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'Renegotiated identities': stories of women who are initiated traditional healers and work in a hospital environment in a different capacity

Human, Leoni

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Chapter 2

Literature Review

2.1. Introduction

This chapter provides a review of literature which looks at the role of traditional healing systems in South Africa in dialogue with western medicine. As this study is based on the experiences of traditional healers who work in a hospital environment, discussion will also provide an overview of research on perceptions of traditional healers in western medical health care facilities by western health care professionals and patients.

2.2. Traditional Healing in South Africa

2.2.1. Introduction

The past few decades have seen a renewed interest in African traditional healing practices which are widespread in nearly every African community (Bannerman, 1982; Burhman, 1981; Cheetham and Griffiths, 1982; Edwards, 1986; Gregory, 2003; Thornton, 2002). This is partly due to increased recognition through social research of traditional systems of healing which incorporates a person's culture and belief system (Donald and Hlongwane, 1971; Maema and Sekudu, 2002; Warren, 1986; Swartz, 1998). In South Africa integration of indigenous healing systems into Western frameworks of treatment has increased (Long and Zietkiewicz, 2003; Muelelwa et al., 1988, Peltzer, 1998; Swartz, 1998).

Studies on the prevalence of African traditional healing in South African communities suggest that traditional beliefs and practices concerning illness and health are still widely followed (Burhman, 1981; Fipaza, 2003; Freierman and Jansen, 1992¸Ngubane, 1977; Van Dyk, 2001), constituting a wide network of largely unrecognised health care service (Muelelwa et al., 1998).

In identifying traditional healers fulfilling important roles in psychology and psychiatry in South Africa, Edwards (1986) sees the issue of integration between traditional and modern medicine approaches within the framework of bio-psycho-social medicine as an ongoing debate. Despite frequent calls for integration, Edwards (1986) argues that medical professionals are seldom informed about traditional healing practices and notes

that there is a considerable resistance to integration from both the South African Medical and Dental Council (S.A.M.D.C.) and the South African Medical Journal (S.A.M.J.). Arguments against the inclusion of traditional healers in modern health care facilities present traditional healing practices as unsafe, superstitious, lacking in control of its members, standards and practices in which poor uneducated families are exploited by charlatans with no peer review mechanism; as such not receiving any official recognition by the S.A.M.D.C. (Mahape, 1995). There is also a lack of training for traditional healers and medical practitioners to cross refer in a co-operative manner (Maema and Sekudu, 2002) equally called for by health care professionals and traditional healers (Freeman, 1992; Maake et al., 1998). Edwards (1986) and Swartz (1998) appeal to health care professions to adopt an inclusive approach which sees patients being referred to a traditional healer when they may benefit from such intervention.

As part of effecting cooperation between the two approaches in South Africa, Edwards (1986) promotes continued research which focuses on traditional and bio-medical practices within medical, academic and research institutions. Edwards (1986) identifies the following areas as needing research: large representative groups of patients, traditional healers and modern health care practitioners' assessment of the demand for and opinions about problems and implications of greater integration of traditional and western medicine. He argues that such research should focus on the effect of modernisation, education, economic, socio-cultural and political change on traditional societies in transition and related health seeking practices and behaviour.

In response to increased debates on the role, acceptance and inclusion of African traditional healing practices into mainstream western medical professions (Peltzer, 1998; Van Dyk, 2001), Swartz (1998) suggests that cultural psychology in South Africa has to consider the contextual meaning of culture and the manner in which different cultures are perceived. Underpinned by concepts of change and growth, Swartz (1998) defines culture as a changing set of guidelines which directs people's worldview and understanding of how to conduct themselves in their communities and convey these principles to the next generation through symbol, language, ritual and art.

Psychology has to consider that traditional healing incorporates a person's culture and belief system. Research into these traditions provides different avenues available to

understanding 'culture-bound' behaviour in South Africa (Swartz, 1998). Due to a growing interest in alternative and indigenous supplementary practices, there is a need for understanding the worldview and cosmology of African traditional healing (Donald & Hlongwane, 1971; Edwards, 1986; Ngubane, 1977; Swartz, 1998¸Thornton, 2002; Van Dyk, 2001). Muelelwa et al. (1998) encourage traditional healers and Western health care professionals to engage in meaningful dialogue on South African health policy whilst Ingstadt (1998), emphasises the preservation of cultural heritage as African society is rapidly undergoing social transformation. Psychology has to consider the meaning of individual behaviour as contextually culture bound and look more specifically at how different cultures are perceived (Swartz, 1998). In an attempt to address current social health issues such as the HIV/AIDS pandemic, integration or cooperation between traditional healers and modern health care professionals has become imperative (Kahn and Kelly, 1996; van Dyk, 2001).

2.2.2. Indigenous Healing Cosmology and Perspectives on Health and Illness

An understanding of traditional cosmologies on illness and healing is required to grasp the meaning of healers and their practices in the South African community (Holdstock, 2000; Makinde, 1988). Hammond-Tooke (1989) explains that healing practices form part of a wider cultural conceptual framework marked by a strong relationship between healing and belief and in which disease and illness causation are closely related.

In South African indigenous healing cosmology, some central themes are common to the variations in belief that are specific to particular groups (Hammond-Tooke, 1989; Burhmann, 1981, 1984; Edwards, 1985; Hirst, 1993). African indigenous belief systems are inextricably linked with magical understanding and include beliefs in the danger of witches and harmful spiritual influences and the use of ritual, ceremony and animal sacrifice for ancestral favour and protection (Freierman and Jansen, 1992; Thornton, 2002). African cosmology perceives all of nature, the elements together with animals and plants, as reflecting the primal energy of God that can be used to heal the human body (Fipaza, 2003¸Makinde, 1988). The traditional healer in South Africa uses innumerable ingredients from all sources of nature to cure (Fenyves, 1994). The general African worldview involving health and illness revolves around the harmonious balance of the universe, resulting in good health (Ngubane, 1977).

Traditional views on illness are based on complex pervasive ancestrally grounded belief systems, adopting a holistic approach to healing as opposed to western dualist conceptions of the person (Swartz, 1998). African cosmology is marked by a sense of interconnectedness and interdependence of natural, social and spiritual forces, with an emphasis on the protective, directive and causal role of the ancestors (Donald and Hlongwane, 1971; Edwards, 1985; Fenyves, 1994; Fipaza, 2003; Freierman and Jansen, 1992; Hammond-Tooke, 1974; Hirst, 1992). Edwards (1986) found that traditional and western practitioners work from different orientations but stresses that a significant degree of agreement indicates possibilities for the integration of traditional and modern medicine in South Africa.

Affliction and cure is of the human being as a whole and is seen as arising out of imbalances of the natural, social and spiritual forces operating on the individual (Ngubane, 1977; Edwards, 1985). Central to the cure is an explanation of the cause and a restoration of the elements that have been disturbed (Wessels, 1985). Causes for illness range from social, moral or spiritual transgressions; invoking ancestral anger (Donald and Hlongwane, 1971¸Edwards, 1986; Ngubane, 1977). Among the IsiZulu, the notion of disease *(isifo)* encompasses physical sickness together with misfortune and imbalance (Edwards, 1985; Ngubane, 1977). Thus anything which brings one into disharmony, be it with the environment or others, can be perceived as potentially causing disease. Many tribal societies consider illness and disease to stem from spiritual disharmonies (Cheetham and Griffiths, 1982). Based on a fundamental belief in ancestral power, the ideology of traditional healing emphasises a connection between illness and disturbed social relations (Willis, 1969 as cited in Fenyves, 1994). Healing practices therefore often focus on a struggle against social disorders and witchcraft (Edwards, 1985; Fipaza, 2003; Fenyves, 1994; Lambrecht, 1997).

Indigenous cosmologies recognise three primary causes for mental illness: ancestral possession or interference, inherited misfortune or as result of witchcraft, in which case it often denotes possession (Edwards, 1985; Ngubane, 1977). In the case of ancestral intervention, rituals are performed to appease the ancestors and thus cure the disease. Ailments believed to be hereditary are considered incurable and bestowed in forms resembling epilepsy and schizophrenia (Donald and Hlongwane, 1971; Edwards, 1986; Ngubane, 1977).

For the sake of ancestral contact and protection, rites and ceremonies form part of the daily life of most indigenous communities, being a specific requirement at all major life-cycle events. Most forms of affliction are responded to with the appropriate ceremonial rite (Donald and Hlongwane, 1971). The individual for whom the ceremony is performed is re-established within both the living and deceased ancestral kinship community. Neglect of the appropriate ceremonies leaves an individual vulnerable in terms of ancestral protection (Ernest, 1992).

Ancestral reverence is fundamental to the understanding of African cosmology and initiation into its traditional healing practices (Ngubane, 1977). Ancestors are understood as benevolent familial spirits, who preserve and honour traditions of a tribe, protecting family and community against misfortune; but may send or allow illness and misfortune when social norms are violated or rites incorrectly performed (Van Dyk, 2001). Holdstock (2000), states that in Africa, the relationship with the ancestors is the primary route to divine power and healing. African traditional healing presents a direct connection to the African past. Ancestral reverence is the primary factor associated with continued good health; a secondary explanation for illness causation is witchcraft (Edwards, 1986).

The ancestral reality is a "lived experience, a tangible reality that permeates all aspects of life" (Berglund, 1976, p.7). This along with a pervasive kinship system guides, orders and directs individual existence toward the well being of the whole lineage (Preston-Whyte, 1974). In looking at the role of ancestors Ngubane (1977) explains that the spirits of deceased ancestors (*Amadlozi*) are concerned with the lives of the living, and either protect or discipline them. Ancestors usually bestow blessings on the living and withdraw them only in exceptional cases. Prevention of offending the ancestors and losing their protection and mediation with God is *the* matter of primary concern in African tradition. Freierman and Jansen (1992) says that the worldview that inspires cults of affliction includes the idea that ancestral spirits, ultimately expressions of the power of God, influence or intervene in human affairs and are held responsible for visiting their sentiments and forces upon humans through sickness and misfortune. The ancestors and God work together. During rituals God is invoked to make all healing possible, but God is believed to work through his angels in helping people.

2.2.3. Types of traditional healers in South Africa

There are generally three different categories of traditional healers identified in South Africa; namely the herbalist, diviner and faith-healer (Edwards, 1985; Fipaza, 2003; Hammond-Tooke, 1998). Although some differences in Nguni and Non-Nguni based traditions occur, Edwards (1986) emphasises shared universal components of traditional cosmologies on healing and says that: "whereas the archetypal shaman is an all in one type of healer, modernisation has resulted in increasingly role specialised traditional healers" (p.1273).

Ngubane (1992) and Edwards (1985) identifies three main types of Zulu traditional healers i.e. the Inyanga or traditional doctor, usually male, who specialises in herbal treatment; and the Isangoma who operates as spiritual medium, usually female, and the prophet or faith healer, a category seen to have originated as result of a shift to modern and Christianised frameworks such as the African independent church movement.

Burhmann (1981) identified two different types of Xhosa healers namely the diviner and herbalist. By reference to differences in training rather than overlapping functions, Burhmann (1981) uses the term 'Inyanga' to denote either. Later, Fipaza (2003) distinguished between three broad categories of traditional healers in the Xhosa culture, namely; diviners (*aMagquira),* herbalists (*aMaxhwele)* and faith healers (*aBathandazeli)*. Fipaza identifies diviners and faith healers as traditionally ´called´ into initiation and service in a similar manner whereas the herbalist voluntarily enters apprenticeship with a qualified herbalist. Operating from a cosmological perspective in which African church cosmology and Christianity has merged, the spiritual- or faith healer is not strictly considered an indigenous healer as this category of healers emerged alongside colonialism and the introduction of Christianity in Africa (Edwards, 1986). Characterised by extraordinary abilities in miraculous healing (Fipaza, 2003), the category of the faith healer serves to integrate the role of the ancestors with Christ and the Holy Spirit (Edwards, 1986).

Fenyves (1994) identifies five different types of healers, all with distinctive roles; Nyanga, Sangoma, Setshupsa, the Dreamer and the Faith Healer. Fenyves echoes Fipaza (2003) in identification of herbalists but distinguishes between two kinds of specialists; namely *Nyangas* as *Mangomas,* and *Sangomas*. While the diviner or Nyanga

characteristically works with bones, the *Sangoma* does not always do so. Fenyves (1994), states that the Sangoma's primary role in serving the community is to convey messages from the spirits and the ancestors.

Divination denotes inquiry about future events or matters, hidden or obscure, directed by a deity who, it is believed, will reply through significant tokens (Hammond-Tooke, 1989). Divination is one of the techniques the diviner uses in treatment of social problems (Hirst, 1990). The diviner's role is to discover the hidden causes behind misfortune and prescribe appropriate action (Hammond-Tooke, 1998). The healing powers reportedly gained from the ancestors have been explained as a sentient and external spirit-mediated process, the workings of intuition and the accessing of the transpersonal field of information to gain healing knowledge (Grof, 1991; Lambrecht, 1997; Somé, 1994). Such divinatory practices were originally used by shamans, diviners and seers and have changed over time and among cultural groups from bone throwing to the incorporation of more trance and mediumistic orientated divination (Edwards, 1986; Hammond-Tooke, 1989; Makinde, 1988).

In drawing from both Nguni and Non-Nguni traditions, all participants in this study identified themselves as diviners, and refer to themselves both as Sangomas and Inyangas. Diviners are specifically called to their profession by their ancestors through the sending of an illness syndrome, referred to as *thwasa* (Ngubane, 1977; Hammond-Tooke, 1998). This refers to the process of gradually becoming or emerging as a diviner (Hirst, 1992). Directed by the ancestral spirits and considered to have supernatural clairvoyant powers the diviner is able to identify supernatural causes for illness (Hammond-Tooke, 1989; Burhmann, 1984). Zulu diviners are most commonly not possessed by their spirits (Ngubane, 1977) but communicate with them through thoughts, auditory or visionary instruction, or use a medium by which their guidance is interpreted, such as the bones (Fenyves, 1994). Fipaza (2003) further notes that diviners interchange the role of a doctor in diagnosis, sale and dispensing of treatment whilst simultaneously divining the cause of illness and providing solutions to spiritually or socially centred complaints (Makinde, 1988).

Green and Makhubu (1984) also distinguish between diviners and herbalists as different types of healers. Herbalists do not divine but make diagnoses on the basis of physical or

mental symptoms and are more concerned than diviners with medicines and the function of the human body. Diviners function predominantly as diagnosticians and commonly combine the use of herbs and a set of bones when performing divination (Haram, 1991) but also encounter social and psychological problems (Fenyves, 1994). Considered to have extensive knowledge of herbal medicine (Ngubane, 1977), much of the healing performed by diviners include ritual, psychotherapy and medical treatment (Fipaza, 2003).

In Zulu society the diviner's role can be likened to that of a priest (Ngubane, 1992). To attain this status of ancestral contact the diviner has to undergo various forms of abstinence and withdrawal from society, avoiding all sources of pollution including the dead. Thus the diviner reaches a state of purity, maintained by observance and practice of what is considered "moral and upright behaviour" (Ngubane, 1992, p. 370). In the keeping of confidence and adjudicating in cases of conflict or sorcery, the diviner's is a highly responsible status, not left to chance, but maintained and controlled by social order in the way churches control and discipline clergymen (Ngubane, 1992).

2.2.4. Initiation: Becoming a traditional healer

Diviners undergo an experience of intense training and initiation which appeases or domesticates ancestral spirits (Hammond-Tooke, 1989) which is seen as a calling through an ancestrally bestowed illness believed to be incurable by modern medicine (Ngubane, 1992). This process is known as *´ukuthwasa´*; derived from Xhosa for 'the emergence of something new', specifically an individual experience of ancestral summoning to service as a diviner or faith healer (Fipaza, 2003). *'Ukutwasa*' is diagnosed by a qualified traditional healer as the ancestors' desire for individual training, initiation and service in indigenous healing (Hammond-Tooke, 1989; Ngubane, 1977).

Initiation is a gradual process involving a series of ancestral cultural rituals such as *intlwayelelo, intambo yosinga* and *goduswa* (Hirst, 1992). The initiate is to learn from their teacher between these rituals before final initiation. Hammond-Tooke (1989) indicates that in the Nguni tradition, these rituals typically come within two years after the initiate has submitted themselves for training. During the *ukuthwasa* experience, rituals are directed at the ancestors, including sacrificing a cow, a sheep or a goat (Ngubane, 1977).

The period of *ukuthwasa* where the initiate is typically removed from the community during the time of training, observing numerous taboos in order to avoid ritual pollution, can be likened to a journey in the spirit world, where the healer gains spiritual guidance as per ancestral instruction (Hammond-Tooke, 1989). This understanding parallels Jung's notion of *individuation* (Campbell, 1986). As with the hero's journey, the initiate undergoes a period of spiritual apprenticeship under a teacher or *'Gobela'*, during which time they receive instruction in divination, herbal treatment or muti, traditional dancing, craft, ritual and ceremonial celebration; finally to be initiated as a competent diviner (Fipaza, 2003); the 'wounded healer' who has survived the ordeals of initiation (Campbell, 1986).

Thwasa is associated with characteristic psychological or emotional states such as *umbilini;* an anxiety based condition, or *ukuxozula;* fainting fits not analogous to epilepsy, usually occurring in a ritual context of ancestral communication (Fenyves, 1994). Initiation to become a diviner is considered a major sacrifice and commitment (Ngubane, 1992). Generally initiates, who do not readily submit themselves for training, react acutely to ancestral calling and become increasingly unwell (Hammond-Tooke, 1989). Prior to and during initiation, diviners often exhibit disturbed, dysfunctional psychological behaviour and mental states which cease on completion of initiation (Lambrecht, 1997).

In reference to traditional healers, Peltzer (1998) denotes diviners as Sangomas and Inyangas as doctors. This is a broad definition which also includes practices existing before modern medicine such as homeopathy and chiropractics. Some power struggles exist between diviners and herbalists as initiation through ancestral calling denotes a higher social-spiritual status for the diviner (Freeman, 1992).

Hammond-Tooke (1989) relates the life of a healer as difficult, marked by living in solitude, following strict dietary and sexual restrictions, thus avoiding ritual impurity. Healers mostly resist their ancestral calling because of a frequent demand of tirelessly treating patients. Hammond-Tooke (1989) found only six women out of one hundred who responded positively when asked if they wanted to become traditional healers.

In drawing on ideological forces and cultural values, initiation can be seen to serve societal control systems in symbolically connecting the individual to the community

(Lincoln, 1981). Initiation also provides a space for social support and protection from abusive relations through compulsory self seclusion (Long and Zietkiewicz, 2002). In acquiring the diviner's role, traditional initiation may also allow women to empower themselves in an otherwise male-dominated society which privileges male socialisation (Hirst, 1992; Ngubane, 1977). This is contextually bound to the understanding that a woman's socio-political status reflects that of a male relative in the sense that womanhood is not recognised as significant in male dominated socio-political arenas (Lincoln, 1981). Initiation into African traditional healing, however, changes a woman's status whereby she is perceived with increased regard and presence. Subsequently, women's initiation has cosmic significance in some cultures where initiation is performed for the benefit of the initiand, the society and the cosmos and ritual re-enactment transforms and reifies the initiand into a sacred cultural link between past and future (Hammond-Tooke, 1989; Campbell, 1986, Gregory, 2003). As such, women's initiation becomes an act of self-affirmation and a rite of solidarity with other women participating in the initiation (Lincoln, 1981).

Hammond-Tooke (1989) draws parallels between adolescent initiation rites and initiation into African traditional healing. The process of *ukuthwasa* in many ways parallels adolescent initiation and denotes the attainment of social maturity, elaborated by some researchers as a metaphoric transformation that takes place gradually in the person who suffers the ordeals to subsequently become a diviner.

Some parallels with African traditional initiation and other indigenous traditions do exist. Grof (1988) looks at how people from other cultures recognise a spiritual calling and the challenges of this process. The process of *ukuthwasa* is often a time of psychological and spiritual hardship for initiates (Hammond-Tooke, 1989). This is exacerbated by the lack of a good teacher facilitating the process or failure to observe the prohibitions of *ukuthwasa* (Makinde, 1988). The diviner's role is also viewed as a culturally endorsed strategy and therapeutic means for allowing psychically gifted individuals or those facing a spiritual emergency to come to know and heal themselves and others, which is the ultimate purpose of any diviner (Capra, 1974; Grof, 1988; Lambrecht, 1997).

Initiation into African traditional healing can also be seen as a metaphor for transformation (Campbell, 1986; Hammond-Tooke, 1989; Lambrecht, 1997). Rites of

passage primarily enable individuals to pass from one social position of status to another (Van Gennep, 1980). Here the initiate experiences a divine vocational call and undergoes intensive training, subsequently becoming a diviner through a gradual process of transition, ceremonially marked by rituals, until successful completion of final initiatory ordeals and recognition by the ancestral and living community (Ngubane, 1977). This process of initiation is echoed in traditional shamanic initiatory practices. Lambrecht (1997) and Somé (1994) discuss the relationship between traditional healing practices in Africa and indigenous forms of shamanism. They draw parallels with regard to the process of shamanic initiation and *´ukuthwasa´*, as experienced by the African indigenous healer, more specifically, the diviner. As with initiation into traditional healing, shamanic initiatory practices also aim to bring about personal transformation based on a belief in and regular contact with the spirit world and the dual existence of applying their knowledge in the physical world through healing of others (Grof, 1988; Hall, 1994; Somé, 1994). As with the traditional healer, it is imperative for the shamanic initiate to complete the process and training of initiation in order to contain their own experiences and ensure the continued good health and fate of themselves and their community (Edwards, 1986; Hammond-Tooke, 1989; Burhman, 1981; Lambrecht, 1997).

In South Africa altered states of consciousness are an important feature in the initiation and practice of diviners (Lambrecht, 1997). As elsewhere around the world, South African diviners also make use of psychoactive plants to induce visionary phenomena and connect with ancestral and spiritual powers (Grof, 1988; Lambrecht, 1997; McKenna, 1997).

2.2.5. Daily practice and community role: 'Being a traditional healer'

The role of African traditional healing in the South African community is diverse and inseparable from daily life. No two healers are alike, and healing practices vary a great deal over short distances and timeframe (Van Dyk, 2001). The traditional healer as a recognised authority on the supernatural is an accepted ancestral medium (Edwards, 1986). Diviners make common use of ritual, which has a powerful healing effect in fostering and recreating community cohesion and resolving conflicts whilst reintegrating the ill (Hewson, 1998; Hirst, 1992).

The office of traditional healer, as most trusted and respected in the community, serves

to re-establish the balance of social and spiritual forces within the different social functions (Fenyves, 1994). Hirst (1993) emphasises the traditional healer's ethic to take action in the face of illness or social disorder and considers the multifaceted role of a diviner as teacher, healer, midwife, counsellor, witch, prophet and visionary (Ingstadt, 1998) to represent traditional ways of understanding illness and healing (Gregory, 2003).

Hirst (1992) sees the role of diviner as culturally sanctioning the individual to make sense of their own experiences, and giving them the means with which to heal themselves. He likens this to the archetypal death-rebirth experience of shamanic initiation as it is characteristically identified by the suffering of an affliction or crisis, the acceptance of the calling to be a diviner and subsequent death of the old self and rebirth of the new healer-self along the journey (Grof, 1988; Hirst, 1992). Campbell (1986) sees the traditional healer as *'wounded surgeon'* in suffering a trauma and finding therapeutic value and social support through the initiation process. Traditional healers, as diviners and herbalists, have undergone a process of rigorous training and initiation which enables them to serve as mediators, spiritual messengers and translators between the living and ancestral realm as well as within the social structure of the society (Gregory, 2003).

2.2.6. Modernisation and Traditional Healing

The role of the South African traditional healer is a changing one. The traditional healer operates as healer, witch, prophet and health care worker (Ingstadt, 1998). Cooperation between the traditional healer and mental health care professions presents important implications for the future of health care in South Africa (Gregory, 2003). Research into this area needs to be conducted in a culturally sensitive manner so as to minimise the effects of acculturation on traditional systems of healing (Baran, 1975; Mahape, 1995).

Acculturation is one reason cited for resistance to integration of traditional healing and western medicine (Muelelwa et al., 1998). As individualism replaces collectivism, acculturation is seen to have destructive effects as shifts in traditional beliefs, values and customs places pressure on the strength of the extended kinship system, eroding practices, values and responsibilities which are no longer clear and well defined (Donald and Hlongwane, 1971; Fipaza, 2003). As with many other non-industrialised countries,

the South African context of socio-political transition lends itself to increased demands and pressures of a modernised western lifestyle which involves a shift from traditional beliefs, values and customs to modern worldviews (Fipaza, 2003). Increasing symptoms of traditionally western-based illness such as bulimia and anorexia is seen as indicative of such cultural erosion in traditional communities (Edwards and Moldan, 2004). Anyinam (1987) also notes the increase of western-based disease amongst African people such as cancer, cardio-vascular diseases, schizophrenia and hypertension.

Diverse positions form part of the debate on acculturation. Uzoka (1980) sees acculturation through urbanisation and industrialisation as psychologically and socially damaging to indigenous people affected by the demands for a shift from traditional beliefs, values and customs to adopt a more western worldview. Baran (1975) states that the result of ongoing socio-political changes brings about a wide range of identities in cultural transition where " Some rural, mostly older generations still strongly and implicitly identify with rural culture, whilst others, youth in particular, are seen to reject traditional culture. Yet others have loosened their ties with traditional culture without having gained an integrated alternative" (Baran, 1975, p. 71).

Baran (1975) believes that integration raises some issues such as the conflict of identity from a semi-traditional background through exposure to western orientated achievement goals. The African person faces a loss of a clear role definition and a sense of belonging, which forms part of the traditional social order. In identifying with the western goal of individual achievement, there is a shortage of sufficient political and economic freedom in attempting to live a competitive and individually oriented existence (Baran, 1975).

In addition to identity issues, much of the conflict is experienced by those who have consciously rejected the traditional belief system with its appropriated ritualistic solutions, placing the individual under ancestral protection and affirming their social status (Donald and Hlongwane, 1971). This group of individuals were found to commonly experience feelings of vulnerability, doubt and guilt, originating from their residual beliefs and cultural identity. Some of them have lost their unquestioning faith in traditional healing, but utilise it, due to insufficient access to modern health and psychological services and social resources.

In contrast, Fenyves (1994) cautions against the dangers of traditional healers neglecting to carry out their important social, psychological, spiritual and physical function in the community through the process of 'integration' into western medical frameworks elsewhere in Africa. Warren (1986, as cited in Fenyves, 1992) identified instances where healers have been successfully incorporated into a system of health care professions without losing their own status and autonomy. Freeman and Motsei (1992) challenge the idea that traditional healing and western health care operate from such distinct premises that it prevents integration, although they emphasise modern biomedical approaches' discomfort with supernatural belief systems. Additional factors such as lack of funds and information, professional medical elitism and a genuine concern that indigenous practitioners' practices are harmful to patients, serve to contribute to misunderstandings about traditional beliefs (Fenyves, 1994; Mahape, 1995). Fenyves (1994) notes however, that modern and traditional systems and world-views are in a process of merging, making it possible for these two systems to integrate.

2.3. Traditional Healing and Medical Health Care in South Africa

2.3.1. Introduction

This part of the discussion will look at how dialogues on traditional healing practices have developed in South Africa. Some differences between traditional and modern approaches to health care will be highlighted in order to consider ways in which the biomedical model may draw on indigenous healing paradigms. The second part of this discussion will provide an overview of research studies which explore perceptions on the interface between traditional healing and health care in South Africa and elsewhere in Africa.

2.3.2. Dialogues on Traditional Healing and South African Health Care

Previously, modern health care workers were largely resistant to indigenous health care practices and healers (Donald and Hlongwane, 1971; Fenyves, 1994; Fipaza, 2003; Kelly and Kahn, 1996; Van Dyk, 2001). Spiritual explanations for disease do not fulfil the rational requirements of a modern medical approach. Although modern health professionals have considered traditional medicine as inferior in the past (McKee, 1988) the biomedical model currently draws on the resources of traditional healers in addressing issues such as HIV/AIDS and community based interventions (Green, 1988; Peltzer, 1998; Thornton, 2002; Van Dyk, 2001).

African conceptions of health and illness as holistic differ from modern (western) dualist assumptions (Burhmann, 1984). A prevailing perception is that there is a tendency for medical doctors to treat the physical aspects of a disorder, and diviners to focus on its spiritual and emotional aspects (van Dyk, 2001). Van Dyk (2001) maintains that an understanding of the diverse cultural and social belief systems in Africa must be integrated into western-based involvement.

In highlighting some differences between modern and traditional healing practices Fenyves (1994) argues that modern medicine's focus on disease control removes traditional healing responsibilities from the patient, who defers this responsibility to the doctor and medical technology. Fenyves (1994) states that the focus on quantification, measurement and eradication of disease neglects an appreciation of the patient's experience and understanding of their illness.

Fenyves (1994) cautions that abstraction of disease from its social framework, ignores social conditions and leads to degeneration of the social, physical and occupational environment. Modern medical practitioners need to remain aware of their perceptions of illness and the realities constructed by a specific medical culture (Mattingly and Garro, 2000;Terre Blanche and Durrheim, 1999). Swartz (1998) emphasises that the psychologist as social researcher is engaged in a process of discovery and meaning making, and needs to remain aware of the concept of mental health as culturally loaded and characterised by the categories used in dominant western biomedical culture, predominantly regarding the dualist separation of body and mind. Swartz (1998) urges psychology to consider the effects of a dualist conceptual barrier placed between mental and physical health within the biomedical perspective.

Traditional belief systems do not make a strict distinction between body and mind or spirit. Instead, the traditional perspective perceives illness and health as an interconnected combination of mental, physical and spiritual existence (Edwards, 1986; Hammond - Tooke, 1989; Ngubane, 1977; Swartz, 1998). The biomedical split between body and mind presents difficulties as South Africa encounters increasing rates of lifestyle-related disorders. Ngubane (1992) contrasts western medical practices of recording patient history and symptomatology prior to examination with the practices of a traditional healer who divines the illness and its cause prior to diagnosis and treatment.

As such modern medical practice effectively distances the patient from the doctor. Modern medicine focuses on curative measures and sophisticated technology which is expensive and often perceived not to meet the needs of local cultural health practices (Ngubane, 1992).

In contrast to Ngubane (1992) and Fenyves (1994) Edwards (1986) considers the distinction between traditional and modern medicine to be arbitrary within a context of community, which affects the interchange between healers and patients. Here, 'modern' is used to denote western-orientated biomedicine in contrast to local, culturally relativistic traditional healing approaches which Edwards considers to be functionally strong.

2.3.3. Perceptions on Integration between Traditional and Modern Medicine

A vigorous debate exists regarding the involvement of traditional healers in primary health care formulation, planning and implementation. This debate includes traditional healers as well as policy makers and practitioners of modern bio-medicine (Anyinam, 1987). In 1978 the World Health Organisation (WHO) called for integration of modern scientific medicine with useful traditional practices and promoted the development of suitable policies as a first step in the refinement of modern medical services. In encouraging participation in modern health service they emphasise the need to approach traditional practitioners with understanding and recognition of their skills (Bannerman, 1982; WHO, 1978b).

Various research studies explore ideas on the integration of modern and traditional approaches in South Africa and present different perceptions on the interface between traditional healing and health care in South Africa (Edwards, 1986; Peltzer, 1992; Thornton, 2002). Research on acceptance and inclusion of ethno-medicine into government policies and modern medicine found ambivalence amongst biomedical practitioners toward indigenous healing practices (Anyinam, 1987). In addition, recognition of traditional healing practices as an acceptable health resource was objected to by black biomedical practitioners within the modern health sector (Freeman, 1992).

In seeking reasons for this resistance from the modern health sector, Freeman (1992) points out that while the contextual influence of traditional cosmology may be ignorantly unrecognised by the modern health worker, traditional medicine may be harmful, ineffective or simply serve as a placebo in some cases. Another aspect which raises questions is the issue of training and registration of traditional healers as not being open to the same evaluation as modern health care. Before being registered the modern health care professional has to fulfil the requirements of standardised exams at predefined training institutions whilst traditional healing practices lack formal standards of certification (Freeman, 1992; Mahape, 1995).

Harriet Ngubane (1992) also reports resistant perceptions of western practitioners to traditional healing practices in their reprimanding patients for wasting time in consulting a traditional healer instead of a doctor. Miscommunication is further reinforced through the frequent need for a nursing translator. Hall (1994) presents a western medical doctor's personal account of initiation into traditional healing in Swaziland and provides an inclusionary perspective which supports integration between traditional and modern approaches as complementary.

It is also important to consider the perceptions of nurses on inclusion of traditional practices into modern health care (Edwards, 1986). Nurses are required to be culturally aware on multiple levels and have to provide health care and treatment to patients in a culturally acceptable and comfortable context (Davis, 1986). Nurses observe and interact with patients on a continual basis and thus are best able to collect and identify information consistent with a patient's cultural perspective (Leninger, 1978)

This also relates to other areas of nursing health care such as the training of psychiatric nursing staff. Bryn Davis (1986) raises issues of culture in psychiatric nursing and motivates a multidisciplinary base for health care, in particular for nursing care. The nurse is recognised as having the closest and most frequent contact with patients and is thus able to deal with the person in their social context in applying models of nursing grounded in the needs of the patients as primary concern. Davis (1986) calls for an ethnographic approach to understanding the role of the nurse in a cultural context. He relates this to psychiatric nurses in particular as the separation of that which is deemed normal and abnormal is often informed by culturally identified concerns and

understanding. Thus, ethnographic informed practice may serve to assist the health care worker in obtaining a culturally sensitive understanding of the context and worldview of their patient.

In exploring nurses' perceptions of traditional healing, Burhmann (1984) identifies widespread illiteracy amongst traditional healers as challenges to co-operation and indicates a need for developing alternative methods of training traditional healers. Secrecy furthers misunderstanding, as some traditional healers are reluctant to share their knowledge in fear of offending the ancestors who represent and guard this knowledge (Burhmann, 1984).

Subsequent studies on the attitude of nurses towards indigenous healers in South Africa found most nurses in rural hospitals to perceive indigenous healers as helpful to the community and to encourage joint health promotion between modern and traditional practitioners (Muelelwa, et al., 2002). Interestingly Muelelwa, Sodi and Maake (2002) also found that whilst most nurses wanted traditional healers to refer patients to the hospital, less than half would send a patient to a traditional healer.

Mahape (1995) looks at the attitudes of professional psychiatric nurses toward working alongside traditional healers as providers of mental health care in the South Western Townships of Johannesburg. Her study revealed that psychiatric nurses did not perceive the presence of traditional healers in the hospital to threaten the role of nursing in patient care. Participants indicated an overall attitude of support toward traditional healers in considering them effective and beneficial to patients and their families as they play a significant role in the life of the modern black person (Mahape, 1995).

In relevance to the present study, Mahape (1995) found that a large number of participants indicated that they did not perceive working with nurses who are also traditional healers to lower the standards of the nursing profession. Nurses who were willing to work with traditional healers perceived enough similarities between the two approaches to allow them to communicate effectively (Mahape, 1995). Most nurses in this sample encouraged patients to consult traditional healers if they perceived their condition to be beyond the scope of modern medicine. Mahape's findings indicate useful

possibilities for co-operation between nurses and traditional healers in the area of mental health care.

Studies on perceptions of modern health care workers on inclusion elsewhere in Africa revealed that although a majority of nurses in Nigeria considered traditional practices to vary in its effectiveness with the specialisation of healers, a significant portion were in support of formal collaboration (Maake, et al., 1998). In Nigeria, Ojanuga (1980) found western trained doctors to be in favour of indigenous healers providing treatment in government health facilities. In Swaziland nurses support the idea of a two-phase treatment plan whereby patients first consult with doctors in the hospital and then traditional healers at home (Maake, et al., 1998).

In South Africa patients are found to access a wide range of health care facilities such as clinics, doctors, pharmacists, hospitals and traditional healers, including faith healers (Mahape, 1995). From the patient's point of view the contrast between traditional and western services are evident in at least four major aspects with regard to the doctor-patient relationship: communication, preparation of the case history, information about diagnosis and the view taken and expressed of resort to other practitioners (Edwards, 1986; Freeman, 1992¸Ngubane, 1992). The implications of hampered doctor-patient communication must be considered in the need for interpreters where the effects and risk of inappropriate phraseology and incorrect translation is obvious (Muelelwa, et al., 1998). Equally evident is the accessibility and ease of patient-practitioner communication upon consulting a traditional healer. Traditional healing has a holistic approach where physical diagnosis forms as much part of consultation as spiritual guidance (Anyinam, 1987).

Congruence between the worldview of the patient and the traditional healer has important effects for treatment compliance (Muelelwa, et al., 1998). Despite such congruence, Ngubane (1977) points out that fear of reprimand may prevent patients from informing modern health care workers of their consulting a traditional healer.

Although traditional healers recognised as well embedded within African culture, Anyinam (1987) challenges claims by others that 80% of South Africans consult a traditional healer (Cheetham and Griffiths, 1982; Edwards, 1986; Gregory,

2003¸Ngubane, 1977), finding instead that western biomedicine is the preferred choice of treatment. This finding is confirmed by Ojanuga (1981) in Nigeria, as patients were found to consult traditional healers only when their expectations were not fulfilled by medical doctors. The results of these studies confirm the results of studies by the Community Agency for Social Enquiry (1995) where only a small sample of African community members indicated that they consult traditional healers.

In support of Anyinam's (1987) sentiment Muelelwa, et al. (1998) found most villagers in Umtata, Eastern Cape, to ask for western trained health care professionals and institutions instead of traditional healers. Muelelwa et al (1998) further found that although a significantly higher amount of patients chose to be treated by western practitioners a considerable number also supported collaboration between traditional healers and modern health care workers in a hospital context.

Maema and Sekudu (2002) explored patients' perceptions on integrating traditional healing practices with western psychiatric treatment and found that whilst most patients preferred to follow western psychiatric treatment, others failed to do so for reasons often informed by traditional healing practices in South Africa. By considering the influence of traditional belief systems on black mentally ill patients, they were able to identify traditional healing as providing complementary contribution to a sensible combination of methods for curing a given disease (Maema and Sekudu, 2002). In their discussion Maema and Sekudu (2002) emphasise the importance of faith in influencing and determining a person's choice of treatment, and consider the personal belief system rather than the treatment of the practitioner, as a primary factor necessary for the precipitation of healing in the process of recovery.

The abovementioned study took place at Weskoppies hospital and focused on black mentally ill patients' perceptions of traditional healers in a hospital environment. Maema and Sekudu (2002) provide two case studies to illustrate how cultural norms, values and beliefs may influence choice of treatment and recovery and present four main reasons to explain the readmission of black mentally ill patients after initial treatment and discharge. The first reason for discontinuance of medication and treatment was a belief that the illness was caused by witchcraft, which cannot be treated by western medication. Secondly, treatment poses challenges for a patient who does not believe that modern

medication will remove the bewitchment or break the curse. In the case of those who perceived their illness to be ancestrally bestowed, modern medication was considered ineffective. In the third instance non-compliance followed instructions by a traditional healer. Aside from the influence of traditional beliefs, a fourth group of patients were readmitted due to a lack of a sufficient support system and family conflict (Maema and Sekudu, 2002).

In looking at patients' reasons for consulting a traditional healer, Ernest (1993) conducted a study at the Department of Family Medicine, Umtata Hospital and found physical pain to be a primary reason for consultation. Spiritual advice and ancestral protection served as secondary concerns in consultation. Factors influencing the decision to consult with a traditional healer included social pressure, belief in witchcraft and congruent beliefs or healing cosmology (Ernest, 1993). In looking at patients' perceptions elsewhere in Africa, a study in Botswana by Chipfakacha (1994) found that the majority of women of childbearing age prefer the services of traditional birth attendants to western health professionals at the postnatal clinics. As with patients who would consult a traditional healer in a hospital, Maake, Muelelwa and Sodi (1998) found rural women to be in favour of traditional midwifery practices over western methods; which contrasted with ambivalence and resistance to traditional practices by nurses in the urban setting (Maake, et al., 1998).

A primary question arising from the abovementioned studies pertains to the influence of traditional treatment on African patients for the purposes of recommendation and improved social intervention based on an understanding of patients' reasons for consulting a traditional healer. Modern medicine is increasingly noted as the treatment of choice by patients (Muelelwa, et al., 1998) while traditional medicine is perceived to be more popular in rural areas which lack modern health care services and facilities (Edwards, 1986). Although traditional and western practitioners work from different orientations they are largely in agreement on diagnosis and treatment as well as being perceived as equally helpful by patients (Edwards, 1986). The South African patient has the availability of both traditional and western medicine (Ngubane; 1992) and may utilise alternative medicine either as an initial source of health care or as last resort when expectations have not been met by modern medicine (Mahape, 1995).

In contrast to some resistance on the part of modern health care workers toward traditional healing practices, Ngubane (1992) found acceptance and support for modern bio-medical health care services amongst traditional healers in South Africa. One of the reasons for this could be that traditional healers were perceived to have altered their earlier attitude of secrecy and were becoming more active in joining health care programmes (Mahape, 1995).

In discussion of his study on traditional healers' views on social and mental disorders in the Northern Province, Peltzer (1998) states that mental health care services in South Africa has to take into account the beliefs of those it is serving and, in responding to the context in understanding of its activities, the mental health care practitioner has to be aware of traditional attributions to social and mental disorders.

Green and Makhubu (1984) explored attitudes of healers toward paraprofessional training and found that traditional healers expressed enthusiasm at being trained in modern medicine, desiring more cooperation with modern practitioners in order to improve their healing skills. They point out that information about modern health care professions' attitudes to inclusion is limited due to widespread illiteracy and a lack of formal education amongst traditional healers, which present challenges to effective communication. A survey of physician and nursing attitudes toward healers indicated resistance to integration from modern health care workers (Green and Makhubu, 1984). In reporting their findings, Green and Makhubu (1984) emphasise the importance of overcoming communication difficulties through strategies, which systematically explore resistant attitudes, and so develop traditional healing practices.

In confirmation of the aforementioned findings, Maake et al. (1998) reported traditional healers to support cooperative referral with primary health care workers for conditions that cannot be treated effectively through purely traditional intervention. Some traditional healers objected to certain practices of modern health care workers advising patients to discontinue traditional herbal treatment.

In recognition of both strengths and limitations Edwards (1986) supports the idea of health education for traditional healers. In lieu of providing such education, Edwards (1986) identifies the role of traditional healing organisations to include research on

integration as well as providing primary health care education to traditional healers. Organisations play an important role in facilitating integration through informed understanding on both the part of traditional and modern health care practitioners (Freeman, 1992).

Edwards (1986) found a large percentage of healers to support the idea of a traditional healer's organisation which they perceive as an opportunity for sharing their healing knowledge and learning from modern bio-medical practice. In representing traditional healers through a separate statutory body not affiliated to the Medical and Dental Council, organisations also serve to protect and legally control traditional healing activities by registration of healers (Maake, et al., 1998). In contrast to this formulation Edwards (1986) presents the formation of organisations as a way to promote rather than directly control indigenous healing practices.