological distress in Namibia or being related or caring for somebody who has sought treatment, and (c) being 19 years of age or older. Four cases were sampled (Table 3 includes the demographic information of each case). This phase consisted of seven participants, five of whom were formally interviewed and two of whom were informally interviewed. Participants ranged in age from 24-62 and were mostly men (n = 5).

Procedure

This research occurred in two qualitative method phases: (a) an ethnography of Ovambo mental health and (b) a multiple-case study approach, grounded in the ethnographic findings (Figure 2), to explore the lived experience of psychological distress in northern Namibia. Given that the study requires multiple phases, each is outlined independently here. In addition, the ethnographic process of reflexivity is included to position myself within the scope of data collection and analysis and to illuminate those
characteristics and biases I possess which may impact the course of this research. Prior to their participation, each participant was fully informed as to the purpose of the study and given the opportunity to provide or decline consent to participate.

**Ethnographic Reflexivity**

Transcending one’s biases to analyze qualitative data as though the researcher were free of assumptions regarding the topic of study is impossible (Foley, 2002; Maso, 2007). Moreover, to assume one’s biases are irrelevant negates the reality of the lived experienced being studied whether that is in ethnography or any other qualitative approach (Maso, 2007). My biases, informed by both my cultural values and training, are engrained in my perceptions of psychological processes, and although I as a researcher can focus on unique cultural manifestations of psychology, these values and preconceived notions will never be absent from my understanding of mental health among the Ovambo. These biases, however, also align me to the research in a way that can be beneficial in providing an in-depth and rich analysis.

My reflection begins with my cultural value. As a White male living in the United States and coming from a middle class family, I have had a plethora of opportunity to which many people from marginalized groups have not had access. With this privilege, I have had the chance to study Ovambo culture and Namibian history as well as develop a distinct passion and interest for psychological experience in this culture so far from my own. The opportunity to better know psychological experience in Namibia begins with my opportunity to have spent two months conducting qualitative field work in northern Namibia, Ovamboland, during June and July of 2009. What I studied then, the psychology of Namibian liberation (Bartholomew, 2012) and the implications of
economically-motivated child fosterage (Brown & Bartholomew, 2014), exemplifies both my interest in indigenous Namibian and Ovambo psychology, but it also represents the mere fact that I have had the means to travel to another continent and engage with another culture. This is an opportunity that many Namibians, in a country with high rates of unemployment (Kanyenze & Lapeyere, 2012), have not had.

In addition, I also have a clear idea of some avenues of treatment for mental illness in the United States. I have spent four years training in counseling psychology, and although I have often focused on diversity and multiculturalism within therapy, my training is bound by United States and modern Western values ascribed to psychotherapy. In the Western, cultural-majority context, psychotherapy and psychopharmacology are valid means of treatment that are culturally agreed upon methods (Wampold, 2001). I have worked with numerous clients from various contexts in the United States presenting with unique sets of symptoms that warrant individual attention. However, I have, in clinical practice, worked with these clients using specific diagnostic criteria (American Psychiatric Association, 2000; 2013), implying the identification and treatment of markers of psychological distress. My clinical training has been effective and fruitful within the context of the United States; however, the trans-nationality of this training is questionable. That is to say that many of the diagnostic categories and identifiable symptoms I have come to know and work with in a therapeutic relationship may not carry the same meaning for the Ovambo. Failing to recognize this entrenched perspective which has served me well in my context could lead to the over identification of similarity as well as a descriptive approach which seeks to fit Ovambo psychological distress in a Western mold.
My training, as well as my own cultural values, certainly may influence my exploration of Ovambo mental health. However, this reflexive process encourages me to understand the values I bring to my research and, as part of the ethnographic research process, recognize that what I am studying is an inherently culturally bound experience. The understandings I give to psychological distress and treatment are not universal, and therefore, they may be inapplicable for the Ovambo men and women I will interview and observe. My role as a researcher is to appreciate this cultural uniqueness of mental health in the current study and insure my training does not impede or blind knowledge construction in this study.

**Ethnographic Phase**

Although the inductive process of ethnographic research (O’Reilly, 2012) makes a concrete research plan difficult in that deviations may from a given proposal are likely to manifest as the data and understanding of the cultural process of Ovambo mental health evolves. However, the ethnographic phase will begin with my immersion into Ovambo culture by living with an Ovambo family in northern Namibia. Immersion into an Ovambo community in northern Namibia, facilitated by existing community contacts I have already developed, is integral to building a base for ethnographic interviews. Heyl (2007) stated that ethnographic interviewing is different than survey interviewing, and even open-ended interview processes, in that the ethnographer must build a relationship with the participants through duration and frequency – that is length of time in the field and frequent interactions with participants. The procedure for this study begins with building a relationship among an Ovambo community in Northern Namibia by first soliciting approval from the regional council of Ohangwena – the region in which this
research was conducted. Once approval is attained, I immersed myself in the community by focusing primarily upon observations until comfort is built within the community.

Once I had built rapport with multiple community members, I was able to engage in preliminary observations and information conversations about mental illness and its treatment in Northern Namibia. I was able to ask open-ended questions of trusted individuals to develop a sense of those community members, practitioners and otherwise, who would be able to offer their insight into Ovambo beliefs about mental health. These informal conversations and observations also assisted in analysis of the interview data.

After I had begun to conceptualize initial beliefs about Ovambo mental health, I undertook identifying the participants for formal interviews. Formal interviews were conducted with identified co-researchers, or participants, (Creswell, 2013) who possess knowledge specific to the cultural belief systems surrounding mental health among the Ovambo. General Ovambo participants were interviewed first and assisted in leading me to identification of a traditional healer and Western-trained practitioners. Each participant was interviewed using a semi-structured interview protocol. Though most of the participants were interviewed individually, six of the General Ovambo participants were interviewed as a focus group. These protocols were unique for the General Ovambo participants and the Practitioner participants. The questions for these interviews included “what beliefs do you have about psychological problems?,” “how do you know if somebody has mental illness?,” “how are those people with mental illness perceived in the community?,” “how do you describe mental illness?,” and “how are psychological concerns resolved?” Each interview protocol was translated from English to Oshiwambo by a single Ovambo individual in the case that participants preferred to be interviewed in
Oshiwambo with the assistance of a translator. These translations were then translated back into English by a separate Ovambo individual. Translations were then compared to the original English questions and determined to be accurately translated and appropriate for use in a translated interview. All questions for the ethnographic interviews can be found in Appendices A-H. Unwritten informed consent was obtained prior to each formal interview. Interviews were ongoing over the course of my three-month time-span in the field.

**Ethnographically Contextualized Case Study Phase**

The multiple-case study phase of this research began after initial ideas about mental illness had emerged from the qualitative data collection. Cultural understanding of mental health and its treatment among the Ovambo allowed me to collaborate with community members to identify those people who had experienced and been treated for mental illness. In this way, even though ethnographic interviews were ongoing at the time of case study interviews, the findings from the ethnographic phase influenced who was sampled for the second phase as well as the questions asked of these participants. Each of the four cases consisted of the family of the individual who had been treated, the individual who had been treated, or both the individual and the person’s family. Participants across the cases were formally \((n = 5)\) and informally \((n = 2)\) interviewed.

Each participant in the case study phase was interviewed individually in Northern Namibia. They were also given the opportunity to select the setting to participate. Interview locations included a fish shop, multiple homes, and seating areas outside of cuca shops. All participants consent to participate prior to being asked any questions and were instructed that their responses were entirely voluntary and confidential. Interviews
were semi-structured and open-ended to facilitate the emergence of each participant’s life history with respect to mental health. Separate interview protocols will be used for family members and those individuals who have endured and sought treatment for mental illness. These interview protocols were translated and back translated in the same procedures detailed for the ethnographic interview protocols. Both translations were found to be accurate and appropriate for use in Oshiwambo translated interviews (Appendices E, F, G, and H for these interview protocols). Questions to be asked during the individual interviews, expected to last 40-90 minutes, consist of “How did you know there was something psychological you were struggling with?,” “how were you received in your community as a result of your mental illness?,” “how did you decide when and from whom to seek treatment?”, and “what roles did Ovambo and Western treatments play for you?” Questions were also shaped by the ethnographic findings as they developed. For example, one case was selected on the basis of a history of attempted suicide, as suicide was a common finding in the ethnographic data. This led to questions specific to suicidal ideation.

**Data Analysis**

Prior to any data analysis, regardless of the phase, I re-engaged in the reflexive process in order to remain aware of my biases that may influence qualitative interpretation. Given that the data in this study was collected in two phases, participants’ data from the ethnographic and case study phases will be analyzed sequentially. Analysis of the ethnographic data will provide a cultural portrait (Creswell, 2013) of Ovambo value systems ascribed to mental health which will provide the context of understanding for the multiple-case phase. Both phases of analysis were guided by the tenants of the
respective method; that is, suggestions for ethnographic analysis (Cortazzi, 2007; Creswell, 2013; Emerson et al., 2007; Madison, 2005) and suggestions for multiple-case study analysis (Stake, 2006).

Because it serves as the basis for the identification of Ovambo people experiencing culturally relevant psychological distress, the ethnographic data was analyzed first. All data, observational field notes, notes from informal interviews, and transcriptions of formal, semi-structured interviews were horizontalized; that is, I read through all the data to identify those factors that are significant to the meaning system surrounding mental health among the Ovambo. This process gave way to the construction of a cultural depiction of Ovambo culture, including the physical settings relevant to mental health (Creswell, 2013). Additionally, significant statements and significant field notes will be interpreted into meaning units. These meaning units were then grouped together into themes or patterns that are indicative of Ovambo cultural values pertinent to mental health and therapeutic practices. Identification of codes, interpretation of meaning units, and aggregation of these into themes is advocated in ethnographic methods (Creswell, 2013; Madison, 2005). Thematic narratives serve as an avenue to understand how mental health ‘works’ within Ovambo culture.

The ethnographic data is also separated based upon type of participant. That is, thematic analysis for the General Ovambo participants and the Practitioner (Westernized and traditional) are presented independently. Although they are naturally related to one another, they represent responses to distinct questions that, when integrated, form an overall cultural portrait of mental illness and its treatment in Northern Namibia. The cultural portrait is included in Chapter Four.
Although the ethnographically contextualized case study method provides no specific information with regards to analytic approaches, Stake (2006) has provided detailed information as to how multiple-case study data can be analyzed individually and across cases. Creswell (2013) suggests the analysis of single case or multiple cases ought to begin with a narrative description of the case itself; therefore, each of the cases in this research is depicted with respect to the person being interviewed, her or his context within Ovambo culture, and her or his lived experience of psychological distress. After these narratives were crafted, the transcripts of the individual interviews from each case were analyzed using coding and thematic analysis. Stake (1995) has previously referred to this as case aggregation, but more recently refers to this as an analytic strategy in which researchers focus on the cross-case analysis of data (Stake, 2006). In so doing, the findings are aggregated into patterns, or themes. Identification of themes, or patterns experienced across individuals relevant to the phenomenon or quintain (Stake, 2006), begins with identification of significant statements. All significant statements from the cases were be interpreted into meaning units and then grouped into themes in order to encapsulate the experience of living with psychological distress in Ovambo culture across the participants in this study’s cases. Because the data from both phases were analyzed separately, though the case study data were interpreted with respect to the ethnographic findings, the analyses are presented independently from one another in Chapter Four.

**Qualitative Validation**

Because qualitative methods do not rely upon standards of reliability and validity, several steps in this study will be undertaken in order to insure the verification. Specifically, I employed three of Creswell’s (2013) standards for validation across both
phases. First, I used the field notes I took during data collection and existing South African mental health literature to triangulate findings in order to more fully interpret participants’ lived experiences of mental health in context. Second, all research findings were discussed with cultural informants, while I am in the field, after each phase. This process of member checking (Creswell, 2013) will assist in crafting more representative ethnographic and case study thematic narratives by allowing the voices of participants to be more prominent. Member checking also allowed me to insure that my biases addressed during reflexivity did not undermine or overpower the reality of Ovambo mental health. For example, I reflected on my training as a Western psychology trainee who routinely conducts psychotherapy. My bias for this as a treatment modality was consistently attended to when discussing the role of traditional healing and the nature of witchcraft in mental health. Attention to the voices of participants also led to my discussion of ideas about mental illness development being rooted in the cultural prescription of behaviors. Lastly, all findings were critiqued via a peer review process that led to agreement on the analyses presented. Lincoln and Guba (1985) advocated for a peer reviewer who pushes the researcher in her or his questioning of the findings, which “keeps the researcher honest” (Creswell, 2007, p. 208) in her or his interpretations. The person conducting the peer review for this study was a qualitatively trained psychologist familiar with the Ovambo context and culturally driven research. Feedback from the peer reviewer was incorporated in thematic narratives where appropriate.
Chapter 4

RESULTS

Though analysis was ongoing during the fieldwork with respect to shifting the content of questions I asked (e.g., a developed attention to suicidality), formal analysis began with the ethnographic data. I transcribed formal interviews verbatim, resulting in 107 single-spaced pages of transcribed formal interviews. Formal interviews conducted in Oshiwambo were transcribed only with the English translation from the interpreter. Those statements pertinent to beliefs about psychological distress as well as mental health care were identified in each interview and coded into meaning units. This resulted in the identification and interpretation of 642 meaning units for the ethnographic phase. Thematic analysis was conducted independently for the General Ovambo participants and the Practitioner Participants. Analysis of the General Ovambo participants’ data led to the identification of the following themes: (a) Where Madness Comes From: Witches, Sickness, and Other Explanations, (b) Omananamwengu and Eemwengu, (c) The Role of Families and Communities for Omananamwengu and Distress, (d) Witchdoctors, Frauds, and Odudu, (e) Counseling, Medicine, and Religion as Means for Healing, and (f) Seeking Care: Decisions Based on Belief and Need. Thematic analysis of the Practitioner participants’ expressions led to the identification of the following themes: (a) Mental Health Services in the North, (b) Traditional Beliefs and Healing, (c) Explaining Mental Illness through Modern and Traditional Lenses, and (d) Integration of Treatment Modalities. The cultural portrait of mental illness and its treatment in Northern Namibia is presented as an integration of the thematic findings from these two samples. Tables 1 and 2 provide examples of the significant statements and meaning units for each theme.
Ethnographic Phase: General Ovambo Thematic Findings

The participants labeled as General Ovambo participants are those who were asked to articulate general beliefs about mental illness and its treatment in Ovambo culture. Specifically, the interview questions were guided by an aim to understand overarching Ovambo belief systems related to the development, perceptions, and treatment of mental illness. The thematic findings indicate a dynamic construction of these beliefs and the ways in which cultural tradition and modern developments have influenced conceptualizations of psychological problems.

Where Madness Comes From: Witching, Sickness, and Other Explanations

Prominent among the General Ovambo participants’ expressions about mental illness was a balance between traditional explanations and modern ideas about how mental illness comes to be. That is, many reported adherence to old ways – in which it is believed that being witched by other Ovambos or experiencing a disconnect between oneself and one’s ancestors prompts the onset of mental illness. Explanations also surround interfering with other people – that is, stealing from others or “touching people’s things” was frequently cited as a primary avenue through which somebody would be cursed. This is balanced by Westernized beliefs that spawn from colonialism, the Church, and the proliferation of Westernized education offered to younger Namibians. Modernization through Western influences has left many with an understanding of the development of mental illness that is medical in nature. However, all participants identified mental illness as madness, regardless of whether the source was magic or illness. This concept is substantially divergent from the plethora of psychological diagnoses available in Western literature and practice.
**Witching and Curses.** All participants in this phase of the research alluded to the prominent belief that mental illness, or madness, is brought on by a person having been witched or cursed. Often, participants categorized witching and cursing as magic or magical things. The emphasis on witchcraft was clear, as one participant expressed that “if someone becomes mad, or mentally unstable, normally it’s linked to witchcraft,” reflecting the common nature of this belief in Ovambo culture. Interestingly, ideas about witching and being cursed were instilled in participants at a very young age: “When I was young, that age, nay, my parents always tell me while I’m growing up – to us we just say it’s a witched person. It’s a mad one.” According to one participant, witching and cursing were used as general explanations for hard times in one’s life. He indicated that the Ovambo do not believe in psychological problems; rather, “They say ‘no I’m drinking beer [all the] time, then I might be stressed,’ and they think ‘I’m bewitched to drink alcohol.’ So many people, still in Africa, don’t believe in those psychological things.” Another participant echoed this sentiment as he described a cultural belief system in which people cannot often identify the cause of mental illness and instead express it as a function of being witched. This participant stated that “if they believe in African culture that people can witch other people…you can hear people saying ‘no that one is mentally ill because he was witched.’” This idea of being witched instead of mentally ill is further complicated by it being “something one can[not] prove.” The experience of psychological distress becomes abstracted from the individual as ascribed to an external force weighing on and determining the maladaptive behaviors of the person himself or herself. Because “the belief is that [mental illness is] never a clinical problem,” cultural understandings of psychological distress become situated in the realm of witches and
curses. Situating explanations of mental illness in this abstracted realm imparts a sense that psychological problems are “magical things [and] magical matters.” Moreover, these expressions reflect a historical belief among the Ovambo that illness is not a product of one’s own lived experience or physical state and is, instead, entirely generated from these magical matters.

How one became witched or cursed also serves as an interesting place of analysis. Some felt as though witching came from somebody “trying to get rich,” suggesting that greed itself was a primary reason a person would become witched. Apparent in participants’ beliefs about how one becomes witched was the idea that seeking financial gain through magic would lead to a person being cursed. One participant described this process:

You want to become rich, for example, or maybe you want to be a tycoon.

Then you come to me, because I am a [witch], I know how to make people rich, and I will tell you: ‘you should go and do that and that and that.’ If you miss, now, doing some of the things that I told you to do as a witchcraft, then you become mad.

In such instances, a curse is not placed on somebody by another Ovambo. Rather, the belief shapes behaviors by preventing individuals from being greedy or seeking gain above others. Even those who attempt to become a witch out of desire for personal gain may fall prey to being cursed if the prescribed procedures are not abided by exactly. Failure to attend to the exact procedures for financial gain, becoming a witch, or any other desire can leave of a person “[ending] up mad.” Another story provided with regard to how one becomes cursed is related to childbirth. One participant described a situation
in which women become cursed by not leaving the room where they gave birth shortly after a child is born. Those women who leave the room too early become cursed and go mad. Potentially, attaching the idea of witching and being cursed to greed or specific post-childbirth behaviors represents a cultural prescription for behaviors.

Alternative accounts for one being witched or curse lie in the interpersonal interactions between the Ovambo. Some people will seek out a witchdoctor in order to actually witch another person: “Some people do witch others for certain reasons known to them. You will see a normal person and just like that someone become mentally ill.” Some Ovambo actively seek out vengeance on other families or individuals as a means to correct perceived transgressions, so these people “say I lost something from my brother from this other family.” These transgressions are brought to somebody, a witchdoctor or traditional healer, who has the power to place curses on others: “[The] traditional healer says ‘what is it you want me to do for you.’ Then they say ‘I want this family to be die, to be sick people, to be mad.’” Jealousy was also used as a reasoning as to why a person could be cursed. That is, if one Ovambo sees another person as “a successful businessman,” a person could be led to seek a witchdoctor to curse the successful person because “they are jealous of him.”

**Disconnecting from ancestors.** Some participants also described the rich role of ancestors in Ovambo life and culture. The exact process by which ancestors make a person mentally ill appear unclear; however, several believed that the Ovambo develop psychological distress “through the ancestors.” When a person is “hearing [ancestor’s] voices, [the person] must talk to elders then do something to disconnect that voice between [the] ancestors.” Failing to disconnect oneself from ancestors’ voices leads to
hearing ongoing voices from angered ancestors; thus, it appears that ancestors, in Ovambo culture, interact with people out of malice rather than out of care.

The belief that being plagued with the voices of one’s ancestors is further reflected in the importance of revering one’s own ancestors for purposes of protection. One participant characterized the importance of attending to and respecting one’s ancestors as well as the consequences that manifest when this respect is not paid: “us Ovambos we normally believe on our ancestors. We think they are the ones who protect us. We think they are the ones who provide [for] us. If you are not humble to them, then we lose that protection.” Losing protection from one’s ancestors by not engaging in rituals, like offering food or drink to them in reverence, leads to the potential for their voices to foster discontent in an individual. Ancestors that become angry “make you go their way,” such that one may die or go mad.

“Touching others’ things.” Stealing or meddling in other people’s things or affairs also appears to be a way of understanding the onset mental illness. Cultural beliefs dictate that one should not touch those things belonging to another person without serious consequence. One participant described this concept being instilled in her as a child: “the culture where I was growing up, my family tribe, we cannot touch someone’s things, property. Because the family said you touch some from [another] tribe, you’re going to be mad…you’re going to be crazy. You cannot touch it.” This same participant, as well as others, expressed concern that if they were to touch ‘things’ belonging to another person, madness would ensue. Interestingly, this curse from touching other people’s belongings can pass across generations, as those “who are cursed are just getting cursed
because a long time ago their family was cursed,” because one member had touched something belonging to another family.

More explicitly, stealing is also directly tied to one being cursed. A general belief that theft leads to madness as a function of a curse is clear: “Most of the people who are mentally ill, they once tried to took something that did not belong to him.” People who are mentally ill are potentially believed to have stolen from others, whether that be out of greed or another reason. Moreover, the lesson about stealing and touching others’ things appears to be a lesson learned in youth. Participants expressed having learned this idea from parents, that they will become mad if they steal from others or touch others’ things.

**Religion, sickness, and emotional duress explanations.** Though traditional explanations were prominent and expressed by each participant, religion and other modern explanations influenced the importance of traditional beliefs. Specifically, “if you are Christian and you believe in god, you must leave those [beliefs],” behind because of their sinful, non-Christian nature. Those subscribing to Westernized, Christian beliefs view mental illness as demonic rather than explaining it through curses: “[if] you are talking like that, I’ll say it’s a demon. Then I will take you to Church. I will pray for you.” Although the belief changes to better suit a colonized mindset, a religious explanation still removes the onset of mental illness into a realm that is not tangible. Labeling the mentally ill as demonic still represents a certain mysticism; however, many participants expressed a sense that their being “born again Christians” or holding Christian faith is preventative in their attaching themselves to traditional explanations for mental illness. Participants do, however, remain aware of tradition and observe these explanations in Ovambo culture despite its intersection with Christianity.
Few of the participants “look at [mental illness] like a person just sick,” indicating that there are explanations that exist within individuals rather than purely external forces accounting for mental illness. Participants who expressed that psychological symptoms spring from illness also indicated that certain emotional experiences may lead to the onset of distress. Psychological trauma from the Namibian liberation war, living in exile during the liberation struggle, and domestic violence were all life experiences discussed that participants thought could contribute to a person’s development of mental illness. Those who have developed this more psychological conceptualization of the onset of mental illness are also considered to be more educated – those who go to school leave behind tradition. Additionally, several participants discussed divergent views on alcoholism as an explanation for psychological distress. Most felt it was not a symptom or experience of psychological distress, yet some felt as though “alcoholism also leads to mental problems,” because it incites abnormal behavior in people. Although these few participants were able to discuss illness, emotional trauma, and alcoholism as sources of psychological distress, Ovambo cultural beliefs are never free from tradition. One participant, for example, stated that there are several “competing [circumstance] for mental illness,” including witchcraft, alcohol, and stress. Thus, clarity in terms of how mental illness is explained is often muddied.

**The timing and gender of mental illness development.** Participants also described, in generalities, their beliefs about the time of onset and other demographic factors related to the development of psychological problems. Although these participants were mixed with respect to their identification of a specific gender experiencing mental illness more often, several were able to articulate their beliefs as to why men or women
were more prone to mental illness. Those who stated men were more likely to develop psychological distress believed that this was a function of masculinity preventing men from expressing their feelings.

Age was also cited as an important component of the development of mental illness. Those participants who were able to identify an age group in which the mentally ill fall stated the state develops “from 18 and above,” “around 30 upward,” or from “maybe 20 and above.” Though the reasoning behind the age delineation is less clear without consideration of other findings, confining the onset of mental illness to adulthood aligns with many of explanatory mechanisms for its development. Greed, jealousy, and stealing may be more serious during adulthood and taken as a greater disruption of group cohesion or harmony. Moreover, the visibility of the mentally ill may become more apparent in adulthood when individuals are no longer under the supervision of confinement of their families.

Though various explanations for mental illness emerged throughout these interviews, central were ideas about witches and curses. These beliefs were recognized, and held to at least minor degrees, in all participants including those who felt themselves more aligned to Christian or Westernized ideas about mental illness. Within each of these explanations, however, is an interesting idea – the singularity of mental illness in Ovambo culture. Participants explained the development of madness rather than exploring specific disorders that might be intelligible in Western theory and practice.

Omananamwengu and Eemwengu

The narrow culmination of what leads to mental illness is best exemplified by the Oshikwanyama term omananamwengu, which translates to madness in English.
*Omananamwengu* is analogous to mental illness in that it encapsulates all Ovambo understanding and cultural beliefs about mental illness and psychological distress. No participants identified depression, anxiety, psychosis, or other deficit-oriented psychological state. All symptoms that were indicative of psychological distress to participants were encompassed by madness with *eemwengu*, the mad one (or person), being used to label the individual. These individuals are readily visible and identifiable in Ovambo culture. They are apparent “in society even if they are walking around and doing certain things that you see he is crazy they are never confined.” Confinement of the psychologically impaired itself is a negative idea despite the extent to which those labeled as *eemwengu* are undervalued in Ovambo culture. Being identified as *eemwengu* also carries the belief that one was witched – an Ovambo person does not simply become *eemwengu*, according to generally held beliefs. Although people most often believe the state comes from bewitchment, those who believe in more medical and psychological conceptualizations of mental illness also identify *omananamwengu* as the only observable psychologically distressed state. The idea of madness clearly represents a culturally constructed symptom cluster, or syndrome, that consists of unique symptoms and carries very negative value in Ovambo society.

Several key symptoms (see Table 5 for a list of symptoms identified in the analysis of data from both phases of this research) emerged as identifiable, abnormal behaviors that would lead an Ovambo person to identify another Ovambo as being *eemwengu*. Behavioral presentations of symptoms are key in Ovambo identification of *omananamwengu* as one can identify a mad person based on “the things the person does,” that are beyond normal Ovambo behaviors. Those people who exhibit “inappropriate
manner” are said to hear voices, see people who are not there, and run quickly from place to place. Similarly, omananamwengu also entails individuals simply talking too much. That is, eemwengu individuals may “talk nonsense things [and] can talk for the whole day.” Others engage in disorganized behaviors or search for food in dumpsters in the village rather than taking meals with their respective families. Additionally, people labeled as eemwengu express grandiose delusions of self, and are often proclaiming “‘I want to be rich,’ or something, ‘I have a lot of business,’ you see. In fact, the things are not there.” Part of this grandiosity stems from a lack of self-awareness among those who are mad. The family and friends of a mad person are responsible for identifying these behaviors in the individual as “those who are mad right now, only few of them understand [their] mental illness.”

Violence was also often identified as a clear indicator of madness. One participant described his cousin, who was living in his parents’ house at the time, as mad as well as exceptionally violent and strong: “you can’t even imagine what that was like. Taking two men down at the same time, like if I’m holding her and my other cousin maybe holding her down and she’s starting to beat people.” Another participant described her eemwengu neighbor when she was a child as somebody she was taught to fear because “he will beat you when you come from school.” Verbal abuse also accompanies this feared physical violence: “the person can insult just unnecessarily. Sometimes he can insult, just throwing the words in the air…that is a sign of a person being mad.” Cultural beliefs and lived experiences dictate a sense of fear and perception that psychologically ill people are inherently dangerous. Some even fear that those who are mad will beat children, and as a
result, “some [eemwengu] are walking just around chains because people are very afraid for them to run around, to beat people.”

Violence is also seen as a symptom of omananamwengu that is largely specific to men (though one participant described an eemwengu woman who was violent). Symptoms are also more readily observable according to gender lines. Beyond violence being more common among men, women are considered to “talk too much” far more often than mentally ill men.

Where some individuals considered to be mad are violent and potentially dangerous to others in an Ovambo community, some people suffering from omananamwengu are socially isolated. Some individuals become “quiet, not talking,” in situations where an Ovambo person might normally be vocal. Those who become quiet and do not talk are also commonly withdrawn from others. Such people experience a type of isolation and loneliness that is not prominent in an Ovambo society that normally consists of extended, supportive kin networks. Eemwengu itself is also an isolating term. Specifically, the Ovambo refer to somebody as mad to separate those who act abnormally from the group. Using eemwengu to describe a person is “offensive because someone [tell] them, like, you are a person of a different group. You are saying [they] are not part of everyone.” Being pushed from the whole or the group constitutes a substantial insult in Ovambo culture. The “whole life of a person is lost” as a result of being mentally ill and being isolated, which grows from one’s own symptoms and one’s place in Ovambo society.
The Role of Families and Communities for Omananamwengu & Distress

Because those Ovambo labeled as eemwengu are inherently marginalized in society due to the isolating term, understanding the position of psychologically distressed individuals in society is essential. How people interact with those suffering mental illness varies greatly within the Ovambo context. Many believe that these individuals are well cared for by families whereas others perceive them as directly removed from society and even chained in isolate to prevent them from interacting with members of the community. Acceptance and support of a mentally ill person is not necessarily uncommon; however, it depends immensely on the disposition and availability of the person’s family. Additionally, peer and kin relationships among the Ovambo are related to emerging and increasing rates of suicide in Namibia.

Many participants reported positive social experiences with respect to the role of families and communities in the lives of individuals labeled as mad. Primarily, social acceptance and support, according to some participants, is built into Ovambo family structures: “there is somebody who is going to relieve me of that place so I’m in a position to recuperate or whatever…someone, somewhere there that I can always share with. You don’t have an institution or need for a psychologist.” Thus, families are seen as a naturally occurring, supportive social institution that acts in times of need when one member begins to suffer symptoms of mental illness. Participants contended that “the family always try their very best” to help and societal norms of helping other members of one’s family fosters this desire to take care of one’s own. Families are also responsible for securing the treatment of an individual they consider to be mad. Members of one’s family, often the elders, decide on when treatment should be sought and where this
treatment should be found: “So they can go to witchdoctor or they can go to the hospital where he can be given his pills and something,” depending on the preference of the family. Families “want their family member to be part of their family even though at times they might go wild and two or three days might go past before they find the person.” For these families, medicine and hospitals become mistrusted sources of care because it is through the support of one’s family that one becomes well. This caring mechanism and desire to maintain a family structure is largely responsible for those instances in which a family is truly accepting and understanding as well as helpful when one of its members develops omananamwengu. Although this help may not always be accepted by the person who is psychologically suffering, many families are intentional in providing any support possible.

The tendency to care for those in distress can also extend outside of the family. Those who have the opportunity to speak about psychological distress with friends “get better by talking it through,” and others are informed of useful treatment information by interacting with other members of the community. Additionally, friends and members of the community also play a pivotal role for families attempting to help one member suffering from mental illness. Family members are often unaware of available traditional healers, if this type of treatment is preferred by the family. As a result, many seek consult with people close to the family who may know where to find traditional healers. At times, small amounts of help are offered by community members to those considered to be eemwengu.

Ovambo society provides some avenues, even outside of families, to offer support and care for those who are enduring mental illness, but social support is certainly not
guaranteed. Rather, very often, *eemwengu* are treated poorly and extremely marginalized by other Ovambo. The insulting nature of the term is observed in the way that *eemwengu* are mistreated in town – where men are sometimes chained out of fear and women are raped and taken advantage of because of their weakness. The Ovambo often “look at [the mentally ill] like they are a weak person. Like you are weak and unable to handle your own problems.” Labeling the mentally ill as weak leads to perceptions of these people as useless. They become “just a useless person in the family…[people are] waiting for him or her to die.” Further, the mentally ill are often pushed to the margins of Ovambo society as the government does little to help: “Because you cannot kill a person, they are just there to die. They are useless and to [others], it’s not about his rights – just a useless person!”

The extent of social isolation and removal from society can be observed in families. Though some try their hardest to care for those who suffer psychological concerns, others simply do not. Family and kin are responsible for caring for the mentally ill, but many worry that by associating with a person labeled as *eemwengu*, they too will develop this syndrome. Because of this fear, “some family will want to hide that person to be seen by other people. Some of them will send them to cattle post.” Being put deep into the forest hides this person from contact with other community members and places the person’s abnormal behavior outside the visibility of a family. As such, *eemwengu* people fall further into isolation and are given none of the necessary care to overcome their symptoms, merely because they do not function in a way normal Ovambo ought to function.
Social relationships in Ovambo culture are immensely influential to the psychological well-being of its people. Suicidal ideation is the best representation of the influence social relationships have on people’s psychological mindsets. Some individuals expressed that suicide accompanied the auditory hallucinations indicative of *omananamwengu*; however, suicide is also linked to deteriorations in interpersonal relationships. A person could “get disappointed even by a boyfriend or mother or sister then she hung herself.” Although suicide rates are high in Namibia to the point that suicide is discussed openly in newspaper articles, the Ovambo do not often directly tie it to mental illness. Instead, it is posed as a way of righting wrongs that occur in interpersonal relationships. Thus, a link between interpersonal relationships, social processes, and distress comes to the surface by means of suicidal ideation.

The Ovambo pride themselves on fostering strong kin ties and community connections. Though these connections are real and formidable in their own right, they have the potential to falter with respect to caring for the mentally ill. Some families make significant efforts to care for their ‘mad ones’ whereas other communities and families ostracize and hide their suffering members. Certainly, social and familial relationships play a substantial role in how those suffering psychological problems are treated inside families and communities; they also represent a guiding force in the management of illness through choosing types of treatment.

**Witchdoctors, Frauds, and *Odudu***

To many Ovambo, “seeing a traditional healer is the norm,” and is an acceptable practice when it comes to the treatment of mental illness – “those mad people, they just send them to the [traditional healer] and they give them something.” Traditional healing,
however, is fraught with a great deal of complex dynamics. Namibian culture, including those cultural groups beyond the Ovambo, has seen a proliferation of traditional healers. Several are advertised in newspaper classifieds, promising riches and sexual prowess. However, these ‘new’ healers stand in the face of tradition and throw it aside in favor of profit and false promise. What constitutes a traditional healer is exceptionally variable in Namibia and in Ovambo culture. People see witchdoctors, frauds, and traditional healers – odudu in Oshikwanyama – for varying reasons. Odudu are the only practitioners among this group that are guided by tradition and belief. The others, in some way, feed upon the desires of a village, town, or person for their own gain, creating substantial problems and misperceptions regarding the nature of traditional healing.

False healers and witches. One participant laughed at the concept of traditional healers in today’s Ovambo culture. He expressed his disbelief in ‘traditional healing’:

My friend, we are in the lost world right now. I keep on telling people that there’s no traditional healers. Those people are here to have money. They are even saying [they can cure] bad luck and [provide] job opportunities. Like me myself, I’m working for my graduation in September, they are saying that they can get jobs for me. They can get evil spirits. They can bring back a lost lover within 24 hours. How is that?

These new healers are driven by monetary gain, and as a result, promise a great deal of unattainable things to the people who desperately seek their help. These fake traditional healers, who can also be referred to as witchdoctors, function because people choose to believe them: “It’s an easy way to go make money because the only thing you need is for this person to believe that you are going to heal them.” This belief, which may
be driven by greed or some other self-serving goal, is largely what makes it difficult to
determine the difference between a fraud and a true healer. However, one can more easily
delineate the difference by assessing how much the supposed healer is charging – too
much, and it is likely a fraud, whereas “true traditional healers they don’t charge people
too much because they don’t make a living from people.” Because of the false promises
offered, many Ovambo believe that the practice of witchdoctor’s should be considered “a
crime” as it drains people of their resources and pushes traditional healers away from the
people. The selfishness of the frauds is what prevents them from serving the purpose of a
cultural healing tradition – to promote the wellness of an individual and retain the
harmony of a community.

Witchdoctors, however, are not without power in Ovambo culture. Those with
powers that are considered witchdoctors “have power but they are not using it for good.
They are using it for bad.” Their powers often are used “to curse people, or help curse
people,” rather than providing some sort of healing experience. Witchdoctors also cause
duress in broader communities and between Ovambo families. For example, traditional
healers and witchdoctors are often believed to carry a gift of sight – being able to know
about a person and her or his life without having asked any questions. One area in which
this gift of sight is relevant beyond identifying ailments is identifying the source of an
Ovambo person’s curse. For instance, a man believes he is cursed, so he is inclined to
pursue treatment in-line with a belief about cursing. This brings him to a witchdoctor or a
traditional healer (odudu) to lift the curse. Ovambo beliefs dictate that it is plausible this
man was cursed by another member of the Ovambo community. A witchdoctor would tell
the cursed person who brought the curse upon him, potentially leading the cursed man to
seek vengeance of his own and pay the witchdoctor to curse the other person. A traditional healer, however, values harmony within the community, regardless of the source of a curse: “[for] traditional healers, it’s very wrong to tell someone who did this to him and who did that to him because it will cause something in the community.” The greed and mischief of witchdoctors is significantly responsible for the waning visibility of true odudu in Ovambo culture, as these healers “want to keep that dignity and stick to their original [practices].”

**Odudu.** Distinguishing witchdoctors from traditional healers also elicited a sense of what true healers do in practice. None of the participants in the general sample had admitted to seeking care from a traditional healer, or odudu, though it is plausible that the modern secrecy of healing and my position as a community outsider prevented some from sharing this information. Despite never seeking care from these people, many were able to identify the cultural components of the healing practice. Participants identified ingestion of herbs, use of various meats and livestock, noise of drums, and ritualistic dress as some of the key components of odudu practice. Each of these methods, however, is not unique to mental illness – instead there is a generalist, or holistic, approach taken by odudu in their implementation of technique. Odudu alone know how these components actually work, and the people are expected to rely on the practice of these healers in order to receive the benefit of treatment. The Ovambo believe that one can seek care from an odudu and that man or woman can immediately know what is wrong with a person: “the moment you go there, those people know you.” By knowing what is wrong with a person, it is believed the healer can begin to conceptualize ways to lift a curse or cure omananamwengu, which is often thought to be generated from magical means.
Cultural beliefs also surround the ways in which an *odudu* becomes aware of and develops his or her powers. Ovambo beliefs contend that people who have powers to genuinely heal others are able to connect with ancestors, and these ancestors use the *odudu* as individual vessels to provide help to the living. For example, people “say that the traditional healer is the ancestors talking [to you],” in times when you are ill or mad. Though angered ancestors may incite distress and lead to *omananamwengu* when they are not respected, it appears as though the reverential attitude toward ancestors as well as their protective nature is an additional process in healing. They provide cultural protection to an individual, and when respected, they may also facilitate one’s healing, using an *odudu* as a means of communication and treatment. The powers *odudu* possess, however, are not simply learned experiences. One may experience an awakening illness in which one is not truly ill but is instead being told by ancestors that a person has healing powers. Family relationships also promulgate healing powers across generations. In line with Ovambo matrilineal beliefs, *odudu* abilities may be passed through one’s maternal ancestors: “there’s a lineage. It’s been passed from the great-grandmothers. It’s a family thing.” Passing healing powers across generations is not without its own problems, though. “Only certain families can heal people, and if the new generation doesn’t carry on that, then no one else will carry it on,” which suggests that modernization and education of younger generations impedes *odudu* lineage.

These practices, in many ways, are effective because they are culturally understood ways that healing occurs. When people think of traditional healers and the need for some sort of treatment, “they think [*odudu*] help,” and many Ovambo strongly prefer traditional treatments for their families: “if anybody in my family was a crazy,
hospital is the last place that I would be thinking about [going]. I would think traditionally…to go to our traditional healers.” People may hide their seeking of traditional treatments, and it may no longer be as automatic of a response, but the preference for and belief in traditional healing in Ovambo culture is clear. Madness is a curable condition, according to the Ovambo, and therefore, it does not require hospitalization or counseling. In fact, many Ovambo do not believe that counseling or hospitalization is effective in treatment for mental illness even though traditional healing is fading and *odudu* have retreated to Angola, where the Ovambo also historically live, because of witchdoctors and frauds. Only tradition can treat a condition that is explained by another tradition: “a person who gets mad or crazy, you just think the person is witched. That is when they are not taken to the hospital. You can take them to the traditional healer.” Belief in traditional healing persists, in part, because beliefs about witching are still used as explanations for the onset of mental illness.

The extent of this belief in traditional healing is also likely influenced by a certain sense of faith and commitment to the intangible (i.e., curses and witches) in Ovambo culture. One participant summarized the differences between Western ways of thinking and her sense of faith rooted in her culture:

I think the difference between [the Ovambo] and the Westerns, [Ovambo] are very strong believers. Stronger believers than the Westerners. We live by belief. It’s a matter of faith. It’s a matter of you telling – if I tell my children ‘you should never go into that, behind that bush and they ask me why and I tell them because traditionally, culturally if you go behind that bush you’ll be set on fire.’ My child would believe from an African concept. But if you
come from the United States and I tell you, ‘you’re never supposed to go behind that bush,’ and you ask me why and I say ‘if you go behind there, you will be set on fire,’ you guys live by reason. You want to understand why, so you will go and clad yourself in fireproof clothes and go behind that and see that. But for me, just because I was told that and I believe that, I don’t have to challenge this faith of mine or whatever cultural belief I have in order to prove whether it is or whether it’s not. So for me to actually believe in a sense, that deeper sense of me because I have this state and I am going to this traditional healer that I believe—because of that strong sense of faith.

Her strong sense of faith is what pushes her to rely upon the methods in traditional healing. They do not work because of deep, scientific inquiry. Herbs, ritualistic dress, drums, or whatever techniques employed by traditional healers are effective in treating mental illness because they exemplify the core faith and belief held by many Ovambo. If this belief erodes or another person yearns for a Westernized need to understand the mechanisms of treatment, another modality of psychological care may be necessary.

**Counseling, Medicine, and Religion as means of Healing**

Though all participants addressed the role of Ovambo traditional healers when addressing mental illness and psychological problems, the Ovambo are also keenly aware of other ways that mental illness is treated in Namibia. Chief among these alternative approaches to abating mental illness is counseling and hospital care, but religion plays a substantial role as well. Younger Ovambo, and those who have removed themselves from their traditional beliefs, see these Westernized and colonial systems as more sensible.
Counseling and hospital intervention. Counseling and hospital intervention for mental illness often go hand-in-hand in Northern Namibia. Although some non-governmental organizations (NGOs) provide mental health services, many people identify psychiatric nurses and social work counselors as the primary avenue to receive mental health services within the Western paradigm. The Ovambo are aware that hospital services, and counseling, are available to them: “we do have, in the north, in Oshikati I think, hospitals for people that are mentally ill.” Pills and injections are given at the hospital with little explanation as to why they are being given, and those treated for mental illness, or physical illness for that matter, are never informed of a diagnosis. Instead, those being treated for mental illness are expected to place their faith in a provider treating a condition that the individual likely has no conceptualization of beyond madness. Unquestioning faith plays a substantial role in belief in traditional healing, but this concept seems to have been extended into formalized mental health care in hospitals. Even still, many “people they feel that [counselors] are helpful” in treating mental illness. When people are taken to the hospital for psychological treatment, some Ovambo witness “[the distressed] getting better. Not talking too much. Not running.” Counselors also work with more routine experiences of stress despite much of the Ovambo beliefs about mental illness being encapsulated in madness. They work with people navigating things like marital concerns and even aim to foster a sense of empowerment in women who have been victimized and abused.

Accompanying this sense of trust that modern, Westernized counseling and medical approaches are effective is a pervasive sense of mistrust in counseling. Specifically, many Ovambo believe that the process lacks confidentiality and that sharing
their experiences with a counselor will only lead to rumors being spread in the town. People worry that “when you go for counseling and then you hear your story somewhere else,” and because one’s story will be re-heard in a community, the Ovambo “won’t trust [counselors] because of it.” Others extend from this mistrust and question the efficacy of counseling on the basis that counselors also struggle themselves. For example, were one to see a counselor drinking alcohol in the community, others would wonder if this counselor is capable of helping people stop drinking: “I know him. How can he help me if he takes alcohol too?” Another participant described seeking help from a psychologist after her mother passed, but she stopped going to therapy because she “felt discouraged [when] she ended up telling me herself that she goes to a psychologist.” This left the participant wondering how her therapist, who also sees a therapist, could possibly be able to help: “how would she be able to help me if she has problems of her own? It’s like me being so sick with cancer yet I go to this doctor that also has cancer.” Apparent in this extension of mistrust is an Ovambo belief that counselors or psychologists are unable to help because they themselves do not always stand to a strict standard of exemplary behavior.

Because so many Ovambo are believed to mistrust counselors and avoid hospitals, another modern, colonial idea about the treatment of mental illness has taken hold in those who have grown away from traditional belief. Religion, which was a tool of colonial regimes used to stomp out traditional practices by labeling them as sinful, provides a place for many people to seek refuge in times of psychological distress. One participant described a “mass counseling” experience provided for the well-being of the war veterans, and another stated “I don’t believe in those traditional healers. Seriously. I
believe in god,” reflecting his belief that only through prayer and attending church services could people find alleviation from distress.

Various avenues are available for the Ovambo to seek treatment for psychological concerns. Deciding on whom to seek for treatment leaves one wading through traditional healers, witchdoctors, counselors, nurses, and pastors. The mechanism that guides this actual choice, therefore, becomes a valuable point of understanding Ovambo mental health care. That is, what people believe about mental illness and the extent to which a person believes or trusts in a specific type of treatment intrinsically propels one to seek a certain modality of care.

**Seeking Care: Decisions Based on Beliefs and Needs**

With the variety of types of treatment available to the Ovambo, a distressed person, or more likely that person’s family, must make a decision about the type of care to be sought. This rests largely on belief – beliefs that are naturally wavering because of the influence of modernization and colonial history exert on Ovambo culture. Some hold a belief in a Western, medical paradigm for treatment whereas others adhere to a traditional model. But, the Ovambo recognize that for something to be effective, one must actually believe in the process: “a person who only believes she can get better if she’s injected. Then this doctor gives her an injection and she feels better because she believed. The same is true with people who go to the traditional healer. They trust.” Choosing who will provide one’s treatment is a delicate balance of individual and family beliefs (“there are some things that people believe that ‘I have this condition, I’m going for this [treatment].”’), need, and treatment efficacy.
Because many Ovambo so strongly believe in the practice of traditional healing, this propels many families to take their psychologically distressed members to a traditional healer. Those who do not trust hospitals turn to deeply rooted cultural beliefs, even if their chosen, neo-colonial religion considers traditional practice to be sinful. Those who bend in their strict adherence to a given Christian faith will “go whenever it suits them,” or a need exists for a family member to receive care. Abandoning Christian faith whenever suits a person relates naturally to the idea that certain conditions may lead one to seek a specific type of treatment. Ovambo belief often dictates that one’s mental illness is a function of witchcraft, which would then lead a person to believe that traditional healing is the only avenue to heal psychological distress. For example, somebody that is brought to a hospital and given medication for mental illness might still be believed to be cursed, and this person’s family would in turn take him or her to a traditional healer in order to truly cure the condition. From another perspective, those who believe that mental illness is a deterioration of one’s psychological well-being or even a general sickness are more inclined to seek help from a hospital or a counselor. Thus, belief about the cause of a problem dictates the desirable treatment.

Some Ovambo find that a singular treatment is not effective. Fluidity between help seeking develops when one leaves a hospital or a traditional healer without having attained a desired change. Participants readily identified this fluidity. Some see their community members going “to the hospital and after they take the medicine and don’t improve, then they seek traditional help.” This switching between types of treatment can go in either direction: “some can even go the hospital then later to the traditional healer. Or traditional healer and when they see the situation is not [getting better], hospital later.”
The Ovambo are willing to switch the type of treatment being received if the person being treated or that person’s family believe that the type of care is insufficient in its healing capacity. Although a deep sense of tradition and faith in one’s culture may allure a person to traditional healing, such people are willing to redirect their path to healing by going to hospitals and counselors. Embedded within this fluidity is further evidence of the role many families play in finding treatment for a psychological distressed person or an eemwengu. Kin come together to rely upon their knowledge, beliefs, and resources to find whatever type of treatment they consider to be efficacious in the treatment of madness, curses, or mental illness. Those eemwengu abandoned by their family are likely left to overlook their distress and forgo treatment because no perceived need exists.

**Ethnographic Phase: Practitioner Thematic Findings**

Adding to the cultural understanding of mental illness and its treatment among the Ovambo in Namibia are the perspectives held by the various practitioners who aim to promote psychological wellness in Northern Namibia. Counselors, psychiatric nurses, and a traditional healer offered their insights and described their experiences regarding how the Ovambo become mentally ill and the ways in which they are capable of acting to treat psychological concerns.

**Westernized Mental Health Services in the North**

As Namibia has modernized and incorporated colonial ideas of medicine, treatment, and education, infrastructure has developed to treat mental illness through Westernized ideas. Psychiatric hospitals, counselors in general hospitals, and other counseling-centered organizations can be found in Northern Namibia. Each aims to intervene when mental illness weighs on a person, however, each does so differently. To
promote this avenue of treatment, individuals have sought training at the university in Namibia. This training has elicited ideas about how change or healing occurs within Westernized paradigms, which has contributed to psychological and medical explanations for the development of mental illness, free of Ovambo traditional beliefs. The practitioners formally interviewed in this ethnographic phase, a psychiatric nurse and several counselors, provided a great deal of insight into the way counseling and mental health services function in Northern Namibia as well as how the Ovambo feel about these practices.

**Training in mental health services.** Counselors and psychiatric nurses who have degrees of some sort require university training. Three of the counselors in the sample had sought graduate education at a university in Namibia and an additional three had been trained by an NGO as lay counselors. The psychiatric nurse had been trained in her field at the Bachelor’s level at the same university in Namibia. That such training exists indicates attention to developing mental health care as field. The training for the formally educated counselors and the psychiatric nurse varied based on level of education whereas the lay counselors received their training within a month’s time.

Their training experiences are also unique to the type of services provided. Lay counselors embed themselves in the communities and in rural villages and require training specific to needs that manifest in these contexts. University training in social work prepared the formally educated counselors to provide clinical services. Counselor preparation left these participants equipped to work in counseling, identify symptomatic concerns of clients, and aim to promote change in their lives. Some of this training was also experiential: “we do community work where we have projects just like in target
groups at schools.” Psychiatric nurses are taught the skill set to navigate clinical care in a hospital and the aptitude to identify a spectrum of clinical disorders. Although each is trained in unique modalities of care and in different degrees, these practitioners are all taught within a framework of Westernized theories of mental health.

**Processes and practices used in Namibian mental health services.** Training in counseling and psychiatric nursing leads to specific means of providing mental health services. Such services are provided in hospitals, in community-based agencies, and in villages or towns that are out of the reach of medical centers. Hospital settings primarily provide medication and monitor patients’ dosages and respective well-being. Minimal care is provided, and the medical staff rarely informs individuals of their diagnoses, whether it be related to psychological or physical health. Here, maintenance and returning somebody to a semblance of normalcy is advocated as the primary means of intervention. This type of treatment may be depersonalized and align very concretely with Westernized medical models for treating mental illness, but it is deemed to be necessary because “you have to do it. Otherwise people won’t…these medications are the medications that are calming down and bring them back to an orientation.”

Counselors, however, take a more individualized, therapeutic approach to the process of treating psychological disorders. Their services are, at times, provided in hospitals but emphasize the personal growth and empowerment of clients through building strong therapeutic relationships and providing a sense of support. Prior to any service is provided, counselors inform clients of confidentiality, in part in response to community based concerns that individuals do not believe or trust that counseling is a private process. This basic psychoeducation gives way to beginning evaluations in which
counselors work to identify clients’ presenting concerns. Counselors then express “love and care” to clients and actively listen to any presenting concerns.

Goal development, improving the therapeutic relationship, and other techniques such as visualization and challenging clients are then used to promote client insight. Clients are encouraged by counselors to “learn to accept the situation” by considering presenting problems in their entirety. For Western trained counselors in Northern Namibia, looking at a “whole problem, where it come from, [helps to] find out where the problem lie,” and facilitates clients learning that mental illness is linked to their lived experiences and not a product of witching. Drawing attention to a whole problem is intended to address the onset of strange behavior and foster clients’ self-awareness that would otherwise be entrenched in traditional beliefs. Moreover, clinicians actively work to challenge ideas of witching in Ovambo culture on the basis of things like clients’ religious beliefs, such that one must “confront the bewitchment on a Christian basis,” in order to help clients see that witching is not real. Attending to these beliefs reflects the ways in which cultural beliefs are woven into the processes and practice of counseling in Northern Namibia. Although counselors recognize that it might not be an exact adherence to lessons taught in counseling training or textbooks, they “have to do it because [otherwise] you’re not going to be very helpful.”

These Westernized practitioners also recognized the natural importance of family education with respect to the recovery of an individual who has suffered some psychological difficulty. Practitioners not only accrue the responsibility of treating the individual but simultaneously insuring the families have proper understanding of how to prevent further psychological complications outside of counseling. This indicates another
unique emphasis of treating mental illness among the Ovambo – families are naturally thought to be a key mechanism to sustaining any change in maladaptive behaviors. Because of the lifelong nature and potential re-development of distress, families are integrated into treatment. Counselors tell families “if you are with him or her, try to avoid him or her to feeling alone because if he is alone, he can think a lot and it can lead to think back and even to commit suicide.” Informing families of the needs and vulnerability of a distressed person provides another means of intervention for practitioners working with the Ovambo to assure clients maintain any gains from treatment.

**Perceptions of counselors in Ovambo culture.** Though counselors actively see change in their clients and are intentional about monitoring clients’ developments through follow-up sessions and word-of-mouth communication, concerns persist about the intersection of Ovambo belief systems and respect for counselors and counseling. Many Ovambo question whether or not counseling is entirely related to HIV/AIDS because many people with the autoimmune virus are also provided counseling services. Practitioners are persistently aware of the ongoing struggle they face to find respect within the cultural norms of the people they intend to serve: “when I say that I’m a counselor, sometime they look and say ‘you are a counselor?’ They don’t like you, they don’t like counseling.”

Despite this frequent uphill battle to provide services to psychologically vulnerable people throughout Northern Namibia, optimism persists among Western-trained practitioners. Actively educating communities has led to Westernized treatments gaining greater traction and being perceived as a valuable means of alleviating distress.
Potentially, this traction is also related to individual clients and their families in times of distress moving away from traditional beliefs and believing that “counseling...is the only way that people are able to manage their lives.” Moving away from traditional healing and respecting counseling as a profession, however, is entirely mitigated by the strength of traditional beliefs in a given area of Northern Namibia. Rural areas more distant from growing towns hold onto traditions whereas areas that have “become Westernized, modernized – [tradition] tends to have a lesser role,” and the Ovambo there are thought to be more amenable to seeking mental health services from counselors and hospitals.

**Westernized practitioners’ perceptions of traditional healing.** Because they advocate for reliance upon Westernized models of treatment and intervention for psychological concerns, practitioners in Northern Namibia have complex conceptualizations of the role of traditional healing. Each sees traditional practices as ongoing and prominent in Ovambo culture. Many also believe that many Ovambo “run to traditional healers,” especially in times of panic: “when the [shit] hits the fan, they tend to go back to the traditional ways of healing.” As such, practitioners worry that traditional healing, especially that offered by fraudulent healers and witchdoctors, more often makes matters worse for an individual in distress. Practitioners “never recommend clients to go to these traditional healers,” out of worry that psychological concerns and distress could compound for individuals who seek traditional treatments. When Ovambo consistently seek traditional healing for chronic mental illness, the result is disadvantageous to the individual seeking services whereas going “through counseling and [receiving] education, the mental problem is assessed...solved, and truly understood by the person.” Similarly, practitioners worry that traditional healing leads to greater discontent in
Ovambo communities. Healers can claim to know who brought a curse upon a person, leading to interpersonal conflict “even if [clients] know it’s not the reality.”

Caution aside, counselors and the psychiatric nurse in this sample were open to the potential efficacy of genuine traditional healing (i.e., those healers who can be trusted and are not solely interested in monetary gain). The psychiatric nurse described her experience beginning to work in the hospital when the doctor with whom she worked instructed her to identify psychological conditions that might be best treated traditionally:

When we were training, the doctor that was there at that time, the first question he usually asked the patient: “is this something that has come from spirits – inhabitants according to what he heard?” And then, he’s likely to ask whether in the family there’s someone under those conditions and how that person was treated. Is that person alive or is he past? And if he happen to hear that there was such a person in the family, he wants to hear who has treated that person. Because what I happened to ask him – ‘Why did you ask that question?’ He said that there are such traditional healers who can have such patients and cure those problems.

This sentiment was echoed among several of the counselors. Specific symptoms, like those indicative of psychosis are believed to be treatable by genuine traditional healers: “most of the psychosis patients, people recognize to take them to the traditional healer.” Because traditional healing can work for some and because it is “engrained into the Oshiwambo culture,” counselors hold some positive perceptions of traditional healing practices in Northern Namibia.

Traditional Beliefs and Healing
Though complicated by the emergence of Christianity and Westernized health services in post-colonial Namibia, traditional healing as a practice of treating both physical and mental illnesses pervades in Ovambo culture. The belief is steeped in cultural norms and practices, but traditional healing is marred by a modern context in which some manipulate the traditional beliefs of many Ovambo in the hopes of financial gain as a fraudulent healer. Such a state fosters greater rifts between traditional and modern mental health care; however, traditional practice can still be found in its most culturally aligned and genuine form in Northern Namibia. Those healers (*odudu*) who adhere to tradition find and hone their powers through culturally believed means and engage in specific treatments that identify the ills within a whole person in order to alleviate one’s suffering. Ovambo traditional healers find themselves in an interesting predicament – many of their fellow true healers have retreated to Angola where Ovambo traditions still hold more strongly whereas those left in Northern Namibia practice in secrecy within a broader, Westernizing environment.

**Becoming an *odudu***. Becoming a traditional healer necessitates adherence to traditional beliefs. That is, one cannot merely declare oneself a traditional healer; rather, the powers held by an *odudu* are passed through family ties, whether those are direct during life or through ancestral intervention. The traditional healer interviewed for this study described her realization of her powers as one of revelation in a time of illness. She had fallen ill and gone to Angola to find a traditional healer to cure her. When she found a healer, the man indicated to her that he did not see illness in her; rather, he saw ancestors speaking within her and providing her with the power to become a traditional healer herself. This revelation led to her engaging in the cultural practice and spending
time learning from this man in Angola who “showed her how to use everything,” to improve people’s health. Her training largely revolved around introduction to the specific rituals but also significantly emphasized this ability to connect to her ancestors. In fact, connecting to ancestors’ spirits actually guides ways of intervening with individuals seeking traditional services: “a person doesn’t have to say anything, but the ancestor will show [the healer] that this person will be [suffering in] this and this and this way.” Thus, training in traditional healing relies upon acceptance that the link between the healer and ancestors is real and valuable and that one learns how to heal through connections to these voices.

**Ritual in traditional healing.** Traditional healers may use variations of specific rituals in their practice, however, common threads appear throughout Ovambo cultural beliefs. A holistic sense of the individual seeking care is prominent. Those with mental illness are seen “like most other people. [She] sees some of them [who are] witched and cursed.” Despite being willing to work with any person who suffers including those believed to be cursed, traditional healers are also guided in specific rituals based on the needs of those seeking treatment.

The healer in this study noted that her ritual begins with her natural connection to ancestors and flows from their ability to speak through her. She also noted that specific clothing facilitated her connection to her ancestors. Connecting to her ancestors allows her to use her power of sight to “see what is wrong with the person,” without having to ask. The intervention, guided by ancestor communication, is crafted to a specific concern identified in the person seeking care: “for those that are having a mental sick [I] can give them different herbs…because those having the mental problems are having different
problems.” Other rituals in traditional healing are described elsewhere in this study, but this healer relies primarily on herbal intervention for the treatment of mental illness. Ingestion of herbs, whether through smoke or drinking them, leads the ill individual to “vomit all the things out. All the things that you get [when you are] witched.” Vomiting results in the expulsion of a curse or whatever other magic has caused omananamwengu in a person. Giving somebody these herbs to induce vomiting of spirits and curses allows traditional healers to “change that person.” Change is instant and observable as traditional healers can “make [omananamwengu] go off like a switch.”

**Perceptions of traditional healers in Ovambo culture.** Evidence indicates that traditional healers are respected within Ovambo culture, especially in light of the clear prominence of witching and cursing as ways of explaining psychological concerns. Traditional healers are conceptualized as a valuable part of Ovambo culture despite their dignity being tarnished by the proliferation of false healers and witchdoctors. Those who respect their powers and protect their craft are respected even if they often practice in secrecy. The traditional healer interviewed indicated that she does keep her practice relatively secret, with members of the community creating a word-of-mouth network of referrals for her. Potentially because it is a waning tradition, “people are happy for [me] to keep doing this.” Odudu that maintain their practice in a way that agrees with Ovambo traditions see the importance of their role in Ovambo culture and believe that they are respected in the culture because, even in the face of Namibian modernization, people continue to seek the services of those healers who value providing help.

**Healers’ perceptions of Westernized mental health practitioners.** Traditional healers not only endure a culture in which their practices are altered by modern frauds,
but they also carry their traditions into an era in which Westernized systems of health care are becoming more visible in Namibia. The healer interviewed in this study recognized that the two types of treatment can co-exist and simultaneously attend to the psychological needs of the Ovambo community in Northern Namibia. *Odudu* are not universally effective in all cases and face barriers at times with people seeking services; therefore, many appear to recognize the need to refer individuals still in need to hospitals and counselors. When an *odudu* encounters somebody for whom their treatment is ineffective they actively recognize the need for further care: “I can tell that this person cannot [be] healed. So [I] refer some of them to the hospital.” A willingness to refer individuals who do not benefit from traditional practices represents recognition from this traditional healer that counselors “are also helpful and should be taken into consideration.” Being open to mutual referrals (i.e., when traditional treatments are ineffective) is potentially a means for these two disparate forms of psychological care to forego believing that one treatment is better than other and instead focus on beliefs and needs of those struggling with mental illness.

**Explaining Mental Illness through Modern and Traditional Lenses**

Accompanying divergent ideas about the course and components of psychological treatment are unique understandings of how mental illness emerges in Ovambo client. Because cultural beliefs about witches and curses remain prominent explanations for mental illness among the Ovambo, Westernized practitioners experience themselves confronting frequent uphill battles. They must educate communities and justify that their work is useful even though it is often entirely aligned to a new way of thinking about illness that goes beyond cursing. Traditional healing, on the other hand, continues to
adhere to beliefs that ancestors incite distress and people suffer mental illness often at the hands of a curse.

**Westernized practitioners’ conceptualizations of mental illness.** Westernized practitioners’ ideas about the development of psychological concerns in clients varied. Explanations included distress being rooted in interpersonal conflicts in and out of families, alcohol abuse, and pathological descriptions such as depression, anxiety, and schizophrenia. Some also draw from pervasive social problems, primarily gender-based violence, as substantial contributing factors to ongoing psychological distress among the Ovambo and throughout Namibia. Where psychiatric nurses are more attune to pathological symptoms in hospitalized patients, counselors and lay counselors are attentive to a person’s lived experiences and that their experiences of stress contribute to psychological concerns and even attempted suicide. Though counselors working with the Ovambo believe individuals come to counseling because “they realize that they have a problem,” counselors also recognize that many Ovambo might recognize moments in which their “behavior’s not right.” Recognition stops at this point as many Ovambo may not believe in or understand the nature of invasive psychological symptoms: “I think the psychopathology part of it is still very, very limited and the understanding of mentally ill is still very limited.”

Training in Western theories of psychology lends itself to the identification of symptoms that can be found in Western diagnostic texts. Counselors and psychiatric nurses work with people who display symptoms like hallucinations (“he can see people coming – you look there, you cannot see anything”), anger (“you will see that the person is very angry”), and even hopelessness (“they feel like hopeless, they don’t even have
anything, their life is meaningless”). Alongside identification of symptoms is attention to maladaptive behaviors and cognitions, especially suicidal ideation and suicide attempts. Suicide rates are considered to be high in Northern Namibia, and despite an overall cultural belief that suicide is unrelated to mental illness, practitioners attend to the condition in a way that reflects the belief that suicide is based in psychological distress. Clinically exploring suicide is fueled by psychological and interpersonal hypothesizes, including believing that “resilience, the ability to bounce back,” and “lost self-esteem,” are responsible for suicidal ideation. Practitioners trained in Western models of mental health and illnesses adhere to concepts stemming from Western psychological theory. They understand the need to bridge cultural gaps and understandings in their therapeutic processes; however, they possess beliefs about the onset of mental illness that are often substantially different than those held by the general Ovambo population as many still rely on theories of magic.

**Traditional explanations of mental illness in treatment.** Traditional healing in Ovambo culture is predicated on the concept that people fall ill, psychologically or otherwise, because of influences from ancestors, curses, and being bewitched. *Odudu*, therefore, are guided by a belief that mental illness, or *omananamwengu*, develops in a person because of spiritual and magical forces. Healers treat people who have “signs of a strange attitude…having thoughts like running away. [Some] are so quiet and some are like the person just want to run away.” These symptoms are also identified by Western-trained practitioners and others in Ovambo communities, but the distinction lies in where these come from. To *odudu*, “those sick people are witched,” and not suffering from underlying psychological concerns.
Ovambo healers certainly espouse traditional ideas about the onset of mental illness, but these concepts are not foreign to Western-trained practitioners either. For example, a counselor can be working with a client who has attempted suicide and believes she was “just attacked by evil spirits.” Others recognize that traditional beliefs continue to be prominent in rural areas in Northern Namibia. These beliefs represent a consistent struggle for counselors and other Western-trained practitioners working with the Namibian Ovambo. They aim to improve understandings of psychological concerns but struggle to do so when all things, including routine and daily mistakes, are explained by the Ovambo as coming from witches. Counselors see “cases where a woman drops her cell phone in the toilet and it was bewitchment.” Although counselors disagree with these culturally grounded explanations of mental illness, Western-trained practitioners in Northern Namibia do use them to conceptualize culturally competent therapy.

Integration of Treatment Modalities

Because traditional beliefs still hold strong places in Ovambo culture and given the expansion of Westernized treatments in Namibia, the question of treatment integration naturally arises in this context. Would treatment be effective if *odudu* and counselors as well as psychiatric practitioners worked with one another to treat psychological distress in various individuals? The answer is complicated by beliefs of counselors and traditional healers as each offers their own ideas about how mental illness occurs and how it is actually treated. The relationship is made more complex by the lack of communication in Northern Namibia between traditional healers and Westernized practitioners. The traditional healer interviewed believes that her “communication with the social workers is not good.” Similarly, the psychiatric nurse believes Westernized
practitioners do not routinely seek communication with healers: “I don’t think they respect communication there. It’s because not many nurses are aware about traditional healers.” However, ethnographic findings suggest there is some recognition in Northern Namibia that cultural beliefs are significant with respect to treatment of mental illness.

Several participants advocated for an integration of traditional and modernized practices. The traditional healer believes that she would benefit from working together with counselors because “[counselors] are also helpful.” Several of the clinicians also supported this sense of integration: “we work with traditional healers as well. We have some work with the local counselors…I think there is a role for them and they can play a really productive and constructive role.” Of the seven Westernized practitioners interviewed, four advocated for some form of useful integration. Along with the traditional healer, these individuals see the potential in combining Ovambo beliefs that include things like curses and ancestral influences with Western concepts in therapy such as building trust, promoting confidentiality, and developing self-awareness in counseling to better understand psychological distress.

The three practitioners who gave no indication that they support integration of traditional healing and counseling practice offered explanations largely based in mistrust of traditional healing. They see traditional practices as ill-informed and manipulative, and traditional healing as not free of manipulation in its current form in Namibia. One counselor believed that “one [odudu] would think it’s positive and the other would think it’s negative,” which she believes is due to the for profit nature of those healers who are frauds and manipulative in Ovambo culture: “The traditional healer is making business. For us, we are not making profit. We are just helping people.” Those who do not
advocate for integration instead promote modernization of mental health services for the Ovambo and “hope that [the Ovambo] realize that social workers are effective in helping people’s lives,” where traditional healers fall short.

**Ethnographic Cultural Portrait: Ovambo Mental Illness and Psychological Treatment**

Mental illness and psychological distress are clearly evident in the belief systems of Ovambo culture. Prominent in Ovambo culture is the conceptualization of psychological distress through witches and curses brought on by stealing or doing something to disrupt interpersonal relationships. Though modern explanations of mental illness now co-exist with have traditional ideas, tradition remains strong in Ovambo life. Those who are witched experience *omananamwengu* (madness) and become *eemwengu* (a mad person). *Omananamwengu* represents a set of culturally identifiable symptoms, including “running everywhere,” “talking nonsense,” and the presence of auditory and visual hallucinations. *Eemwengu* are often marginalized in Ovambo culture, but some families are intentional about caring for those who suffer and finding proper treatment. Cultural beliefs largely propel individuals to seek traditional healing, which relies upon ritualistic connection to ancestors and herbal treatments for mental illness. However, modernization and post-colonial social institutions have led to the promotion of Westernized forms of counseling and psychiatry in Northern Namibia. Mistrust towards these types of treatment is common among the Ovambo, but many have developed respect for these treatments. Regardless, what appears apparent is that individuals in need of psychological treatment rely upon family beliefs about treatment to decide on the type of care to seek. Belief in the type of treatment is a necessary component of Ovambo help
seeking and fuels desires for integration of traditional and Westernized mental health care in Namibia. Understanding the personal implications of this cultural information, however, requires further analysis of individual lived experiences of psychological distress in Ovambo culture.

**Ethnographically Contextualized Case Study Phase Results**

To ground the ethnographic findings in the psychological experiences of Ovambo individuals who have suffered psychological distress and been treated, a case study phase was undertaken to explore these lived experiences. The data in the case study phase was horizontalized in that all formal interviews were transcribed verbatim and read to identify those statements significant to the lived experience of mental illness and its treatment in Ovambo culture. Notes taken during the informal interviews were similarly analyzed in conjunction with the transcripts to augment the specific case. Transcription resulted in 30 single-spaced pages of interviews. All significant statements were interpreted into meaning units, resulting in the identification of 196 meaning units across all four cases. Each case was analyzed independently at first in order to establish the particular components of each experience. The particular and contextualized details of each case are presented in a de-identified manner to provide insight into the lived experiences of the participants. In moving beyond the particular of each case, cross-case analysis was undertaken to determine themes. Four cross-case themes were identified: (a) Development and Symptoms of Mental Illness, (b) Marginalization and *Omananamwengu*, (c) Family Roles in the Lives of the Distressed and *Eemwengu*, and (d) Belief in Treatment. Table 3 summarizes the salient, particular information of each
case, and Table 4 provides examples of the meaning units and significant statements in each theme derived in the cross-case analysis.

**Case 1: Petrus**

Petrus was not interviewed for this study due to his unavailability on account of a busy work schedule. However, his uncle, who was responsible for finding the traditional healer that treated Petrus, provided his experience of his nephew’s mental illness and how it was alleviated. The uncle noticed Petrus’ psychological concerns when he had returned from Thailand where he had been studying abroad at the university level. Petrus had loaned money to his roommate, who was from Western Africa, and had asked for the money to repay him. His family believed that this roommate then cursed Petrus, leading to his symptoms of madness. Petrus was brought back to Namibia where he immediately went to the North to be reunited with his mother, grandmother, and the uncle being interviewed.

Petrus’ uncle noticed several problematic behaviors. As a result, he and his sister (Petrus’ mother) considered their treatment options for ‘the boy.’ They first thought to take him to the hospital but decided this treatment would not be fruitful. Instead, Petrus’ uncle relied on the referral of another Ovambo man in his village to seek out traditional healing. The uncle was put in touch with a traditional healer who he then met with to determine if his interventions would be effective. Traditional healing was decided upon as the best way to resolve the issue, and Petrus and his mother were brought to the traditional healer to stay for two weeks. The treatment consisted of natural remedies “like tree bark, some herbs, and he has got a tail – I don’t know if it’s a horse tail or an ox tail on a stick.” His uncle also noticed that the healer tied a horse tail hair around Petrus’
wrist on the “very first day he took him. It remains there while he is treated. And he said you should keep that there until it falls off.” Treatment went much quicker than expected, and Petrus was instructed to return home with his mother and uncle after only a week of the anticipated two week treatment. When his uncle retrieved him, he recognized the change in his nephew immediately: “when I went there to pick him up, then I can agree. I can see for myself.” His uncle experienced some initial worry about Petrus immediately after his treatment, but his fears were reduced when Petrus returned to his normal, well-mannered self, and “from then until today, everything is fine.”

**Case 2: Mathew**

Mathew was first made aware of his mental illness shortly after finishing his year 12 in secondary school. He had moved to Windhoek in search of work and found himself struggling to find employment and to avoid alcohol abuse. As his symptoms began to set in, which was readily evident to his mother and other members of his family, Mathew was brought back to the north. He was making “fire and just walking too much. Cleaning too much,” which led his family to be concerned about his mental illness. His mother shared a similar account regarding the onset of his mental illness. She stated that Mathew was “[saying] unusual things,” as a function of his not “[finding] a job in Windhoek, and when he came back, he was [this way].” This led to her identification of Mathew as having experienced *omananamwengu*, which his father has also struggled with throughout his life.

Shortly thereafter, he was brought to the Eenhana hospital to be treated for his psychiatric condition. Mathew’s mother has been a practicing nurse for nearly 30 years and thought to immediately seek hospital-based treatment for her son. After an initial
assessment at the Eenhana hospital, Mathew was transported to a larger town and hospitalized in the psychiatric ward there for three weeks. He described his medical treatment during this hospitalization: “everyday, you have to get the medicine everyday at the morning and in the afternoon and night as well. And the injection as well.” Doctors and nurses had not informed him officially what his medications were for, but even though “they did not [him] me what kind of medicine…[he] knew that it is for mental illness.” Mathew was given no formal diagnosis that he was made aware of, but those monitoring his care attended to his “pill and injection” dosage. He was released after the three-week stay and has been medication “up ‘til now. Maybe it’s now 3 maybe 4 years now.” He believes his mental health is now intact and that he has not endured any ongoing problems. His mother echoes this sentiment: “he’s getting better,” but she still sees problems including “he drinks too much,” which is echoed in informal observations of Mathew in the community.

Case 3: Kleopas

Kleopas is a 44 year-old man who has lived his entire life in the North. At the time of the interview, he claim to have been free of psychological symptoms and considered himself healed “maybe just five months.” His family was very involved in his treatment process, and two of his cousins participated in informal conversations to provide additional information about his experience. According to Kleopas, he began hearing voices shortly after his mother had died. One of his cousins wondered if Kleopas was witched because “maybe he went to the witchdoctor” asking to be given riches. His symptoms became immensely negative influences in his life, and his family decided to find treatment for him. Based on their cultural beliefs, they decided Kleopas would be
best treated by a traditional healer. He “went there” near his hometown to stay with a healer who “was treating [him] nicely. And from there, even if something was wrong, everything was okay.” He was also brought by his family to the hospital in his hometown where he received medication and was seen briefly in counseling. Kleopas was given no formal diagnosis from his time at the hospital, but his family refers to his condition as *omanamanamwengu*. Further, he relies on church as a form of additional report and believes that he benefits from people praying for him.

Kleopas vividly described some of the components of his treatment with the traditional healer. He inhaled herbs provided by the traditional healer: “they burn it and you smoke or something.” The traditional healer also incorporated ritualistic use of cattle in Kleopas’ treatment: “and they slaughter black cattle. They slaughter it then I’m told to lay on top of the cattle. They take me in a blanket…they take me in a piece of the skin of the cattle.” Today, Kleopas considers himself to be okay “because that time, [he] wouldn’t be able to stay with you alone. [He] would run away,” suggesting that his former symptoms of running everywhere are no longer present. He has also found gainful employment and considers himself to be returning to normal adult responsibilities expected of an Ovambo man, but some of his kin members remain concerned about him.

**Case 4: Frans**

Frans is a 29 year old man who has also lived his entire life in Northern Namibia. He is a trained construction worker who has often struggled to find long-term work. Furthermore, he represents a unique case in this phase of the study. Frans is included because he attempted suicide in September of 2009. According to him, this is not indicative of mental illness. However, his case is included because of the high rates of
suicide throughout Namibia and the ethnographic findings, primarily those from the Western-trained practitioners, that suggest suicide is a pandemic problem related to the psychological well-being of those Ovambo who attempt to take their own lives.

Frans hung himself in his parents’ home where he was found by his brother because of an argument he had with his girlfriend. He believed he had provided everything for her, but she wanted to leave him, which was too difficult for him to cope with. After his brother cut the rope he had used to hang himself, Frans was taken to the hospital in his hometown. Here, he was medicated heavily in order to be sedated. His medication eventually wore off and he was taken to see one of the social workers functioning as a counselor in the hospital. She offered him encouragement and worked to instill hope for the future. After their treatment ended, the counselor “even used to call [him] asking ‘how are you, how [are] things are going now, are you talking?’” Sometime after his counseling, however, he continued to struggle with alcohol abuse and he unintentionally set his room on fire, “so [he] lost everything. It was even difficult to start again.” At this point, Frans “wondered if maybe someone was trying to witch,” him due to his attempted suicide and his misfortune of having set his room on fire after being too intoxicated. His parents considered attending to a potential curse through traditional avenues: “my parents were trying to take me. They were saying ‘ah we can take you there to a guy’ other than traditional.” However, Frans first consulted the counselor with whom he had previously worked, and he was dissuaded from seeking traditional healing to ward off a curse. He believes that, since that time, he has been more fortunate and has not experienced suicidal ideation despite entertaining the idea that he had been cursed.
Cross-Case Analysis

Though each instance of mental illness discussed rests upon the unique and particular experiences of the individuals, several shared patterns exist across the cases. Cross-case analysis allowed for the themes shared by the four cases to emerge and suggest some of the salient experiences of mental illness and its treatment in Ovambo culture.

Development and Symptoms of Mental Illness. Three of these four cases are directly identifiable as instances of the Ovambo psychological condition omananamwengu. Frans is the only case in which no diagnosis was given with respect to madness of psychological concerns despite worries that he had been cursed. However, looking across these cases elicits a greater understanding of the diverse beliefs pertinent to the onset of psychological distress, or omananamwengu, and the underlying symptoms of the condition.

Distress commonly developed from manifest concerns in people’s contexts. Kleopas believes he became eemwengu because of his mother’s death, Mathew felt “that thing develop because [he was] sick,” and Frans alluded to interpersonal problems leading to his attempted suicide. Curses and potential witching may also have caused these states of psychological discomfort. Family members recognized that potential curses may have resulted from the distressed individual having sought to be “blessed with money and good luck,” whereas others were thought to be witched for other reasons by acquaintances. Adherence to cultural belief is pertinent in one’s conceptualization of the etiology of omananamwengu. That is, Kleopas and Petrus come from families that are more attentive to Ovambo cultural practices, and therefore, explain mental illness from a
stance influenced by magic and *odudu*. Frans’ family is similarly influenced, leading him to question if he had been witched. Mathew, however, comes from a family that has a history of mental illness and includes individuals who work in the medical field. Therefore, their belief about the onset of his illness is informed by him being sick rather than him being bewitched.

Although both traditional and medical explanations were clear in the explanation of mental illness and psychological distress, several symptoms of psychological distress were clearly identified (see Table 5). Abnormal behaviors, beyond simple difficulties in coping with negative experiences, were readily observable. For example, Petrus’ uncle noticed that it “takes him almost three times to come in the room within a minute. Just to go out and come in, go out and come in,” and from that, “you could see from the scene that he is not fine.” Others were thought to be walking or running too much, such that they were constantly moving. Accompanying this sense of consistent movement was unusual speech. *Omananamwengu* appear to say “unusual things,” and this nonsense suggests to observers that the person is mad.

*Eemwengu* also experience more thorough and potentially destructive symptoms, including auditory hallucinations, suicidal ideation, and inclinations to set fires. Two of the cases (Mathew and Kleopas) included individuals who had set their homes on fire while sober. Kleopas described this process: “I was burning the hut. I burned it. That time my mother passed away, in the middle night I just wake up and start to burning my own house and from there going to burn my mother’s.” Mathew also set his house on fire: “I make three, maybe, types of fire. Just that house is where I sleep, and I make fire there.” For some, setting fire appears to be linked to auditory hallucinations in which commands
were given. Kleopas experienced voices “voices, they come from behind the wall,” prior to his burning his home. These same auditory hallucinations instructed him to kill himself: “I hear all the persons – they don’t want me. They want to kill me.” Petrus also told his uncle he experienced commands from auditory hallucinations: “He sat down and start talking to me, telling me that he hear voices of people calling him that ‘you are finished, you are dead, you are nothing, you are idiot,’ – those voices are coming for him.” Others might feel “meaningless,” such as Frans did, without hearing these voices. He felt life would be better and less meaningless if he died: “I got no job. No money. So things better if I end up committing suicide.”

Participants were also split with regards to the influence of their substance abuse. Frans worried that, when he accidently set his room on fire while too intoxicated, that he was cursed, relating the potential of his substance abuse to be linked to a magical source. Mathew and his mother both worried that he had been drinking too much, which resulted in his psychological instability. Alcohol abuse in Ovambo culture may be so severe for some individuals that it contributes to or worsens psychological concerns. Interestingly, many Ovambo may readily ascribe the onset of mental illness to too much substance abuse. However, this is not always the case as many develop these symptoms free of drug and alcohol abuse. Petrus’ uncle, for example, asked Petrus if he had been using substance: “I asked him if there’s anything he touched, something like drugs, maybe he took some alcohol or anything. He said no, he did not.” Because substance abuse was not present for his nephew, the uncle recognized the severity of his abnormal behaviors.

**Marginalization and Omananamwengu.** Ovambo culture espouses a strong belief in social support and interpersonal relationships. However, when a person
expresses himself or herself in a way that deviates from the standard expectations of Ovambo adults, this person is pushed to the margins of communities and, on occasion, families. Ethnographic evidence indicates that many eemwengu are cast aside and even discriminated against in Northern Namibia. Each participant faced some degree of discrimination in their homes at the hands of other members of the Ovambo community.

Shame, mistreatment, and accusations of poor character are commonly experienced by eemwengu and those Ovambo experiencing less intense forms of psychological distress. Frans described a sense of shame when he walked into town: “it was like eating [me] up. It was like feeling shame to walk to town or even to people who know you.” People questioned why he had attempted suicide, leaving him feeling isolated and hoping that “they will think of something else,” rather than focusing on his problems. Northern Namibian, though a largely populated area, still feels like a small region, and people come to know the business of others. According to Mathew, “they know me. Those people they know me,” and they were keenly aware when he was mentally ill: “they treat me very badly.” Others are considered dangerous, like Kleopas, out of the assumption that they will attack people in town. Such discrimination also occurs within families, which are normally thought of as supportive and caring for those who suffer mental illness. Petrus, for example, was fostered at a young age to live in Windhoek with an aunt and uncle. When he returned as omananamwengu from Thailand, this aunt and uncle immediately accused him of using drugs:

To make things worse, the uncle – the brother to his mother – says ‘no, you have been imbibing in those things, you have been taking drugs,’ and so on. He was kind of not knowing as to how to explain to his parents that there was
nothing wrong with him.

Apparent in these lived experiences is a communal assumption that those who experience *omananamwengu* or any degree of distress deserve the experience and ought to be embarrassed by it. *Omananamwengu* and *eemwengu* are used offensively themselves as they separate the individual suffering from the ‘normal’ group. Shame develops as a function of feeling outside of the norm, leaving those suffering from psychological distress lingering at the edge of society and possibly untreated.

Though this shame pervades their lives during the throws of psychological distress, mistreatment by other Ovambo appears to wane when one is treated for mental illness. For Kleopas, “now they’re different. They treat me [normal],” whereas before people feared a violent outburst from him. Mathew’s mother also sees an improvement in how her son is treated in their town. To her, “the community likes him very much because he’s not sick. Before he was.” A return to normalcy within a person’s psychological state seems to promote a return to normal treatment among the Ovambo community, but whether or not this transformation of social treatment is complete is unclear. People who have been known to be mentally ill struggle to overcome that label, as community members still say “that’s the mental that one,” perpetuating some degree of social isolation despite recovery.

**Family Roles in the Lives of the Distressed and Eemwengu.** The closeness of Ovambo kinship and the role of families in providing support to those suffering from mental illness are not lost in these cases. Largely, these participants reflect the positive findings identified in the ethnographic phase (i.e., the supportive nature of Ovambo
families). However, not every family member is universally supportive and mental illness suffered by an individual often causes stress that ripples through a kin network.

The roles of families in the lives of those with *omananamwengu* or those experiencing more general distress is most evident in their identification of treatments for the person suffering. For some, they would not have known they were struggling with mental illness had a family member not noticed their distress. An individual with mental illness can even see himself as doing well: “it was very hard to me to see. Me, in my thinking, I must say I was good. Because everything I was thinking I was doing better. But they decide I am doing wrong.” Family members may also respond in a way that intends to re-integrate the individual back into normal ways of living, free of distress. Frans experienced his family as providing him financial support and attending to his well-being out of concern that he might attempt suicide again, which he credits as a pivotal experience in his life: “it was very, very important and today I am with them because they love me still.” Ovambo families can offer reassurance in the lives of those who struggle with holding onto normalcy and endure ongoing distress: “they are telling me no problem. You are going to be alright.”

Recognition of an *eemwengu* within the family leads to an internal discussion about how to proceed. Families weigh their beliefs and their treatment options while emphasizing that “what we have to do is see where we can get assistance for him, whatever the case may be.” Doing whatever is necessary equates to deciding if the distress person should be brought to a traditional healer or the hospital for medication and counseling. Petrus’ uncle was inclined towards traditional healing to alleviate the madness in his nephew, and “was looking at who those people, some in Angola, that treat
people…[with] the idea to take him back to Angola,” where traditional treatment is still prominent among the Angolan Ovambo. He was able to find a healer closer to home, however, as a result of his personal connections within his town in the North. Petrus’ mother was equally invested in his treatment process as she actually went with him to the traditional healer for treatment. Others go to the traditional healer “because a relative, he wants to take me there…he take me the traditional healer.”

Families are equally involved in taking individuals to a hospital if necessary. Although families might struggle to identify an instance of mental illness from a medical sense, when such a state is recognized, supportive families will take that person to a hospital. Once Mathew’s family recognized that he was struggling, his “mother said ‘okay, let’s go to the hospital.’” Other families are equally as active in taking a person to counseling or insuring their medications are taken. Commitment to the treatment of these individuals reflects Ovambo values, especially the importance of re-establishing harmony and ease in families after a disruption.

Attention to mental illness is not universally easy in Ovambo families. The process of treatment and the presence of symptoms themselves can be disruptive and upsetting. Mathew’s mother described how the tension in her family regarding Mathew begins: “It’s a lot because he doesn’t work anymore. He gets a pension fund but when he gets his pension fund he just spends it in town and doesn’t come home with anything.” According to Mathew, there has been “some disappointment as well,” as he has navigated his treatment and recovery. Ovambo culture is highly attuned to one’s contribution to the group, and being unable to contribute as a function of mental illness may naturally lead to discontent within even close families.
Belief in Treatment. Central to deciding on what type of treatment to seek is belief. The Ovambo have hospitals, counselors, and *odudu* at their disposal for the treatment of mental illness. Some individuals receive both Westernized and traditional types of care, switching back and forth as necessary such as Kleopas, whereas others seek just traditional healing (e.g., Petrus) or just medical and counseling-based treatments (e.g., Frans and Mathew). The route taken often depends on the perceptions of one’s family with respect to what is a reasonable type of care.

For some, Namibian hospitals are not up to the task of treating an individual with mental illness. People worry that “if [the mentally ill] go to hospital they will be just be [treated] the same. Even if I came today fighting or whatever, if you come there, we are just going to be in the same the ward [as non-psychiatric patients].” Hospitals often do not provide information about a person’s actual mental illness, and families worry that this hinders a person’s ability to actually improve. Thus, these Ovambo rely on tradition and their beliefs that healing occurs when an *odudu* can make use of spiritual connections and natural remedies to alleviate symptoms of madness. Petrus’ uncle felt pleased with the treatment his nephew received: “at the end of the day, what I got from the action is positive.” Kleopas, though he received medication, counseling, and traditional healing, believes in traditional practices because he sees the remarkable improvements in his own life: “when I go to the traditional, from there I stop hearing [voices].” Those who seek traditional healing do so because of a sense of trust that overrides the prominence of medical treatments in Northern Namibia. These people might have to work harder to find a healer in the North, but they believe mental illness is a function of curses and potential bewitching. As such, tradition becomes the primary response in times of duress.
Traditional healing is not an answer for all. Many Ovambo, especially younger individuals like Mathew and Frans, have deviated from traditional beliefs. Mathew feels “there’s no perfect traditional healer in my belief as well,” and recognizes that many are after the money of their patients instead. Those who do not believe in tradition place their trust in the hands of medical interventions and sometimes counselors to relieve psychological distress. Mathew’s family believes in hospitalization to deal with psychological concerns; thus, he was brought to a psychiatric ward when his symptoms became too invasive. Those who believe in the hospital are confident because “in the hospital, they take their job very seriously and [patients] will turn out to be okay.” Frans considered traditional treatment but felt more encouraged by his positive experiences in counseling, and this encouragement eclipsed any belief he might have had in curses. Some Ovambo are developing an understanding that medical treatment and counseling may take time whereas traditional healing is often considered to be a singular treatment – a person meets with a healer once or stays with him or her for a short amount of time and is then healed. Medical and psychological intervention may take longer, but this has not dissuaded some Ovambo from turning to this modality of treatment.

Because of the role belief plays, efficacy of specific treatments is naturally uncertain. Traditional and modernized treatments in the lives of psychologically distressed Ovambo are not without their inherent flaws. Some traditional healers are frauds and medical treatments often do not fully inform patients. This contributes to a context in which multiple types of care may be sought, depending on the need of a given person. Integrating types of treatment may be best for those individuals who believe in *omananamwengu* as a curse or as interference from ancestors as long as they are willing
to trust treatments offered by counselors and hospital staff. What appears most important is that the individual is able to benefit from the treatment. This belief in the modality of intervention seems to be directly tied to the belief that mental illness is curable. Regardless of the type of treatment sought, each of the individuals in these cases were believed to be cured of their psychological distress, even if some symptoms were observed to linger (e.g., Mathew’s drinking). Potentially, this belief in treatment speaks to the possibility that intervention alleviates these external causes of distress.

**Integration of Ethnographic and Case-Study Findings**

The findings from both phases of this research reflect the conceptualization of mental illness as madness in Ovambo culture. Moreover, both phases emphasize the role of alignment between believed etiological sources of psychological distress and the type of treatment (traditional or Westernized) that may be most efficacious. Ovambo culture provides a context in which some eemwengu are cared for and others are left isolated in their experience of psychological distress. Being a ‘mad one’ imparts shame within communities and, at times, in families despite their role and importance in treatment for somebody who is suffering mental illness. Omananamwengu emerged in these findings as a culturally relevant understanding of how mental illness is defined. This syndrome is a cultural belief, based in traditional understandings of the onset of mental illness (witching and cursing) but is also used as a descriptor by those who adhere to medical explanations of mental illness (e.g., Matthew). Westernized practices is developing and increasing in Northern Namibia and appears useful to some Ovambo but will benefit from attention to the cultural beliefs and contextualized experiences identified in both phases of this research.
Chapter 5

DISCUSSION

The findings of this multiple phase qualitative study offer further insight into the cultural understandings and lived experiences of mental illness and psychological treatments among the Ovambo in Northern Namibia. The results point to the culturally based conceptualizations of mental illness as madness (*omananamwengu*), regardless of whether or not an individual believes in traditional or modern etiology. To the Ovambo, this condition can be treated by either counselors or traditional healers, depending on what is actually believed in by the individual in need of care. Treatment seeking, however, is also predicated on the beliefs as families as many Ovambo families band together in times of need to support those who are suffering from distress. Family support is not always the case, as those who suffer mental illness sometimes become outcasts in both society and in their family networks.

Although the narrow categorization of mental illness in Ovambo culture persists, various types of Westernized treatments have developed further since Namibia’s decolonization. Training programs exist for psychiatric nurses, clinical social workers, and psychological counselors. As such, many practitioners are trained from a Western perspective, and these types of treatment are readily observable in Northern Namibia where traditional healing is also waning as a function of modern, fraudulent healers. Westernized treatment faces several impediments, however, as it is often mistrusted. Many Ovambo still prefer traditional healing as a method of alleviating psychological distress, or madness, that stems from curses, witches, and angered ancestors. These findings are the first of their kind among the Ovambo in Northern Namibia. Moreover,
they provide useful information in informing any Westernized treatments in Northern Namibia by indicating cultural beliefs about mental illness among the Ovambo.

Interpretation of these data is incomplete without attention to my role in the development of the analyses. As a White male from the United States trained in Western psychological practice, I carry with me my own means of asking questions and understanding mental illness. Furthermore, inquiring about the nature of traditional practices and cultural beliefs may elicit some reluctance from respondents. Though no substantive claim can be made, the results provided and discussed are founded in quality interpretation, made by myself as a tool of the research with attention given to my own biases. Being accompanied by an interpreter throughout the research and being guided by members of the Ovambo community while I lived in Northern Namibia were key to my deriving the deep qualitative data. That traditional healing is a secretive practice cannot be ignored when considering my role as an outsider. Many Ovambo individuals I discussed traditional healing with informed me that traditional healers are hard to find in general but that many Ovambo may be weary to inform me of their locations because of my nature as an outsider. The one healer found, as well as the other participants, provided full answers to my questions either in English or in Oshikwanyama. My impressions of the data are evident in the interpretation (see Chapter 4) and the discussion of the relevance of these findings. I witnessed a cultural perspective of mental illness different than my own and a culturally-sensitive practice of Westernized counseling in Northern Namibia that was recognizable to me but significantly different than my own training. With this in mind, the findings are situated within the extant literature on mental illness in
non-Western contexts and lend information to a region in which more knowledge about mental health and illness is needed.

Understanding Ovambo cultural beliefs about mental illness and its developments provides valuable insight that can inform any mental health practice, traditional or Westernized, in Northern Namibia. The understanding of mental health in Namibia is limited (MHSS, 2005) and much of the empirical and theoretical literature from the country focuses on Westernized conceptualizations of mental illness. Though research has alluded to or quantitatively identified symptoms of distress related to depression (Ruiz-Casares et al., 2009; Shifiona et al., 2006) and posttraumatic stress (Bartholomew, 2012; Feinstein, 2002), the cultural meanings of syndromes and symptoms would augment understanding of mental illness in Namibia. Augmenting conceptualizations of mental health needs in Namibia does not imply abandoning Westernized modalities of treatment or even those definitions of mental illness. Rather, the intention is to draw attention to the importance of understanding the intersection of culture and mental health through social constructivism. To that end, the current research offers insight into Ovambo cultural beliefs about distress and treatment as well as the nature of Westernized mental health care for the Ovambo, the processes in Ovambo traditional healing, and the experience of living with mental illness in Northern Namibia.

**Ovambo Beliefs about Mental Illness and Treatment**

The initial question for this research was intended to guide an exploration of the beliefs Ovambo individuals have about mental illness and its treatment in Northern Namibia. Various beliefs about mental illness and its onset manifested in the Ovambo individuals in this research. Participants across the samples were cognizant of traditional
explanations and modernized understandings of psychological distress as an illness rather than a curse. In contrast, Ovambo cultural tradition frequently explains the onset of mental illness with respect to some sense of mysticism and spiritual connections to ancestors that is aggregated into a singular category of mental illness (i.e., *omananamwengu*). Knowing this culturally-constructed syndrome can help inform psychological healing and intervention in the Ovambo context. Additionally, beliefs in mental illness and various types of treatment modalities (traditional and modern) reflect broader cultural and psychological processes, such as the use of witches, curses, and ancestors as a means of social control and social prescription of behavior.

**Witches, Curses, and Ancestors as Etiology for Mental Illness**

Ovambo cultural beliefs include a reliance on abstracted and external explanations for the onset of mental illness. Somebody becomes bewitched by seeking personal gain and cursed by stealing or angering ancestors. These explanations externalize the onset of mental illness but also reflect common belief systems in African culture (e.g., Mzimkulu & Simbayi, 2006; Sabone, 2009; Sorsdahl et al., 2010; Thomas, 2007; Vranckx, 1999). Although this way of understanding the etiology of mental illness is external, these sources of mental illness also represent an alternative, non-Western, way of defining the concept itself. Various schools of thought and theoretical orientations to treatment pervade Western psychological practice. Each relies on a specific understanding of where mental illness comes from and how it develops within an individual. Witches, curses, and angry ancestors are the Ovambo traditional means of explaining where mental illness actually comes from. Participants did recognize that some divergence exists today – those who have become educated no longer adhere strongly to these traditional beliefs.
However, many who believe in Westernized perspectives of mental illness continue to describe distress only as madness, mistrust counselors, and are unable to identify how mental illness develops beyond being a sickness.

The role of ancestor reverence in Ovambo mental health is also a shared experience in African culture. Among the Xhosa of South Africa, for example, angry ancestors is a primary way of explaining mental illness in an individual (Mzimkulu & Simbayi, 2006). Having this information assists in understanding the importance of traditional beliefs in Ovambo culture. Ovambo healers are believed to be able to connect with ancestors, and through this connection, foster the reduction of a person’s madness. Attention to ancestor reverence, however, is not confined to traditional practices because it represents a broader understanding of where mental illness comes from in Ovambo culture – ignoring ancestors, who are normally protective and revered by the Ovambo, leads to distress. Clinicians who openly integrate African ideas of ancestor reverence into psychological practice may be poised to offer a more culturally sensitive treatment (Bojuwoye, 2013). According to Bojuwoye (2013), the “key premise in the belief in ancestral spirits is about influences…on the behavior” (p. 80) of the living. Connection to ancestors represents an emotional bond that helps inform African beliefs on making healthy lifestyle choices and weighs on the well-being of living descendents (Bojuwoye, 2013). Because ancestors are respected in many African cultures and are a connecting point in the lives of Africans, Bojuwoye (2013) contended that counselors can employ ancestors as examples of positive behavior to be provided for clients. Moreover, counselors who reestablish connections to ancestors through therapeutic processes may contribute to the overall health of African clients because of the belief that well-being
deteriorates when links to ancestors are severed (Bojuwoye, 2013). Western-trained psychological practitioners in African settings can benefit from engaging their respective communities to understand the “psychological constructions relevant to the local communities, who invents the constructs, how the constructs evolve, and for what purposes” (Mpofu, 2002, p. 184). Part of this among the Ovambo may be attention to ancestral relations.

Because ancestors and curses exist outside of the individual, the Ovambo perceive mental illness as something that can be easily treated, especially through traditional practice. The ritual may be more effective because it acts to remove a condition in a person’s life, such as a curse, rather than fostering insight into the underlying constructed experiences of psychological distress. Similar reasoning has been found in Namibian Caprivi culture (Thomas, 2007). The idea of manageability of mental illness represents a psychological perspective that one can overcome a state of impairment. Traditional healers in Ovambo culture will naturally make use of this perspective as their interventions are predicated on the idea that rituals remove the external cause of madness. Westernized practitioners, however, may benefit from integration of these ideas into counseling. The explanatory model promotes belief that the condition is temporary; therefore, being able to use this sort of mindset of manageability and discuss it in counseling processes may instill a greater sense of hope in clients. Western psychotherapy espouses the value of increasing clients’ hope that change will happen through counseling (Frank & Frank, 1991; Bartholomew, Scheel, & Cole, 2015). Believing that mental illness is manageable because a treatment is readily available represents a different conceptualization of hope for change and symptom alleviation.
Potentially, this idea of hope in benefiting from treatment is a universal condition of psychological healing whereas the ritual (i.e., therapy or *odudu* intervention) is not. The Ovambo might have hope in an *odudu* treatment but not in counseling. Mistrusting Westernized paradigms of mental health care may be due to Ovambo hope and belief that psychological distress is manageable because traditional intervention weakens magical or spiritual influence.

**Omananamwengu as a Cultural-Bound Syndrome**

Related to unique explanations of mental illness etiology, the Ovambo concept of *omananamwengu*, or madness, is indicative of a set of symptoms grouped together by cultural belief. Culturally bound psychological syndromes are thought of as those maladaptive or abnormal mental states that are observable within the context of a single culture (Levine & Gaw, 1995). Although some psychiatric and psychological literature have dismissed the notion that symptoms group together uniquely in cultural contexts, others have contended that such cases are “discrete syndromes that cannot be subsumed under Western diagnostic categories” (Thakker, Ward, & Strongman, 1999, p. 851).

*Omananamwengu* is a vast set of symptoms (see Table 5) that reflects the cultural beliefs about the content of mental illness among the Ovambo. Tseng (2007) refers to psychopathology that arises from cultural beliefs as a pathogenic cultural condition. Those instances in which *omananamwengu* is linked to curses and witching clearly reflect a pathogenic cultural condition. Even those who explain *omananamwengu* through a medical lens (e.g., Case 2: Mathew) remain adherent to this cultural label of mental illness. This conceptualization of mental illness is different from the numerous diagnoses possible in Western theory and practice. In Western practice, various symptoms are
categorized under diagnoses as a means to guide treatment (APA, 2013); however, in Ovambo culture, symptoms all fall under the general idea of madness, meaning conditions like depression, anxiety, and others are not culturally identified.

Though some of the symptoms noted in *omananamwengu* are similar to those in Western culture, they represent a unique meaning system. Constructivist understandings of mental illness suggest that understanding psychological distress requires conceptualizing the nature of distress within the social context of the suffering individual (Thakker et al., 1999). For example, *thwasa* in the Xhosa culture may appear similar to a psychotic disorder (APA, 2013), but it carries unique cultural meanings that lead to its interpretation as a non-pathological experience (Mzimkulu & Simbayi, 2006; Yen & Wilbraham, 2003b). Alternatively, culturally relevant symptoms may simultaneously be observed in Western diagnoses, but this does not imply that the same diagnoses are exportable to non-Western contexts. *Omananamwengu* consists of a set of symptoms that are abnormal in Ovambo culture. Those who engage in these behaviors are referred to as *eemwengu*. Importantly, the deviation from normality can be situated within African conceptualizations of selfhood. Unique in African developmental psychology, selfhood becomes full in adulthood and rests largely upon knowing oneself through the collective (Nsameneng, 1992). *Omananamwengu* is considered as a deviation from expected adult behaviors, which suggests some aspect of normal personhood does not manifest and is instead socially labeled as deviant.

Because this social system for labeling exists among the Ovambo, this becomes the way in which mental illness is collectively constructed and expressed. The Ovambo believe, regardless of whether or not an individual subscribes to traditional or modern
etiological explanations for mental illness, that this state of madness can be applied to all individuals enduring distress. Recognition of this state has vast implications for practice, especially if counseling or psychiatry is attentive to Ovambo cultural beliefs.

**Social Control in Ovambo Concepts of Mental Illness**

*Omananamwengu* is also a consequence in Ovambo society. The conditions that lead to one being *eemwengu* include touching other people’s things and selfish consultation with witchdoctors. These behaviors are contrary to normal expectations of an Ovambo adult. One should not steal from somebody or touch someone else’s things; nor should one person desire personal gain beyond that of group well-being. As such, abnormal behaviors that are contrary to Ovambo culturally prescribed ways of being are said to lead to mental illness. Being the ‘mad one,’ a person is isolated from society – a fate naturally undesirable in a context that promotes strong networks of kin (Brown, 2011; Brown, 2013; Brown & Bartholomew, 2014). This exemplifies an intersection of social control and mental illness in Ovambo culture.

Social control, in its dominant form, describes the ways in which individuals conform to a given majority group value (Martin & Hewstone, 2007). Sorcery and magic reflect cultural means of exerting social control (Whiting, 1950). That is, one’s behavior is molded based on the believed implications of behaving in a way contrary to socially expected norms (i.e., not conforming). Sorcery and social control have been described in various cultural contexts, including the Paiute Indians of North America (Whiting, 1950) and in the Philippines (Lieban, 1960). Lieban (1960) outlined his identification of social causes for sorcery in the Philippines: “of the twenty-two sorcery cases…twelve involved disputes over land-ownership or use; among the other ten, the issues were miscellaneous
including theft, vandalism, political competition, difficulties of a shopkeeper with customers and suppliers, adultery, and a rejected suit in courtship” (p. 140). These acts disrupt harmony within a collective of individuals and reflect reasoning for sorcery that is similar to many of the reasons for curses identified in Ovambo culture. Moreover, the use of sorcery and traditional ‘magic’ are described in historical accounts of the Ovambo (Tönjes, 1996). The Ovambo prominently noted stealing or interacting with witchdoctors as reasons for curses being brought upon individuals. However, others identified transgressions against another person or family leading to revenge witching.

Whiting (1950) referred to the role of sorcery in societies as a type of coordinate control. She conceptualized coordinate control as a social system in which peers retaliate against one another based on perceived transgression. Sorcery (analogous to witching and cursing) and magical processes are more prominent in those cultures with coordinate control because they represent one person enacting retaliation on another as a function of perceived slight (Whiting, 1950). Potentially, coordinate control determines the way social control takes shape in Ovambo culture. Retaliation and punishment for transgression occurs at peer levels and is carried out by means of witching and cursing. Thus, Ovambo behavior becomes socially controlled according to the script that selfishness or disrupting interpersonal relationships within a family or community will lead to one being cursed, witched, and mad. Importantly, mental illness is used as a consequence. Mental illness, or omananamwengu, is not only an undesirable state of being based on its symptoms, but it is marginalized in Ovambo culture. Those called eemwengu are isolated from the group. Therefore, curses and witches in Ovambo culture maintain conformity by imposing fear that a person who commits a transgression or
attempts to set himself above others by being greedy will be isolated from the cultural community. This fear is likely powerful enough to construct normative behaviors among the Ovambo given values of group cohesion and cultural scripts around interpersonal closeness (Brown, 2011; Brown, 2013; Brown & Bartholomew, 2014).

**The Role of Belief in Treatment**

Frank and Frank (1991) have long contended that psychological healing cannot occur without the distressed person believing in the healing capacity of the given ritual. Whereas the normal ritual in dominant Western culture may be psychotherapy, other cultures develop unique rituals that are believable to the members of the culture (Mariarch, 2003; Mpofu et al., 2011). The Ovambo expressed belief in types of treatment across the phases of this study. General participants identified the reality that treatment choices are selected by families based on their belief in traditional or Westernized care. Case study participants had their decisions made for them based on the beliefs of their families. Belief does more than guide treatment; belief may also be a mechanism in the healing process that contributes to the experience of change or symptom alleviation. The case study individuals each identified themselves as being free of psychological distress after their respective treatments. Moreover, each identified their treatment experiences, alongside those treatments being trusted by their families, as the primary reason for this improvement. Because these beliefs are held at the family level, the importance of kinship in determining one’s behavior and one’s health is further emphasized in Ovambo culture. Additionally, evidence of this nature is affirming in these few cases that one’s belief in a type of treatment propels, in some ways, the efficacy or perceived utility of
that avenue of care. Belief may, in turn, impede the efficacy of some types of treatment as well.

Specific Ovambo beliefs may align to specific types of treatment. For example, ancestor reverence in African culture often implies that individuals believe deceased ancestors influence the lives of living descendants for better or for worse. If this belief is held, one’s interaction with ancestors influences changes in behaviors, implying that attending to this conceptualization during a psychological healing ritual is worthwhile (Bojuwuye, 2013). Ovambo șôdu working with and through ancestors might represent the component of the healing ritual that is understandable and believable to Ovambo who identify ancestors as influential on their behaviors. This alignment with cultural beliefs makes the traditional treatment transparent and agreeable within the cultural context.

Curability of Mental Illness

Related to the concept of belief in treatment within the data for this study is the concept of mental illness curability. Evident in the data is a perception that treatment, regardless of the shape it takes, should result in the deterioration of the given mental illness. Individuals go to șôdu, counselors, or the hospital to do away with the given distress. However, this concept is contrary to many Westernized conceptualizations of psychological treatment. For example, Western psychologists have posed that psychological distress is a normal component of life that may ebb and flow in conjunction with lived experiences (Hayes et al., 2012). Therefore, even when one receives psychological treatment, outcomes may be framed within symptom improvement and the accrual of new coping skills rather than being cured. Ovambo cultural identification of being cured after brief treatments through tradition or
modernized interventions reflects an external representation of the root of mental illness. Ones curse is lifted or medications cure the illness, and symptoms are believed to be entirely absent. Considering the cases, this is not readily apparent. Both Martin and Kleopas, for example, continue to exhibit some struggles with psychological distress yet consider themselves to be cured.

**Western Treatment Modalities in the Ovambo Context**

The second question of this research revolved around treatment modalities available in Northern Namibia – specifically, what are the processes involved in traditional healing and Westernized treatments in Northern Namibia? Although many participants mistrusted Westernized psychological and psychiatric interventions, the evidence simultaneously indicates its potential as a modality of treatment for the Ovambo in Northern Namibia. For example, three of the four cases benefited in some way from Westernized intervention (see Table 3). That counselors were willing to consider culturally sensitive treatment in the context of Northern Namibia offers further insight to the value of this type of intervention within the Ovambo context. The counselors and psychiatric nurse interviewed suggested the importance of attending to cultural beliefs in their work to an extent that might be divergent from their training. Westernized training at universities might encourage cultural competence while readily adhering to Western theory, which naturally inclines one towards a more complex understanding (i.e., additional diagnoses and etiological sources) of mental illness than omananamwengu. In the North of Namibia, practitioners have little choice but to culturally adapt their practice to build a bridge between their services and those Ovambo struggling with psychological distress. Being culturally competent within the context of counseling is considered to
contribute to the overall therapeutic experience of clients (Sue & Sue, 2008). This may be especially true and necessary in international contexts (e.g., Heppner et al., 2008; Moodley & Stewart, 2010). Counselors, psychiatrists, and nurses expressing a sense of openness and humility towards clients who hold diverse, non-Western explanatory models of mental illness is pivotal in the Namibian context. Such a stance towards counseling, in general, has been shown to be a positive influence on clients’ experiences and benefits from this type of treatment (Hook et al., 2013).

An important example of this is the use of lay, volunteer counselors through NGO’s in Northern Namibia. Because concepts of mental illness are culturally constructed, knowing the sources of the constructed ideas of mental illness requires that practitioners in Africa engage with the communities they serve (Mpofu, 2002). Lay counselors embedded in villages naturally engage in communities. This mindset was also clear with some of the trained counselors interviewed. They were aware that diverse cultural conceptualizations of mental illness exist among the Ovambo and that they must be attended to, integrated into, and at times, challenged in the counseling process. Interestingly, this idea of cultural-integration was experienced by counselors as contrary to their training experiences. This may change as counselor training in Namibia continues to grow. But, the fact that counselors working with the Ovambo of Northern Namibia interact with communities and provide volunteer counselors to remote villages suggests that community engagement is valued as a way of finding an avenue to promote Westernized counseling as a useful treatment.

Though the value of being culturally competent was clearly expressed, the Westernized practitioners were varied in their beliefs about integration of traditional
practice and counseling or psychiatric care. Several did indicate that there would be substantial value in finding ways for competent and genuine *odu du* to work alongside and mutually refer with counselors. Trimble (2010) offers insight into this sense of collaboration in Native American culture through a specific case study. He described an instance in which a Native American woman was diagnosed with posttraumatic stress disorder and an acute personality disorder who, through the experience of a culturally meaningful dream, was propelled towards seeking traditional treatment per her cultural history (Trimble, 2010). Collaborative treatment was effective in this case. Similarly, the case study evidence from the current research provides similar insight. Kleopas was brought to a traditional healer, a hospital for psychiatric medication, and a counselor. His case represents one of simultaneous use of different types of psychological treatment. Even though multiplicity in his treatments was not brought about by integration of traditional and modern practitioners, his receiving both types of intervention reflects the potential benefits of using in combination both traditional and Western methods. This process is proposed elsewhere as well, as people in need of care tend to do what will work in order to alleviate symptoms (e.g., Moodley & Sutherland, 2010).

The Ovambo may believe in both Westernized treatments and traditional treatments, though indigenous treatments seem more prominent in African contexts (Berg, 2003; Mpofu et al., 2011). The variance in Westernized practitioners believing in the worthwhile nature of integration represents one of the ongoing challenges of this process as well (Bojuwuye & Sodi, 2010). Some of the counselors in this research indicated an exceptional skepticism towards traditional healers, and this is not wholly unfounded due to a plethora of fraudulent healers throughout Namibia. However, some of
the sample was even skeptical of those *odudu* who could be considered genuine. Similar evidence manifests in other African contexts where some practitioners trained in Western practice express skepticism towards traditional healers (Kahn & Kelly, 2001) and others believe integration of treatments is beneficial (Mahape & Peltzer, 1999). In the interest of providing services that work for a diverse base of clients, mental health services for the Ovambo may improve if a network of trusted collaboration between genuine *odudu* and Westernized practitioners can be established. Some of this network has been fostered by a few counselors in Northern Namibia, but further effort is necessary to build a system of mutual referrals based on clients’ needs.

**Ovambo Traditional Healing**

Also central to the second question of this study is the nature of traditional healing in Ovambo culture. The prominence of traditional healing is clearly waning in post-colonial Namibia, even in the rural North for several reasons. Participants alluded to the need for secrecy surrounding traditional healing because of its stigmatization by religion as well as for the purpose of maintaining the dignity of the practice. Many healers appear to have retreated to Angola, where the Angolan Ovambo have been previously referred to as culturally “deep [Ovambo] Kwanyamas” (Brown & Bartholomew, 2014, p. 126). Though the tradition has become more secret, it is clear that it offers some value to the cultural context and is open to the potential integration of Westernized and traditional treatments.

Indigenous healing practices are often preferential in African contexts (e.g., Berg, 2003; Mpofu et al., 2011) and are frequently the first form of intervention sought (e.g., Kahn & Kelly, 2001). The practice in Ovambo culture represents a means of attending to
the onset of mental illness in a manner that compliments beliefs about curses, witches, and ancestors. Similar findings have been identified in other Namibian cultural groups as well (Vranckx, 1999). Interventions in traditional healing, whether they include the use of herbs, the ability to know somebody’s distress without speaking, connections with ancestral spirits, or the ritualistic slaughter of livestock, are accepted by many Ovambo. These interventions developed naturally within the cultural context as magical abilities are given credibility through culturally established belief. Cultural beliefs shift over time, especially with the oppressive cultural reality of colonial rule and post-colonial development. As such, traditional beliefs may wane or become masked and integrated into new colonial realities when they are stigmatized or outlawed by oppressive regimes. Interestingly, Ovambo beliefs persist in many ways. Several participants indicated that, in times of duress, an Ovambo family would default to traditional beliefs even if that family believes in Western concepts or a specific religion that decries traditional values. Thus, the role of traditional healing is still pertinent in Ovambo belief systems and reflects the patterns noticed in other cultures in which various cultural groups maintain the prominence of traditional practice in psychological healing (e.g., Farooqi, 2006; Kahn & Kelly, 2001). Traditional healing also offers the Ovambo a means to seek treatment when psychological problems manifest and counseling is mistrusted. Although counseling appears mistrusted by many general Ovambo, traditional healing seems far less accessible, from my outsider perspectives, than counseling in Northern Namibia. This dynamic represents a unique problem in the Ovambo context – traditional healing has become stigmatized and secret but counseling is not universally considered a valid form of intervention.
Because traditional healing is less available, finding ways for the practice to co-exist with modern interventions may be useful but requires collaborative attitudes among healers. In other African contexts, traditional healers have expressed openness towards integration of traditional and modern treatments (e.g., Campbell-Hall et al., 2010). The healer in this research expressed a similar disposition. She hoped for a way to refer between herself and the hospital in her village. However, this opinion is potentially complicated by the genuine nature of being a traditional healer. Several participants across the phases of this research understood that witchdoctors and fraudulent healers cause substantial problems. Westernized counselors were skeptical about healers, in part, because of this potential. Plausibly, the witchdoctors and frauds that have come to dominate visible ‘traditional’ practice in Ovambo culture would disavow integration on the basis that their business would be disrupted. Odudu are interested in the care of the distressed more than their profit; therefore, odudu may be poised to advocate more for integration if avenues for collaboration are opened.

Alternatively, the cultural practice around odudu and traditional healing itself may preclude access to the healing system by non-Ovambo people. Specifically, a degree of secrecy may permeate the cultural practice of healing and contribute to the efficacy of these treatments themselves. Ovambo people may then believe that without secrecy surrounding the treatment process, any interventions would be ineffective. Though several participants indicated that traditional healers are few and far between in Northern Namibia today, two of the four cases (Petrus and Kleopas) were treated by a traditional healer in Northern Namibia. The fourth case (Frans) considered seeking a traditional healer. This may suggest that many Ovambo know how to find a traditional healer, but
only do so when the need truly arises. In times when need for such a practitioner is not prominent, secrecy surrounding the practice takes hold. Ethnographic participants indicated that faith without questioning is necessary for traditional healing to be effective. As such, cultural beliefs and faith might prevent Ovambo individuals from sharing the underlying secrecy of this practice with outsiders. Secrecy may then become part of the healing itself and simultaneously speak to the heightened cultural value of *odudu*. Conceptualizing the role of secrecy alongside the proliferation of fake traditional healers, however, requires much further empirical exploration.

**Living with Mental Illness in Northern Namibia**

Lastly, the current research was undertaken to ask what is the lived experience of those who have experienced mental illness and psychological treatment in Ovambo culture. The experience of mental illness, though considered treatable in Ovambo culture, is a difficult process to endure. Divergent evidence from this research simultaneously indicates that enduring psychological distress in Ovambo culture can be met with support from families as well as remarkable marginalization. Apparent in the cases and in the perspectives offered by ethnographic participants is a sense of shame that accompanies mental illness. Frans, for example, felt a great deal of shame returning to the village after he attempted suicide. Similarly, suicide in the ethnographic phase was seen as a way to cope with shame and correct the experience of interpersonal distress. Negative internalization of oneself as a function of mental illness is a further impairing process in an already difficult situation. The Ovambo question how a person became mentally ill and wonder if it was something that the individual did to himself or herself. Assumptions can be made that the *eemwengu* individual wanted to be rich or have good luck.
Family Involvement in Mental Illness and Treatment Seeking

Relationships are key in Ovambo culture and support throughout kin networks is common in times of need and distress (e.g., Brown, 2011; Brown, 2013). With respect to mental illness, the role of families is ever present. A family can care for an individual with mental illness, as was true in each of the cases included in this research, or they can ignore a person’s difficulties and hide him or her from public eye. Some other African cultures view abnormal psychological symptoms from a more positive lens (e.g., Mzimkulu & Simbayi, 2006; Sabone, 2009). This is not true in Ovambo culture. Omananamwengu is seen as entirely problematic. Those who experience this madness are identified and separated from the broader cultural group because they are different. This stigmatization is in stark contrast to what has been observed generally in sub-Saharan Africa. Others have suggested that, in sub-Saharan contexts, “psychopathology is also collective, and the bearer of the illness is taken care of by the group” (Mwiti & James, 2013, p. 77). Collective care is not universally realistic in the Ovambo context. Even if families and extended kin networks are exceptionally supportive and caring for the individual suffering mental illness, such support may not exist outside of homes in social communities. Certainly, this does not indicate that families automatically denounce somebody experiencing omananamwengu. Rather, the findings suggest that these individuals are socially ostracized frequently outside of kin networks but also need a supportive family system, especially given the Namibian government’s developing awareness of mental health needs in the country (MHSS, 2005).

Understanding the nature of social support and family relationships also seems pivotal to any psychological intervention used for those Ovambo suffering from mental
illness. Westernized practitioners identified the role of families in maintaining treatment gains and other data confirm the importance of these relationships. Moreover, the findings from the case study phase affirm the ethnographic assertion that families help facilitate the treatment seeking of a psychologically distressed person. Counselors can make use of this information (i.e., the role of families in Ovambo culture) to promote well-being of the distressed and insure that supportive environments are fostered. Many do this already, but it represents another avenue through which Ovambo culture can be bridged with modern, Westernized clinical practice.

Limitations and Future Research

Although this study offers a thorough consideration of the nature of mental illness in Ovambo culture and the dynamics of psychological treatment in this context, the research is not without its limitations. First and foremost, I am an outsider to Ovambo culture. I bring my background as a Western-trained clinician to any work I do within the realm of mental health. This is not to say that training makes me incapable of understanding diverse explanations of mental illness; rather, that my predisposition is toward Western models of diagnosis and therapy. Having this outside perspective may be beneficial, in some capacity, in terms of being able to interpret some of the psychological processes ongoing within Ovambo cultural beliefs. From another perspective, being an outsider may create a natural barrier that inhibits my ability to fully gather information about cultural beliefs. Such a barrier is possibly constructed by participants’ perceptions of an outside like myself asking seemingly mundane questions about cultural beliefs pertinent to mental health and psychological treatment. However, my perception was that participants were open to the research process and in their expressions. This is further
complicated by the use of an interpreter in several interviews. Though English is the official language of Namibia and the majority of interviews were conducted in English, several interviews were interpreted by a single interpreter. Despite the competence of the interpreter, some important concepts and ideas are possibly lost in the translation process.

Furthermore, the sample of this study was imperfect in the gender representation in the case study phase and the limited access to *odudu*. Generalization is not the intention of ethnographic or case study research, but future work should account for the sample limitations of the current research. In the case study phase, no women were included as none were found available or willing to participate in the community where this research was conducted. Because the participants in the ethnographic phase did discuss some symptomatic variation between men and women experiencing *omananamwengu*, sampling men and women is necessary in any future research.

Similarly, only one traditional healer was available to participate in this study. Genuine *odudu* are difficult to identify in Ovambo culture, especially in Northern Namibia. Future research should consider identifying Ovambo traditional healers in Angola as well to gain a greater understanding of the processes in traditional practice. Moreover, future research could clarify and confirm the role of Ovambo cultural beliefs pertinent to this indigenous practice that exist in a different post-colonial context (i.e., Angola versus Namibia).

Future research should also more explicitly explore help seeking behaviors and preferences. This research indicates the importance of individual and familial beliefs about the selection of treatment modalities. However, help seeking can be more directly conceptualized if future research can explore why individuals choose to seek or avoid help for psychological concerns. This could be similarly useful to study throughout
Namibia. The current research focused solely on the Ovambo in Northern Namibia. Namibia is home to numerous cultural groups, each worthy of their own explorations with respect to beliefs about mental illness and psychological intervention. These beliefs are also potentially made more complex in the urban-rural differences in Namibia. Since independence, several Namibians, including the Ovambo, have migrated for work purposes to larger urban centers (e.g., Tvedten, 2004). With this comes more frequent potential exposure to Western ways of thinking and ideas, especially in educational settings. Exposure to Westernized ideas has altered beliefs in Northern Namibia and may do so much more substantially in larger Namibian cities. Flowing from this concept as well is the need to assess treatment efficacy in Namibia. No study has yet sought to measure outcomes of treatment, traditional or Westernized, and this information is pivotal in conceptualizing the landscape of mental health practices in Namibia. Any such endeavor, however, should be done with methodology in mind such that researchers do not impose ways of assessing treatment efficacy in Namibia that are less understandable to participants. Instead, such future research could rely on ways of eliciting local knowledge to better conceptualize beliefs about treatment effectiveness.

Conclusion

The purpose of this research was to understand Ovambo cultural understandings of psychological distress and the available types of treatment in Northern Namibia while also developing a sense of the lived experience of mental illness in Ovambo culture. These findings offer a depth of exploration not found in many other empirical mental health research in Namibia. Other studies have appropriately worked to identify symptom presentation in Namibian culture (e.g., Feinstein, 2002; Haidula et al., 2003; Ruiz-
Casares, 2010; Ruiz-Casares et al., 2009; Shifona et al., 2006). These studies are important in adding to the mental health knowledge in a country that is still attempting to more fully understand the actual psychological needs of its citizens (MHSS, 2005).

Augmenting these findings with conceptualizations of treatment and illness in Ovambo culture provides additional information to inform any psychological interventions in Northern Namibia. Moreover, this information places Namibian mental health needs and perceptions within the scope of culturally-specific and indigenous psychological knowledge. Indigenous and cultural perspectives in psychology move researchers and practitioners away from an imposition of Western methodologies, theories, and practices (Greenfield, 2000). Explicitly identifying these cultural processes through methods that are suited to understanding culture, such as an integration of ethnography and multiple case-study, makes cultural and indigenous psychological knowledge explicit in ways that may be otherwise unattended given the prominence of Westernized training in Namibia.

Counselors have a responsibility to be culturally competent and traditional healers can benefit from mutual collaboration with modernized practitioners. This is made possible by making use of culturally based information and understanding the cultural dynamics that explain the etiology of mental illness. Ovambo traditional beliefs about the onset of mental illness persist despite modernization. Individuals and their families develop their own beliefs about what types of treatment are most valuable and, therefore, efficacious with respect to alleviating symptom distress. Potentially, Westernized practitioners may benefit from continued community-based psycho-educational outreach to help clarify the nature of mental illness within the context of Ovambo cultural beliefs. The findings from both phases of this study are integrated to more completely understand
how mental illness is understood and explained in Ovambo culture, how distress is treated in Northern Namibia, and how individuals in Ovambo culture live with and seek treatment for mental illness. Making use of the findings from both phases of the research could be beneficial to any conceptualization of counseling in Namibia as well as institutional attention given to the regulation of traditional practice.
References


Retrieved from


*Counselling Psychology in Africa, 1,* 1-11.


<table>
<thead>
<tr>
<th>Themes</th>
<th>Meaning Units</th>
<th>Significant Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where Madness Comes From: Witches, Sickness, and Other Explanations</td>
<td>Madness comes from witching</td>
<td>“through interventions of witchcraft is where we will find someone getting mad.”</td>
</tr>
<tr>
<td></td>
<td>Magic and mental illness</td>
<td>“We think its magical things. Magical matters.”</td>
</tr>
<tr>
<td></td>
<td>Mental illness can come from sickness or magic</td>
<td>“I believe that mental illness is the result of different conditions that could – from different aspects. Some people become mental retarded or having mental infection as a result of a certain sickness or I also believe that, you know, Africans, they are such people that they have those traditions. And some of them they might use them to turn other people into other kind of things. For example, somebody – I don’t know the right word to use. They use the magician people so they can do something to someone and that person becomes mental retarded.”</td>
</tr>
<tr>
<td>Omananamewngu and Eemwengu</td>
<td>Omananamwengu as a simplified explanation of mental illness</td>
<td>“Because usually in the past, like in Oshiwambo, there’s no such medicine. There’s only another thing like he’s mad, that’s all and they don’t really try to see what causes this.”</td>
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<td></td>
<td>Person’s life is lost to madness</td>
<td>“the whole life of a person is just get lost from [omananamwengu].”</td>
</tr>
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<td></td>
<td>Isolation as a symptom</td>
<td>“withdrawn. Loneliness. And then I think maybe, but that’s the most common, isolating themselves from others.”</td>
</tr>
<tr>
<td>The Roles of Families and Communities for The Roles of Families and Communities for The Roles of Families and Communities for</td>
<td>Family needs to act when one is mad</td>
<td>“what happens is that the family needs to act.”</td>
</tr>
</tbody>
</table>
**Omananamwengu and Distress**

Mad people seen as useless in society

“You find them dirty, not wearing nice, not eating nice – it is just like a useless person. Because you cannot kill a person, they are just there to die. They are useless and to him, it’s not about his rights – just a useless person!”

Whether or not an *Omananamwengu* is cared for differs across families

“That differ from family to family. Some family will want to hide that person to be seen by other people. Some of them will send them to cattle post. But some of them who understand why, they take care of him.”

**Witchdoctors, Frauds, and Odudu**

Secrecy surrounding traditional healing

“Now, um, so if people actually in your family would stand up and go to a traditional healer, a lot of people would keep it a secret.”

True healers do not charge excessively for their services

“True traditional healers they don’t charge people too much because they don’t make a living from people.”

Although you must consult others in community, traditional healing is still kept secretive

“So, basically you will have to go to people who have people suffered the same condition and maybe seen a certain improvement. It’s really secretive, this traditional healer anything. More especially those ones that are known to be true.”

**Counseling, Medicine, and Religion as Means for Healing**

Worries about confidentiality in counseling

“Yeah and [say for example] like when you go for counseling and then you hear your story somewhere else.”

People would trust social workers from different tribes

“It would be better if social workers were different people like only come here for work and don’t.”

Believes psychologists can be smart but still does not believe they are effective

“I watch movies, you know, with psychologists and whatever. It’s quite interesting, but I think it’s really somebody who has the acumen and understanding of the human mind and can be so smart. They ask questions
about whatever the other person has to say. There are some of them that are really skillful and some of them that just study and I don’t know, but I need to see that confirmation from day to day. I have not seen that yet.”

<table>
<thead>
<tr>
<th>Seeking Care: Decisions based on Need and Belief</th>
<th>Need for belief in treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>“But it’s all a matter of what the psychological problem or illness, it’s a matter of belief. You need to believe in the treatment.”</td>
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</table>

| Church or traditional healers based on belief |
| “Like, for example, I’m a Christian and I will start acting like mad, my family might think that I’m betwitched and they will take me to [odudu]. It’s either they take me to [odudu] or they take me to church.” |

| There is some fluidity in seeking treatment modalities |
| “Yeah. They can do that. They can do that whenever. They can even go the hospital then later to the traditional healer. Or traditional healer and when they see the situation is not [getting better], hospital later.” |
### Table 2

*Themes, Sample Meaning Units, and Sample Significant Statements from Westernized Practitioners and Traditional Healer (Phase 1)*

<table>
<thead>
<tr>
<th>Themes</th>
<th>Meaning Units</th>
<th>Significant Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services in the North</td>
<td>Counselor challenges peoples beliefs about being bewitched by attending to religious beliefs</td>
<td>“Yet if you look at the religious part of Ovambo culture, the majority of them are Christian. I often confront that many times to say that ‘you’re a Christian but you’re still worried about the bewitchment. Let’s have a look at how you – is it god or is it the spirits.’ But the stories are absolutely amazing.”</td>
</tr>
<tr>
<td>Some situations, like, grief, must be accepted in counseling</td>
<td></td>
<td>“But in situation that you cannot change, you find yourself that there’s no other way to change that situation, like if someone past away. Those are the situation that you don’t have anything to do for, you have to learn to accept although the person might, we advise them and counsel them to grieve and counseling them through bereavement to accept.”</td>
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<tr>
<td>Value counseling relationship</td>
<td></td>
<td>“It’s like we normally build up [the] relationship.”</td>
</tr>
<tr>
<td>Traditional Beliefs and Healing</td>
<td>Communication with ancestors is felt spiritually</td>
<td>“they communicate spiritually. Spiritually but only from a man’s voice not her woman’s voice. A man’s voice comes from her body.”</td>
</tr>
<tr>
<td></td>
<td>Healer believes communication with counselors is poor</td>
<td>“She says the communication with the social workers is not good…she said some people come to her first.”</td>
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<td></td>
<td>Through ancestors, traditional healer knows what is wrong with a person</td>
<td>“The person doesn’t have to say anything, but the ancestor will show her that this person will be this and this and this.”</td>
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<tr>
<td></td>
<td>Counselor sees a</td>
<td>“There’s no education. There’s no – I ask</td>
</tr>
<tr>
<td>Explaining Mental Illness through Modern and Traditional Lenses</td>
<td>clear lack of understanding of mental illness exemplified in people not knowing their own diagnoses or medications</td>
<td>people ‘so what was your diagnosis?’ Not only me but from doctors as well, no the doctors have not told. Please bring in the paperwork, and you read [medication]. This is an anti-psychotic drug that these people are taking. Yeah, so I think definitely more awareness, more understanding you know.”</td>
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<tr>
<td>Counselor believes some people develop mental illness as a function of stress</td>
<td>“Some of them just started like that because someone made them angry and they start behaving in non-traditional ways. Some of them went to school and that time start talking, talking, talking. For instance, they start experiencing pressure more.”</td>
<td></td>
</tr>
<tr>
<td>Psychological problems come from an inability to cope with variety of problems</td>
<td>“it develops like a person have many problems. And the problems, he doesn’t know how, doesn’t want to accept the situation or she tries to cope with the situation is where the problem starts and it leads those people into, to suffer from other health related problems like stress, social maladjustment and others.”</td>
<td></td>
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<tr>
<td>Integration of Treatment Modalities</td>
<td>Important to integrate counseling and traditional healing</td>
<td>“we work with traditional healers as well. We have some work with the local counselors, we’ve had some personal growth training with them and that was very helpful. I think there is a role for them and they can play a really productive and constructive role.”</td>
</tr>
<tr>
<td>Believes that traditional healers would not accept working together</td>
<td>“Yes. I think that would help, but I don’t know how we would make each – one [traditional healer] would think it’s positive and the other would think it’s negative.”</td>
<td></td>
</tr>
<tr>
<td>Traditional healers would not integrate because they help only for their business</td>
<td>“The traditional healer is making business. For us, we are not making profit. We are just helping people, but for him if people start coming here now, even they discover he is not doing anything to you but in counseling is for the mind.”</td>
<td></td>
</tr>
<tr>
<td>Case 1: Petrus</td>
<td>Age: 34; Gender: Male</td>
<td>Interview Data: Formal interview with uncle</td>
</tr>
<tr>
<td>Case 2: Mathew</td>
<td>Age: 26; Gender: Male</td>
<td>Interview Data: Formal interview with individual, Formal interview with mother</td>
</tr>
<tr>
<td>Case 3: Kleopas</td>
<td>Age: 44; Gender: Male</td>
<td>Interview Data: Formal interview with individual, Two informal interviews with cousins</td>
</tr>
<tr>
<td>Case 4: Frans</td>
<td>Age: 29; Gender: Male</td>
<td>Interview Data: Formal interview with individual</td>
</tr>
</tbody>
</table>
Note. * Case 2, 3, and 4 all sought psychiatric care to some degree; however, none was informed of a formal diagnosis. Case 4 did not believe his attempted suicide indicated mental illness.
Table 4

*Themes, Sample Meaning Units, and Sample Significant Statements from Cross-Case Analysis (Phase 2)*

<table>
<thead>
<tr>
<th>Themes</th>
<th>Meaning Units</th>
<th>Significant Statements</th>
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</thead>
<tbody>
<tr>
<td>Development and Symptoms of Mental Illness</td>
<td>Nephew lent somebody money and believed the people he lent money to were responsible for his problems</td>
<td>“What he remembered was that he had borrowed money to somebody, and he went to ask that money. Somebody from, I think he said from Uganda, he borrowed him money and he went to go get his money back and the other guy is kind of refusing and he has got some particular on him. So he was of the opinion, that those guys are the ones that[cursed] him. He had that belief.”</td>
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<tr>
<td>Meme noticed walking as an abnormal behavior</td>
<td></td>
<td>“he just started walking, walking from dusk till dawn.”</td>
</tr>
<tr>
<td>Attempted suicide because he had no job</td>
<td></td>
<td>“Actually, got no job. No money. So things better if I end up committing suicide.”</td>
</tr>
<tr>
<td>Marginalization and <em>Omananamwengu</em></td>
<td>Some members of his family believed he had been on drugs which led to his behaviors despite no substance abuse at all</td>
<td>“To make things worse, the uncle – the brother to his mother – says ‘no, you have been imbibing in those things, you have been taking drugs,’ and so on. He was kind of not knowing as to how to explain to his parents that there was nothing wrong with him. He was cursed, he did not do those things. Not drugs, it was not his fault.”</td>
</tr>
<tr>
<td>Treated poorly by some and well by others after hospitalization</td>
<td></td>
<td>“Yeah, some are treating me very badly. They – ‘that’s the mental that one’ ah what, what. Some are treating me very nicely. Some are treating very badly.”</td>
</tr>
<tr>
<td>Has been treated as a dangerous person</td>
<td></td>
<td>“Sometimes they treat me with danger way. Bad way.”</td>
</tr>
<tr>
<td>Family Roles in the Lives of the Distressed and <em>Eemwengu</em></td>
<td>Nephew’s mother stayed with him for duration of the treatment</td>
<td>“His mother was working at that time. She was working somewhere in Ohangwena. So she decided to stay for two days or so. When she hears from the healer that he’s going to stay shorter than that, she decided to stay for, until she’s done.”</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Uncle believes family has to be at the treatment to see progress but recognizes that it depends on the healer</td>
<td>“Yeah, yeah, because you have to be there. Yeah, you have to be there to see the progress and it depends on from healer to healer.”</td>
<td></td>
</tr>
<tr>
<td>Family told him he would be alright</td>
<td>“Then I will come back from there, I was asking about the farm, they are telling me no problem. You are going to be alright.”</td>
<td></td>
</tr>
<tr>
<td>Belief in Treatment</td>
<td>Traditional healing would not cure his mental illness</td>
<td>“Ah, I don’t really believe in that one. Yeah, they say people are sick in the mental illness, some they go to the traditional healers.”</td>
</tr>
<tr>
<td></td>
<td>She only believes in hospital treatment</td>
<td>“She only believe in hospital. She doesn’t believe in traditional healing. Only hospital can help. She trust the hospital because they make him sleep and then he sleep. They [help] him.”</td>
</tr>
<tr>
<td></td>
<td>Kleopas thinks the traditional healer is responsible for curing him</td>
<td>“It stopped the time I go to that woman who cured me. When I go to the traditional, from there I stop other things to hear.”</td>
</tr>
</tbody>
</table>
Table 5

*Symptoms of Omananamwengu as Derived from Phase 1 and Phase 2*

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Present in Phase 1</th>
<th>Present in Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting fires</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Running everywhere</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Thinking too much</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Alcohol Abuse</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Auditory Hallucinations</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Visual Hallucinations</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Violent Behaviors</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Poor Hygiene</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Self-Grandiosity</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Foraging village for food</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Figure 1. A map of Namibia’s population (including gender population statistics) by region. Map taken from the Republic of Namibia (2011), Population and Housing Census Preliminary Results.
Figure 2. Research phases and summaries of participants, procedures, and forms of data collected in this study.
APPENDIX A
ETHNOGRAPHIC INTERVIEW PROTOCOL

Tell me about yourself:

Age, occupation, kinship status, etc.

What beliefs do you have about psychological problems?

Do you have any Ovambo stories about people who have psychological problems?

How do you know if somebody has psychological problems (mental illness)?

How does a person come to have psychological problems?

Why does a person have psychological problems? Is it their fault or the fault or some other force?

How do you describe mental illness?

What words do you use to describe it?

Who experiences it (i.e., men/women?, Specific ages?, etc.)?

What does it mean when somebody has psychological problems?

How are those people with mental illness perceived in the community?

How are psychological concerns resolved?

What do Ovambo people think of Western psychologists/social workers/counselors?

What do they do to help people?

What do Ovambo people think of Ovambo healers?

Tell me about Ovambo healers and how they do their work.
APPENDIX B

ETHNOGRAPHIC INTERVIEW PROTOCOL (OSHIWAMBO TRANSLATION)

Lombkielenge kombinga:

yoye eedula, ilonga, noshotu.

Uuna omaitavelo ashike kombinga yuudu womomutwe?

Uunapo oshipopiwa shamoshiwambo shinasha novanhy wenu uudu
womomutwe?

Oho shimono ngeipe utya omunhu okuna uuda womomutwe?

Ohasheende ngahelipi omunhu a kale nuudu womomutwe?

Omolwa shike omunhu ha kala nuudu womomutwe? Opena epuko limwe ile
eenghono dimwe ndakufa ombinga?

Oto Iatulula ngehelipi uudu womomutwe?

Ohonlongifa iliyalihipi kuufatulula?

Oolye nana hava kala nuudu?

Ota shiti ngahelipi nge omunhu eova uudu womomutwe?

Ovanu ava vena oudu womomutwe ohava ningwa ngahelipi momikunda deni?

Uudu womomutwe ohau kandulnap ngahelipi?

Ovawambo ohava diliadila ngahelipi kombinga yova hakuli vo udu womomutwe
a ohava kwafele ovanhu ngahelipi?

Ovawambo ohaya diladila ngahelipi kombinga yeedudu?

Lombwelenge kombinga yeedudu dakashiwambo nonghene handi lowgo?
APPENDIX C

ETHNOGRAPHIC INTERVIEW WITH PRACTITIONERS (INDIGENOUS OR WESTERN)

How were you trained in your profession?

*If indigenous healer:* How did you know you had healing capabilities?

When do people come for you for psychological concerns?

What symptoms are they exhibiting?

Where do these symptoms/experiences come from?

How do you work to heal them?

How do you know that the treatments you employ are useful?

How are you perceived in your Ovambo community?

*For Indigenous Only:* Are there some symptoms that Westerners may see as ill that you do not?

*For Indigenous Only:* What are your perceptions of psychologists/psychiatrists/counselors/social workers and the work they do?

How often do you interact with them?

What do you think they think of you and your work?

*For Western Only:* What are your perceptions of Ovambo healers and the work they do?

How often do you interact with them?

What do you think they think of you and your work?
APPENDIX D
ETHNOGRAPHIC INTERVIEW WITH PRACTITIONERS (INDIGENOUS OR WESTERN; OSHIWAMBO TRANSLATION)

Owa deulwa ngahelipi meifano loye?

_Nge odudu:_ owashiiva ngahelipi oho hakula?

Onaini ovanhu hava uya kwoove nge vena uudu womomutwe?

Omadidiliko ashike hava mono?

Omadidiliko ohadi peni?

Oho longo ngahelipi opo u va hakule?

Oho mono ngahelipi kuty a oku hakula knoye okwa pumbiwa?

_Yeedudu:_ Openasha omauliko amne ouangolo hava dulu lumona uudo nde oue ito shimono?

_Yeedudu:_ Omadiladilo oye okuli ngahelipi kombina yovaxingi mwenyo noilonga yavo?

Olungadpi hamu kwatafana navo?

Eshi watala hare kudiladilile ngahelipi ove noi loncia yoye?

_Ya Ngolo:_ Omadiladilo oyo okuli ngahelipi kombinga yeedudu daka shinambo?

Olungapi hamu shaken/popyafana nva?

Eshi watala hare kudiladilile ngahelipi ove noilonga yoye?
APPENDIX E

CASE STUDY INTERVIEW PROTOCOL

Tell me about yourself:

Age, gender, occupation, kinship, etc.?

How long did you struggle with psychological problems?

How did you know there was something psychological you were struggling with?

What did you experience and what did you call it (in Oshikwanyma/other dialect?)

How did you know it was a problem?

What caused the problem?

How were you received in your community as a result of your mental illness?

How were you received in your family as a result of your psychological problem(s)?

How did you decide when to seek treatment?

What factors influenced your decision?

How did you decide who to seek treatment from?

What was your treatment like and what did you experience?

How long did it last OR How many times were you treated?

What roles did Ovambo and Western treatments play for you with regards to lessening psychological problems?

What do you think of Western treatments? Of Ovambo treatments?

When did you feel like your symptoms had lessened? What did you notice?

How has your life changed?

How has your role or experience in your community changed?
What would you do if you were to experience these problems again?
APPENDIX F

CASE STUDY INTERVIEW PROTOCOL (OSHIWAMBO TRANSLATION)

Lombwelenge kombinga yoye:

Eedula uukwashiki kookanhu, iilonga nosho tuu?

Uule shifike peni wakala nuudu womomutwe?

Owa shiiva ngahelipi kutya uunasha shapuka momutwe?

Oshike nana wamona nowe shufana shike?

Owashiiva ngahelipili kutya uudu?

Uudu owa etna nana koshike?

Owa tambulwako ngahelipi momudingonoko weni weni eshi una uudu womomutwe?

Owa tambulwakop ngahelipi kouapambele voye konima eshi wamonika oudu womomutwe?

Owa hoolola ngahelipi kutya naini uka konge omau-haku?

Oinima ilipi oyo yiku kufifa ehooololo?

Owa hoolola ngahelipi kutya oto hakulwa ngahelipi?

Okuhakulwa kwoye okwali ngahelipi woshike nana wamona?

Osha kwata efimbo lifike pene ile owe hakuzwa lungapi?

Omauhaku opashiwambo nooshingolo a dana onghandangala ngahelipi?

Omalipulo oye eelingahelipi kombinga yomauhaku opangolo kufaafanifa waa omoshiwambo?

Onaini na uda kutya omalidu oyo okwa shuna pedu? Noshike nana wamona?

Onghalamnenyo yoye oya shindja ngahelipi?

Oshinakuwanifna shomomuknda osha luunduluuka ngahelipi?
Oto ningi shike ngeenge wahangika kuudu waafaafana?
APPENDIX G

CASE STUDY FAMILY INTERVIEW PROTOCOL

How was he/she treated in your family?

How do you think he/she was treated by the rest of your community?

What impact did you perceive her/his experience of distress to have on your family?

Was this something you discussed with other community members? Other relatives?

Were you, as a family, involved in the treatment at all?

Tell me about your involvement?

If you were not involved, how did that feel?

Were you not allowed to be involved? If so, why?

How did you know treatment would be useful for him/her?

When did you know treatment would be important?

What kind of treatment did you think would be the best for him/her?

How did you know that it would be effective?

What did you expect treatment to consist of?
APPENDIX H

CASE STDY FAMILY INTERVIEW PROTOCOL (OSHIWAMBO TRANSLATION)

Oknali a hakulna ngahelipi kovapambele?

Oknali a hakulna ngahelipi kovakwashinana?

Omaundjuu ashike wamona mokukala nomunu ena uudu oo mepata leni?

Eshi oshinima nga mweshi kundafana nova knashiwana ile oudapembele?

Ove onge omupambele owa kufa ngo ombinga mouhaku waye?

Lombwelenge kombinga yokufo mbinga loye?

Ngeenge ino kufa ombinga, owuudite ngahelipi?

Kakwali weefelna ukuke ombinga? Nge osho omolwa shike?

Owa mona ngahelipi kutya uuhaku otau kwafele?

Onaini wamona kutya uuhaku owafimana?

Owa mona ngahelipi kutya uuhaku ulipi uwa kuye?

Owa shiiva ngahelipi kutya otau longo nawa?

Owa teelela ouhaku ukale wakwatelamo shike?