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Rainbow Knowledges: Adolescence and Mental Health in Post-Apartheid South Africa

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Acronyms:

ANC	African National Congress
MDGs	Millennium Development Goals
TRC	Truth and Reconciliation Commission
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
WHO	World Health Organization

Preface:

The motivation for my research emanates from personal experience. During adolescence I experienced a series of life events that significantly affected my mental health. While I have since learned to successfully manage these difficulties my experiences had (and continue to have) a profound affect on my personal growth, professional development and academic pursuits. In retrospect I have come to several realizations about child and adolescent mental health. First, I believe that the mental health experiences and needs of young people differ from those of adults and thus require specific attention within health, education and community settings. Second, I believe that the social and institutional stigma associated with mental health problems remains one of the most significant barriers to helping young people overcome mental health difficulties and must be combated if any progress in in this area is to be achieved. And finally, I believe that mental health is not a privilege, it is a fundamental human right that must be afforded to all. Together these beliefs have led me to conduct this research. They are ideas connected to personal experience, motivated by passion, and perhaps most importantly driven by curiosities about what makes the human condition and social world worth examining.

Abstract:

Global models based on Western cultural values and biomedical approaches have influenced the social constructions of adolescence and mental health in post-apartheid South Africa. The expansion of Western cultural norms and the hegemony of biomedicine have also contributed to the marginalization of local adolescent and mental health knowledges as illegitimate, irrational and inferior. This research explores the interaction between global and local adolescent and mental health knowledges in an attempt to understand the degree to which some normative elements of adolescence and mental health are applicable to South African society. In doing so this research argues in support of developing more socially- and culturally-informed interventions that may help to re-establish pertinent local knowledges displaced by hegemonic frameworks and address adolescent and mental health issues at the local level.

Relevance to Development Studies:

Adolescent mental health is recognized as a crucial public health and development issue both internationally and within South Africa. The formative stages of physical, emotional, intellectual, psychological and social maturing that characterize the period of adolescence, combined with the reality that mental health problems (including mental disorders) most often onset during these years, make young people a relevant population for development studies. Furthermore, the intersection of adolescent mental health with other social determinants of health such as stigma, HIV/AIDS and poverty, as well as the identification of mental health as a fundamental human right makes this research significant for the field of development studies.

Keywords:

Adolescence, apartheid, knowledges, mental health, mental illness, power, South Africa, stigma, truth claims.

Chapter 1: Introduction

1.1 Indication of the Problem

Mental health is a fundamental human right. According to the United Nations Convention on the Rights of the Child (UNCRC) children and adolescents have a right to the "enjoyment of the highest attainable standard of health" (UNICEF 1989) including mental health. Mental health is a central element in the ability to live a fulfilling productive life and the capacity to achieve psychological resilience. It is also related to wider social development issues including the promotion of gender equality, empowerment of women, eradication of extreme poverty, decrease of child mortality, improvement of maternal health, and reduction in the spread of HIV/AIDS (Prince et al. 2007: 859; Miranda and Patel 2005). If left unaddressed, mental health problems[1] among young people may impede academic performance, personal relationships, social inclusion, employability, civic participation, and leave some at a higher-than-average risk of homelessness and contact with the criminal justice system (McDaid et al. 2008: 79).

However despite its centrality to both personal and communal quality of life, mental health remains a largely ignored global health issue (Miranda and Patel 2005: 0962). Moreover, though there is growing awareness that mental health is as an essential component for the overall health of children and adolescents, the recognition of its importance is limited and the mental health needs of young people remain largely unaddressed (Hoven et al. 2008: 261; Patel et al. 2007). Mental health has been described as a "pariah or stepchild of the health services" (Masilela 2000: 3), and child and adolescent mental health specifically has been has been referred to as the "orphan of the orphan" (Kirby 2007: 6). Within mental health interventions and policy children and adolescents have also been an under-recognized focus of attention (Harper and Cetin 2008: 223; Shatkin and Belfer 2004: 108). The relatively new development of the child and adolescent mental health field, a lack of understanding of how young people experience mental health problems and widespread stigma associated with mental disorders[2] have traditionally contributed to the neglect of young people within mental health strategies.

Increasingly however, mental health is being recognized as an important public

[1] 'Mental health problems' refer to difficulties that may impede an individual's mental health including but not limited to mental disorders
[2] The terms 'mental disorders' and 'mental illness' are used here interchangeably. Mental disorders are commonly characterized by disturbances in thinking, cognition, perception, emotion, or behaviour. Examples from Western medicine include depression, anxiety disorder, schizophrenia, attention deficit disorder, substance abuse and mental retardation.

health and development issue, in particular within parts of the developing world. South Africa is one such case where mental health issues have received growing attention. A legacy of apartheid that has had major consequences for the mental health of citizens, epidemiological studies examining the prevalence of mental disorders, rights-based approaches to adolescent development, and comprehensive policies that recognized the unique mental health needs of young people have all helped raise the profile of mental health within South Africa.

As South Africa has made the transition from a system of apartheid to democracy the country has undergone an intense period of social change. In the process increased exposure to globalized ideologies have influenced the social constructions of adolescence and mental health. The export of Western cultural models of adolescence, which appear as the globalized norm, have left young people in South Africa frequently cast in the shadow of Western images (De Boeck and Honwana 2005: 8; Nsamenang 2002: 61). Additionally, the influence of Western biomedical approaches to health, including mental health, and the "Eurocentric enterprise" of adolescent psychiatry (Nsamenang 2002: 61) have reinforced the hegemonic position of 'modern' science in the new South Africa. As Walker observes (2006: 78), through ideas and practices it is the powerful in society who promote dominant discourses that often pathologize or subjugate the customs of non-dominant groups. In the context of South Africa the overwhelming production of cultural and scientific knowledge emanating from the West has likely had a significant effect in shaping constructions of adolescence and mental health in post-apartheid society, as well as contributed to the marginalization of traditional, indigenous and local knowledges as illegitimate, irrational and inferior.

Here the problem lays not so much in the adoption of globalized Western ideologies themselves – for indeed they may greatly enhance the understanding of adolescence and mental health within South Africa – but rather in the adoption of globalized Western ideologies at the expense of perhaps equally pertinent and useful local knowledges. Young people in South Africa grow up and cultivate their identity in ways that do not necessarily conform to globalized Western cultural models of adolescence. Widespread traditional health practices[3] too view health and illness in ways that contrast with dominant biomedical and

[3] Traditional health practices are also sometimes referred to as local, regional, folk, indigenous or ethnomedicine (Baer et al. 1997: 9, 192) and are defined by the Traditional Health Act of 2007 as: "The performance of a function, activity, process or services based on traditional philosophy that includes the utilisation of traditional medicine or traditional practice and which has as its object (a) the maintenance or restoration of physical or mental health function; or (b) the diagnosis, treatment or prevention of a physical or mental illness; or (c) the

'scientific' approaches to mental health. Estimates suggest that between 150,000 and 200,000 traditional healers practice in South Africa (more than five times the number of doctors of 'modern' medicine) (Pretorius 1999: 249; Kale 1995: 1182) and whose services are extensively used to treat a variety of mental health problems. Local adolescent and mental health knowledges, by virtue of their cultural pervasion and social use, therefore have great legitimacy in South Africa.

As South Africa attempts to cope with its legacy of apartheid, uphold its cultural diversity within a changing national identity and address developmental issues amidst the influence of globalized Western ideologies, looking at adolescence and mental health from local perspectives may help to gauge the extent to which some normative elements of adolescence and mental health constructed within Eurocentric worldviews are appropriate for South African society (Nsamenang 2002: 65).

1.2 Political and Social Development in Contemporary South Africa

South Africa's modern political and social conditions have emerged from a complex past of inequality, discrimination and underdevelopment. While black, coloured[4] and Indian peoples today constitute over three-quarters of the South Africa's 47 million population, historically it has been the white minority who have occupied a position of political, social and economic privilege, and who have exercised their authority to marginalize the various linguistic, cultural and knowledge traditions of non-white inhabitants. Under the systems of colonialism and apartheid black, coloured and Indian South Africans were largely treated as second-class citizens. Through systematic oppression, government action limited the rights of non-white inhabitants and reinforced their position as unwelcome 'guests' in the 'white' South Africa (Republic of South Africa 2006: 38). Policies termed 'separate development' divided African populations into ethnic 'homelands' and resulted in the forced eviction and mass resettlement of over three million people, the relocation of which led to the creation of overpopulated and inadequately-resourced rural slums. At apartheid's height racial segregation pervaded across social sectors from education to housing to healthcare, resulting in inequitable schooling opportunities, substandard living conditions and inferior provision

rehabilitation of a person to enable that person to resume normal functioning within the family or community; or (d) the physical or mental preparation of an individual for puberty, adulthood, pregnancy, childbirth and death" (Republic of South Africa 2007: 5).

[4] Contentious term still used by South Africa to refer to people of mixed race origin.

of public services for non-white residents. Children and adolescents were adversely affected by conditions of inequality too – a reality acknowledged by President Mandela when he admitted that the "apartheid state violated not only the rights and opportunities of young people through its repressive and discriminatory policies. It also ignored the special needs and concerns of youth" (1997). More drastically, gross human rights violations against young black, coloured and Indian citizens in the interest of maintaining white privilege have led some to accuse the apartheid state of "perpetuating intentional and active child abuse" (Lockhat and van Niekerk 2000: 292).

Ironically, it was these policies and programmes of control that also served as catalysts for political and social resistance. The growth of the Black Consciousness Movement of the 1960's "reawakened a sense of pride and self-esteem in black [South Africans]" (Republic of South Africa 2006: 39). Additionally, the Soweto uprisings of 1976, which culminated in a series of violent confrontations between black youths and South African authorities over the forced and unwanted integration of Afrikaans into the education system, epitomized the foray of youth into political activism. Across the country resistance in the name of 'the struggle' united black Africans and provided motivation to confront the apartheid state. By the 1970's and 80's civil unrest mounted in a series of protests that were met with the imprisonment of anti-apartheid leaders and an escalation of state-sponsored aggression. In response the international community strengthened support for the anti-apartheid cause, and amidst the pressure of financial, trade, sport and cultural sanctions Frederik Willem de Klerk replaced Pieter Willem Botha as South Africa's president. As one his first acts, President de Klerk mandated the emancipation of liberation movements and release of political prisoners thus ostensibly ending apartheid's legacy.

In 1994 South Africa's government made the transition from a system of apartheid to one of majority rule following the country's first multi-racial democratic elections. The newly elected African National Congress (ANC) under president Nelson Mandela ushered in a wave of political and social reforms that aimed to promote the reconstruction and development of the country's institutions for future generations, as well as meet the various challenges inherited from the apartheid era. A new constitution laid the groundwork for democracy and the government's establishment of a Truth and Reconciliation Commission (TRC) under the leadership of Archbishop Desmond Tutu brought human rights violations perpetrated under apartheid to justice. Additionally, the inauguration of the National Youth

Council and South Africa's ratification of the UNCRC were early post-apartheid milestones that reflected Mandela's personal interest in the status and well-being of children and youth.

Yet with the promise of hope lay reason for despair. As Bray et al. observe, South Africa's "post-apartheid society was unevenly *post*-apartheid" (2010: 22). In the decade following democratic transition the country faced many obstacles that impeded the progress of development. Expectation for successful implementation of change was high, financial resources were scarce and strict policies stalled the process of social service transformation (Milne and Robertson 1998: 129). The legacy of apartheid had major consequences for the country's health sector too. Disempowerment and discrimination had weakened South Africa's health system (Coovadia et al. 2009: 828) as evidenced by the TRC's final report in which it emphasized that "the health sector, through apathy, acceptance of the status quo and acts of omission, allowed the creation of an environment in which the health of millions of South Africans was neglected… facilitating violations of human rights" (Republic of South Africa 1998: 250). Furthermore, the underdevelopment and unequal distribution of mental health resources and the lack of strategic plans for health care provision created major obstacles for the enhancement of child and adolescent mental health in South Africa (Milne and Robertson 1998: 132). Alongside weakened infrastructure, the livelihoods of South African citizens were also affected by the social transformation that followed apartheid. Socio-economic disparities in standards of living and quality of life, especially among black populations, became widely entrenched (Milne and Robertson 1998: 128) leading some scholars to proclaim that class had supplanted race as the foundation of social division in post-apartheid society (Bray et al. 2010: 23).

Though many problems continue to affect the country, after 15 years of freedom South Africa has reason to be optimistic. While less politically active than previous generations, young people remain aware and engaged in social and political affairs (Everatt 2000: 22). Mental health too continues to gain ground as a crucial public health and development issue (Draper et al. 2009: 342; Lund et al. 2008: 14). Finally, by some indicators, the country's social, political and economic conditions are conducive to addressing issues of globalization, the digital divide, poverty, HIV/AIDS, sustainable development and state performance (Republic of South Africa 2006: 43-44). In 2005 South Africa's Millennium Development Goals (MDGs) mid-term country report indicated that it had already met some of the MDGs targets and was on pace to achieve those remaining (United Nations

Development Group 2007: 5). Thus despite its past of inequality and underdevelopment, as the dawn of the 21st century arises, South Africa is poised to effectively address many of the social, political and economic challenges that have affected both their country and the surrounding sub-Saharan region.

1.3 Justification and Relevance

Much has been written about adolescence and mental health in South Africa (Bray et al. 2010; Lund et al. 2008; Norris et al. 2008; Kleintjes et al. 2006; Seekings 2006; Bhana and Bhana 1985) prompting the question: Why are these topics in need of further investigation? Several reasons are offered here in response. First, literature on children, adolescents and youth in South Africa has predominately focused on atypical groups and issues (Bray et al. 2010: 28) such as the problem of activist youth or the plight of AIDS orphans. Yet while these populations (and conditions) are certainly deserving of attention, overall they do not constitute the experiences of most young South Africans. Predominant focus on atypical groups suggests the need to move beyond a pathologization of young people as merely vulnerable or problematic and toward perspectives that recognize the agency of adolescents, as well as the constructive ways that they contribute to the advancement of society. Second, in general the youth development model has been criticized for being overly ethnocentric, masculine and "especially limited in understanding the experiences of young people who are of colour, indigenous or other than the dominant language background" (Wyn and White 1997: 62-63). These criticisms suggest the need to develop alternative models of development inclusive of local knowledges and marginalized groups of young people. Finally, the aforementioned "Eurocentric enterprise" of adolescent psychiatry (Nsamenang 2002: 61) and a scarcity of literature that focuses on the position of traditional health practices in relation to the hegemony of biomedicine (Yen and Wilbraham 2003a: 543) provide opportunities to re-examine the conceptualization of mental health within more contextualized African worldviews.

1.4 Research Objectives and Questions

The central objective of this research is to analyze the interaction between global and local adolescent and mental health knowledges in the context of contemporary South Africa.

To meet this objective this paper posits the research question:

- How do global and local adolescent and mental health knowledges interact in post-apartheid South Africa?

Underlying this research question are several other related inquiries that ask:

- What are the global and local knowledges that underlie social constructions of adolescence and mental health? How are these knowledges similar or dissimilar? What power relations exist between them?

However, while these related questions are touched upon and do help to inform this paper's analysis, gaps within academic literature precluded them from being fully addressed within the scope and limitations of this research.

1.5 Methods and Sources

To address the research objectives and questions this paper adopts a literature review methodology. As a common research methodology in social science, a literature review may be used to provide an account of what has been said about a topic by various scholars, researchers and institutions. Specifically, this research adopts a theoretical review as a kind of literature review to critically reflect on the established points of knowledge and theories related to the topics of adolescence and mental health.

Several different types of secondary sources will inform this theoretical literature research. Conceptualizations of adolescence, sociologies of mental health and theories of power, knowledge and truth will be explored using literature from the social sciences in the form of journal articles and books. Biomedical and traditional mental health knowledges will be investigated using literature from the human sciences also in the form of journal articles and books. Finally, in attempt to understand the hegemonic position of Western cultural and biomedical models of adolescence and mental health this research draws from government and non-government reports, state legislation and policy strategies. Where possible during this research process sources from non-Western authors and institutions were used to try overcome the 10/90 divide – a phenomenon that sees 90% of the world's scientific and

social science research published by the richest 10% of countries (Tyrer 2008: 79-80; Saxena et al. 2006: 81-82).

1.6 Position of the Researcher

At the outset it is worth clarifying my position in relation to the proposed research, for as Walt et al. emphasize "position can influence the issues that researchers focus on and therefore the research agendas created and the research questions asked" (Walt et al. 2008: 314). On one hand, as someone who has had lived experience with mental disorder, who has encountered first-hand the stigma associated with being labelled 'mentally ill', and who has worked in multiple Western mental health care environments, my experiences may enhance the potential for greater epistemic privilege given my capacity to see research issues from the perspective of both the oppressor and the oppressed (Hartsock 1998). On the other hand, as a white researcher with no first-hand knowledge of South Africa, or of the African continent, my lack of direct exposure may limit my understanding of the various conditions that underlie South Africa's social, cultural and political landscape. As South African anti-apartheid activist Dr. Ramphele highlights in relation to her research conducted in isiXhosa-speaking communities, "knowledge of language, idioms, customs and traditions and their distortions is an essential tool in tackling social questions, which leaves white social scientists, generally unfamiliar with black South African languages, at a disadvantage" (2002: 22). My position is therefore imbued with both challenges and opportunities. The challenge is for me to step beyond my position as a white, middle-class researcher from a 'developed' country whose understandings of mental health and young people have been largely influenced by Western cultural norms and biomedical knowledge. While my opportunity is to look from the outside in with some degree of objectivity, and some provide insights into adolescent and mental health issues for local researchers and development workers to investigate further.

1.7 Structure, Scope and Limitations

The structure of this research consists of five chapters. Chapter one has already introduced why adolescence and mental health in South Africa are topics worthy of examination, outlined a brief history of social and political development in South Africa and

established a theoretical literature review as a research methodology. Chapter two will present the dominant concepts of adolescence and mental health and introduce the ideas of Michel Foucault and Boaventura de Sousa Santos that will form the theoretical basis for this research. Chapter three will examine how the global model of adolescence compares and contrasts with local knowledges of young people. Chapter four will explore the relationship between global and local biomedical and traditional mental health knowledges. Finally, chapter five will bring the discussions about adolescence and mental health together and attempt to argue in support of new paradigms that incorporate both global and local knowledges into the development of new and more culturally- and socially-informed adolescent and mental health frameworks.

As with most studies, the scope of this research was invariably influenced by an array of internal and external interests that shaped what could or could not be studied. Two significant choices determined the scope of this research. First, the choice was made to examine social constructions of adolescence rather than those related to children or youth. Adolescents were chosen as a focus of investigation because of their central participation in the transformation of South African society, and because according to Western medicine the physical, emotional and social developmental phases that characterize the adolescent years make this group particularly susceptible to the onset of mental health problems. Second, the choice was made to focus (though not exclusively) on mental disorders over other aspects of mental health. While mental health clearly intersects with issues related to socio-economic status, educational opportunities, political stability, social engagement and physical well-being, focus on mental illness was chosen out of personal interest and because of the rich contrast between Western biomedical classifications and traditional African aetiologies of mental disorders.

The scope of this research was also determined by its limitations. Despite attempts to represent and contextualize various local knowledges existent in South Africa, not all were adequately explored. The geographical distance of the researcher, as well as gaps in the academic literature, precluded a complete and fully contextualized representation of adolescent and mental health knowledges in South Africa. Additionally, this research finds limitations in the use of terms such as 'adolescence', 'mental health', 'mental illness', 'traditional healing', and 'biomedicine'. Though simplified and separated at times for comparative purposes, this author acknowledges that in reality these terms are highly

complex, interdependent, politicized, and fraught with difficulty when used across cultural settings. These terms therefore should be recognized not as static definitions, but rather as evolving concepts whose meanings must be understood within specific historic and geographic contexts.

Chapter 2: Theoretical Framework

The theoretical foundation of this research is comprised of both conceptual and analytical frameworks. Before analyzing adolescent and mental health knowledges at the local level, it is worth considering how these terms are conceptualized globally. The conceptual framework (section 2.1 and 2.2) thus aims to understand the concepts of adolescence and mental health from globally dominant Western cultural and biomedical perspectives. Subsequently, the analytical framework (section 2.3) presents an introduction to the theories of Foucault and de Sousa Santos, and highlights the theoretical insights relevant for analyzing the interaction – or more specifically the social constructions, differences and power relations – between global and local adolescent and mental health knowledges.

2.1 Adolescence

The period of adolescence is a formative stage of physical, emotional, intellectual, social and psychological maturing that has been said to "begin in biology and end in culture" (Flanagan and Syversten 2006: 11). Modern conceptualizations of adolescence, a significant portion of which have been based on Western cultural models, are premised upon several foundational ideas. The first suggests that adolescence is a time of new identity and first experiences (Call et al. 2002: 72) whereby young people pass through a series of mental and physical developmental stages in the transition from being children to being adults. These phases may include independence from adults, social mobility, moral progression, sexual experience, cognitive maturation, resilience, physical growth, and school to work transitions. Though widely accepted, criticisms of this approach include the overemphasis of neat transitional stages based on Western cultural norms (Bray et al. 2010: 41) and the treatment of adolescents as 'becomings' rather than 'beings'. Debates also surround the global applicability of stage-based models of adolescence. Some maintain that the stages of mental and physical adolescent development are indeed globally pervasive, citing the homogeneity of developmental stages, as well as a surplus of studies which show that adolescence is not a culturally-specific phenomenon but rather a universally recognized life stage (albeit one that is characterized by different behavioural, cultural and social markers) (Flisher and Gerver 2010: 143; Richter 2006: 1903). Others however contest the idea that adolescence is universally experienced, claiming instead that the concept is socially constructed. In support

of the latter argument, scholars have argued that until recently the social categories of 'youth' and 'adolescents' were not recognized in an African context (De Boeck and Honwana 2005: 6). Additionally, some societies simply have no term to describe adolescence, while other nations such as India and Japan have subsumed adolescence under the broader definition of 'youth' (Brown and Larson 2002: 5). Implicit in these examples is the idea that adolescence as a life stage is neither unique enough to warrant special attention, nor pervasive enough to merit universal acceptance.

A second foundational idea supposes that the adolescent individual exists separate from their surrounding social environment. The theory of a 'pre-social' self that is independent from social interactions and conditions (Wyn and White 1997: 53) likens adolescents to blank canvases upon which social processes are projected. Here adolescents (as well as children and adults) are thought to possess a 'hereditary blueprint' that provides the foundation for a 'self' prior to the process of socialization. More recently however, the separation of the individual from the social has been replaced by interdependent theories, which assert that the adolescent 'self' is a complex interaction between biological, social and cultural factors (Richter 2006: 1903). Interestingly, the shift from binary adolescent models that separate the individual from the social, to inclusive frameworks that recognize the relationship between the two, similarly parallels the shift in psychological theory from Cartesian mind/body dualism to more holistic mental health perspectives.

A third basis suggests that adolescence is a time of turbulence. Since the early 20th century the adolescent years have been commonly characterized as a period laden with "storm and stress" (Hall 1908: xiii). More recently pathologies of adolescents (and youth) as 'in trouble' (Ansell 2005: 18) have portrayed young people as passive victims of social conditions – vulnerable to 'risk factors' that place them 'at risk' and in need of adult protection in the process of developing their identity or growing up as 'normal' (De Boeck and Honwana 2005: 3; Wyn and White 1997: 54). Adolescents have also been problematized as deviants – prone to and engaged in risk-taking behaviour that impinges upon their 'normality', and which locates the 'problem' "either in the *individual*, as a deficiency, or with *family relations*, which are seen in terms of social pathology (illness)" (Wyn and White 1997: 54). While these perspectives merit attention (for indeed adolescents in certain conditions may be vulnerable to risk and engaged in its practice) it may be overly simplistic or false to depict adolescents as social problems that must be controlled by society and conformed to

the mainstream. Moreover the portrayal of adolescence as riddled with stress, anxiety and angst has important mental health implications, for under this description what young person could not be labelled as having some form of mental health problem?

Recently however, positivist adolescent development approaches have challenged the normative conceptualization of young people. In an essay on the study of adolescence Richter (2006: 1903) argues that most adolescents do not go through a period of 'storm and stress. She also concludes that simplistic unidirectional models which presume that hormonal changes during puberty inevitably lead to rebellion, neglect the multiple and complex interactions between biology and culture. Increasingly adolescents and youth alike are being seen as agents in control of shaping and providing meaning to their experiences. Young people indeed participate in the construction and reconstruction of their own lives – not merely subjected to, or 'made and broken', by external social, economic and political conditions, but acting as 'makers and breakers' of their social reality (De Boeck and Honwana 2005: 199). From this perspective adolescents are not necessarily in need of adult protection. They actively explore spiritual, religious, cultural and political ideas in the development of an ideology and in making sense of the world around them (Flanagan and Syversten 2006: 13). Yet in spite of these positivist development approaches, still largely absent from the conceptualization of adolescence is any discussion of how young people define themselves. While young people may constitute a 'silent majority', they are certainly anything but quiet. Biomedical and risk-based approaches may be useful in understanding adolescence, yet too often these notions tend to portray young people from the 'outside' without taking into account that young people seldom refer to each other as adolescents, nor deem one another as 'at risk' (Wyn and White 1997: 55-6, 80). The gulf between the lived experiences of adolescents and the expert-driven perceptions of their reality therefore may be very opposed.

Taking into account the dominant social constructivist and biological determinist theories of adolescence, as well as positivist development approaches that counter discourses of young people as social problems, this research aims to understand adolescence from a relational perspective. It seeks to recognize the contexts, pathologies, social processes, institutional structures, and cultural matrices within which young people live (Ansell 2005: 22; Reynolds 2005: 100; Wyn and White 1997: 10-11), while simultaneously giving attention to the 'silent others' who are all too often marginalized within development and mental

health discourses.

2.2 Mental Health and Illness

As many scholars and international institutions have recognized, there is no health without mental health (Prince et al. 2007). For over 50 years the World Health Organization (WHO) has defined health as: "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization 1946). The WHO also defines mental health broadly as: "A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (World Health Organization 2005a). Mental health is thus an integral component of the capacity to lead a productive and fulfilling life.

Modern conceptualizations of health and illness may be separated into two main streams. Biomedical models, which are founded upon Western medical systems and dominate globally (Baer et al. 1997: 11), support the idea that health and illness are both absolute and universal. Biomedical approaches largely adhere to forms of reductionism that "radically separate the body from the nonbody" (ibid 1997: 11) and reduce illness to its causes and symptoms – "labeling parts of whole" (Walker 2006: 72) while focusing on the curative treatment of diseases rather than on individuals themselves. In doing so biomedicine has been criticized for neglecting the social, cultural, political and economic contexts that surround health problems (Ansell 2005: 92). In contrast, sociological models subscribe to the idea that health and illness are neither absolute nor universal, but rather socially- and culturally-constructed. Accordingly, these approaches may emphasize the relativity of illness, as well as highlight the mediating role that culture plays the conceptualization of health and illness.

Unsurprisingly, biomedical and sociological models of health and illness are reflected in the fields of mental health and psychiatry. Etic approaches emphasize the universality of mental health/illness, as well as the global applicability of psychiatric taxonomies and mental health care interventions based on Western practice. Alternatively, emic approaches rooted in theories of cultural relativism emphasize the contextualized relationship between mental illness and social environments (Patel 1995: 1291). While mental illness as a phenomenon

appears to be part of the "universal human experience" (Patel and Winston 1994: 437), neither the classification of mental disorders based on Western psychiatric categorizations[5], nor the acceptance of a global pathology of mental illness is unanimous (Patel 1995: 1295). In a study assessing beliefs about health and illness in three countries, Furnham et al. (1999: 189) argue that in 'developed' nations the aetiology of health problems (and by extension mental health problems) are most often attributed to the individual and the natural world. Whereas in developing world, the causation of health difficulties are largely ascribed to social and supernatural conditions.

The dichotomy between these causal explanations of illness – the division of which appears to be a Western construct (Furnham et al. 1999: 190) – emphasizes how discourses about health and illness are often positioned as 'Western' and 'other'. As Patel and Winston maintain (1994: 438), the hegemony of biomedical models and Eurocentric aetiologies have "reduced illnesses encountered in other cultures which do not resemble Western categories to 'culture-bound' or 'masked' representations of 'real' illness". Additionally, as Yen and Wilbraham argue (2003b: 578-9), "deploying constructions of 'African culture' and the 'African mind' as bound to intellectual primitivity, irrationality and superstition, the indigenous healer is positioned as 'other'". Here biomedicine, in an attempt to maintain its hegemonic position, may marginalize traditional, indigenous or local health practices through the production of discourses that represent these knowledges as illegitimate, irrational and inferior.

Drawing from biomedical and traditional medical knowledges, as well as etic and emic psychiatric approaches, this research conceptualizes mental health in holistic terms. It aims to understand mental health not merely as the absence of disease, nor located solely within the body or mind, but also situated within complex social and cultural settings. Additionally, this research seeks to understand biomedicine and traditional medicine not as polarities of one another, but rather as systems on a spectrum – filled with power struggles and intertwined with cultural arrangements (Baer et al. 1997: 8).

[5] Specific categories of mental illness as defined by ICD-10 (International Statistical Classification of Diseases and Related Health Problems) or DSM-IV (Diagnostic and Statistical Manual of Mental Disorders

2.3 Power, Knowledge and Truth

Few modern figures have had as much influence on contemporary critical thought as Michel Foucault. A French philosopher, sociologist and historian, whose works have influenced post-structuralist, post-modernist, feminist, post-Marxist and post-colonial thinking (Mills 2003: 1), Foucault's theories have largely focused on the themes of knowledge, power, truth and discourse. His legacy rests (at least in part) in his willingness to question what we know; who knows; how we know what we know; and the ways in which knowledge is produced and reproduced in relation to historical progress.

Foucault's theories about the intimate connection between power and knowledge are outlined well in his 1980 essay entitled 'Prison Talk'. In it he asserts, "it is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power" (Foucault 1980a: 52). Several ideas are contained here – in particular the notion that power is not possessed, but exercised. From Foucault's perspective power is *used* not *had*. Criticizing the theory that power is something in the hands of the powerful and which the powerless are trying to obtain, Foucault instead builds upon the idea of power as ephemeral – not merely held but flowing between individuals and institutions. He states, "Power must be analysed as something which circulates, or rather something which only functions in the form of a chain. It is never localised… power is employed and exercised" (Foucault 1980b: 98). Here Foucault highlights the idea that power (and knowledge too for it is interconnected with power) is dispersed – not simply centralized from the top down, but also decentralized and present within everyday social interaction, institutional practice and cultural representation.

Also implicit in Foucault's quote regarding the interaction between power and knowledge is the recursive relationship between the two, such that the production of knowledge is a claim for power, and whereby imbalances of power relations provide opportunities for the production of knowledge (Mills 2003: 75). Certainly knowledge is power, but equally true is the idea that power emanates from the production, control and dissemination of certain knowledges. Those who are in a position to know produce knowledge. At present, Western science often flourishes at the top of what might be considered a hierarchy of knowledges. For sociologist Boaventura de Sousa Santos the epistemic privilege granted to Western science, whether intentionally or unintentionally, at times discredits (or declares non-existent) knowledge that is not recognized or legitimized by

scientific discourses (de Sousa Santos et al. 2007: ixx; de Sousa Santos 2006: 16). Moreover, the hegemonic position of modern science that is often deemed the "sole criteria of truth and aesthetic quality" (de Sousa Santos 2006: 16) often dichotomizes scientific and non-scientific knowledges respectively as 'Western' and 'other'/'non-Western', further marginalizing knowledge that is not produced under the dominant scientific canon.

Through the production and preservation of knowledge, each society upholds its 'regime of truth' (Foucault 1980c: 131). Truth, much like knowledge, is bound to power and similarly operates amidst the individuals and institutions that generate and sustain it. For much of the Western world, and increasingly elsewhere, the scientific discourse is hailed as the personification of truth. Employing instruments of rationality and empirical evidence the scientific method has contributed (at times with great success) to the acquisition of new knowledge and the interrogation of old. Yet for all its attempts at impartiality "the objectivity of science does not imply neutrality" (de Sousa Santos 2006: 14). Indeed for both Foucault and de Sousa Santos objective truth is an apparition. Foucault asserts that since the producer of knowledge cannot be separated from the conditions in which knowledge is produced, there is no independent truth – "truth is a thing of this world" and thus only claims for truth exist (Foucault 1980c: 131). De Sousa Santos likewise contests the existence of a pure or complete knowledge (de Sousa Santos et al. 2007: xi; de Sousa Santos 2006: 18). Instead he promotes ecologies of knowledge that encourage "non-relativistic dialogue among knowledges, guaranteeing 'equality of opportunities' to different kinds of knowledge" (de Sousa Santos et al. 2007: xx). Importantly however, an ecology of knowledges should not presume and equality or equity of knowledges. Rather for both theorists the goal should be a liberation of knowledges from systems of subjugation and the advancement of conversation between heterogeneous knowledges be they global or local.

At the heart of theorization by both intellectuals is an argument in favour of a "new politics of truth" (Foucault 1980c: 133). For Foucault his aim is not so much in a total emancipation of truth from power, but in "detaching the power of truth from the forms of hegemony, social economic and cultural, within which it operates at the present time" (Foucault 1980c: 133). De Sousa Santos too, in confronting the monoculture of scientific knowledges, calls for an approach that seeks to enhance the contribution of marginalized ideas, decolonize knowledge and power, and advance social justice through promotion of epistemic diversity (de Sousa Santos et al. 2007: xi, xx, ixx; de Sousa Santos 2006: 21). Indeed

it is through this emancipation of truth and cultivation of epistemic diversity that so-called 'alternative' knowledges may counter-hegemonic discourses, oppose imbalances of power and wage 'war' in the 'battle' for the status of truth (Foucault 1980b: 132).

2.4 Conclusion

Problematizing the concepts of adolescence and mental health, and drawing upon the theories of Foucault and de Sousa Santos, this research attempts to challenge the hegemony of Western cultural and biomedical models of adolescence and mental health. In doing so this research argues in support of incorporating both global and local knowledges into the development of new and more socially- and culturally-informed adolescent and mental health frameworks. Such new frameworks may help to re-establish pertinent local knowledges displaced by hegemonic Western cultural and biomedical models, as well as enhance the design of context-specific interventions necessary to address adolescent and mental health problems at the local level. Importantly, the intent of this research is not to make any moral judgements about the legitimacy of certain knowledges, nor to polarize them as Western and 'other'. Rather this research seeks to understand globalized Western and local knowledges as interdependent – sometimes juxtaposed or in conflict with one another, but nonetheless woven together in a complex social tapestry.

Chapter 3: Adolescence in South Africa

To argue in favour of re-examining the global model of adolescence, requires first an understanding of the unique ways that young South Africans experience this phase and the ways in which their adolescence differs from Western cultural norms. As I have outlined in chapter 2.1, the globalized model of adolescence presumes that young people transition through universally similar stages of development, cultivate individualistic identities separate from social processes, and grow up amidst great turmoil. This however is not necessarily the case in South Africa. While the global model may be a useful starting point for understanding adolescence within the context of South Africa, alone it inadequately captures the diverse social, political and cultural experiences that constitute what it means to be an adolescent in the post-apartheid era.

3.1 Stages of Adolescence

Who are adolescents in South Africa? Despite their demographic significance, there appears little consensus in South Africa about what constitutes the period of adolescence. In some cases the adolescent years are defined by age range. South Africa's policy guidelines for youth and adolescent health define adolescents as those aged 10 to 19, while South Africa's policy guidelines for child and adolescent mental health define adolescence as the period between 12 and 18 years of age. Age-based categorizations also extend beyond policy to include social science research. Two recent works on South Africa cite slightly less prolonged periods of adolescence ranging from 14 to 17 years and 15 to 19 years (Bray et al. 2010: 41; Steyn et al. 2010: 177). Yet despite common usage, adolescence is not a ubiquitous term. South Africa's 1996 National Youth Commission Act, as well as two Statistics South Africa's reports (2001; 2005) based on nationally-representative census findings make either no or scarce mention of adolescence as a developmental stage.

Adolescence may also be understood in terms of its transitional phases. In a 2005 report on the present and future states of young people in South Africa, Morrow et al. promote a life-cycle approach that treats adolescents as "flowing from and to a series of stages" in the course of their development (2005: 3). South Africa's policy guidelines for child and adolescent mental health likewise emphasize that the development of a young person "proceeds epigenetically" (Republic of South Africa 2008: 8) such that the emotional,

social, physical, intellectual and moral skills learned during adolescence are preceded by competencies learned during prior life stages. For example learning difficulties experienced in childhood, if left unaddressed, may lead to school failure or truancy during the adolescent years. Adolescent transitions too may be marked by certain rites of passage such as sexual maturation, school completion, employment, marriage and parenthood. Yet within the context of South Africa, the over-simplified distinction that adolescence starts at the onset of puberty and ends with the adoption of so-called adult roles such as marriage and employment (Flisher and Gerver 2010: 143) may neglect the myriad of transitional adolescent experiences unique to process of growing up in post-apartheid society. As Bray et al. observe:

> Reality in societies like South Africa is very different to the clear transitions that characterised northern European and North American societies in the mid-twentieth century. There is no neat movement from school to work, from financial dependence to independence or from living with parents to marriage and parenthood of one's own. Childhood, adolescence and adulthood are not neat sequential phases, but experienced and ascribed in various ways at various points in an individual's maturation. (2010: 41)

Proof that adolescence is being experienced in non-sequentially ways may be evident in the reality that this period is being prolonged for some and contracted for others. The early onset of puberty and delays into socially defined adult responsibilities suggest that for some young South Africans the period of adolescence is being extended. Research indicates that collectively urban South African girls (and perhaps urban South African boys) are entering puberty at an earlier age (Jones et al. 2009). Moreover, the expansion of educational opportunities and high rates of unemployment have delayed adolescent transitions into prescribed adult roles (Bray et al. 2010: 39-40; Morrow et al 2005). In Cape Town for example, studies have identified that by the age of 22 fewer than half of young people are currently working, less than one in ten are married, and more two-thirds still live with parents or guardians (Bray et al. 2010: 39-40; Biddecom and Bakilana 2003). These figures indicate that by what many age-based categorizations consider to be the end of adolescence, a majority of young South Africans have still not completed the transitional phases that often characterize this phase of life.

Yet while the period of adolescence has been prolonged for some, for others it appears to have contracted. Conditions of poverty have forced some adolescents into street work at an early age in place (or in absence) of educational opportunities. The effects of

HIV/AIDS have also required some adolescents to adopt adult responsibilities earlier than normal, taking on roles as caregivers or heads of household. Finally, along with socio-economic conditions, within some cultural contexts adolescents may experience initiation rituals that accelerate the transition to adulthood. For example, in Xhosa culture boys are initiated into manhood through circumcision initiation rituals that symbolize masculine virility, prepare one for marriage (Vincent 2010: 434), and signify the relatively rapid transition from boyhood to adulthood (*Ulwaluko*).

What emerges from the above picture is that the stages of adolescence are neither static nor homogenous. As South Africa has become increasingly exposed to global political, social and cultural norms, perhaps it is unsurprising that the stages of adolescence, as well as adolescent identity itself, have evolved alongside these influences. In contrast to global models that often presume a unified and absolute construction of adolescence, the diversity of age-based categorizations and transitional experiences within the context of South Africa appear to support the idea that adolescence is experienced not as a series of neat sequential phases of development, but rather as complex, nuanced and sometimes highly disordered transitions. From a political standpoint, recognition of a complex and disordered adolescence compounded by devastating health and socio-economic conditions seems hardly favourable to a portrayal that sees adolescence along comparatively positivist transitional phases, such as from school to work and from marriage to parenthood. Thus the adoption of a global model of adolescence – presented as ordered and rooted in Eurocentric stages, may be seen as appropriating the local realities of adolescence – presented as chaotic and underdeveloped.

3.2 Participation and Agency

The aphorism that adolescents ride the waves of history (Brown and Larson 2002: 12) (or indeed that they create waves of history themselves) is perhaps nowhere more evident than in South Africa where amidst the ebb and flow of apartheid's past adolescents have emerged as central figures in the country's social transformation. From the Soweto uprisings in 1976 until the end of apartheid young South Africans – black, male, urban youth in particular – came to epitomize the struggle against the apartheid state (Everatt 2000: 1). Due to participation in school boycotts, violent protest and authoritarian resistance, young South Africans were frequently labelled as *being* rather than as *having* problems. Media and

political institutions did little to abate this image characterizing young people as undisciplined aggressors and perpetuating waves of panic over the social and moral danger posed by the so-called 'lost generation' (Seekings 2006: 5). In the lead up to democratic elections the 'youth as problem' discourse had important political implications. The production of government commissioned research[6] aimed at examining the threat posed by black youth, contributed to the discourse of South African adolescents as problematic. Through the exercise of power, government leaders therefore reinforced their position as controllers of moral order and in turn delegitimized the political stance of young anti-apartheid sympathizers.

As South Africa made the transition from a system of apartheid to one of democratic rule political leaders and anti-apartheid activists rewrote the script about young people. Adolescents and youth were lauded as "harbingers of democracy" (Comaroff and Comaroff 2005: 20) and became heroic vanguards of a social upheaval against the apartheid state. While the Black Consciousness movements and Young Lions generations were clearly active in the realization of a democratic South Africa, the government too was also active in countering much of the 'lost generation' discourse. During the election years the aforementioned government sanctioned research projects expanded and deflated the myth of moral panic by proclaiming any absence of a 'youth crisis' (Seekings 2006: 5; Morrow et al. 2005: 5). Policy too "punctured the myth of 'lost generation'" (Seekings 2006: 9). The production of a new 'truth' about young South Africans was therefore a highly social and political process. In the situated context of South Africa's democratic transition, the changing discourse of adolescents may be attributed as much to the political opposition trying to garner votes and support from historically alienated black youths, as to the resistance of young people themselves.

With the liberation era over and having made little gains in the implementation of policy commitments or the establishment of formal youth structures, the immediate post-apartheid era was maligned as a period of "great disillusionment" and "lost opportunities" for the youth sector (Everatt 2000: 9, 25). By the mid 1990's the 'youth as problem' discourse had re-emerged. Young people were again seen in terms of the threat they posed, rather than the potential they personified, and discussed (if at all) in relation to crime,

[6] In 1990, the National party government commissioned research from the Human Sciences Research Council", followed by the establishment of a separate project organized by religious leaders and the opposition African National Congress under the auspices of the Joint Enrichment Project (Seekings 2006: 5).

HIV/AIDS, academic failure and social and political disinterest (ibid 2000: 1).

Policies too, through the use of language such 'at risk' and vulnerable to 'risk factors', label adolescents pejoratively and victimized them as social problems. Such policies also reinforced the idea that older generations, by virtue of their authority and autonomy, were responsible for protecting the young. While much of the global adolescent discourse has shifted towards agency-based perspectives, the view that young people are vulnerable and in need of adult protection still has weight locally. Parents within some South African communities place well-defined boundaries on child and adolescent independence, and young people are frequently positioned relative to their parents rather than as agents in control of their own well-being and development (Bray et al. 2010: 65). In other societies, such as within Nguni culture[7], strong patriarchal social norms may engender behaviours of obedience and subservience towards adults (particularly men) that constrain adolescent agency (ibid 2010: 73). Here globalized notions of individuality and autonomy contrast sharply with local ideologies of compliance and interdependence. They also contrast with the obligation for some adolescents to construct ethnic identities consistent with cultural scripts (Nsamenang 2002: 69). In turn theses scripts may place more value on obedience and respect than on agency and individualism. Debates about adolescent agency also appear to be reflected in discussions about whether to see young people as 'beings' rather than as 'becoming' adults. Reports that treat young people "neither as children nor as unformed or incomplete adults, but rather as young adults with their own strengths, talents and energies" (Morrow et al. 2005: 3), highlight that within the context of South Africa young people are indeed seen as 'beings' in their own right. Yet it is also evident that understanding adolescence in terms of its 'becoming' remains part of African ideological origins. Cameroonian author Nsamenang notes that within African social ontogeny adolescence is sometimes constructed as a 'way station' between childhood stages of social preparation and adult social integration (2002: 69).

Indeed, as much as adolescents may ride the waves of history, so too does truth and knowledge about them. What discussions about the participation and agency of young South Africans clarify is that knowledges are both hybrid and historically situated constructions (de Sousa Santos et al. 2007: xxxix). The discourses of young people from 'lost' to 'liberators' to 'threats' shows that truths and knowledges are not inert, but rather produced, ever-evolving

[7] The Nguni people of South Africa reside across the country and include the Zulu**,** Xhosa and Ndebele.

and at times cyclical. Moreover, though development discourses have a tendency to emphasize the "deepening of oppositions" between specialist and local forms of knowledge (ibid 2007: xxxviii), the idea that adolescents in South Africa can be *both* agents and vulnerable or 'beings' and 'becomings' demonstrates that knowledges are not always (or even often) dichotomous, but rather may coexist alongside one another.

3.3 Attitudes and Identity

In the wake of South Africa's democratic transition, somewhere between the polarized notions of young people as 'lost' and 'liberators'; 'criminals' and 'comrades'; 'privileged' and 'underprivileged', are the experiences and identities of so-called 'ordinary' adolescents. As Seekings observes:

> Children and adolescents in South Africa attend school, do chores at home, fight with the people with whom they live, seek to maintain relationships with absent parents, look for work, watch television and play sports, and have - or aspire to have - closer relationships with other boys or girls. In short, they do the kinds of things that children and adolescents do in many parts of the world, even if conditions vary from place to place (2006: 14).

Yet while it is certainly true that the experiences of adolescents in South Africa are similar to those in other in other parts of the world, it is equally true that the experiences of young South Africans are unlike adolescents elsewhere. The complex 'cultural braid' (Nsamenang 2002: 67) of South African society makes the construction of an 'ordinary South African adolescent' a daunting, if not an impossible (and perhaps pointless) task.

In the immediate post-apartheid period, with fears of a youth crisis having re-emerged and a united political consciousness fragmented, young South Africans grew up amidst a period of rapid social change and globalization. The transition to democracy opened up South African society exposing historically disadvantaged young people to Western ideologies, capitalist frameworks and globalized norms (Stevens and Lockhat 1997: 254; Leatham 2005: 62). This exposure had a profound influence on how adolescents recognized themselves as African and maintained connection to traditional values in the presence of Western modernity. As Stevens and Lockhat argue (1997: 254), while the emergence of a 'Coca-Cola culture' and an embracing of American individualism, competition and individualistic aspirations provided opportunities for some black adolescents to integrate socially, the adoption of Western cultural symbols also led black adolescents to develop

identities that marginalized them from perhaps more traditionally African social realities. For example, shifts towards adolescent individualism and autonomy conflict with traditional African value systems in which adolescents grow up developing a sense of communal existence and collective responsibility (Leatham 2005: 60-61). Here the tension between internal ideologies and external value systems, as well as between 'new' and 'old' worldviews, is representative of the dispersed power dynamics that play out in everyday life and cultural manifestations. Thus for some South African adolescents who are socialized to incorporate more holistic attitudes into their lives than their Western counterparts (ibid 2005: 47), they face the conflict of rejecting their cultural heritage in favour of Western norms, or perhaps more positively, seeking a hybridized identity relative to African and Western cultural influences.

Alongside the impact of Western culture, changes in race relations have had (and continue to have) a significant influence on the attitudes and identities of young people living in post-apartheid society. Affirmative action programs and the abolition of discriminatory legislation have helped black adolescents make the transition from a socially excluded minority to increasingly socially integrated majority. Yet as a result black adolescents have also been forced to "redefine themselves according to many of the norms and values which they opposed and rejected" during the apartheid years (Stevens and Lockhat 1997: 254) and like other young people, encountered the task of "reconstructing their identity in a non-racist discourse" (Wyn and White 1997: 147). Thus as recipients and creators of global youth culture, black adolescents are confronted with retaining a consciousness of themselves as South African, while developing their own unique cultural styles and traditions (Leatham 2005: 62). Adaptation for white, coloured and Indian adolescents has been no less complex. The shift from a position of political power to a social minority, along with the establishment of equal opportunity policies and job competition with better-educated black youth, has jeopardized the privileged status of the white community. For whites, these threats may engender racist resentment towards black groups benefiting 'at their expense', generate pessimism about the social conditions of modern society, and may cause white youth to doubt their certainty of being South African (Norris et al. 2008 53). A similar situation exists for coloured and Indian adolescents. Though having gained political rights, the loss of certain privileges may also reinforce antipathy towards blacks and complicate their understanding of what is means to be South African (ibid 2008

53).

In the post-apartheid society, race relations are frequently framed within the discourse of a 'rainbow nation' – a term first used by Archbishop Desmond Tutu in reference to the development of a cohesive and multi-cultural South African society. Though originally invoked with good intent, as Valji warns (2003: 26), the myth of the 'rainbow nation' has created a national identity that has been primarily top-down in its delivery. Here the political few may be seen as exercising control over the collective majority. Through political rhetoric and appeal to a united national identity, the rainbow nation discourse has been actively promoted as the 'political economy of truth' within the new South Africa. Ironically, though the rainbow nation discourse has historically aimed to enhance racial tolerance and national harmony, it may also contribute to the marginalization and subsuming of other linguistic, cultural or ethnic individualities under an "umbrella identity" (Norris et al. 2008: 53). This naturally has consequences for the realization of a plurality of knowledges within South Africa. As Cronin (1999: 20) cautions, "allowing ourselves to sink into a smug rainbowism will prove to be a terrible betrayal of the possibilities for real transformation, real reconciliation, and real national unity that are still at play in our contemporary South African reality".

Together with societal transformation, as well as evolving national and racial identities, the attitudes of young South Africans are also in flux. Research examining the future outlook of adolescents provides a glimpse into the multiple and heterogeneous ways in which young South Africans grow up and develop their identity. In a birth cohort study entitled 'Birth to Twenty', researchers found that black and coloured adolescents tend to be more certain about their South African-ness, have a more collective identity, and have more positive expectations about South Africa than both white and Indian youth (Norris et al. 2008). In contrast, white adolescents place greater importance on personal identities, and compared to blacks, coloured and Indians, place relatively less importance on unified racial, cultural and national identities (ibid 2008: 51, 56). These findings may be explained in part by the pervasive concept of *Ubuntu,* a humanist philosophy common in South Africa that emphasizes the value of community spirit, shared ancestry and existential interconnectedness. Though as Yen and Wilbraham caution, the holistic approach of *Ubuntu* should not be over-romanticized in its care for marginalized peoples, used as evidence of a homogenous African culture, nor pitted against constructions of Western individualism

characterized as selfish and competitive by comparison (2003b: 567).

Other research examining the future expectations of South African adolescents from various socio-economic backgrounds found that among black and brown respondents freedom of speech and human rights figured as South Africa's strongest assets, while HIV/AIDS, poverty and unemployment were identified as its most serious problems. In contrast white respondents identified beautiful scenery as South Africa's biggest advantage and violent crime as its major disadvantage (Steyn et al. 2010: 184). These finding suggests that for black and brown adolescents their identities and expectations of the future may be more closely tied to conditions of adversity that affect them disproportionately relative to whites.

While conditions of poverty, crime, unemployment and HIV/AIDS have no doubt taken their toll the psyche of some adolescents, the willingness of young people to endure hardship and persevere in spite of these obstacles stresses the fact that South African adolescents are, in general, highly resilient individuals. Accounts of adolescents are not "stories of 'failure' or of a 'descent' into marginality" – rather they are narratives of success in confronting challenges of past and present (Bray et al. 2010: 22). Adolescents today, regardless of cultural background, are positive about the future expectations of South Africa (Steyn et al. 2010: 179). They remain active in social and political development, engaged in the process of constructing and reconstructing their own identities, and crucially, in cultivating their social, psychological and emotional health.

Chapter 4: Mental Health in South Africa

For most countries in Africa mental health research, social services, financial support and policy development have not been commensurate with the burden of mental health problems. Too often African interventions have centered on physical health and communicable diseases, with mental health neglected as a footnote – limited to the psychiatric domain and frequently separated from holistic, spiritual and emotional care (Brown and Larson 2002: 17). Historically, the hegemony of biomedicine has rendered traditional health knowledges illegitimate and underappreciated their role in the diagnosis, and treatment of mental health problems. Today the services of traditional healers are used by 60 to 80 per cent of South Africa's population (Pretorius 1999: 249-250). Though traditional health practices sometimes differ in their conceptualization of mental health and illness from biomedical paradigms, by virtue of the number of patients seeking their services, traditional knowledges do in fact constitute legitimate forms of knowledge (Menenes 2007: 352). This chapter explores differences among traditional and biomedical health knowledges and attempts to uncover any power relations that may exist between them.

4.1 Mental Health as a Public Health Issue

In the wake of apartheid, and in the light of reconciliation efforts, mental health has emerged as a crucial public health and development issue in South Africa (Lund et al. 2008: 14; Draper et al. 2009: 342). Several factors may explain why this is so. First, the impact of apartheid on the mental health of South Africa's citizens, and the subsequent inquiry into those effects by the TRC and other groups, have brought issues of psychological well-being out of the shadows and into the mainstream during the post-apartheid era. A legacy of violence, exclusion and discrimination perpetuated during apartheid left many in South Africa with deep-seeded emotional wounds, psychological trauma and feelings of social isolation – the consequences of which still resonate. In particular the effects of apartheid were exceptionally harmful for black children and adolescents (Hickson and Kriegler 1991: 141; Lockhat and van Niekerk 2000: 291). As one report on human rights and mental health notes, "apartheid inflicted pain and psychological trauma on millions of black South Africans, from the violence of the regime inflicted on the young to the denial of human dignity embodied in the apartheid laws and their implementation" (American Association for

the Advancement of Science 1998: online). Though historically resilient, the self-esteem and coping abilities of adolescents have also been affected by stressors of social change and political unrest. Accordingly, these conditions have influenced adolescent development leaving young people today faced with the challenge of overcoming mental health problems, such as trauma and stress, exacerbated by systems of apartheid and colonialism (Mental Health and Poverty Project 2008).

Second, nationally representative epidemiological studies that reveal the widespread and cross-cultural prevalence of mental disorders in South Africa have enhanced awareness for the need to address psychological problems. Today, mental disorders rank 3rd in their contribution to the burden of disease following HIV/AIDS and other infectious diseases (Bradshaw et al. 2007: 439). Recent epidemiological studies have also found that 16.5% of South Africans report having suffered from common mental disorders such as depression, anxiety and substance abuse in the last year (Williams et al. 2008: 214). While no national studies assessing the prevalence of mental disorders in children and adolescents have been conducted in South Africa, some literature does reveal that young people suffer from mental disorders in similar proportions to adults (Kleintjes at al. 2006), and that the majority of anxiety, mood and substance abuse disorders onset before the age of 26 (Stein et al. 2008: 115). The lifetime prevalence of mental disorders (which is comparable to other African and international rates), as well as the average age of onset of mental illness, additionally does not appear to vary between socially-defined racial or cultural groups (Williams et al. 2008; Stein et al. 2008; Kleintjes et al. 2006; Hugo et al. 2003: 715). Like nations elsewhere, widespread evidence-based epidemiological studies have helped clearly identify the prevalence of adolescent mental health problems in South Africa, and in turn helped elevate mental health from an under-researched, misunderstood and marginalized topic to an increasingly fundamental public health issue.

Third, rights-based approaches to both health and adolescent development have advanced the awareness of mental health as a fundamental human right. South Africa's ratification of the UNCRC in 1995, one of the ANC's first acts following democratic elections one year prior, signalled a commitment to rectify past human rights violations and afford young people privilege to the "highest attainable standard of health" (UNICEF 1989), including mental health. The subsequent development of mental health policies also stressed South Africa's dedication to mental health rights, as indeed the "absence of policies designed

to address the mental healthcare needs of children and adolescents stands in direct opposition to the rights established by the Convention" (Shatkin, et al. 2008: 81). South Africa's policy guidelines for child and adolescent mental health insist that the rights of the child need to be recognized before 'optimal' mental health may become a possibility (Republic of South Africa 2008: 8), while South Africa's Mental Health Care Act promotes the best interests of mental health care users, including rights to knowledge, privacy, dignity and legal representation (Republic of South Africa 2002).

Finally, within policy interventions focus on mental health has helped legitimize its significance at the political and legislative level. In a 2004 study assessing the international absence of mental health policy, authors Shatkin and Belfer found that of the 191 countries recognized by the United Nations (UN) only 35 had any mental health policy that might impact on children and adolescents; and of those only 14 met level 'A' criteria which required having identifiable national policies or plans recognizing the unique mental health and development problems of children and adolescents. Among the 14 countries with level 'A' policy criteria, South Africa and Chile stood out as the only two low- or middle-income countries to have developed child and adolescent mental health policies or plans (Shatkin and Belfer 2004; 2008). While South Africa currently has no formally acknowledged national mental health policy, nor any clearly discernable strategy for policy implementation strategy, the mere development of child and adolescent mental health policy places South Africa at the forefront of global progress to effectively address mental health issues among young people.

4.2 Social Determinants of Mental Health

Many scholars and international organizations have recognized that mental health problems are closely associated with various social determinants of health. These determinants may include low socio-economic status, gender disadvantage, job insecurity, social conflict and physical health problems such as having HIV/AIDS (World Health Organization 2010; Mayosi et al. 2009; Prince et al. 2007; Miranda and Patel 2005). In the context of South Africa, amidst conditions of high unemployment, housing insecurity, incomplete education experiences, growing HIV prevalence, and rapid social change, mental health problems among adolescents may be particularly pronounced (Seekings 2006: 6;

Morrow et al. 2005: 25; Everatt 2000: 24).

Three social determinants of mental health relevant (though not unique) to South Africa are stigma, poverty and HIV/AIDS. Stigma may be broadly defined as: "An attribute that is deeply discrediting" such that a stigmatized individual is reduced "from a whole and unusual person to a tainted, discounted one" (Goffman 1963: 3). More specifically, stigma associated with mental illness may be defined as: "The negative attitude (based on prejudice and misinformation) that is triggered by a marker of illness" (Sartorius 2007: 2). Markers of illness naturally differ across geography and cultures, but may include physical differences (e.g. amputation, cleft lip), moral/character 'flaws' (e.g. substance abuse, criminal behaviour), psychological abnormalities (e.g. hallucinations, paranoia), or marks of culture such as race, nationality, customs or religious beliefs. When deemed flawed or inferior these marks discredit the individual in the eyes of society (Yang et al. 2008: 219). Social context may therefore be seen as playing an important role in the location of stigma within the person who is being stigmatized.

The stigma associated with mental health problems, including mental disorders, has been observed worldwide (Ssebunnya et al. 2009: 6). As a major barrier to the social inclusion, quality of life, help-seeking behaviour and provision of care for individuals who experience mental health problems (Hoven et al. 2008: 261; Rose et al. 2007: 97; Sartorius 2007: 2), stigma not only affects those who experience mental health difficulties, but also marks family members, communities, mental health professionals, as well as institutions that provide treatment for young people. For example, young people with mental illness may be victimized by peers, negatively portrayed by media and may experience the stigma of being falsely labelled as unpredictable or socially dangerous. Stigma may also lead to practices of social rejection, isolation and abuse (Hugo et al. 2003: 716), as well as cycles of discrimination that reduce self-confidence and reinforce negative attitudes associated with mental health difficulties (Sartorius 2007: 2).

While few studies have investigated levels of stigma towards people with mental illness (Kakuma 2010: 117), a recent analysis of mental health policy development and implementation in South Africa found that stigma towards people with mental illnesses remains highly problematic (Lund et al. 2008: 52). The report cited that misconceptions about people with mental health problems included being weak, lazy, mad, insane, incapable, unintelligent, abnormal, violent, unpredictable and worthy of incarceration. The report also

found that the consequences of these inaccurate beliefs reinforced the practice of labelling, and in turn resulted in individuals with mental disorders feeling neglected, isolated, abused, rejected by family and peers and without basic rights (ibid 2008). Stigma associated with mental health problems may also be particularly pronounced in some societies by beliefs that mental illness is incurable and caused by evil spirits (Ssebunnya et al. 2009: 11). As McDaid et al. highlight (2008: 79), "consequences of poor mental health in low-income countries may be even worse than in high-income ones, because of the absence of social protection safety nets, compounded by the high levels of stigma and superstition".

Poverty too exists as an important social determinant of mental and general health (World Health Organization 2010; Mental Health and Poverty Project 2008). Poverty and mental health difficulties coexist in a recursive relationship such that poverty may precede mental health problems, and mental health problems may result from poverty (Ssebunnya et al. 2009: 6). For adolescents, the stressors associated with absolute and relative poverty, including financial insecurity, overcrowded living conditions and access to food, nutrition, water and sanitation may impede mental and physical health. Adolescent mental health may also be compromised by indicators of poverty such as low levels of education (Patel and Kleinman 2003: 609). In a recent study assessing perceptions of stigma and poverty in Uganda, researchers found that because of stigma and a lack of parental encouragement young people with mental illness were less likely to attend or complete school thereby enhancing risk of trans-generational poverty (Ssebunnya et al. 2009: 10). While the relationship between poverty and mental health difficulties does not imply that all those who live in conditions of scarcity are mentally ill, for indeed one can be both poor and mentally healthy (just as one can be rich and experience mental illness), poverty nonetheless exists as a salient risk factor for mental health problems such as psychological trauma, emotional distress and social instability. Poverty alleviation programs may therefore also be seen as a form of mental and general health promotion.

A third (though by no means final) social determinant of mental health is HIV/AIDS. Relative to those uninfected, people with HIV/AIDS are more likely to suffer mental health problems that affect overall health outcomes (Miranda and Patel 2005: 0962). Currently, South Africa has one of the highest HIV infection rates in the world (Stephenson 2000: 165). Estimates suggest that over 60 per cent of new HIV infections occur among those aged 15 to 25 years (with adolescent girls most often diagnosed), and that between 1.5

and 2 million young people below the age of 15 have been orphaned by the epidemic (ibid 2000: 166). For some AIDS orphans, threats of poverty, substance use, abuse, participation in criminal behaviour and involvement in the sex trade (Call et al. 2000: 83), not to mention the secondary psychological trauma of losing a loved one and the heavy burden placed upon young people forced to head families in the event of parental loss, may exacerbate mental health problems. Moreover the stigma associated with pandemic, described eloquently by former UN special envoy to HIV/AIDS in Africa Stephen Lewis as the "bane of progress [which] savages and ravages, ostracizes and isolates those who are living with the virus" (2005: 69), resonates as a strong deterrent of mental health promotion and a barrier to help-seeking behaviour.

4.3 Traditional Health Practices

By offering culturally appropriate treatment as well as other services, traditional health practices may help in addressing the mental health care needs of South Africans, and in the general promotion of mental health (Nattrass 2005; Mbanga et al. 2002; Freeman et al. 1994 all cited in Sorsdahl et al. 2009). The may also help to alleviate part of the burden that conditions of poverty, stigma and HIV/AIDS can have on the mental health of adolescents.

Traditional medicine has deep roots and remains widely practiced in many countries around the world including South Africa. Though traditional health practitioners in South Africa are neither homogenous in practice nor classification, they are generally divided into herbalists or *inyanga/izinyanga*[8] and diviners or *sangoma/izangoma*[9]. More recently, prophets, Christian diviners (*abathandazi*), traditional surgeons (*ingcibi*) and traditional midwives/birth attendants (*ababelithisi*) have been added to the lexicon of indigenous healers (Pretorius 1999: 250). The role of the *sangoma* – whose methods are grounded in a holistic approach to physical and mental health treatment – is to identify the origins of illness, advise family of the rituals that need to be performed to alleviate suffering, and if necessary refer the sick individual to an *inyanga* who would supply traditional curative medicine. In addition to treating physical ailments, the practices of the *sangoma* and *inyanga* have also been valuable in the identification, diagnosis and treatment of people with psychiatric problems. Though historically underappreciated, the traditional healers have been integral in helping many

[8] Plural of inyanga
[9] Plural of sangoma

South Africans cope with psychological trauma experienced during and following apartheid (Xaba 2007: 330).

In the understanding and management of mental health problems, the practices of traditional healers differ in two significant ways from biomedical approaches. The first is in the causation of mental illness. While mental health and illness are concepts that may be identified in all cultures (Patel and Winston 1994: 438), there is no unanimous agreement on the classification of mental disorders (Patel 1995: 1295). Within traditional health systems mental illness is attributed variety of causal interpretations that conflict with the universal Western psychiatric categorizations. For example, the aetiology of mental illness may be attributed to cultural or supernatural factors. Cultures such as the AmaXhosa[10] recognize a variety of mental disorders but attribute only a few to brain abnormalities (Patel 1995: 1294). Other mental illnesses are ascribed to supernatural factors including witchcraft, possession of evil spirits, lack of religious faith, disobeying authority, failure to appease ancestors and committing sins (Kakuma 2010: 122; Botha et al. 2006: 622; Patel 1995: 1294). In some traditional South African cultures, sickness is therefore not seen so much as a question of what illness is, or how it occurs, but rather connected to questions of morality such as: "Why am I sick?" or "Why am I being punished?" (Baer et al. 1997: 6). In this sense traditional health practices have been criticized, and indeed undermined, for providing social or spiritual explanations most comforting or most in accordance to African cultural norms in comparison to the 'rational' aetiologies of Western psychiatry that locate the causation of mental illness in the body/brain (Yen and Wilbraham 2003b: 565). As another example that illustrates the blur between biomedical and traditional interpretations of 'illness', in some South African cultures the initiation of *thwasa* or 'calling'/'awakening' to become a traditional healers closely resembles the experience of a psychotic episode (Kakuma 2010: 122). Culture and local knowledge may therefore act as central elements in the construction of mental illness, as well as in how individuals with mental illness seek help (Hugo et al. 2003: 716). They may also factor into the mental health literacy of the general population. A 2003 South African study examining community attitudes towards mental illness found that the causes of certain mental disorders such as schizophrenia and panic disorder were more likely to be considered due to stress or weak character than medical disorders, and that 'talking it over' was a believed to be a more effective treatment option than approaching a medical

[10] The AmaXhosa people live primarily in south-east South Africa.

professional or taking medication (Hugo et al. 2003: 717-8).

A second difference between biomedical and traditional health practices manifests in the treatment of illness. Whereas biomedical approaches tend to give primacy to treating symptoms of the mind and body rather than deficiencies in society (Busfield 2000: 543), traditional African systems of healing more often embrace a holistic, egalitarian and non-invasive approach to health and treatment of illness (Xaba 2007: 323; Furnham et al. 1999: 190). Traditional beliefs, which may have their origin in the epistemology of African religions, see a person not only as a bodily entity but also as the "personification of past, present and future relations between the living and the dead" (Xaba 2007: 321). Thus in the diagnosis and treatment of illness, traditional healers often employ methods that not only seek to identify the origins of disease, but also who or what caused it, and why it has manifested at this particular point in time (Pretorius 1999: 252). In considering the patient within his/her social environment as a family and community member, the traditional healer may use methods of observation, patient self-diagnosis, reports from family members and divination approaches to diagnose and treat illness. These illnesses may include mental disorders or 'culture-bound syndromes' such as spirit possession, sorcery, ancestral wrath, neglect of cultural rites and defilements (ibid 1999: 252; Kale 1995: 1183).

In contrast to traditional health practices, biomedical approaches tend to focus more readily on the symptoms of disease and the location of illness within the body or mind. However in doing so biomedical approaches have been criticized for their separation of the body from the nonbody (Baer et al. 1997: 11), the subtraction the individual from the illness, and for reducing the patient to the "portrait of the disease" (Foucault 1989: 15-16). Medical and psychiatric professions too have been criticized for the relationship they impart between clinician and client; whereby the clinician – positioned as 'expert' – and the ill individual – positioned as a 'case' or 'patient' – imply that the client is 'abnormal' or having a 'pathology' that requires 'treatment' or 'intervention' (Walker 2006: 77). Here the client experiencing illness – defined and labeled as 'abnormal' or 'mentally ill' by the 'gaze' of the clinician who operates in a position of power – becomes stigmatized and discredited by society.

Of course, as Nsamenang and Dawes caution (1998: 84), one must also "be careful not to lapse into a love affair with indigenous culture", nor into one with traditional health practices. Recently, until the 2007 Traditional Health Act was passed, a lack of formal regulatory measures opened up the field of traditional healing to a variety of charlatans, some

of whom have exposed their patients to harmful and ineffective treatments, or even claimed to have a cure for AIDS (Richter 2003: 12). In addition, while the services of traditional health practitioners (which are often more accessible than Western forms of mental health care) are used by a majority of South Africa's population (Sorsdahl et al. 2009: 434; Pretorius 1999: 249-250), for people with diagnosed mental disorders they may not be the primary option for consultation or treatment. A recent study found that participants with a diagnosable mental disorder[11] more frequently consulted Western health practitioners than traditional healers for their mental health care needs (Sorsdahl 2009). In its treatment of mental health problems, Western medicine should therefore not be undermined in any attempt to provide legitimacy to traditional knowledges.

4.4 The Hegemony of Biomedicine

The long history of indigenous medicine, along with the widespread use of traditional practices give credence to local health knowledges in South Africa. However, over the last century, with the expansion of Eurocentric cultures and thought into more and more remote areas, biomedicine has come to "supercede in prestige and influence even professionalized traditional medical systems" (Baer et al. 1997: 212). This is most certainly the case in South Africa, where through the production of knowledge, development of policies and professionalization of psychiatric practices, biomedicine has been sustained by systems of power as the penultimate 'régime of truth'.

There exists little doubt that biomedical and Eurocentric approaches to mental health occupy a hegemonic position globally (Nsamenang 2002; Nsamenang and Dawes 1998: 74-77; Baer et al. 1997: 10; Patel and Winston 1994: 438). They also do so in South Africa. Despite the fact that a majority of South Africa's population is African, within the mainstream the dominant models of mental health care are entrenched in Euro-American ideologies and cultures (American Association for the Advancement of Science 1998: online). Several factors may explain the hegemonic influence of biomedicine.

Within the last two decades major breakthroughs have been made in the scientific understanding of mental health and mental disorders. New neuroscience technologies, as well as advances in genetics and pharmacology, have expanded the frontiers of mental health

[11] Based on Western DSM-IV classification systems.

information and confirmed the global ascendency of scientific knowledge. As de Sousa Santos recognizes (2006: 14), "scientific knowledge, however supposedly universal, is almost entirely produced in the countries of the developed Global North and, however presumably neutral, promotes the interests of those countries". Moreover through a complex and iterative process knowledge is often produced and transferred with great imbalance. For example, high-income countries produce an overwhelming majority of scientific and social science research with 90% of published scientific activity worldwide coming from the richest 10% of countries (Tyrer 2008: 79-80). Imbalances in research in terms of population and disease burden have led some to refer to the problem as the 10/90 divide (Saxena et al. 2006: 81-82). This divide persists in the field of mental health research where only 6% of publications emanate from low and middle-income countries (LMICs) (ibid 2006: 82). Here the overwhelming production of knowledge coming from the West has likely had a significant influence in shaping constructions of mental health (and mental health problems) in South African societies, as well as contributed to the stigmatization of non-Western or non-scientific knowledge as both illegitimate and inferior.

National policies influenced by international agents too have conferred a hegemonic status upon biomedicine. Policy development, much like the production of scientific knowledge, is rarely a neutral process. In many cases policies are highly politicized documents developed and framed by a plethora of values, goals, interests, ideas, institutions and actors, which inherently direct attention toward some elements and away from others (Yanow 2000: 11). Policies too are often attached to agendas that promote and maintain the status of those in positions of power. For example, Colebatch (2002: 97) notes that much of health policy is about the maintenance of an 'illness industry' that promotes a discourse of treatment and treatment organizations. Such discourse may also be subsequently seen as subjugating the interests of those groups not included in policy formation. As an authority on health within the United Nations system, the World Health Organization (WHO) has had a significant influence in framing global and local health issues. Specifically, the WHO's emphasis on neuro-scientific knowledge, pharmacological treatment, evidence-based research and categorization of mental disorders based on Westernized classifications have undoubtedly influenced the conceptualization of mental health from a Eurocentric and 'modern' scientific perspective. South Africa's policy guidelines for child and adolescent mental health draw heavily, and at times verbatim, from the WHO's mental health policy

and service guidance package for child and adolescent mental health policies and plans (see Appendix I). By adopting the WHO's language, as well as their approach to adolescent development and mental health, South Africa's mental health policy simultaneously diverts attention away from traditional understandings of mental health (which do not appear within the policy) that may be more (or at least equally) applicable to South Africa's diverse cultural environment. In his theory on the 'sociology of absences' and in conceiving of a new way to think about hegemonic influence, de Sousa Santos argues (2006: 15) that "what does not exist is in fact actively produced as non-existent". Within South Africa's mental health policy, omission of traditional health practices may be seen as an attempt to actively devalue and render invisible that which does not conform to the globalized biomedical approach. While it may be overly altruistic to ask policies to counter hegemonic discourses, it seems self-evident that they should, at the very least, reflect the various knowledges existent within the social reality the policy attempts to address.

The hegemony of biomedicine has also been reinforced through the professionalization of African psychology and psychiatry. In an analysis on the marginalization of indigenous medicines in South Africa, Xaba (2007) argues that 'modern' scientific medicine achieved its dominant position not because of its inherent supremacy, but because agents including (but not limited to) missionaries, the state and the medical establishment have actively excluded practices of traditional and indigenous medicine. He explains that Christian missionaries, in attempt to spread their message, often condemned African religious and cultural beliefs as inferior. Xaba further argues that the state through legislation and limited financing also denounced traditional medical practices. The Health Act of 1974 banned traditional healers from practicing traditional medicine (Kale 1995: 1183), and historically, the government of South Africa has not financially supported the services of traditional healers because of their unlicensed status (Pretorius 1999: 256). Finally, doctors, psychologists, and psychiatrists of 'scientific' medicine – threatened by the increasing urbanization of indigenous practitioners – undermined the practices of traditional medicine through discourses of illegitimacy and irrationality. Indeed, the fact that non-Western societies are more influenced by culture and tradition in their attitudes towards mental illness (Botha et al. 2006: 622), or that beliefs about the causation of mental disorders emanate from spiritual or religious teachings, is sometimes used as evidence to claim the inferiority of 'irrational' indigenous healing that exist in the shadow of 'rational' biomedical

paradigms (Yen and Wilbraham 2003b).

While 'scientific' medicine may be superior to traditional medicine in many ways, there are other fields in which traditional health practices are unmatched (Xaba 2007: 345). The hegemony of biomedicine should therefore not be seen as all-encompassing. As Baer et al. emphasize, "biomedicine is unable to establish complete hegemony in part because elites permit other forms of therapy to exist but also because patients seek – for a variety of reasons – the services of alternative healers" (Baer et al. 1997: 215). Biomedicine has also been unable to establish a complete hegemony because traditional medicine has become increasingly legitimized in South Africa. The African National Congress Health Plan of 1994 brought traditional medicine to the attention of many when it announced: "Traditional healing will become an integral and recognized part of health care in South Africa. Consumers will be allowed to choose whom to consult for their health care, and legislation will be changed to facilitate controlled use of traditional practitioners" (Republic of South Africa 1994: 44). More recently, the Traditional Health Practitioners Act of 2007 established a framework for traditional health services that in turn helped legalize and legitimize the practices of indigenous medicine (Republic of South Africa 2007; Gqaleni et al. 2007: 177). From a Foucauldian perspective, though hegemonic discourses may indeed result from the effects of power, they may also provide opportunities for resistance. That is they allow for or even produce alternative forms of knowledge that may undermine and expose dominant discourses (Foucault 1978: 100-101). Power must therefore be seen not merely as oppressive in its exercise, but productive in its potential, for as "vehicles of power" (Foucault 1980b: 98) traditional health practitioners and institutions are potent agents for resistance, opposition and social change.

Chapter 5: Conclusion

Though it may be tempting, especially in a country like South Africa that straddles the 'developed'-developing world divide, to polarize biomedical and traditional health approaches, or position African people as caught between medical cultures, perhaps a more constructive thought is to see these knowledges as both legitimate and the gulf between them as slowly converging. Together, practices of traditional health and contributions from Western medicine form a plurality of mental health knowledges in South Africa. Having analyzed the ways that globalized models of adolescence and mental health compare and contrast with local and traditional knowledges, as well as the power relations that exist between them, it is worth turning to an examination of how these differences can help inform new approaches to address issues related to adolescence and mental health.

5.1 Towards Contextualized Frameworks

As South Africa has become increasingly exposed to globalized cultures and value systems, a formidable challenge for the country is to address adolescent and mental health issues relative to traditional and contemporary ways of life. African views have the potential to enhance the fields of social science by informing them about what may or may not be universal aspects of adolescence (Nsamenang 2002: 63). Traditional health knowledges too may help to inform areas of biomedicine about the universality of Western psychiatric taxonomies and approaches to mental health. Local knowledges are therefore not 'antiquated' belief systems holding out against the rise of modernity. Rather they offer insights that can and should advise the development of more socially- and culturally-informed programs and policies. Such contextualized frameworks thus may offer alternatives to current development models that have a tendency to 'think globally and act locally'.

The support of socially- and culturally-informed interventions of course inevitably prompts the question: What exactly does it mean to be socially- or culturally-informed? Indeed there is no single answer, which is precisely the point. To develop socially- and culturally-informed programs and policies means to incorporate global and local knowledges into the design of interventions that are able to be effective alongside a plurality of evolving social and cultural contexts. Thus for adolescent frameworks being applied in South Africa this may mean the expansion of aged-based categorizations to appreciate the increasingly prolonged period of adolescence. It may also mean designing population- and geographic-

specific interventions for groups such as AIDS orphans or youth in poverty. Such programs can help to enhance the understanding that young people across social, economic and cultural lines may not experience their adolescence in neat sequential phases, but rather in complex and at times disordered transitions. Finally, socially- and culturally-informed adolescent models may take into African value systems of *Ubuntu* and interdependence, which may co-exist alongside more Western notions of autonomy and individualism. Local knowledges may therefore be highly useful in understanding issues related race, South African identity and youth cultures not as we want them to be, but as they are (Everatt 2000: 25).

Contextualized mental health frameworks may also help to understand how traditional health knowledges can operate alongside biomedical approaches. As we have seen, polarizing these knowledges appears of little help. As De Sousa Santos notes:

> "If we take biomedicine and African traditional medicine as an example, it makes no sense to consider the latter, by far the predominant one in Africa, as an alternative to the former. The important thing is to identify the contexts and the practices in which each operates, and the way they conceive of health and sickness and overcome ignorance (as undiagnosed illness) in applied knowledge (as cure)" (2006: 20).

Though friction and power dynamics clearly exist between Western biomedical and traditional health knowledges, as de Sousa Santos argues, one must avoid dichotomizing knowledges, or favouring one over the other, where both may thrive complementarily. Setting 'traditionalism' against 'modernity' does little to advance discourses surrounding mental health (Nsamenang 2002: 96). Because biomedicine focuses largely on the symptomology of disease, while traditional health practices focus more on holistic and social healing, the two systems have the potential to complement each other well. Moreover, the current existence of legally-registered traditional health practitioners and African doctors trained in Western systems may ease the transitional integration of traditional healing into formal mental health care systems (American Association for the Advancement of Science 2010: online), as well as contribute towards the development of a "new cross-cultural psychiatry" (Patel 1995: 1291). Indeed if mental health is to be recognized as not merely the absence of disease, holistic and interdependent forms of health care that emanate from traditional practices may offer great insights into the consideration of mental health from social, cultural, family and community perspectives.

5.2 Conclusion

In general, global cultural and biomedical models have been effective in enhancing the protection, provision and promotion of adolescent mental health in South Africa. Yet simultaneously, these models have also contributed to the marginalization of local and traditional adolescent and mental health knowledges as illegitimate, irrational and inferior. The reluctance of 'scientific' medicine to engage in dialogue with traditional health practices has allowed young South Africans to needlessly suffer and die from conditions that might have been mitigated if the two medical systems were able to cooperate, or at least acknowledge each other (Xaba 2007: 345). While an equality of knowledges should not necessarily be the objective, recognition of an ecology or 'rainbow' of adolescent and mental health knowledges may help to further effectively address the social, psychological and emotional needs of young South Africans.

For the elusive maxim 'mental health for all' to have any meaning in South Africa knowledge must be gained from cross-cultural psychiatric research, mental health services must be provided free of hegemonic constraint, and children and adolescents must become priorities areas for government and mental health systems. Moreover, if South Africa is to truly live up to the title of a 'rainbow nation' and shed images of historic injustice, local adolescent and mental health knowledges must be at the very least granted legitimacy alongside globalized Western discourses, and at best integrated into public programs, policy interventions and the wider social milieu.

Appendix I

* Bolded text represents difference between policy documents.

Section	South Africa's Policy Guidelines for Child and Adolescent Mental Health	WHO Child and Adolescent Mental Health Policies and Plans Package (WHO 2005b)
A.	[These guidelines] address mental health in the prenatal period (conception to birth), childhood (birth to 9 years) and adolescence **(12 to 18 years).** They adopt a broad definition of child and adolescent mental health: Child and adolescent mental health is the capacity to achieve and maintain optimal psychological functioning and well-being. It is directly related to the **degree of age-appropriate bio-psycho-social development achieved using available resources.**	This guidance package addresses mental health in the prenatal period (conception to birth), childhood (birth to 9 years) and adolescence **(10 to 19 years)**. It adopts a broad definition of child and adolescent mental health: Child and adolescent mental health is the capacity to achieve and maintain optimal psychological functioning and well-being. It is directly related to the **level reached and competence achieved in psychological and social functioning.**
B.	Child and adolescents mental health includes a sense of identity and self-worth; sound family and peer relationships; an ability to be productive; a capacity to use developmental changes and cultural resources to maximize development.	Child and adolescent mental health includes a sense of identity and self-worth; sound family and peer relationships; an ability to be productive **and to learn**; and a capacity to use developmental challenges and cultural resources to maximize development. **Good mental health in childhood is a prerequisite for optimal psychological development, productive social relationships, effective learning, an ability to care for self, good physical health and effective economic participation as adults.**
C.	There are a number of factors that can affect the mental health of a child or adolescent. Broadly speaking, these can be divided into risk and protective factors. The former refers to factors that increase the probability of mental health difficulties, while the latter refers to factors that mediate the effects of risk exposure. As the term "bio-psycho-social" in the above definition suggest, these risk and protective factors can exist in the biological, psychological and social domains. [Table1] provides examples of risk and protective factors in each of these domains	There are a number of factors that can affect the mental health of a child or adolescent. Broadly speaking, these can be divided into risk and protective factors. The former refers to factors that increase the probability of occurrence of mental health problems or disorders, while the latter refers to factors that moderate the effects of risk exposure. As the term "bio-psycho-social" in the definition of mental health used earlier suggests, these risk and protective factors can exist in the biological, psychological and social domains. [Table 1] provides examples of risk and protective factors in each of these domains.
D.	An important focus of these policy guidelines is to promote development of all children and adolescents, whether they are suffering from mental health problems or not. This can take place through, on the one hand, reducing the impact of risk factors and, on the other hand, by enhancing the effects of protective factors. However, a proportion of children and adolescents suffer from overt mental health problems.	This module emphasizes the need to promote the mental health of all children and adolescents, whether or not they are suffering from mental health problems. This can be done by reducing the impact of risk factors on the one hand, and by enhancing the effects of protective factors on the other. However, a proportion of children and adolescents suffer from overt mental health disorders.
E.	Some children and adolescents are in difficult circumstances, for example through having been subject to physical, emotional and/or sexual abuse, experiencing or witnessing violence, suffering from intellectual disability, being addicted to substance such as alcohol or cannabis and being **HIV/AIDS sufferers and/or orphans through AIDS.** Some	Some children and adolescents are in difficult circumstances; for example, they might experience physical, emotional and/or sexual abuse, experience or witness violence or warfare, suffer from intellectual disability, **slavery or homelessness, migrate from rural to urban areas, live in poverty, engage in sex work,** be addicted to substances such as alcohol and

	of these difficult circumstances can be related to mental health problems in a number of ways. They could, for example, serve as risk factors for mental health problems, as occurs when a child who has been sexually abused suffers from post-traumatic stress disorder as a result of the abuse. Alternatively, the mental health problems could serve as risk factors for difficult circumstances, as occurs when an adolescent becomes addicted to alcohol through trying to deal with depressive feelings. Whatever the nature of the relationship between mental health problems and difficult circumstances, **general** intervention strategies can be used as a guideline to address the needs of children and adolescents in difficult circumstances.	cannabis, or be **infected or affected by HIV/AIDS.** Difficult circumstances and mental health problems can be **interrelated** in a number of ways. They could, for example, serve as risk factors for mental health problems, such as post-traumatic stress disorder in a child who has been sexually abused. Alternatively, mental health problems could serve as risk factors in difficult circumstances; for example, when an adolescent uses alcohol **or drugs** to deal with depressive feelings. Whatever the nature of the relationship between mental health problems and difficult circumstances, **specific** intervention strategies are necessary to address children's and adolescents' needs.

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