CHAPTER 7

7.0 ALTERNATE AND TRADITIONAL MEDICINE AND CANCER TREATMENT

7.1 Alternative Medicine

At a time when an estimated 50% of the serious cancers diagnosed in the United States were curable with existing therapies, and access to scientifically sound experimental trials had been considerably simplified with the National Cancer Institute's Physician Data Query computerized information system, Curt (1993) wrote that it seemed inconsistent that unsound methods of cancer treatment should continue to be a significant public health problem. However he noted that the problem was increasing rapidly. Ten years later more cancers are curable with existing therapies and the influence of alternative treatments is even more widespread. .Much of this trend has been expanded by the internet.

Curt (1993) noted that the result of many of these unsound approaches was that patients spent time and money on ineffective therapies. He also pointed out the potential for greater harm. Cancer patients who sought and obtained unsound therapy might not receive treatments of proven efficacy or appropriate experimental treatment approaches based on proven research. In addition some of the more popular unsound treatments were potentially harmful in themselves. Curt (1993) also pointed out that the clinician treating the patient could not ignore

the influence of alternative forms of treatment and had to equip him/her self to deal with it in the patients under their care.

"Patients who seek alternative or unsound cancer therapies are intelligent and inquisitive and unlikely to be persuaded that an approach is useless simply because the proponent lacks scientific credentials or has not published in peer-reviewed journals. Moreover, those who offer these useless approaches are generally convinced that they can help the patient. The clinician needs to understand and be able to discuss the seemingly attractive although useless treatments patients hear about through the media or from well-intentioned friends." (Curt, 1993, p. 2745)

Cassileth, Lusk , Strouse , Bodenheimer (1984) point out that education, legislative action, and medical advances have failed to deter patients from seeking unorthodox treatments for cancer and other diseases. In their study using 304 conventional cancer treatment inpatients and 356 patients under the care of unorthodox practitioners, they found that 8% percent of all patients studied never received any conventional therapy, and 54% of patients on conventional therapy also used unorthodox treatments. Forty percent of patients abandoned conventional care entirely after adopting alternative methods. Patients interviewed did not conform to the stereotype of poorly educated, end-stage patients who had exhausted conventional treatment. Practitioners also deviated from the traditional portrait: Of 138 unorthodox practitioners studied, 60% were qualified physicians.

Ritvo, Irvine, Katz, Matthew, Sacamano and Shaw (1999) applied what they called the Risk

Adaptation Model, to further clinical understanding of the motivations of cancer patients in seeking complementary therapies. In the model, patients formally or informally evaluate certain factors when deciding the right treatment method for them selves. Rational evaluations and weighing evidence can play a minor role in a patient's treatment regime, depending on the level of attention regulation and the need to maintain optimistic expectancy. An important point these authors make is that physicians must help patients overcome dysfunctional attentional states, and recognize when complementary treatment decisions signal the need for psychotherapeutic support.

Muthny and Bertsch (2003) point out that the main motive of the users of conventional and alternative medicine was the wish not to exclude any possible treatment options. Only 8% of the sample they looked at was on actual alternative medicine to the exclusion of conventional medicine.

It is apparent that patients are better informed, often downloading from the internet material relevant to their diagnosis. Many also join various internet support groups. Davison, Pennebaker, James and Dickerson (2000) discuss the fact that more Americans try to change their health behaviours through self-help than through all other forms of professionally designed programs. They point out that mutual support groups, involving little or no cost to participants, have a powerful effect on mental and physical health.

Despite this growing trend, little is known about patterns of support-group participation in health care. Many questions arise, which require systematic research (viz. Why do groups

form? Do people seek support at comparable levels across illness categories? Are patterns of support seeking, similar for real-world support groups and computer-based virtual support groups?)

In an effort to observe social comparison processes with real-world relevance, support-group participation was measured for 20 disease categories in 4 metropolitan areas (viz. New York, Chicago, Los Angeles, and Dallas) and on nationwide on-line discussion groups. Support seeking was highest for diseases viewed as most stigmatizing (e.g. AIDS, alcoholism, breast and prostate cancer) and was lowest for less embarrassing but equally devastating disorders, such as heart disease (Davison et.al.,2000).

There is a great deal of sharing of information from various sources among patients and this is often welcomed by the patients who come to feel that only their colleagues in illness can understand what they are going through and what they truly need. Interestingly, chronically ill patients in a sense, bypass authority, and use their peer group, i.e. fellow cancer patients as their point of reference.

Some patients conceal their involvement in alternative medicine while other patients will feel free to discuss their involvement, or part thereof with their physicians. Mackenzie, Parkinson, Lakhani and Pannekoek (1999) explored patients' expectations of physicians when discussing complementary therapies. Themes included: (1) issues of control and collaboration; (2) the need for understanding treatment information; (3) the maintenance of hope; (4) the expectation of non-judgmental, respectful, and compassionate care; and (5) evaluating

received information as an indicator of trustworthiness. They suggest that physicians can promote an integrated approach by understanding how the patient (and physician) is emotionally affected by illness and how this influences communication. Doing so will enable patients to feel more confident in their care and their choices.

It is important for patients to be able to discuss complimentary and alternative medicine with their physicians, to gain a clear picture of the situation. It is also important for physicians not to brush aside the subject but to have some knowledge about what the patient is saying (Tasaki, Maskarinec, Shumay, Tatsumura and Kakai, 2002).

"Nevertheless, many of the conversations with physicians did not satisfy the patients. Several statements in the interviews indicated that patients' perceptions of physicians' attitude discouraged them to initiate or to continue a discussion about complimentary and alternative medicine. The physicians' focus on evidence-based reasoning hindered successful communication about complimentary and alternative medicine because some patients felt that physicians do not consider that such unproven alternative approaches may be of any benefit. (Tasaki et. al., 2002, p. 217)

"However physicians need to be aware that disagreeing with patients' decisions to use complimentary and alternative medicine without showing respect and compassion for such decisions will discourage patients from disclosing complimentary and alternative medicine use and unsuccessful communication will likely result " (Tasaki et. al., 2002, p.218).

They conclude that: "Finally, to continue an open discussion of complimentary and alternative medicine, it will be necessary for physicians to recognise that many patients use different principles of reasoning than those taught in medical schools. Successful communications can only be achieved when physicians recognise that scientific evidence is not all that counts in the life of an individual facing a serious disease. (Tasaki et. al., 2002, p.219)

Spiegel (1993) has argued that conventional medicine has failed to sufficiently consider the individual being treated.

”Modern medicine has largely focused on the physical side of the problem, aggressively attacking the illness, often ignoring the person who has it. On the other hand, 'alternative medicine' has focused on the person rather than the disease, insisting that it is simply 'mind over matter': Fix it in your mind and the physical problem will take care of itself. This approach is equally wrong. It is the interaction of mind and body that matters, coping with illness is both a mental and a physical process. We live better not by denying or avoiding illness, but by bringing out full resources to bear in facing the situation and living beyond it. Serious illness is a threat to life. A diagnosis of disease such as cancer seems at first to bring an end to life, but what it really does is change it. There is life after cancer and heart disease. What we think and feel is relevant to the course of disease, but it does not provide us with straightforward control over it either. In this book I describe what I have learned from cancer patients about how one can live fully in the face of illness, how mind and body can work together, how facing dying can intensify living." (Spiegel, 1993, p. V11-V111)

The controversial dissident position on HIV/AIDS treatment has significantly influenced treatment resources and education campaigns in Africa. Schuklenk, (2003) highlighted the problem and described how a small but vocal group of biomedical scientists propagated the views that either HIV was not the cause of AIDS, or that it does not exist at all. He argued that when these views were rejected by mainstream science, this group took its views and arguments into the public domain, including actively campaigning in newspapers, radio and television programmes, with very harmful consequences as a result of the rejection of allopathic medicine. He discussed two distinct ethical questions; viz.

What moral obligations do such minority-view scientists have with regard to a scientifically untrained lay-audience, and what moral obligations mainstream newspapers and government politicians have when it comes to such views?

Schraub (2000) discusses questionable or unproven methods which are used by cancer patients throughout the world. Treatments include drugs, vitamins,

herbs, diets, healing, "psychological" treatments, folk medicines, and homeopathy. The exact frequency of questionable methods in cancer is difficult to evaluate because of the variety of methods, some being used as complementary treatments to conventional ones and others, as curative alternative treatments. The situation is made more difficult by the fact that the number of patients using alternative methods is often unknown. In Europe, data are available for the Nordic countries, Switzerland, Germany, Austria, United Kingdom, the Netherlands, France and Italy. High frequencies of alternative medicine use are observed in German-speaking countries (52-65%). In North America, many publications give frequencies of between 7% and 54%. In Mexico, the frequency is 50%, higher than in Argentina (17%). In

Australia, 22% have used complementary medicines. There is a general lack of data from countries in Africa and in Asia. While some products are used all over the world (e.g. mistletoe, vitamins), others are country specific, (for example specific diets in the Netherlands). Some traditional medicines are also country specific (for example Chinese medicine and Ayurvedic medicine in India). Both alternative and complementary unproven methods are prescribed either according to classical concepts of cancer treatment or according to their own concept of the world and of life.

Many and various treatments have been offered by alternative medicine. Most claim to boost the immune system or the body's resources, thereby warding off the cancer and others claim to attack the cancer itself.

7.2 Quackwatch

Quackwatch was founded in an attempt to counter misleading medical information that is being disseminated on the internet. Quackwatch (2000)'s purpose is to combat health-related frauds, myths, fads, and fallacies. Its primary focus is on dubious information or unproven claims. It was founded by Barrett, a psychiatrist, in 1969, as part of the Lehigh Valley Committee Against Health Fraud. In 1997, it assumed its current name and began developing a worldwide network of volunteers and expert advisors.

Barrett (1999a) feels that although most Americans are harmed by "quackery", few perceive it as a serious problem and even fewer are interested in trying to do anything about it. He lists

several misconceptions which appear to contribute to this situation. These include views such as the following:

(a) personal experience is the best way to tell whether something works;

(b) "minor" forms of quackery are harmless; and

(c) government somehow protects us.

He feels that the main reason for "quackery's" success is its ability to seduce unsuspecting people.

In another effort to assist patients to make their way through the bulk of the oncology information on the internet and elsewhere, Barrett (1997) writes articles on the QUACKWATCH Website to assist the patient to avoid being misled or manipulated. He points out that promoters of quackery know how to appeal to every aspect of human vulnerability, and that what sells is not the quality of their products but their ability to influence their audience.

Coker (2001) writes, "... Pseudoscience deliberately creates mystery where none exists, by omitting crucial information and important details. Anything can be made "mysterious" by omitting what is known about it or presenting completely imaginary details. Pseudoscience appeals to false authority, to emotion, sentiment, or distrust of established fact. A high-school dropout is accepted as an expert on archaeology, though he has never made any study of it! When confronted by inconvenient facts, the reply is simply, 'Scientists don't know everything!' They not only provide no evidence that their claims are true. They also ignore all findings that contradict their conclusions." (www.quackwatch.com)

7.3 Various Alternative Treatments

7.3.1 'Immune Boosting' treatments

Several examples of alternate explanations and treatments are listed in Quackwatch and on the Internet in various websites. These include the "Transfer Factor", claimed to have "unprecedented" immune boosting ability (Hennen, 2005). Dr. Alivizatos (in Barrett, 2001a) claimed that his serum boosted the body's natural immune system and helped rid the body of cancer. What was extremely dangerous was that he advised the cancer patients to discontinue all chemotherapy and radiation programs before beginning his treatment and for a period of time afterwards. Naessens (in Barrett, 1999]) developed a similar treatment using pseudoscientific terminology i.e. "trimethylbicyclonitramineoheptane chloride" (714X).

The so-called "Di Bella therapy" is an unorthodox cancer treatment which claims to stimulate Di Bella claims that his treatment stimulates the body's self-healing properties without damaging healthy cells (Bertelli, 2001). Gonzalez' treatment for cancer recommends "gland extracts" (ingested pancreatic enzymes that are supposed to seek out and kill cancer cells), coffee enemas, vitamin megadoses, and diets. Gonzalez claims that poisoning occurs when people eat "processed foods" and that an "unpoisoned body" can recognize and destroy cancer (Green, 2001a). "Immuno augmentative therapy" (IAT) was produced in 1977 by Burton, a zoologist (in Curt, 1993). The treatment was based on the theory that cancer develops because of "immuno incompetence," which Burton claimed he could measure and restore using a series of protein fractions derived from the blood of patients and healthy donors.

7.3.2 Direct cancer treatments

One of the most popular health scams that originated in the 1950's was the "Hoxsey method" of cancer treatment (Curt, 1993). Hoxsey described his approach as "essentially chemotherapy" for "the systemic treatment of cancer". The "Hoxsey method" involved two medicines: the "pink medicine" (potassium iodide and pepsin) and the "black medicine" (cascara in an extract of licorice, red clover, burdock root, stillingia root, berberis root, poke root, and the bark of the buckthorn and prickly ash). This complex of plant products was attributed to Hoxsey's great-grandfather, who observed that his horse was cured of cancer after grazing on these plants (Curt, 1993).

Another popularised 'alternative' treatment was "Immunostim" (Barrett, 2001d; Krutzweil, 2001). I FDA laboratory analysis indicated the treatment contained substances found in common cleaning fluids, such as dish detergent and toilet bowl cleaner. Patients paid as much as $7,500 per treatment and had the product injected into their veins. Apart from not being effective in the treatment of cancer it was found that most patients treated with "Immunostim" experienced inflammation of veins. This led to "painful swellings" and then complete closure of the veins (Barrett, 2001d; Krutzweil, 2001).

"Hydrazine Sulfate" is an inexpensive common chemical used by Gold a general practitioner (Green, 2001a). He postulated that a metabolic circuit existed in cancer patients that allow energy needed for tumour growth to be drawn from normal metabolic pathways. This alleged "energy short circuit" causes cachexia in cancer. If the circuit could be broken, cachexia

would be overcome and the cancer would be deprived of the energy needed to grow (Green, 2001a). Also, "Induced Hypoglycaemic Treatment" (IHT) claims to have shown promising results for many cancers, even in late stages (Barrett, 2001c).

"Induced Remission Therapy'" (IRT) claims to shrink large cancer lesions within days as well as removing the symptoms (Barrett, 2001b). Similarly, "Tahitian Noni" juice is claimed to treat, cure or prevent numerous diseases, including cancer. Patients are urged to reduce their dosage of prescription medicines to prevent the side effects of the "Noni fruit juice."(Quackwatch, 1999). Other preparations are "PC-SPES" which is a patented hormonal formula developed by a scientist, Chen (in Strum and Scholz, 1999), for prevention or treatment of prostate disease; "Aveloz sap", which claims to eliminate cancerous growths in one week (Tyler, 2001): and "Essiac" (Comboweb.com, 2001) and "Anvirzel" (Nester, 2000), which have also been a 'famous' alternative cure for cancer.

7.3.3 Unsound devices

Many strange and unsound devices have been produced for the treatment of cancer (Curt, 1993). The "Cancer Detector LEC-03" is claimed to measure the speed with which cancer cells are reproduced (Lehmann, 1999). The "BioResonance Tumour Therapy" treatment is claimed to be "the most effective new development for the natural elimination of tumours and their underlying causes yet discovered "(Barrett, 2001f). It is said to be administered with a "BioResonance Therapy Device" that can detect and modify "electromagnetic emissions" from the patient's cancer cells (Wilcox, 2001)

Another group of devices were designed and built by Reich (1951) These were "orgone energy accumulators" which were treatment devices resembling telephone booths constructed of metal, wood, and asbestos board. Specialized cone-shaped instruments were also designed to treat the head.

7.4 Propaganda

The internet provides a forum for propaganda and manipulation that is particularly effective in vulnerable populations such as the chronically ill.

7.4.1 Derogatory statements on conventional treatment

Derogatory statements on conventional treatment can obviously be very confusing for the cancer patient searching the Internet for answers. One of the most disturbing issues about false claims is that the patient is given a choice by these websites as if this is a fair decision with an equal chance of cure.

Websites that propagate anti chemotherapy can be very sophisticated and subtle in their use of conspiracy theories to influence and manipulate their readers. For example, the Cancell Home Page (2001) claims to expose the fraud behind pharmaceutical company controlled medical research institutions. They claim that these institutions are responsible for preventing numerous safe alternative cancer treatments from getting to the public and that mainstream doctors receive distorted information on alternative cancer treatments. "Therefore, you cannot

rely on mainstream doctors to recommend the correct cancer treatment. You must rely on yourself. If your doctor doesn't have the time or ability to learn about different cancer treatments, should they be treating you? If the National Cancer Institute claims that a cancer treatment is ineffective, but their own test results show that it is extremely effective, are they guilty of murder? Avoid being a victim, visit this non-commercial site: http://www.handpen.com/Cancell/cancell.htm".

ForbiddenMedicine.com (2001) is a website that by the very name tantalizes the rebellious, critical and challenging minds of patients as it begins, subtly at first, to undermine and then to destroy a patient's confidence in the oncologist. It does this with impressive graphics and carefully chosen wording. It is dangerous in that it addresses the state of mind and vulnerability of patients with life threatening illness. Again, some of their actual wording is used to illustrate the strength of their propaganda. For example, "If you ask why chemotherapy and radiation is prescribed for virtually all cancer cases, your oncologist will answer: 'Because it is standard procedure' not 'because it cures cancer' or 'because it raises the odds of survival,' but because it is standard practice, sanctioned by the FDA and the AMA. And, of course, because your oncologist has nothing else to offer .... According to many eminent alternative and holistic physicians, chemotherapy and radiation represent the worst form of "medical quackery", and they should be replaced by "non-toxic treatments" (ForbiddenMedicine.com, 2001a).

They give the patient surfing their website for answers, the idea that their medicine is not only comparable but infinitely superior to conventional medicine and that the patient has to make

the choice. e.g. "If you have been diagnosed with cancer, the most important decision you are faced with is this: Which treatment should you choose, mainstream or alternative? This leads to further questions: Are the cancer treatments of orthodox (allopathic) medicine the best that medical science has to offer? Are they safe and effective? According to alternative/holistic medical experts, many of them highly respected mainstream medical doctors, to apply chemotherapy and radiation therapy to cancer patients is unconscionable, and it should be stopped immediately." (ForbiddenMedicine.com 2001b).

A further example of sophisticated manipulation is evident in the website, rawfood.com (2001). Their claims typically begin to undermine and tamper with the patient's trust in their oncologist, which is often found with these alternative sites.

Walters (2001) gives the same kind of negative propaganda, eg. "The three 'proven' methods of treating cancer, chemotherapy, radiation, and surgery, may actually shorten your life in many instances. Each of these treatments is invasive, has devastating side effects, and treats only symptoms. Each can cause the spread or recurrence of cancer ... While the alternative therapies exhibit great variation, all of them are rooted in the idea that a truly healthy body will not develop cancer" (HealthWorld Online, 2001).

Propaganda is very difficult for a patient to resist especially when sites present their information as authentically academic, and when this patient is vulnerable and traumatized from the diagnosis of a life threatening illness , as well as facing the difficulty of conventional treatment, under the circumstances, a 'choice' of a 'gentler' treatment can be very compelling.

7.4.2 The ploys used by alternative therapy to influence the cancer patient

Barrett and Herbert (2000) point out that 'alternative' promoters are manipulating people emotionally. What sells is not the quality of their products, but the ability to influence their audience. Their basic strategies are to promise complete cure and to eliminate all competition. Fraudulent alternative therapists portray themselves as innovators and suggest that their critics are rigid, elitist, biassed, and closed to new ideas. Such promoters are adept at using slogans and jargon. During the 1970s, they popularized the word "natural" as a selling point. During the 1980s, the word "holistic" gained similar use. Currently, the word, "alternative" is being used to influence patients and possible customers. However, the term "alternative", in its correct usage refers to methods that have equal value for a particular purpose. (An example would be two antibiotics capable of killing a particular organism.) When applied to questionable methods, however, the term is misleading because methods that are unsafe or ineffective are not reasonable alternatives to proven treatment. For this reason, the word "alternative" is placed in quotation marks when it refers to methods not generally accepted by the scientific community and which have no plausible rationale (Barrett and Herbert, 2000).

7.5 Medical Professionals in Alternative Medicine

There are many health professionals who provide alternative medicine and treatment, causing even greater confusion. Javis (1988) suggests reasons such as boredom, low professional esteem, paranoid mental state, psychopathic tendencies and the profit motive for doctors to enter this field. In addition Javis (1988) suggests that many practitioners receive esteem and

satisfaction from the personal power they derive in the self appointed roles, "prophets", or "gurus". An example of such grandiose claims is evident in the treatment claims of Clark (2001), a medical practitioner. She describes herself as an "independent research scientist". She claims that all cancers are alike and are all caused by a parasite, "the human intestinal fluke". If this parasite is killed, the cancer stops immediately and the tissue become normal again. In order to get cancer, a person has to have this parasite.

She claims that it takes 5 days to be cured of cancer regardless of the cancer type. Surgery, radiation, or chemotherapy treatment can be cancelled, because, Clark's recipe cures the cancer. (Barrett, 2001e; Clark, 2001) She claims that her success rate for advanced cancer is 95% i.e. "It only takes days to be cured of cancer regardless of the type you have. It does not matter how far progressed the cancer is, you can still stop it in 5 days. Does this mean you can cancel your date for surgery, radiation or chemotherapy? YES! After curing your cancer with this recipe it cannot come back. This is not a treatment for cancer: It is a cure! (Clark 2001) Her next statement undermines the medical profession and draws the patient into her world, using the common tactics of propaganda: "Remember that oncologists are kind, sensitive, compassionate people. They want the best for you. They have no way of knowing about the true cause and cure of cancer since it has not been published for them. I chose to publish it for you first so that it would come to your attention faster."

Dr. Lorraine Day's website (Day 2001) makes strong claims which are more damaging because of her medical background and the fact that she, herself, apparently had cancer. She is highly critical of the medical profession: "I refused mutilating surgery, chemotherapy and

radiation, the treatment methods ALL physicians are taught. What YOU need to know to make the important decisions for your treatment: Why doctors don't know, and are never taught, how to get you well from cancer and the dangers of chemotherapy and radiation and why cancer is big business! Who controls the Cancer Industry, the FDA and the American Cancer Society. Who controls what the media tells you about cancer treatment?" (Day, 2001)

7.6 How Alternative Treatment Claims Harm Cancer Patients

Javis (2001) has written a penetrating article on how alternative treatment claims can harm cancer patients. He categorizes the harm done by such claims into economic, direct, indirect, psychological and societal consequences. Firstly, he claims that the amount of money wasted on cancer "quackery" is unknown but probably exceeds the amount spent for cancer research. The financial impact upon individuals and families can be catastrophic if they fall into the trap of heroically "leaving no stone unturned" in their quest for a remedy in hopeless cases (Javis, 2001).

Direct harm comes from dubious therapies which can cause death, serious injury, unnecessary suffering, and disfigurement.

There is also indirect harm with some of the worst consequences. Javis (2001) cites the example of a needless death involved an Oregon man who treated his basal cell carcinoma of the mouth with a mail-order remedy for 15 years. What makes this case especially tragic is that since this type of cancer almost never metastasizes, he had many years in which to correct

his folly. Although badly disfigured by the growing tumour, he continued self-treatment. Over-reliance upon dietary treatment is a common means by which indirect harm kills cancer sufferers.

7.6.1 Vulnerability to "QUACKERY"

In an insightful article, Barrett (2001g) discusses vulnerability to manipulation by "alternative therapists". He argues, "Despite the advanced state of medical science, many people with health problems turn to dubious methods. Faced with the prospect of chronic suffering, deformity, or death, many individuals are tempted to try anything that offers relief or hope. The terminally ill, the elderly, and various cultural minorities are especially vulnerable to health frauds and quackery. Many intelligent and well-educated individuals resort to worthless methods procedures with the belief that anything is better than nothing." He then goes on to enumerate the vulnerabilities that victims of quackery might have.

1. Lack of suspicion:

Many people believe that if something is printed or broadcast, it must be true or somehow its publication would not be allowed. The mass media provide much false and misleading information in advertisements, news reports, feature articles, and books, and on radio and television programs. News reports are often sensationalized, stimulating false hopes and arousing widespread fears. He points out that many radio and television producers who promote unsubstantiated health claims say they are providing entertainment and have no

ethical duty to check the claims.

2. People also tend to believe what others tell them about personal experience.

3. Further vulnerability is the belief in magic, with promises of an easy and painless cure.

4. Overconfidence is another problem where some strong-willed people believe they are better equipped than scientific researchers and other experts to tell whether a method works.

5. Desperation characterizes these people when faced with very serious health problems that health professionals cannot cure. They can become desperate enough to try almost anything that arouses hope.

6. Alienation. Barrett (2001g) argues that some people feel deeply antagonistic toward scientific medicine but are attracted to methods represented as "natural" or otherwise unconventional. They may also harbour extreme distrust of the medical profession, the food industry, drug companies, and government agencies.

7.7 Alternative and Complimentary Medicine in Breast Cancer

Shumay and Maskarinec (2003) found that women with breast cancer were more likely to use complimentary and alternative medicine, than with other cancers. They concluded that the

picture emerging was one of active information seekers who were interested in taking whatever steps they felt were appropriate and necessary to assist in their recovery and continuation of active lives after diagnosis.

Alternative and complimentary medicine gives some way of taking control and improving options to preserve life. It is an attempt by someone facing a life threatening illness to improve their health and to take life and death judgements, at least partially away, from their health providers (Muthny and Bartsch, 2003).

Adler and Fosket (1999) attempted to understand the reasons for nondisclosure in the use of complementary and alternative medicine in a 5-year prospective cohort study. The multiethnic, population-based sample consisted of 86 San Francisco residents with recently diagnosed breast cancer. At initial contact, 72% of the participants were using at least one form of complimentary or alternative therapy for breast cancer. Six months later, 65% of participants were using such treatments. Of the women being treated by an alternative practitioner, 54% disclosed their use of complimentary and alternative treatments to their physicians. Conversely, 94% discussed details of their biomedical treatments with their alternative practitioner. Reasons for not disclosing complimentary and alternative treatment use included anticipating the physician's disinterest, negative response or unwillingness or inability to contribute useful information. The perception that the complimentary and alternative therapies used were irrelevant to the biomedical treatment course, were also factors, and the patients' views regarding the appropriate coordination of desperate healing strategies were also factors inhibiting disclosure. Somehow these patients felt more at ease in discussing all aspects of cancer with their alternative therapist, perhaps feeling that he/she was

less threatening and authoritarian.

Smith and Boon (1999) surveyed eight herbal products commonly used in complementary cancer therapies viz. Astragalus, Essiac, Asian ginseng, Siberian ginseng, green tea, garlic, Hoxsey formula, and iscador. They felt that it was critical that health care practitioners begin to routinely ask patients about their use of herbal products as part of their medical or medication history. Given that up to 70% of cancer patients do not tell physicians about their practice of herbal therapies, they suggest that counselling about such therapies can be incorporated in a patient- centred model in a non-judgmental way. Smith and Boon (1999) argues that an unknowing physician is far more dangerous to both the patient and the patient-physician relationship than is disagreeing with the patient's choice.

Boon, Brown, Kennard and Stewart (1999) explored breast cancer survivors' perceptions and experiences as they decided whether to use a variety of complementary/alternative therapies. The findings indicated that most women were faced with having to make a decision based on very little objective, scientific evidence. Women who decided to use a specific therapy generally believed that it had little or no potential for harm, whereas women who decided not to use a specific therapy generally did so because of a perception that the therapy was probably not efficacious and might possibly cause harm.

Alternative medical treatments, conventional therapies, and health-related quality of life were examined by Burstein, Gelber, Guadagnol and Weeks (1999) in a cohort of 480 patients who had received standard therapy for early-stage breast cancer. New use of alternative medical

treatments after surgery was common (reported by 28.1% of subjects). A total of 10.6% of subjects had used alternative medical treatments before they were given a diagnosis of breast cancer. An interesting finding was that subjects who had initiated the use of alternative medical treatments after surgery reported a poorer quality of life than subjects who had never used alternative medical treatments. Mental health scores were similar at baseline among subjects who had decided to use alternative medical treatments and those who did not, but 3 months after surgery the use of alternative medical treatments was independently associated with depression, fear of recurrence of cancer, lower scores for mental health and sexual satisfaction, and more physical symptoms. It is not clear whether this was the cause or the effect of the use of alternate therapies.

Because of the increasing involvement of patients' involvement in the alternative therapies, not recommended and often unknown to the doctor, there are increasing efforts being made to look at including and integrating some of the more 'healthy ' therapies. Herbert, Verhoef, White, O'Beirne and Doll (1999) describe an invitational meeting that brought together Canadian health care providers and researchers having expertise in patient-physician communication with those knowledgeable about complementary therapy and cancer. Although "alterative medicine" has been discussed thus far, there are therapies that can effectively be used with cancer treatment:

Though many people use the word complementary and alternative medicine interchangeably, it is important to know the difference between them. The National Institutes of Health's National Centre for Complementary and Alternative Medicine (2001) makes this quite clear.

"An alternative cancer therapy is one that is promoted as a treatment or cure for cancer, to be used alone, instead of a conventional cancer treatment. A complementary therapy is one that is not proposed as a treatment or cure for cancer, but is promoted to be used as an adjunct to conventional treatment to help control symptoms and enhance quality of life. Surveys in the United States show that at the present time only about 8% -10% of people will take the alternative route alone and refuse conventional cancer treatment. By far the majority of people (about 85%) with cancer go the conventional treatment route and, at the same time, add some of the complimentary , trying to get the best of both worlds." (Holland and Lewis, 2001, p. 181)

Holland and Lewis (2001) lists some of the complementary therapies that enhance well-being and may improve quality of life. These include acupuncture, acupressure, aromatherapy, therapeutic massage such as Shiatsu, Swedish Massage and Reflexology, Yoga, Ginger Root Tea and Tai Chi. She points out that the benefits of complimentary therapies are often indirect. For example, she argues that patients feel in control, feel they have tried alternatives, managed to please family members or simply calmed their anxieties. A more worrisome reason for seeking complementary therapy is when patients feel they are not getting adequate care or understanding from their conventional health providers.

Truant and Bottorff (1999) examined the use of complementary therapies by 16 women, aged 39 to 71 years, who were receiving or had received traditional breast-cancer treatment and who had used or were in the process of considering complementary therapy. It was found that the women made decisions about complementary therapies simultaneous with orthodox

treatment, and most did not disclose such treatment to their orthodox health care provider. The central theme was one of gaining control through complementary therapy use. The 3-step decision-making process, generally followed by subjects, was: (1) Putting a therapy regimen in place; (2) personalizing therapy to fit the subject; and (3) living with the security of complementary therapies.

Balneaves et.al. (1999) explored the relation between health beliefs and women's uses of complementary therapy for breast cancer. The subjects were 52 women living with breast cancer from 3 central Canadian outpatient oncology clinics. Results showed that 67% subjects reported using at least one complementary therapy during their illness, predominantly the therapies of meditation or relaxation, vitamins or tonics, spiritual or faith healing, and herbal remedies. Fifty six percent of subjects sought assistance from a complementary therapist. There was an association between use of complementary therapy and both post-secondary education and preference for an active or collaborative role in treatment decision making. No association was found between complementary therapy and disease variables, beliefs of cancer cause, or satisfaction with health care professionals.

The trauma of being diagnosed with breast cancer is enormous, foregrounding the reality of mortality for the patient.

Verhoef, Hilsden and O'Beirne (1999) provide an overview of the current state of knowledge regarding the use of complementary therapies by cancer patients. They feel that one factor making assessment difficult is the lack of a uniform, clear, and specific definition of the

phrase "complementary therapy." The emphasis by complementary therapies on health and improved well-being, with patients the centre of focus and actively participating in the process, appear to be factors in their attractiveness. They stress that care must be taken to distinguish cancer cure from cancer-patient care. In the latter, a number of complementary therapies have improved patients' sense of well-being. These authors recommend that more research is needed concerning the efficacy and safety of complementary cancer therapies.

7.8 Traditional/Indigenous Medicine

Ajai (1990) stresses the distinction between 'alternative' and traditional medicine, the latter being indigenous to a country.

Ming Liu, Chie Chu, Hsin Chin, Min Chen, Hsieh, Jye Chiou and Whang-Pengl (1997) did a cross sectional study of the use of alternative medicines in Chinese cancer patients. Reasons cited for alternative medication consumption was: hope that it might be of some benefit to their well being or disease control; and maybe even result in a miracle cure. Sources of advice on medication were mostly from strangers (by word of mouth), family, friends, the media, and infrequently from qualified professional Chinese doctors. Reasons for discontinuing such treatment were mostly given as lack of positive effect. These authors pointed out that in Taiwan the public is constantly bombarded by anecdotal reports of `cancer cure' in the media, or `miracle remedies' which has passed down as family heirlooms. A remedy advocated by a person with a post graduate qualification or a pseudo-intellectual is most persuasive and family and friends often confuse logic and science with pure good intention, in channelling the

patient into alternative medical therapy. After finding out that conventional therapy often plays only a palliative role in advanced cancer, individuals of all educational levels often elected to adopt an autonomous independent proactive attitude. Most gained information of such treatment by word of mouth (79%).

In their discussion Ming Liu, et. al. (1997) point out that patients and family become very gullible once cancer has been diagnosed, and fall easy prey to proponents of alternative treatments who are willing to compassionately spend time with the patient.
They conclude that Chinese cancer patients willingly, randomly, and non-selectively undertake alternative medications, with very little or no understanding of the type of medication they have received, its possible effects, side effects or projected treatment duration. Despite these concerns, considerable financial expense and uncertain pharmacological consequences can be incurred.

This is certainly true of patients from many other countries, reacting to the trauma of cancer diagnosis and treatment. The study in many ways has summed up much of what has been found generally and universally in the cancer patient's attitude towards other forms of therapy.

For example, Gupta et.al. (1998) in suggesting a patient education programme in bronchial asthma, in India, outlines many barriers to compliance in this area. One of these is the lure for homeopathy and indigenous branch of medicine for children. Similarly, Chatterjee (1999) studied compliance of malaria chemoprophylaxis among travellers to India. He found that perceived uselessness and confusion arising from alternative regimens were found among

other things, to have influenced the decision making. Moreover, Bhatia, Vir, Timmappaya and Chuttani (1975) present results of interviews with 93 traditional healers in 3 Indian states which indicate that traditional healers are increasingly using modern allopathic medicines in their practice.

By contrast, Subach & Abul-Ezz (1999) presented a case in which belief in faith healing led to discontinuation of immuno suppressive medications after renal transplantation. They found that conflict occurs when patients believe they are healed but continue to experience the illness.

Cai, Dai, Min, Shi, Miao and Luo (2002) studied the therapeutic effects of radiotherapy combined with traditional Chinese medicine (TCM) on non-small cell lung cancer. The incidence of adverse effects was much lower in combined treatment group than in radiotherapy group, and significantly greater improvement in the quality of life of the patients was observed in the combined group.

7.8.1 Traditional medicine in Sub-Saharan Africa

Social scientists typically analyse compliance to health promotion regimes through rational decision making models and can overlook subtle, but powerful contextual variables, such as cultural values and practice (Moore and Knowles, 2003). There are striking differences in the way different human communities evaluate and explain health and confront disease, though there are of course, universals (Ngubane, 1977).

"In order to understand the nature of traditional healing in South Africa, an essential first step is to try and place it within a wider framework, for the ideas and practices associated with traditional healing are part of a wider system of concepts that underlies and reflects perceptions of the world and of humanity's place in it. This cognitive system is usually referred to as a cosmology or world-view." (Hammond-Took, 1989, p.32)

Omonzejele (2003) writing from Nigeria points out that medicine in Africa is regarded as possessing its own "life force", not just as using a system of prescribing. This is because health problems are not only attributed to pathological explanations alone, but also to other "forces". Hence, traditional healers utter incantations to take care of negative forces which militate against achieving cure. Treatment in African traditional medicine is holistic. It seeks to strike a balance between the patients' body, soul and spirit.

The African perspective reflects a belief in an integrated, interdependent, all encompassing world view. This includes animate and inanimate as well as past and present conceptualization. Biological, spiritual, social and interpersonal functioning is inextricably interlinked. Underlying this pluristic but holistic African view of being is a unifying principle of balance between all things. Disturbances in the equilibrium, be they emotional, spiritual or interpersonal, may manifest in discordance at any level of functioning. Africa's belief systems are seen as more spiritual and emotional than the Western belief systems (Chalmers, 1990).

In South Africa the rural Xhosa people of South Africa have retained social cohesion through traditional custom, purity of language, and the dominant role of ancestor worship, traditional

medicine and witchcraft in life-style, beliefs, and ceremonies (Cheetham, 1976).

Cao-Romero and Bishop (2000) point out that traditional healing practice is often the only medicine accessible to people in distant poor regions. Since Western biomedical knowledge is on paper only it has proved extremely difficult to implement locally, leaving village communities, with very little or no health care at all.

Ataudo (1985) examines whether traditional medicine promotes bio-psycho-social fulfilment in African health and argues that every society has its own method of managing illness and of controlling the environment. He suggests that traditional medicine can be used as "psychological opium", as a relief in pain and suffering, thus creating a placebo effect, and concludes that bio-psycho-social health and traditional medicine promote the fulfilment of social and biological needs in African health. However the traditional healer for vast numbers seems to be far more than this.

The success of treatment depends upon: the belief of the African traditional healer in the effectiveness of his/her techniques; the belief of the patient in the healer's power to help; and the trust of the community in the healing potential of the belief system. The author contends that the traditional methods can be compared to the combination of alternative medicine, herbal medicine, and psychotherapy (Winizki, 1997).

7.8.2 Basic philosophy of traditional medicine

Mtebule (1999) in his paper on traditional healing in South Africa cautions the reader not to apply his/her preconceived Western schools of thought or philosophy on to the understanding of this subject. Using Western theories and philosophies to understand traditional healing, the author contends, undermines traditional healing since this presupposes the notion that African traditional healing is non-sensical in trying to explain itself. He feels that what is needed is the recognition of African traditional philosophy in its own right and that after all, people should be able to define themselves in ways that are most comfortable to them.

The belief system model of health is based on the maintenance of harmony between the physical, social and spiritual (Mtebule, 1999).

"Unlike in the West one cannot adopt a purely cognitive, scientific approach when working in Africa. Africa is holistic. It integrates mind, body and spirit in most of its activities." (Chalmers, 1990, p.vi)

Mtebule (1999) explains that the spiritual is represented by the "amadlosi" (the gods or the ancestors) whom it is important to honour and make peace with. Above the "amadlosi", exists "uMvelingani" or "Modimo" (the Supreme Being) who is above all creation and governs the universe and everything in it. The "amadlosi" are the direct ancestors who are often called forth for healings and blessings. The power of the physical world lies in the sacredness of certain animals, herbs and physical spaces. There is an emphasis on the family and certain

rituals to improve family bonds (both extended and ancestral). Sometimes an animal is slaughtered on these occasions.

The ancestors are omnipresent and share the daily lives of the living to the extent that life without them is unthinkable (Schoeman, 1985). This close bond gives meaning to dreams, visions, bodily experiences, illness, sexual practices, marriage relationships, birth and burial rites and, in general, the morals and values which regulate behaviour. The importance of the ancestors is so fundamental to the cosmology of traditional African people, that one can only understand their behaviour and their mental state if it is constantly taken into consideration.

Mtebule (1999) concludes that African healing perspectives are extremely dissimilar to Western practices. They are deeply influenced by a belief in the powers of amadlozi and uMveligani's relationship with the world, both organic and inorganic.

"What is quite clear is that we are dealing with two radically different theories of health" (Hammond-Took, 1989, p.145).

7.8.2.1 Reasons for illness in traditional medicine

The appropriate question is not one that asks: what was the cause of an event, but rather one which asks why the event occurred (Schweitzer, 1985).

"Within the traditional world view, all occurrences and particularly misfortune and illness are

invariably attributed to an agency or an event that is external to the person affected (Schweitzer, 1985, p. 27).

In Southern Africa, spiritual influences on health are emphasised. Illness is frequently attributed to ancestors who, for a number of reasons could have been displeased. Supernatural forces cause illness and also disasters. The ancestors not only cause illness, they prevent it too. To act in this capacity they must be acknowledged and shown respect through appropriate rituals. Failure to appease the ancestors can result in disease. Each individual is responsible for the equilibrium of the whole group and not only for himself. The nuclear family, the extended family , the community , the living and the deceased as well as their interactions are intimately linked in the African view of health and illness. The ire of ancestors can be aroused as a result of inadequate performance of rites of respect (Chalmers, 1990).

"The really important entities are the spirits of deceased ancestors" (Hammond-Took, 1989, p.47).

The ancestors are thought of as withdrawing their protection if they are angered as a group, and without their protection a person is exposed to all dangers (Ngubane, 1977).

"Because of the sickness they are suffering from is sent by the ancestors, its curing depends not on medicine, but on rituals" (Hammond-Took, 1989, p.107).

Ancestors are believed to look after the interests of their dependants but they can also send

illness and misfortune if moved to wrath. As Hammond-Took (1989) explains, ancestor beliefs provide an explanation for sickness and misfortune.

"Failure to respect seniors is a heinous offence which can bring down full ancestral wrath about one's head" (Hammond-Took, 1989, p.65).

Fundamental concepts regarding health and sickness are based on idea of balances and imbalances (Bannerman, Burton & Wen-Chieh, 1983). Bodeker (1994) noted that disease represents a disturbance of the balance so treatment is dedicated to restoring it. Witchcraft is also an important belief, being, the belief that certain individuals driven by envy and malice, send mythical animals (familiars) to harm others (Hammond-Took, 1989).

7.8.3 The traditional healer

In most parts of Africa south of the Sahara, the traditional healers are known to handle approximately 80% of the health problems existing in the area (Madu, 1997).
Within the African culture, traditional and faith healers play an essential role in counseling the community on various personal and communal health-related conditions. This kind of practice is particularly observed among the native populations, among those less affected by Western influences, and among those who have less opposition from Western and Asian religions (Semela, 2001).

Traditional healers occupy a critically important role in African societies. They perform a

function broader and more complex than doctors. They are priests, religious ritual specialists, family and community therapists, moral and social philosophers and teachers, visionaries empirical scientists and perhaps political leaders in addition to being healers in the more restricted Western sense. They meet a multitude of needs, and modernization does not reduce those needs; if anything the needs increase (Green, 1994).

Shai-Mahoko (1996) explored the clinical conditions brought to indigenous healers by people in the rural areas (in this instance the North West Province of South Africa) in search of health care. Data was collected from interviews conducted among 35 indigenous healers recommended by heads from a sample of 40 villages. Of the 35, 60% were Botswanan, 51% were female, 85.7% were aged 30-59 years, 77% were married, and 5.7% were divorced. Thirty-one percent had a lower primary education and 25.7% finished high primary schooling. Twenty-two point four percent had no formal schooling. Sixty-percent of the traditional healers were bone throwers and 34.2% were bone throwers and sangomas. Fifty-four percent received their training "by their ancestors through dreams." Thirty-one percent received formal training in indigenous healing and 14% served an apprenticeship with an experienced healer. Ninety-four percent had a period of training from 2-5 years and 57% were registered with an association for indigenous healers. Seventy-seven percent of these healers relied on bone throwing for diagnosis of health problems. Other treatment methods included sacrification, enema, induced vomiting, ritual performance, and prevention of witchcraft. Findings showed that indigenous healers deal with the same health problems confronting formal health workers, especially in the paediatric field. Healers treated infertility, septic sores, impotence, sexually transmitted diseases, deliveries, "makgome" or "boswagade,"

asthma, mental illness, high blood pressure, palpitations, tuberculosis, alcoholism, diabetes, and cancer. Paediatric diseases that were treated included "tlhogwana," "ditantanyane," measles, "kwashiorkor," and whooping cough. Healers relied on the following methods for disease prevention and health promotion: home fortifying, home cleansing, personal cleansing, scarification, and cultural education in taboos. Interestingly, 74% made referrals to either a western trained physician (17 out of 26) or other healers.

Findings also showed that the services of indigenous healers are not confined to any specific group or social class within the population studied. Clients included highly educated professionals, such as nurses, teachers and religious ministers (Shai-Mahoko, 1996).

7.8.3.1 Different types of healer

Mtebule (1999) explains that there are two basic kinds of traditional healer. One is the "inyanga," who is a herbalist and does not need any supernatural gifts or powers to perform his/her tasks of healing. His or her profession is learned, usually from a mother or father who passes on their knowledge of herbal remedies. The "isangoma" ("sangoma") is skilled in the use of herbs but he/she also has a "calling" from the "amadlosi" because of his/her "inhloko", (psychic powers) and added to this are is his/her use of magic and philosophy. He/she is consulted for far more than physical ailments and specialises in restoring the balance between good and evil. His or her extensive power as a "sangoma" is that he or she is deemed to have an exclusive connection with the mystical world.

Once the person has been diagnosed as being possessed by "idlozi", (a specific ancestor) the person can be sent to an initiation school where he/she learns the skills of the "sangoma" and the mastering of the "idlosi" that possesses him/her. School can last anything from 8 months to one year. Here he/she is taught to master the link between the world of the "amadlozi" (past, dead, spiritual) with the world of "abantu" (present, alive, physical).He/she emerges skilled in divination and also in herbal medicines (Mtebule, 1999).

(Chalmers, 1990) gives a slightly different breakdown of traditional healers and it must be noted here that different nations and tribes have similar but differing terminonology. She notes that collectively healers in South Africa referred to as izangoma, amagquira, dingata and nyanga. In Xhosa tradition the Igquira is on a high level, spiritual and herbalistic. The Amaxhwele is on a lower level using just herbalistic powers. There are also specialists concentrating on one aspect of traditional healing.

7.8.3.2 "Thwasa" - The Calling

The "sangoma's" calling or chosenness usually manifests itself as a pseudo-psychiatric illness with some physical features. It can start with repetitive and disturbing dreams (Mtebule,1999; Kayomba, 2000). An individual who has been destined may have unusual behaviour ranging from weight loss, untidiness and depression to talking to people whom only he can see.

Buhrmann (1977) notes that the "thwasa" experience has often been mistaken for schizophrenia by Western health practitioners. She says, however, that there is little doubt that

this is a meaningful experience and should be seen as a 'creative illness' where a person emerges with a new vision of the world or a new philosophy.

The person with "ukuthwasa" cannot recover until he/she listens to the voices of his ancestors and becomes what he/she must become (i.e. develops his/her potential and in some instances becomes a diviner).

The word, "Thwasa", literally means the emergence of something new. It can be described as a process of initial disintegration during which the afflicted person 's ego is confronted by the deeper layers of the personal and supra-personal unconscious. If successfully resolved, it results in a reintegration in a new and fuller wholeness and individuation (Schoeman 1985).

"The thwasa disease is a gift one receives from one's ancestors , one's grandfathers, whom one does not know but from which one has inherited one's surname" (Schweitzer, 1985 p29).

Dreams play a very important part with "thwasa" because it is through the dreams that one is capable of contacting the ancestors (Schweitzer, 1985). During the period of "thwasa" a person receives from his/her dreams a song which is exclusively his/hers.

7.9 Methods of Treatment

Traditional medicine relies on several factors that are not usually part of the Western scientific approach. These factors include (1) an absence of separation between organic and psychic maladies, which explains in part the similarity between organic and mental therapy; (2) a

system of religious or superstitious beliefs that imparts a supernatural and social context to treatment; (3) the use of a specific animal, vegetable, or mineral pharmacopia in conjunction with divinatory practices and ritual behaviour; (4) secret healing rituals and practices; and (5) the idea of illness as punishment or aggression by supernatural forces (Didillon and Olandzobo, 1981).

Western or allopathiic medicine often is in a secondary role.

"Even today hospitals and modern medicines are invariably the last resort in an illness. First the African seeks relief in the herbal lore of his ancestors and consults the inyanga who is in charge of the physical health of the people. When bewitchment is suspected, which happens frequently, the patient is taken to the sangoma who is believed to have spiritual powers." (Pujol, 1990, p.19)

Chalmers (1990) stresses that treatment is to the whole person rather than just the biological aspects. Plants are believed to be the most powerful source of healing, able to cure any disease and make people strong and in tune with the universe. In this way, the "Inyanga" treats both humans and livestock (Pujol, 1990). Herbal medicine can also contain leaves, bark, root, stems, bulbs, skin, blood, insects and feathers used fresh, dried, whole or powdered (Chalmers, 1990).

Colour and its symbolization play a large role in the treatment of patients.
The symbolic colours are black, red and white, used in a certain rigid order. It can be red

followed by white and black followed by white or just white. Treatment with such coloured medicines is initially intended to establish a balance between a person and the environment. Both black and red expels from the body system what is bad and to strengthen the body against future attacks (Chalmers, 1990; Ngubane, 1997). Schweitzer (1985) also describes the black, white and red medicine. He describes the black medicine as purging the internal evil that has caused the malady. The patient then goes into the red medicine as an intermediate step and ends with a white medicine as an emetic which acts as a physical and spiritual cleaning agent which restores purity and balance.

Ill health and misfortune are seen to be the result of an evil presence which must be stopped before it spreads to the community and the environment. Witchcraft and sorcery can be responsible for certain illnesses and the "sangoma" has to 'sniff these out' (Mtebule, 1999). The traditional healer starts with asking the patient what is 'troubling him/her' and continues to ask if there is family discord or if the "amadlozi" have been honoured lately. The bones are then thrown and the "amadlozi" asked to intervene. After the sangoma gives his/her diagnosis the process of "ukuvhumisoni" (to agree with) occurs. During the process the patient is asked if he/she agrees with the interpretation of the healer by saying "siyavhuma" (we agree). If the patient feels misunderstood he/she does not say this and the healer can redirect his approach and interpretation until it is consistent with the patient's reality.
Mtebule (1999) stresses that "sangomas" are not considered infallible beings and it is quite acceptable to seek a second opinion from another "sangoma".

Oberholzer (1985) also describes the "nyangas" use of the consultation method called

"vumisa", which involves their making statements about the patient's condition to which the patient (and the attending family) respond in the affirmative or in the negative . In this way the "nyangas" make a "diagnosis". They may also use bone throwing as a diagnostic tool. Once they have made a "diagnosis" they prescribe herbs and roots as remedies. These often act as purgatives or emetics.

Chalmers (1990), too, describes the diagnostic process mentioning that devination plays a major part using bones, sticks and spiritual voices. Throwing the bones is a significant part of diagnosis. The bones thrown have different meanings e.g. a young person is represented by shells or a hyena bone representing negative forces.

The African traditional healing activities are in most cases conducted in public. The client, his or her relatives and the community often take part in the healing processes. In spite of the above apparent openness, the nucleus of their psychotherapeutic and medical healing activities remain secret not only to orthodox scientists but also to the public in general (Madu, 1997).

A significant aspect of healing is illustrated in the regular dancing and singing (Schweitzer, 1985) In fact a major element in African healing is reliance on music and dance with an emphasis on bodily awareness (Chalmers, 1990). Dance rhythm and music have become an integral part of life soon after birth in Africa (Holdstock, 1981).

Schoeman (1985) mentions that one of the most important and common healing rituals are the "intiombe". With variations, it comprises of ritual dancing and singing; recall of dreams; recall

of emotionally charged and important events of the past. It also includes discussing present concerns with the accompanying expression of feelings; talking about one's illness, how it started its course and how it affected one. Confessions and actualising the cosmological meaning of various symbols such as fire-making, the preparation of food and the brewing and sharing of beer is part of this as is "vumisa", which means to divine by inspiration from the ancestors. Of central importance during the "intiombe" is "Xhentsa", which is a circular dance which requires vigorous rhythmic pounding on the ground associated with drumming and clapping of hands. "Xhentsa" integrates body and mind, writing the context of the participants' relationships with other people and with the ancestors. The "intiombe" is a group therapy session which involves the total person and is aimed at restoring wholeness (health).

It is also important to understand the different atomotical beliefs of certain people. For instance, as Hammond-Took (1989) points out, the "Lovedu", a Sotho-speaking people of the Lowveld associate the stomach and intestines with digestion, the bladder with urine and genitals with reproduction, but also believe in the existence of an internal 'snake' which is closely associated with fertility and childbirth. This inhabits the body of every individual. At times, stomach cramps are caused by the 'biting' of the snake. As part of treatment these people make extensive use of urine and sea water which they sprinkle around the house. The former may also be used for drinking. Among the Mpondo, a key is tied around the neck of an ailing child to 'lock up the cough' (Hammond-Took, 1989).

7.10 Traditional Healers as Part of A Team

Kiev (1972) gave the warning that if modern medical programmes ignore established religious customs, disruption and resistance may follow. He felt that medical projects are most likely to succeed in Africa when they could be established along tribal lines. It took some time before this was recognised as doctors were not willing to make room for a medical system different or seemingly alien to theirs.

Schweitzer (1985), has argued that much of the early research on indigenous healing in Southern Africa has been descriptive and has tended to disqualify and invalidate the indigenous system in terms of a Western-scientific model.

Okoth-Owiro (1994) notes that in Kenya, before political independence, traditional medicine was marginalised and discouraged, while western medicine remained inadequate and inaccessible to the majority of the population. The colonialists assumed traditional medicine would disappear as it was replaced by western medicine. In 1963 Kenya became independent, and during the 1970's traditional medicine was incorporated into the health policy framework. In addition the World Health Organization (WHO) was asking nations to use their traditional resources.

In 1984, the WHO Global Medium-term Programme on traditional medicine offered observations and direction regarding the practice of traditional healers These indicated that upgrading the skills of indigenous traditional healers rather than creating new cadres such as

village health workers. However this was not always successful perhaps because of the cultural distance between indigenous practitioners and medically educated Africans. The two groups embrace distinct and perhaps intrinsically incompatible worldviews or pardigrams of illness (Green,1994).

By contrast, Oberholzer (1985) in his study, noted that an estimated 2000 traditional healers formed a formidable body of primary health workers and were held in high regard by the local population. In a meeting between the hospital and traditional healers, research on medicines used by the traditional healers was undertaken and the roots and herbs were examined. "Analysis conducted on these medicines revealed the presence of known therapeutic agents. Many potentially harmful agents, were however, discovered in the same plant material" (Oberholzer, 1985 p.41).

Oberholzer (1985) identified areas of conflict in his work with traditional healers . These centred on the fundamental differences between the concepts of life, health and disease. There were also difficulties such as resistance to change, fear of harmful iatrogenic effects of traditional medicine, or difficulty in integrating certain aspects of medicine based on spiritual, moral and other fundamental principles, for example, exorcism.

Attempts to wean patients off traditional medicine were met with resistance and concealment of the use of traditional healers. Cooper and Mullin (2001) studied 167 rural Zulu, Pedi, and Tswana patients (mean age 47.3 yrs) of extremely low socioeconomic status. They found that cultural attitudes toward accepting fate, a high level of trust and deference to traditional

healers, and a highly collectivistic orientation, surrounded treatment decisions and procedures.

Bannerman, Burton and Wen-Chieh (1983), writing with reference to Ghana, felt that the developing countries, with their inadequate resources and a dearth of skilled practitioners needed to adopt unorthodox measures such as exploitation of useful herbal medicines and the incorporation of traditional medicine into the health team. Furthermore they found that the so called orthodox and conventional health care services devised for the third world populations remain culturally and economically unaffordable.

Bannerman, Burton and Wen-Chieh (1983) noted that "The traditional practitioners are the true community health workers in Ghanan society. They invariably have the confidence of the people and whatever level of skill it is , essential that they should understand the real health needs of their community " (pg 320). There was also an attempt made to train some healers in Ghana on such things as oral re-hydration. They hoped that the new direction being taken by the Western medical disciplines will lead to harmonizing of the two systems each respecting the others' essential nature, while growing from it.

Imperato (1977, p.69), writing mostly about the Bambara people, says:

"The availability of modern medical facilities in these cities has somewhat lessened but not abolished , dependence on the traditional system. In Ibadan, Nigeria, for example, where a world renowned medical school and University College Hospital exist, traditional Yoruba medicine still flourishes."

Ezeji and Sarvela (1992) described the relationships between modern and traditional medicine in the Ibo tribe of Nigeria. They found that although Ibos use both health-care services in tandem, modern medicine was generally regarded as a secondary approach. There is a general feeling that illness management is never complete until a traditional treatment is undertaken. It is concluded that, given these data, integrating the 2 health-care systems is a viable option.

Ajai (1990) however, appeared to be very opposed to the integration of traditional medicine into the Nigerian health care delivery system. The existing relationship between the law and traditional medicine and legal consequences of the incorporation of traditional medicine into the national health care system was examined. The Lagos State Government enacted a Traditional Medicine Board Law in 1980 allowing the practice legally. However, Ajai (1990) opposes official sanctioning of traditional medicine though he does recommend research on traditional preparations.

Mullin and Cooper (1998), suggest that building a bridge of conversation and cultural understanding between the health care profession and traditional patients is a crucial first step to delivery of improved medical services in South Africa. In another article they (Mullin, Cooper, and Eremenco, 1998) conclude that medical pluralism should be encouraged and that because traditional healing is the treatment of choice for much of the population, it is important to recognize its benefits and allow traditional healers to contribute to their patients' well-being in Western medical settings.

Chalmers (1990) shows that with the black South African community there is a great deal of

dual usage of Western and traditional health care. There is the perceived need to establish the cause of illness through traditional methods but to affect a rapid cure by means of western medicine. As this is already the preferred form of treatment by the majority of the community. She suggests that western medicine should seriously consider dual treatment.

Green (1994) stresses the importance of how to work with the traditional healer. He sees the concept of 'training' as sounding somewhat superior and patronising and he makes clear that the situation has to be more one of equality.

7.11 Cancer Treatments and Traditional Medicine

Nematoollahi (2003) points out that little attention has been paid to the cultural issues involved in cancer care. A serious problem is that patients often consult traditional healers first, then these patients are beyond help when they arrive at a western hospital or clinic (Green 1994).

Mullin, Cooper, and Eremenco (1998) feel that communication patterns, underlying belief system, worldview, and the difficulties inherent in interacting with the foreign, Western medical establishment all affect the cancer treatment provided to the Zulu, Tswana, and Pedi peoples of South Africa. English and Afrikaans have been the traditional languages for most cancer literature and surveys, materials generally not available to Black patients in their native languages. They found that socio-cultural differences, defensiveness among patients, psychosocial factors, politeness behaviours, and physician-patient relationships all contributed

to a lack of effective communication. These authors concluded that medical pluralism should be encouraged and that because traditional healing is the treatment of choice for much of the population, it is important to recognize its benefits and allow traditional healers to contribute to their patients' well-being in Western medical settings.

Steyn and Muller (2000) did a study in Atteridgeville, South Africa, noting that traditional healers are consulted by a range of people in their communities. They found that they had a basic knowledge of cancer, provide health education to their patients and are willing to participate in cancer preventative strategies. It is shown that with this training they are therefore ideally suited to augment the services of westernized health care workers.

7.11.1 Breast cancer and traditional medicine

Vorobiof and Sitas (2001) pointed out that several studies had shown that black South African women have a lower incidence of breast cancer compared with other races or population groups. Factors influencing this were felt to be: relatively early birth of first child, high parity, breast feeding for many months and a low fat, high fibre diet. However there was a striking difference in presentation, when analyzed by stages, in that only 22% of black female patients presented with early stages I and II in contrast to nearly 69% of the non-black patients. Stages III and IV of breast cancer were the most prevalent in black women (i.e.77.7% compared with the 30.7% of non-black women). In discussing the reasons for this they point out that traditionally, black patients seek a cause for illness within the framework of indigenous beliefs; good health being perceived as consisting of a healthy body as well as a healthy

social, emotional, and spiritual life. Cancer is interpreted as a reflection of conflicts, particularly in social relationships. Many patients with cancer believe that a special witchcraft caused their cancer, and, therefore, their first priority was to reverse the sorcery before presenting to hospital to be treated by modern medicine methods. The patient would seek help first from a traditional healer as a way of dealing with the cause of the disease, and, in their views, this did not imply delaying medical treatment. They also point out that the concept that a painless breast lump was a cancer and therefore a potentially fatal disease is difficult for many black rural women to accept.

Wright (1997) did an investigation into the causes of absconding among black African breast Cancer patients and she describes their beliefs very clearly. Most of her patients were Xhosa speaking and she points out that though they vary from place to place in general the beliefs are similar. She says:

"Although there were differences in the details provided by various informants , there was a remarkable consistency in the absconding patients' indigenous healers' and black lay person's understanding of the causes and treatments of breast cancer. It was explained that cancer patients are believed to have been 'sent' cancer by an angry or jealous person. The enemy commissioned an 'evil sangoma' (sorceror) to poison the patient with the cancer by putting it in her food, taking it to her while she slept or leaving it on the ground for her to walk over. Once the poison had entered the body it moved to a specific area (in this case the breast)" (Wright, 1997, p.1541).

Wright (1997) explains that unless the cancer is drawn from the body through special "imbizas" (indigenous African medicine) it eventually kills the patient. The patient is given "imbiza" to drink and is required to continue with this regularly until the cancer begins to 'come out' of the body in the form of an open and painful wound on the breast. The wound signifies the final healing stages of the cancer. The "imbizas" push the cancer out and the topically applied medicines treat from the outside by pulling or drawing the cancer out of the body until the wound has expelled all the poison (in the form of blood and pus) and begins to heal and close. Treatment is often accompanied by dry diets, where no meat, fats, alcohol or wet foods are allowed, but only stiff maize porridge or sometimes only "imbiza". The indigenous healer is seen as the only legitimate and successful healer of cancer because of his/her expert knowledge of the causes and cure of cancer and for this reason many refrain altogether from consulting the doctor. The biomedical approach is viewed with suspicion as being based on unsound knowledge of cancer where the doctor administered inappropriate and harmful treatments particularly surgery and radiotherapy; for example some believe surgery makes cancer spread to the whole body and radiotherapy scars the cancer, rending it impenetrable to "imbizas".

Vorobiof and Sitas (2001) found that many patients with breast cancer were not necessarily the key decision-makers with regard to the different therapeutic choices available. This was a collaborative process involving family members and sometimes elders of the community. They concluded that education awareness campaigns, uplifting of socioeconomic conditions, access to diagnostic resources, and availability of higher standards of health care, and sensitivity with regard to some patients' beliefs are all necessary. Furthermore, these should be

implemented, and must be considered in an attempt to increase early detection of breast cancer and, thereto, improve long-term prognosis and survival.

7.11.2 Traditional medicine and cancer of the cervix

In a large study of 328 Zulu speaking women with cervical cancer (mean age 49 years), Nair (2000) found low quality of life ratings, increased levels of helplessness and a lack of "fighting spirit". Many were in advanced stages of disease and had co-morbid psychotic disorders. Again this could be due to the fact that all kinds of traditional treatments would be given before the patient presented herself for medical attention.

7.11.3 Carcinoma of the Penis

Nath, Desai and Munkonge (1992) studied thirty-three case reports of patients with carcinoma of the penis in Zambia to investigate the associated environmental problems causing an unacceptable level of morbidity and mortality. They found that due to social and personal reasons, late presentation and poor follow-up were common. They felt that improvement in the poor outcome would only be possible with change in social attitudes and alleviation of ignorance. They suggested educating traditional healers and reasoned that radiotherapy may be an alternative option to improve the morbidity and survival rates in this potentially curable cancer.

7.11.4 Treatment of some other malignant tumours

Alexander (1985) interviewed a group of 119 Tanzanians with cancer regarding previous traditional medical experiences prior to evaluation for radiation treatment. Forty-nine (49.1%) percent of the females and 40.6% of the males had been treated with traditional medicines. Seventy-four percent of the traditionally-treated patients had consulted a traditional doctor prior to being seen by a Western-trained doctor. The most common given treatment was a combination of several traditional methods. More than half of all traditionally-treated patients reported progression of their diseases after (traditional) treatment. The observation that some Nigerian patients use alternative health care services when they perceive that one medical system has failed them provided the impetus for Nwoga (1994)'s survey. The purpose of the survey was to understand why some Nigerian patients rely on traditional healers for cure of cancer by exploring the perceptions of Igbo traditional healers from Anambra State of Nigeria about the causes and treatment of cancer. Implications of the different meanings of illness and disease to patients and physicians provided the theoretical framework for understanding the cultural context of the study. It appears that they have lost faith that western medicine could not help them further, which indeed could have been true.

7.12 Traditional Medicine: Aids and Other Sexually Related Diseases

"AIDS is primarily a heterosexually transmitted disease in sub-Saharan Africa, unlike the pattern found in the industrialized West." (Green, 1994, p.1)

"From a rational perspective the most effective way of coping with the AIDS pandemic is to change sexual behaviour and also to avoid possible sources of contamination such as infected hypodermic syringes or implements used in ritual scarification. In order to do this, it is necessary to have an accurate explanation of how the disease is transmitted. Information has to be translated into knowledge and then into action." (Barnett and Piers, 1992, p.41)

Barnett and Piers (1992) point out, however, that most individuals cope with risks through a combination of rational and non-rational responses. The chain of causality should result in rational behaviour, but in Africa there are different assumptions of the causal chain, such as chance, luck, witchcraft and sorcery. These authors assert that in a sense this logic and these assumptions cannot be seen as irrational if they come from the causes of the disease and are from a different cultural perspective. Many people in Africa are therefore responding rationally to the AIDS epidemic in terms of their own world view and experience.

Barnett and Piers (1992, p.3) explain:

"The Human Immunodeficiency Virus destroys the body's defence mechanisms. It does not kill directly; it opens the way for other infections that do kill as the body becomes decreasingly able to muster its defenses. Thus people die not directly from the HIV but from the effects of other. sometimes normally mild infections which abound in the environment and to which their compromised immune systems allow them to fall prey."

This has led dissidents and healers in South Africa to question the validity of an HIV virus as

people are becoming ill and dying of diseases which have been affecting them for generations and have been treated for generations. Other confusing messages also have been given out (Schukenk, 2003), coupled with certain distortions about AIDS and its prevention in general. For instance, in some of the Swazi community, there were certain attitudes about condoms which undermined the control of AIDS (Green, 1994). Some of these are enumerated:

1. Condoms are a western idea to trick the Swazis into not having a lot of children;

2. Contraceptives cause STD's;

3. Condoms weaken or kill babies in the womb;

4. Condoms burst and can threaten a woman's life;

5. If condoms have to be paid for they must be able to use them more than once;

6. It is immoral to discharge semen into a container or 'over oneself';

7. Condoms diminish pleasure; and

8. Condoms are only used for immorality and one's partner can be insulted.

Green (1994) goes on to say that condoms have a relatively high failure rate in Africa due to

incorrect use and also to the poor quality often found in developing countries. In addition, using a condom depends on male cooperation and women are usually in no social position to insist.

However, at the same time, there is the awareness that the virus can be transmitted sexually, and Barnett and Piers (1992, p.3) point out:

"The virus is fragile. It cannot live for very long outside the human body and passes from person to person via the medium of body fluids such as blood, semen and vaginal secretions. Thus it is not exclusively a sexually transmitted disease, but may usually be. This means that in addition to being deadly it also carries with it many of the stigmatizing and morally resonant associations of a sexually transmitted disease."

There are many complex traditional beliefs about sex and sexual functioning. Bodeker (1994) touches on the concept of "pollution", especially in a woman after birth or menstruating or death. Green (1994) points out that ethno-medical studies in Africa have shown that both healers and their clients tend to recognise the efficacy of Western-style biomedical treatment for certain illness or conditions.

"However conditions characterized by symptoms such as pain in urination and pus discharge from the penis were in all cases thought to be treated more effectively by traditional medicine." (Green, 1994, p.13)

Didillon and Olandzobo (1981) consider the approach of traditional African medicine to female pelvic maladies. The traditional healer must take the social context of the patient into account. As pelvic pain is closely linked to fear of sterility and transgression of sexual standards, the healer must not only cure the disease but restore the patient to her former social status.

7.13 Traditional Medicine and Tuberculosis

Steen and Mazonde (1999) studied the health seeking behaviour, beliefs, and attitudes with regard to 212 tuberculosis patients. They note a marked resemblance between traditional ideas of disease caused by pollution (breaking of taboos) and modern theories of disease spread via germs. They found that subjects who regarded Tuberculosis as a Tswana (vs European) disease used modern medicine for symptom relief but traditional medicine to treat the perceived cause of the disease. All subjects eventually initiated specific anti-TB treatment in a modern health facility. Before the start of specific treatment, 52% of subjects tried one or more alternative treatments during the delay period. After starting modern treatment, 47% of subjects visited or planned to visit a traditional or faith healer. They also found that few subjects had a thorough understanding of tuberculosis from a biomedical point of view.

7.14 The Traditional Healer and Psychiatry

Oberholzer (1985) felt that traditional medicine had advantages over imported systems of medicine due to the fact that it is an integral part of the cultural system and is particularly

effective in solving certain cultural health problems. He notes that the traditional healer, much like the primary health care physician in Europe, only directs approximately 5% of "psychiatric cases" to the western consultation system.

Zoller (1997) showed that "traditional medicine" plays an important role in the treatment of psychiatric and psychological problems in Ghana, although at times it is stigmatized and denied.

Benjamin (1983) integrated group therapy with traditional medicine. He explains that

"Integrated group therapy was initiated as a result of the need to fill the gap in treatment between chemotherapy and social rehabilitation in Black mental hospital patients who were apparently unreachable in view of seeming difficulty in communication, language barriers, different thought processes and personality disturbances"(Benjamin, 1983, p.898).

Oberholzer (1985, p.36) points out:

"It has become one of the priority health care activities...to involve the community of traditional healers in the mental health care process as an attempt to provide an extended, more effective, practical , cost appropriate socially acceptable health service to the population."

The patients consult both Western health practitioners and traditional African healers anyway.

In addition WHO (1981) reported that traditional systems of medicine remain the major source of healthcare for more than two thirds of the world's population.

Historically in Africa and throughout the world, patients with psychiatric complaints have sought out a traditional healer for treatment. Today, to deal more effectively with patients who come for modern medical treatment, it is important to understand, reinforce and even incorporate aspects of traditional healing with patients who also seek out traditional healers. (Holdstock, 1981; Kelly, 1995; Oberholzer,1985)

7.15 Summary

Alternative therapies have always been an attraction for patients who are ill with a potentially terminal disease, many of these as an adjunct to conventional medicine, some as a substitute. The danger is present when a patient with a good prognosis foregoes his/her chemotherapy and diverts to alternative therapy, allowing the cancer to proceed to third and fourth stages.

With the advent of the internet where patients can do their own research, attractive and manipulative websites are propagating expensive, useless therapies and the patient, feeling that they are making a rational decision, often accepts them. Belief Systems and use of traditional medicine are discussed to essentially understand the other factor operant in the treatment of cancer.

One of the large factors in non adherence to treatment in a large percentage of the population

of South Africa is the attachment and commitment which people have to traditional medicine which at times (though not always), is working contrary to conventional medicine. An insight into the traditional treatment of breast cancer makes this very clear.

Traditional medicine is holistic, incorporating every aspect of man: spiritual, emotional, physical and social. Besides an intensive training the healers have a special calling which gives them the permission to practice their skills. It is important to note that whether the oncologist is aware of it or not, many patients in South Africa are being treated simultaneously in the conventional medicine and the traditional medicine healing system.