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**The interface between Western mental health care and indigenous  
healing in South Africa: Xhosa psychiatric nurses' views on  
traditional healers.**

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## ABSTRACT

Xhosa psychiatric nurses stand unique at the interface between Western mental health care and indigenous healing in South Africa. They stem from a cultural history that is embedded within traditional health care discourses and yet are trained and work within a Western psychiatric model. In embodying the intersection between these two paradigms, they are faced with the challenge of making sense of such an amalgamation. These nurses' views are thus valuable in reflecting this intersection and illustrating many of the central concerns that surround it. This study explicates the views of these nurses toward traditional healers and their potential role in mental health care in South Africa. In addition, it illuminates some of the cultural dynamics at work amongst these subjects as they struggle to make sense of their unique cultural position. Using a questionnaire-based methodology, the views of Xhosa psychiatric nurses in a psychiatric hospital in the Eastern Cape, toward traditional healers and their role in mental-health care, were examined. The findings reveal that the vast majority of these nurses believe in traditional cosmology, involve themselves in traditional ritual practices and regularly visit traditional healers as patients. In suggesting ways in which indigenous healing and Western mental health care can work together, 75% of the nurses were in favour of a general referral system between the hospital and traditional healers, most (77%) agreed that certain patients would be better off being treated by both the hospital and traditional healers than they would if they were only being treated by the hospital alone, and 85% of the subjects agreed that patients who are already seeing traditional healers should check if psychiatric medication might help them. These findings indicate that these nurses operate across two healing systems which are at this point not conceptually compatible. This results in deep cultural tension for the nurses. In being entangled in the dialectical tension created in this context, the nurses manage the incongruencies in three general ways: a) Most, in one form or another, incorporate beliefs from both systems into an integrative model, b) some assimilate their cultural belief system into the Western mental health paradigm, throwing off their beliefs in traditional healing, and c) others remain ambivalent in the dialectic between traditional and Western health care discourses. Although this may suggest that these nurses reside within a cultural milieu that is somewhat unhealthy, at another level, in managing and containing the incompatibility between the two systems, these nurses ensure a space for on-going and healthy critique of the underlying assumptions involved in this health care malaise.

## INTRODUCTION

In South Africa, a highly institutionalised Western medical system coexists with traditional beliefs and practices concerning health. Today, health workers face the challenge of accommodating both satisfactorily (Hammond-Tooke, 1989). Since traditional healers of Africa play an important role in the management of mental disorders and in rendering mental health care in the black community, "any planning with regard to mental health services in South Africa has to take cognizance of their role" (Psychological Association of South Africa [PASA], 1989, p.49).

Xhosa psychiatric nurses stand unique in this arena at the interface between Western mental health care and indigenous healing. They stem from a cultural history that is embedded within traditional health care discourse, and yet are trained and work within a Western psychiatric model. In embodying the intersection between these two paradigms they are faced with the challenge of making sense of such an amalgamation. These nurses' views are thus valuable in reflecting this intersection and illustrating many of the central concerns that surround it. In this regard, this study explicates the views of these nurses toward traditional healers and their potential role in mental health care in South Africa. In addition, it illuminates some of the cultural dynamics at work amongst these subjects as they struggle to make sense of their unique cultural position.

Research of this kind may be said to fall within the field of 'cultural psychology' in that it studies "the way cultural traditions and social practices regulate, express, transform and permute the human psyche" and the way "psyche and culture... live together, require each other, and dynamically, dialectically, and jointly make each other up" (Shweder, 1990, p.1).

The thesis is structured in five chapters. Chapter 1 contains a literature review that examines previous research conducted in this area and explores central issues in this field of study. Chapter 2 describes in detail the methodology used in this research. Chapter 3 contains the basic descriptive statistics on the data (the

qualitative results may be found in Appendix B). Chapter 4 discusses the results in two main sections: Section 1 explicates the views of Xhosa psychiatric nurses toward traditional healing and its possible role in mental health care in South Africa. Section 2 interprets the nurses views in terms of the cultural and inter-cultural dynamics at play in this arena. Chapter 5 offers some conclusions as well as recommendations for further research.

## CHAPTER 1

### LITERATURE REVIEW

#### 1.1 Health care sectors

Kleinman (1980) identified three overlapping sectors of health care that occur in any complex society: the **popular** sector, the **folk** sector, and the **professional** sector. "Each sector has its own ways of explaining and treating ill-health, defining who is the healer and who is the patient, and specifying how healer and patient should interact in their therapeutic encounter" (Helman, 1990, p.55).

The **popular** sector is the lay, non-professional, non-specialist domain of the society, where ill-health is first recognised and defined, and health care activities are initiated. Self-treatment, advice or treatment by a relative, friend or family member are examples of popular sector health care (ibid., pp.55-58). The **folk** sector, especially large in non-Western societies, includes individuals who specialise in forms of healing which are either sacred or secular, or a mixture of the two. These healers are not part of the 'official' medical system, and occupy an intermediate position between the popular and professional sectors. Most folk healers share the basic cultural values, and world view, of the communities in which they live, including beliefs about the origin, significance and treatment of ill-health. Traditional healers in South Africa would fall into this category. The **professional** sector comprises the organized, legally sanctioned healing professions, such as modern Western scientific medicine, psychiatry and the *para*-medical professions such as psychologists and physiotherapists (ibid., p.63).

For those who utilise it, folk healing offers several advantages over modern scientific medicine, such as the frequent involvement of the family in diagnosis and treatment. However, "the relationships between folk and professional healers tend to be marked by mutual distrust and suspicion" (ibid., pp.58-63).

In the 1970s, the World Health Organization (WHO) Executive Board concluded that traditional healing systems have been shown to have intrinsic utility, should be promoted, and their potential developed for the wider use and benefit of humankind.

It is already the people's own health care system and is well accepted by them. It has certain advantages over imported systems of medicine in any setting because, as an integral part of the people's culture, it is particularly effective in solving certain cultural health problems. It has and does freely contribute to scientific and universal medicine (cited in Velimirovic, 1990, p. 52).

The WHO stressed the importance of determining the relevance of traditional healing to the primary health care needs of the various populations of a country, and offered support for research initiatives in the area (ibid., p.54).

In 1990, the African National Congress (ANC), in its debates over a future health care system, stated that "the role and function of traditional healers should be recognised as a social reality" and that extensive research was needed in this area (Tshabalala, 1990, p. 41). In 1994, in its National Health Plan, the ANC said the following:

Traditional healing will become an integral and recognised part of health care in South Africa. Consumers will be allowed to choose whom to consult for their health care, and legislation will be changed to facilitate controlled use of traditional practitioners (1994, p.55).

Freeman (1992b) stressed that the central question for mental-health care in South Africa was no longer whether or not there is a need for political, economic and social change, but rather what form reconstruction should take (p.1). It is in this regard that the question emerges as to what role traditional healers should play in mental-health care in South Africa (Freeman and Motsei, 1992).

Research has shown that as much as 80% of the South African population uses traditional healers (Hopa, Simbayi and DuToit, 1996; Freeman, 1992a), and that a large proportion of black psychiatric patients regularly consult with traditional healers (PASA, 1989, p.53). Ferrand (1984) found that 28% of patients in a Johannesburg psychiatric hospital had consulted with a traditional healer in the year prior to his study. Forty two per cent had taken traditional medicines during the same period and 54% said they would like to consult a traditional healer. Forty per cent said they would consult a medical doctor as well as a traditional healer. Olivier (1989), in a massive research project conducted through the Human Sciences Research Council, found

that in South Africa 24.8% of urban black people favour the faith healer as their first choice of professional with which to seek help when ill, and 24% favour the traditional healer (diviner and herbalist). Psychologists and psychiatrists scored lowest on the preference order with 4% and 3% respectively.

Ferrand (1984) concluded that urban Blacks have "generated an informal model of treatment which depends both on Western and traditional care" (p.780). Olivier (1989) concluded that traditional healers should be recognised as workers in the community in order to help people maintain their health (p.34).

This state of affairs is not unique to South Africa. In fact, very similar findings have been revealed in research done elsewhere in the world. Researchers in countries like India (Kapur, 1975), Thailand (Hiegel, 1984), Nigeria (Akighir, 1982), Indonesia (Salan and Marezki, 1983) and Swaziland (Green and Makhubu, 1984) all report that a large proportion of their populations regularly consult traditional healers, and often do so even when Western mental health services are freely available and easily accessible.

The reason for the continued role of traditional healers in black society lies primarily in the fact that they participate in the world view of their patients and have an intuitive understanding of the conflicts that are common in their culture (PASA, 1989, p.53). Kahn (1994) researched the question of what contribution traditional healers could make toward the understanding of the Xhosa patient in a psychiatric hospital. His study showed that the healers provide the knowledge required to access patients' cultural experiences and world-view, and that they offer patients a model through which to 'situate' their illness that is congruent with their own experience and belief system.

The diviners' assessment... grounded the patient's experience within her social situation. Their interaction... provided an understanding that in itself seemed to provide some relief from her condition.... It was the diviners' narrative that provided [the patient] with the tools to make sense of what was happening to her (Hirst, Cook and Kahn, 1996, p.19).

It is evident then that there already exist well entrenched multiple healing systems in South Africa and that "there is a need to find a way to accommodate the contributions made by traditional healers in the mental-health care delivery system" (PASA, 1989, p.55). It is significant to note that in 1996, traditional healers

affiliated with the newly formed Traditional Healers Organisation for Africa, are taking steps to launch their own medical aid scheme as they call on employers and the government for recognition (Jubasi, 1995, p.2).

## 1.2 The medical model and traditional healing

Those who practice modern scientific medicine form a group apart, with their own values, theories of disease, rules of behaviour, and organisation into a hierarchy of specialised roles. The medical profession can be seen as a healing subculture, with its own particular world view. The assumptions underlying "Western medical culture," determine what phenomena are looked at, verified, measured and treated. These structures form the conceptual model within which Western psychiatry operates.

The model of Western medicine is mainly directed toward discovering and quantifying physicochemical information about the patient, rather than less measurable social and emotional factors (Helman, 1984, p. 87).

Kleinman (1980) says that the modern Western doctor's view of clinical reality assumes biological concerns to be more basic, real, clinically significant, and interesting than psychological and socio-cultural issues. Ill-health, therefore, "is largely based on objectively demonstrable physical changes in the body's structure or function, which can be quantified by reference to 'normal' physiological measurements" (Helman, 1984, p. 88). Helman (1984) emphasises that this perspective does not include the social and psychological dimensions of ill-health, and the context in which it appears, which determine the *meaning* of the disease for individual patients, and for those around them.

Many authors (eg. Buhrmann 1977a, 1986; Hammond-Tooke, 1975, 1989; Helman, 1984; Kleinman, 1980; Schoeman, 1985; Schweitzer, 1977, 1978, 1985; Suryani and Jensen, 1992) agree that cultural factors are relevant not only to culture-bound syndromes but also to the common and usual mental disorders in societies and sub-cultures. Suryani and Jensen (1992) comment that "in spite of many publications by cross-cultural psychiatrists showing the importance of culture for Western psychiatry, and numerous studies of cross-cultural

psychiatry and mental health by medical anthropologists, there has been a relative under-emphasis of ethnopsychiatry in the United States and other Western cultures" (p. 301).

Hammond-Tooke (1989) explains that generally Western medical practitioners hold the notion that traditional black beliefs and practices are the result of a "primitive" or "savage" thought process which is so different from that of modern society that mutual understanding, let alone co-operation is ruled out from the start.

The emphasis on spirits, familiars (the *thikoloshe* is the prime image in South African white stereotypes of black "superstition"), medicines made from bizarre ingredients, the outlandish garb of some diviners and herbalists, the fear of witches - all these seem far removed from the clinical procedures and logical thought sequences of Western medicine (p. 17).

Kleinman (1980) asserts that it is generally acknowledged that "clinical phenomena are socially constituted" and that therefore the socio-cultural context should be one of the primary focuses in psychiatric diagnoses and treatment. Schoeman (1985) argues that

each culture has a fundamental project which integrates its diverse manifestations into a meaningful whole. This central theme is expressed in the commonly accepted worldview, which also provides the categories for the experience, interpretation and treatment of mental disorders. Consequently, psychic life should be interpreted in terms of the **cosmological context** of a patient and a diagnosis can only be made on the basis of sound knowledge of the beliefs and thought processes which are accepted by the culture to which the patient belongs.... Only then will one be able to distinguish if and when the person's experiences and behaviour deviate from the accepted norms and may thus be regarded as pathological (p.9).

Schweitzer (1979) suggests that "if psychiatric services are to be relevant in Southern Africa, they need to be responsive to the psychosocial problems associated with the person's experience of illness. This requires psychiatry to broaden its terms of reference beyond those presented by the 'disease' model of mental illness, so as to incorporate cultural dimensions in its application" (pp. 10-11).

The issue of cultural sensitivity in psychiatric diagnostics has been a topic of great interest among many mental health practitioners since the 1970s (Buhmann, 1977, 1986; Hammond-Tooke, 1975; Helman, 1984; Kleinman, 1980; Robertson and Kottler, 1993; Schweitzer, 1977, 1978; Thorpe, 1982).

The *Diagnostic and Statistical Manual of Mental Disorders, Third Edition Revised* (DSM-III-R) (American Psychiatric Association [APA], 1987), did not sufficiently address the issue of 'culture' in diagnostics

(Luckoff, Lu and Turner, 1992). Brody (1990) has pointed out that the term 'culture' was absent in the DSM-III and was mentioned only in passing in the DSM-III-R.

For example, the DSM-III-R glossary definition of delusion notes that "the belief is not one ordinarily accepted by other members of the person's culture or sub-culture" (p. 395). Yet neither the DSM-III-R, nor the training of mental health professionals addresses the cultural dimensions of religious belief required to make such a discrimination. Through its premature "biologism" contemporary psychiatry overlooks essential knowledge about the cultural basis of behaviour and organism-environment interactions (cited in Luckoff et al., 1992, p. 676).

The more recently updated *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (American Psychiatric Association [APA], 1994) (*the DSM IV*) seems to be more culturally sensitive than its predecessors in that it contains a "culture specific" section in its appendix. Included is a glossary of culture-bound syndromes (pp. 844-849) and an outline for cultural formulation in diagnosis (pp. 843-844) that considers the patients under the following headings:

- (1) Cultural identity of the individual.
- (2) Cultural explanations of the individual's illness.
- (3) Cultural factors related to psychosocial environment and levels of functioning.
- (4) Cultural elements of the relationship between the individual and the clinician.
- (5) Overall cultural assessment for diagnosis and care.

In the introduction the authors comment,

A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behaviour, belief or experience that are particular to the individual's culture. For example certain religious practices or beliefs (e.g., hearing or seeing a deceased relative during bereavement) may be misdiagnosed as manifestations of a Psychotic Disorder (p. xxiv).

They add that "it is hoped that these new features will increase sensitivity to variations in how mental disorders may be expressed in different cultures and will reduce the possible effect of unintended bias stemming from the clinician's own cultural background" (p. xxv).

Luckoff, Lu and Turner (1992) comment that "in theory, research, and practice, mental health professionals have tended to ignore or pathologise the religious and spiritual dimensions of life. This represents a type of cultural insensitivity toward individuals who have religious and spiritual experiences in both Western and non-Western cultures" (p. 673). "Religiosity and spirituality are linked to psychological well being, involve issues of love and relatedness, and provide a source of meaning and purpose in life" (p. 680). They suggest that "the

lack of sensitivity to the cultural forces of religion and spirituality reflects the ontological primacy that psychiatry assigns to biology over culture" (p. 675), and go further in saying that when the cultural context of the individual is considered, some problems that present with unusual religious or spiritual content are found to be free of psychopathology. These authors cite an example (Eisenbruch in *ibid.*, 1992) in which the "cultural bereavement" syndrome that occurs among Cambodian refugees, given their experience of being uprooted under violent circumstances, proves to be a "normal, constructive, existential response, rather than a psychiatric illness" (p. 9). This is so even though they often show signs of distress that are not due to acculturation difficulties, such as being visited by supernatural forces and yearning to complete obligations to the dead.

Schweitzer (1978) stresses that in Southern Africa, where the patient and clinician are often from different cultural backgrounds, the influence of culture on the conceptual understanding of illness and the response of people to illness is of particular concern.

Disease in the scientific paradigm of modern medicine, refers to malfunctioning and maladaptive biological and/or psychological structures. Problems of disease are articulated in an abstract, impersonal and technical idiom. The patient's experience of "illness", however, is characterised by the personal and social significance of the perceived discomfort, as well as the resulting life problems. The patient's experience is articulated concretely in personal terms relating to the existential experiences of the discomfort. In Southern Africa, cultural beliefs often mould the experience of illness in terms of personal causation and may include reference to witchcraft, or to ancestral spirits (Schweitzer, 1979, p. 4).

He adds that although the pharmacological and somatic therapies of psychiatry may serve to alleviate the unpleasantness associated with the "disease", successful adjustment or mental health is only achieved when the individual is able to resolve underlying conflicts and feel that s/he is a member of the community.

Thorpe (1982) asserts that due to the fact that many patients in state mental hospitals consult with and receive treatment from a variety of "cultural" healers (p. 1), a knowledge of the cultural factors leading to psychosis would improve the ability of the Western health practitioner in diagnosis and treatment as well as enhance rapport with the patient (p. 5).

Schweitzer (1979) says that it is a well recognised fact in psychotherapy that the person who is most knowledgeable about the patient's value system is best able to be of help and therefore there can be little doubt that the indigenous healer is, in the majority of cases, best able to understand his or her client's difficulties, needs, beliefs, goals, alternatives and expectations.

### 1.3 Traditional healers in South Africa

Historically, the indigenous healers of Southern Africa were agents of the chief. They made rain in times of drought, doctored the warriors before war, doctored the cultivated fields to ensure good harvest, smelt out witches in the tribe at the express command of the chief, and treated illness and misfortune in man and beast (Hirst, Cook and Kahn, 1996). More recently, an additional group of healers have emerged. These are the African faith healers who operate within a paradigm that is an amalgamation of traditional cosmology and Christianity (Hammond-Tooke, 1989).

Broadly speaking, there are three<sup>1</sup> types of traditional healers available to South African consumers (Freeman and Motsei, 1992). First the traditional doctor or *inyanga* (Zulu), *ichwele* (Xhosa). This is generally a male who uses herbs and medicines to treat disease. Second the *amagqira* (Xhosa), *isangoma* (Zulu), *dingaka* (Sotho) - the term "diviner" is often used to refer to these practitioners - operate within a traditional religious supernatural context and may act as a medium with the ancestral shades. Third the faith healers, the *umprofethi* and *umthandazi* (Zulu) or *umthandazeli* (Xhosa), integrate Christian ritual and traditional practices (Freeman and Motsei, 1992; Hammond-Tooke, 1989).

Until the recent changes in the South African constitution, the use of traditional healers in South Africa was officially outlawed (ibid.). The Health Act of 1974 forbade healers not registered with the South African Medical and Dental Council (SAMDC) from practicing or performing any act pertaining to the medical

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<sup>1</sup> Although these authors identify three main types of healers, there are two kinds of faith healers (*umprofethi* and *umthandazeli*). Therefore it is more accurate to say that there are four types of healers available to South African consumers. This will be discussed in greater detail later in the thesis.

profession. The exact number of traditional healers in South Africa and their utilisation is difficult to assess, but it has been suggested that there are over 150 000 practitioners available to the public (Freeman and Motsei, 1992, pp. 1183-1184).

#### 1.4 Traditional healing cosmology

In contrast to Cartesian metaphysics, which is foundational to Western medicine and psychiatry, traditional black South African cosmology does not separate health and ill-health into mental and physical aspects. This view is seen especially in terms of the relationship to the *izinyanya* (shades<sup>2</sup> or ancestors), who play an important role in daily life. For the traditional African, there is an interdependence of the living and the dead (Gumede, 1990, p.10). The shades are seen as friendly protectors, guides and mentors, on the whole, but their displeasure can easily become aroused and they can then cause illness, unhappiness and misfortune for the individual who has earned their wrath. One of the most feared effects of earning the ancestors' displeasure is that their protection is withdrawn and the individual and his/her family becomes exposed to the evils of witchcraft. For health, success and prosperity then, good and constant communication with the shades are vital (Buhrmann, 1986; Schweitzer, 1977, 1985).

The shades communicate with the living mostly through dreams, synchronistic events, lightning, wild animals, illness and misfortune. The living in return communicate with the shades through rituals and ceremonies, in which they ask forgiveness, give praise and offer gratitude (ibid.). Hammond-Tooke (cited in Schweitzer and Buhrmann, 1978) explains that those who subscribe to traditional cosmology operate within a personalised model in which the world is governed by supernatural forces which are regarded as causal agencies. The concept of shades and witches represent important opposing polarities as the prime explanatory causes of misfortune and illness.

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<sup>2</sup> The word *shade* is used in preference to ancestor, whereas ancestor refers to dead ascendants, those who subscribe to traditional Xhosa cosmology live in an undivided world, in which the shades/ancestors are a living presence (Schweitzer and Buhrmann, 1978, p.16).

## 1.5 Diviners

The *igqira* (Xhosa diviner) is directed by the spirit world of the shades and is expected to have supernatural powers arising from this contact. These powers are expected to be used to explain the causes of misfortune and illness to the effected parties and offer guidance as to how to appease the shades in order to restore harmony and/or health to the community/individual. In the sphere of social dynamics, s/he mixes freely within the community, often operating as an arbitrator and decision maker. Diviners are very aware of social order and group cohesion, in particular family harmony and group dependency and operate within multistranded social networks extending through and beyond the local community. Access to the shades instills the diviner's words with the power of the supernatural. They address the individual, but operate in terms of the group, the family very often present during consultation (Buhrmann, 1986; Cheetham and Griffiths, 1982; Hammond-Tooke, 1989; Hirst, 1992, 1993; Schweitzer, 1977).

The *amagqira* favour certain areas where they function best (as do Western practitioners) and these can be called their "consulting areas" which could correspond to Western consulting rooms. If the clientele visit them at their homestead the *vumisa* (consultation) is usually done in the main room which is also a favourite place of the ancestors. Otherwise it is done in the open, next to the cattle kraal or at the homes of the sick if they cannot travel (Buhrmann, 1986, p.32).

Buhrmann (1986) suggests the following to be the most common findings on the cause of illness, misfortune or business failures provided by the *amagqira*:

1. Simple customs or the requests of the ancestors, such as brewing of beer, were not fulfilled. This indicates lack of respect for the needs and wishes of the ancestors;
  2. Some particular custom was omitted;
  3. A ceremony was performed without due regard having been given to essential ritual details;
  4. There has been unethical behaviour of a member of the family or clan;
  5. Envy or jealousy of relatives and neighbours who have resorted to the use of witchcraft
- (pp. 33-34).

In the category of illnesses which are classified according to their concepts, the findings can be:

1. That the person is *pambana* (insane);

2. That she (usually a young girl) is suffering from *isiphoso* (the result of a young man's intense concentration on the girl of his desires);
3. The illness is *mafufunyana*<sup>3</sup>;
4. The person has *thwasa*<sup>4</sup> (pp. 33-34).

In cases of neglect or improper performance of ceremonies, treatment usually incorporates the performance of these rituals under the corrective eye of the diviner. Other treatments may include the use of herbs and remedies as well as various ritual therapies (Buhrmann, 1986; Hirst, 1993).

Diviners take on their role as healer through the process known as *thwasa* (Schweitzer and Buhrmann, 1978). *Thwasa* means "the emergence of something new" and refers to the experience of a "calling" to join the profession of the *amagqira*. This "calling" is associated with "sickness" and "disintegration" and is initiated by the shades who may visit the person in their dreams and/or through animals. Training begins when the affected individual and their family accept the "illness" as the desire of the shades that they follow their "calling" to become a "healer". They then become an initiate (*makwetha*) under the guidance of the *igqira*. This process will normally last for a period of three to five years during which training in participation, dance, dreams, songs and ceremonial rites occurs before the initiate graduates as a fully fledged *igqira* (ibid.).

Although *thwasa* has been described from a psychiatric perspective as representing schizophrenia, epileptic psychosis or a psychoneurotic condition (ibid.), Luckoff et al. (1992) show that anthropological accounts suggest that non-Western traditional cultures distinguish between serious mental illness and psychospiritual problems such as those experienced by "shamans-to-be" (p. 676). Grof and Grof (1989) collected case reports of persons experiencing difficulties when engaged in the intense practice of spiritual disciplines. They argue that such cases should not be diagnosed as mental disorders, but rather as "spiritual emergencies" that can result in long-term improvements in overall psychological well-being and functioning. In this regard, Howse

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<sup>3</sup> *Mafufunyana* is a condition associated with evil spirit possession (Edwards, 1984) and is characterized by "strange and unpredictable behaviour" (Buhrmann, 1986, p. 34-36).

<sup>4</sup> *Thwasa* means the "emergence of something new" and is a condition characterized by a "sickness" in which individuals experience a "calling" from the shades to become a healer (Schweitzer and Buhrmann, 1978).

(1993) found that the experience of *thwasa* among Xhosa shamans (*igqira*) could be easily recognised as a form of Grof's "spiritual emergency".

Hirst (1992) explains that "a characteristic feature of the traditionalist healing profession is that in the course of suffering an affliction or misfortune, the initiate diviner learns to assist others (ie. the clients of the instructing diviner) in managing their afflictions. Thus the diviner is well versed in the local idiom in which healing, helping and the associated problems present themselves" (p. 73).

Many authors (Buhrmann, 1977b, 1986; Cheetham and Griffiths, 1982; Hammond-Tooke, 1989; Hirst, 1990, 1992, 1993; Kruger, 1974; Ngubane, 1977; O'Connell, 1980; Schweitzer, 1977, 1979, 1985) have suggested that the diviner's practice parallels that of the Western psychotherapist and/or social worker.

A great deal of the informal helping that diviners provide to clients falls into the general category of manipulating social networks... the healer is, very often, in possession of highly specific and relative local knowledge which may take the average professional a lifetime to assimilate and master (Hirst, 1992, pp. 73-74).

Hirst questions the ethnographic literature that suggests that the diviner interprets the causation of illness and misfortune in terms of *either* ancestral wrath *or* witchcraft. He suggests that "rather than being a question of either/or, it is more a case of both/and... Diviners manipulate both ancestor and witch beliefs in divination in a mutually reinforcing way - as the carrot and the stick - to bring the phenomenological 'in itself' into relation with 'for others' and thereby to motivate people into good social relations with their fellows" (ibid.).

## 1.6 Traditional healers and the Christian patient

Du Toit (1980) suggests that among black South Africans, it is clear that membership in a Christian church does not necessarily imply a break with traditional supernatural beliefs or religious and ritual practices. Kahn (1994) reported that diviners often consult with Christian patients and that this does not necessarily create conflict.

The diviners explained that they did not have any problem with treating Christians. They said that most of their patients are Christians who have thrown off a lot of Xhosa tradition and that that was in fact the

problem. They suggested that healing often requires a return to traditional custom, and that 'it is actually very good for Christians to realise that there is a spiritual dimension that applies closer to them than Christianity. The ancestor cult says everything that Christianity does' (p.41).

Weiss suggests that psychopathology among blacks in South Africa may at times be in part a result of a need for people to return to practices of indigenous healing they may be abandoning (cited in Swartz, 1986, p.285). Sibisi (1975) gives the example of the notion of evil-spirit possession, explaining that it is used as an idiom to handle the anxieties associated with failure to cope with the changing way of life in colonial and post-colonial industrial society.

These authors thus support the contention that being a Christian in no way excludes the patient from worthwhile consultation with the diviners. Kahn (1994) illustrated this with a case in which a Christian patient was initially ambivalent about the diviners' assessment of her condition because of her religious beliefs, but after using the diviners' explanation to make sense of subsequent psychotic experiences, she wholeheartedly accepted their conclusions and agreed to perform the prescribed rituals.

Christianity made its way into South Africa with the arrival of European missionaries. However, because the mission churches effectively ignored African cosmology in their attempts to convert the populace, they failed to appreciate both the African experience of the power of evil manifested in witchcraft and sorcery, and therefore, the potential spiritual power at the churches' disposal to liberate and to heal (Gumede, 1990; Edwards, 1983). In other words, they failed to offer a belief system in which healing was of central concern. At the same time, the stark materialism and ideological positivism that underpinned much of Western medical therapy excluded areas of reality which were an essential part of the African experience of the world. As a result, both the mission churches and secular medicine often failed to deal effectively with many of the fundamental existential issues of African life (Edwards, 1983). Indigenous Africans were thus in need of a church that had healing as its central concern, and the Independent Separatist Churches of Southern Africa developed out of this need.

There are many such churches in operation today, examples being the African Faith Mission, the Apostolic Holy Church of Zion and the Al Zion Elected Church. Although functioning separately, these churches are often collectively referred to as the Zionist churches or the African Independent churches (Gumede, 1990). The cultural setting is one in which a traditionalist rural peasant society with a typically African cosmology and tribal social structure has been modified over several generations by the impact of participation in an urban consumer economy and by the religious and social values of Western Europe. While working in an urban Westernised milieu, they have retained some of the customs of the traditional, rural society, and much of its views on the nature of God, life and death, but have abandoned a great deal of its sharply differentiated role boundaries and authoritarian social structure. A number of traditional customs are still practiced (e.g., circumcision of males on entry into manhood, ritual brewing of beer and killing of goats and cocks for the shades, and 'bringing home the father' who has died, so that he becomes a shade) and these serve to keep alive traditional ways of thinking, but many have been modified in various ways to suit the urban environment (Edwards, 1983; West, 1975).

## 1.7 Faith healers

African faith healers (*abathandazeli* and *iprofethi*) operate from within 'African' church cosmology. As with the *amagqira* (diviners), these faith healers have a holistic understanding of health and sickness in which all levels of existence are held to be in dynamic mutual inter-relationship. The well-being and vitality of individuals and the community depend upon balanced and harmonious relations within and between these levels; illness and misfortune are the result of disharmony. Thus an individual must be in harmony with himself, with his body, with his family and the wider society, with the natural cosmos, with the world of ancestral shades and spirit powers, and with God (Edwards, 1983).

Edwards (1983) explains that African church communities comprise a major component of black African indigenised Christianity. She examined the Apostolic Holy Church in Zion (Zionist) in Grahamstown, Eastern

Cape, and found that among their main characteristics is a strong emphasis on healing and wholeness to the extent that the church functions primarily as a healing and welfare centre.

For town-dwellers who retain their rural roots and return there for ritual purposes, there can be an acute conflict between allegiance to rural kinsmen and identification with the values of the urban setting (Edwards, 1983). Economic and social hardship are difficult enough to contend with but when endured in a situation where there is no longer a coherent and integrated cultural system in terms of which experience may be construed, personal integration is at risk, and this is a further threat to health. Debility and psychosomatic symptoms flourish in an atmosphere of prolonged insecurity, anxiety and psychological conflict. In a group so prone to these conflicts, the concern is intensified and finds an effective expression in the practices of the Zionist churches (ibid.).

The churches work within a framework that results from a synthesis of Xhosa and Christian components within which both elements are undergoing dynamic transculturation (Edwards, 1983). Their Christianity is Christianity integrated into Xhosa cultural experience, where for instance, what is read in the Scriptures is construed with the logic and concepts inherent in the traditional African understanding of the nature of reality; simultaneously, however, the traditional African framework is being continuously assimilated to the Christian. The God of traditional Xhosa cosmology, known as *Qamata*, and the Christian God are both incorporated into the belief system. Edwards (1983) gives the following example of the way in which the integration of these two belief systems is operationalised:

The bitter-tasting aloe ash, traditionally symbolic of the Xhosa ancestral shades and used by Mr N [faith healer] as a cleansing agent in cases of 'Xhosa poisoning' he identifies with the 'bitter herbs' of Exodus 12:9; spirit-motivated 'dancing in a circle' (*ukugida*) is backed by (1) the prophecy of the pouring out of the spirit in Joel 2:26, (2) Revelation 17 where the great multitude were 'singing *around* the throne in the Temple' and (3) Jeremiah 31:4 where Israel 'shall go forth in the dance'; and the purification rite of 'taking to the water' is associated with the cleansing mentioned in Hebrews 10 especially verse 22 (Edwards, 1983, pp. 179-180).

In this mutual interpenetration of Xhosa and Christian elements, the reappearance of Xhosa features provides stability and cultural continuity, while the Christian aspects are understood to open the way to a greater sense

of the potential for wholeness in the midst of disharmony and threat, through the experience of forgiveness and renewal in Christ, and of living by the power of the Holy Spirit (Edwards, 1983).

The faith healer, like his traditional counterpart, the *igqira*, is perceived as an outstanding person having special powers of clairvoyance and healing which he offers to the service of the community. Through direct intuition, extrasensory perception, visions and dreams, he has access to knowledge in modes familiar to the Xhosa people.

*Abathandazi* stand in the same relation to people and their ancestors as the mediums in Israel stood between the Israelis and Jahweh. *Abathandazi* and *izangoma* form the link between the living and the dead (Gumede, 1990, p.184).

Since the community look to the healer to be a reservoir of, and channel for, spiritual power, his own personal stature is of prime importance (Edwards, 1983). As with diviners, Zionist faith healers are usually "called" to the profession, often in the form of a dream and/or sickness. After joining the church and being healed themselves, they undergo a period of apprenticeship during which they may rise through the ranks of the church hierarchy (ibid.).

Any member of the church is a prospective 'patient'. Anything wrong in a member's life, as well as what the Western clinician would call physical or mental illness, is expected to be presented for treatment at a healing service. However, Edwards (1983) emphasises that typically, Zionist churches attract a steady flow of sick people who are not Zionists. They may be members of mainline or other non-Zionist churches or else non-Christian of one sort or another; they come purely and simply for healing. When they have received treatment they may join the church, particularly when healing has been experienced. Alternatively they may revert to their original church membership, or simply drift away.

Edwards (1983) reports that out of 470 patients treated in a Grahamstown Zionist church nearly 50% were non-members. She explains that it is clear that the Zionist churches are functioning as a kind of healing center in a situation where healing at every level of existence is eagerly sought.

All kinds of illnesses and misfortunes are treated in the church, including paralysis, high blood pressure, digestive complaints, arthritis, fears, anxieties and emotional upsets, marital problems and possession by different kinds of evil spirits. Sickness may be:

- (1) *caused by the patient's sin/not caused by the patient's sin;*  
- Illness and misfortune are thus often construed as both the outcome and the evidence of sin and their purpose is to cause the sinner to turn back to God.
- (2) *sent/non-sent,*  
- Sent illnesses are those deliberately caused by witchcraft or sorcery. For example, someone jealous of the patient may have procured *umuthi* (harmful medicine) from an *ichwele* (herbalist) and put it secretly in the patient's food or somewhere where its influence would produce the desired harm. Non-sent illnesses are picked up by chance. They can be subdivided into (a) illnesses caused by viruses and bacteria which are accidentally picked up ('flying sicknesses'); and (b) illnesses caused by accidental contamination with the invisible tracks of evil agencies (*imikhondo*). In this way 'bad spirits' may inadvertently enter the body by being swallowed or trodden upon.
- (3) *strong/weak,*  
- Strong and weak illnesses are differentiated by whether the illness is difficult or easy to heal. Mr N informed me that the category of strong (difficult to heal) illnesses includes T.B., paralysis, epilepsy, and all diseases caused by evil spirits. His examples of weak illnesses include skin troubles, cancerous tumours, headache and diarrhoea.
- (4) *Xhosa/non-Xhosa.*  
- Xhosa illnesses are those that are regarded as caused by Xhosa witchcraft and sorcery and are not easily treatable, if at all, by Western medicine (e.g., *amafufunyana*). Non-Xhosa illnesses are those which could be treated by a Western doctor as well as by a Xhosa healer.

(Edwards, 1983, pp.182-184)

Healing always involves first the identification and removal of the cause of disharmony, and second, the restoration of order and balance. Generally, the healer will recognise both an empirical and a supernatural cause underlying a particular illness or misfortune (ibid.).

## 1.8 *Umprofethi vs umthandazeli*

Faith healers appear in two forms namely, *umprofethi* or *umthandazeli*. These two types of healers have both a different status and function. *Amaprofethi* tend to function more as prophets who foretell of droughts, diseases and other major events rather than as specific healers who tend to particular illnesses. The *amaprofethi* receive their revelations either from God or the spirits and are considered to be of higher status than the *abathandazeli*. *Amaprofethi* are also less common and are usually consulted when the person is in need of guidance, although this is not always the case. In addition, the *umprofethi* may work independently of

any formal African church. The *umthandazeli* deals more with the treatment of specific illnesses as discussed above (Gumede, 1990; Personal communication, F.N. Mthotywa and M. Sandi, March 1996).

## 1.9 Herbalists

The herbalist (*ixhwele* - Xhosa; *inyanga* - Zulu), unlike the diviner, is not mystically called to his/her profession (Hammond-Tooke, 1989, p.104). The herbalist, usually a man, decides to apprentice himself to an established herbalist who will accept him and learn his medicines. They learn the profession as an apprentice (*udibi*) and move up the rungs to eventually earn the rank of journeyman (*uhlaka-udibi*), thereafter being able to practice alone as a medicine man (*inyanga* - Zulu; *ixhwele* - Xhosa) (Gumede, 1990, pp.85-86).

Hammond-Tooke (1989) explains that herbalists resemble Western society's pharmacists and that they are masters of medicines and have knowledge of a vast array of plants roots and other substances. Although diviners have an extensive knowledge of medicines, and sometimes prescribe medicines for their patients, more generally, patient's will obtain their medicines from herbalists, and the diviner may himself suggest this<sup>5</sup> (Ngubane, 1977). Herbalists have standardised charges depending on the nature of the cured disease. However, much of their work involves dispensing protective medicines (Hammond-Tooke, 1989, p.114).

## 1.10 Witchcraft

As discussed earlier, the belief in witchcraft is of central concern in the cosmology of the traditional African. In this regard, Pool (1994) has criticised previous research into indigenous healing in Africa by pointing out that researchers often assume that to the African the 'supernatural' aspects of indigenous culture are somehow less real or less important than the 'natural' aspects. He explains that even when witchcraft is recognised as

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<sup>5</sup> It is interesting to note that Western doctors and pharmacists work under a similar system in which doctors sometimes dispense but usually refer patients to pharmacists with a prescription.

an important part of the medical system it is socialised; i.e. transformed from a 'supernatural' into a social phenomenon.

When people refer to witchcraft as a cause of illness then this is not interpreted literally, as meaning that witchcraft 'really' causes illness, but as a metaphorical statement about social conflicts and moral issues (pp.261-262).

Pool explains that this occurs because researchers subtly project the definitions and categories of the dominant biomedical hegemony onto indigenous culture, thereby coming up with the 'discovery' that "they really do have a medical system after all and that it basically looks just like ours: naturalistic, empirical, pragmatic, disease-orientated" (ibid.). This, he explains is no different to the surreptitious appropriation of indigenous discourse that certain scholars of religion perpetuated when they discovered that the pagans had believed in one 'High God' all along (p.262). It can therefore not be over emphasised that to the traditional African, witchcraft really does cause illness.

The belief in witchcraft is widespread in South Africa. Olivier (1989) found that 12.8% of the urban black population of South Africa believe that they are suffering from the effects of witchcraft (p.33). The word *thakatha* means to bewitch or to cast a spell, and *abathakathi* are living human beings who have learnt the secrets of nature and delve into 'black magic.' They can cause a wide range of illness and misfortune for their victims ranging from spells of bad luck to poisoning to evil spirit possession (*amafufunyana*) (Gumede, 1990; Edwards, 1984). The transitive Xhosa verb *ukathakata* means to practice evil in secret against another. Witch (*igqwirha*) and sorcerer (*umthakathi*) are both reputedly anti-social people in the community who are motivated by jealousy and envy (*umona*) to harm others, their property and/or livestock (Hirst, Cook and Kahn, 1996). Hirst et al. (1996) explain that when ordinary people encounter an unexpected difficulty or problem, they are quick to interpret all their ensuing illnesses as being the result of witchcraft perpetuated by a member of the opposing cliques, faction or group in their community. It is here that the traditional healer plays the role of detective, for his/her task is to root out the witch that is causing this misfortune. In addition, the healer's task often involves offering counter measures to the spells of the witch in the form of ritual and/or prayer through which the witch's attempts to create misfortune and illness are thwarted (Hammond-Tooke, 1989; Hirst et al., 1996).

Hammond-Tooke (1989) explains that the herbalist is sometimes guilty of 'turning' to witchcraft. Unlike the igqira and the faith healer (who are 'called' to their professions), the herbalist is not always interested in the healing powers of his pharmacopoeia, "to the extent that some of [his] medicines can be used to harm people and, indeed, may consist of pieces of human flesh, the position of the herbalist can be an ambiguous one. In unscrupulous hands the work can become anti-social and here the traditional healer is indeed in danger of operating as a witch" (pp.104-105). Nevertheless, any individual who is interested in anti-social practices may be drawn to practice *ukuthakatha*, for it is often a lucrative practice as individuals in the community who wish to bring harm to others (eg. employers and neighbours, etc.) will often approach a witch and pay them to bring misfortune/illness to the despised other (Hammond-Tooke, 1989).

### **1.11 Models for collaboration**

Swartz (1986) reviewed literature around the question of integration of traditional healing systems and Western mental-health care and found that along with trends elsewhere, and with WHO suggestions, there is considerable interest in the integration of these systems (p.289). Freeman and Motsei (1992) outline various options open to health planners for links between the modern health services and traditional healers. They offer three major alternatives.

#### **Incorporation**

This option suggests that traditional healers be integrated into health care systems as "first line" health practitioners, their function being primarily to provide services researched and designed within the scientific health care system.

In this model the traditional healer functions in a very similar role to that of a Village Health Worker. Both would be involved in preventing illness, promoting health and treating specific disorders - while referring others who require more specific care. It is also possible within this option that certain practices of traditional healers are regulated, and if found to be harmful by the scientific community, are strongly discouraged or even banned (*ibid.*, p. 1184).

Programmes of this kind are being run at the Madadeni hospital in Natal where *inyangas* and *sangomas* have regular meetings with doctors. "This has resulted in patients with chronic diseases receiving their regular (Western) medicines from the traditional healers in their district rather than having to make the trip to the hospital each time medication is needed" (ibid., p.1184).

### **Co-operation/collaboration**

"In this option, both the traditional and Western health systems remain essentially autonomous and each retains its own methods of operation and explanation; however practitioners from the two systems co-operate through the recognition of the importance and health value of the other" (ibid., 1992, p.1184).

This may take the form of "mutual referral" in which practitioners from both paradigms would recognise the efficacy of the other in treatment. This would enable the patient to receive medical treatment from a Western health worker and go to a traditional healer for cultural explanations for the causes of the illness. At present "dual treatment" regularly takes place in South Africa, where patients consult Western doctors for medication and then consult traditional healers within the community, or vice versa. Presently, neither practitioner may be aware that the patient is also consulting the other. (Ferrand, 1984, pp. 779-780; Freeman and Motsei, 1992, pp. 1184-1185).

### **Total integration**

This option involves a "blending" of the two systems, in that people seeking help would receive treatment in the form of a combination of the two. For example, in the case of TB,

a person may be informed of the existence of the tubercule bacillus, and be provided with a scientific explanation of how the disease has taken root in the biological system, but at the same time be informed why s/he of all people developed the problem with an explanation involving witchcraft, annoyance of the ancestors or other "supernatural" reasons (Freeman and Motsei, 1992, p. 1185).

## Exclusion

A number of arguments have been put forward as to why traditional healers should not be included in health care services. They range from outright rejection of the traditional healing system to practical problems of registration (Freeman and Motsei, 1992) as follows:

- (i) The 'harmful effects' of traditional medicine - examples often quoted were: medicinal enemas to treat and prevent childhood diarrhoea, inducing vomiting for patients with weak hearts or tuberculosis, traditional vaccinations done with an unclean razor and medicines given which are dangerous either by themselves or if taken at the same time as modern medicines;
- (ii) Its 'superstitious' nature in that the explanations fall outside the laws of natural science and are therefore 'simply wrong';
- (iii) On the other extreme, inclusion will mean a 'colonialisation' of traditional medicine and be a threat to traditional healers' status and remuneration.

## 1.12 Models from other countries

Suryani and Jensen (1992) examined the psychiatrist-traditional healer-patient relationship in clinical management of mental disorders in Bali where traditional healing is recognised as an official form of treatment, and found that the integrated practice of psychiatry and traditional healers works along several forms:

- 1) the traditional healer comes into the hospital to treat the patient along with the treatment by the psychiatrist;
- 2) the traditional healer refers the patient to a psychiatrist while maintaining continuity of therapy;
- 3) patients in the psychiatric hospital leave the hospital temporarily to attend purification ceremonies by a traditional healer;
- 4) the psychiatrist discusses with the patient the meaning of traditional healers' work, and refers the patient to traditional healers or allows the patient to see them while maintaining continuity of psychiatric treatment.

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(p. 303).

They conclude that, "most psychiatrists in Bali understand the theories and the work of *balian*s (diviners) and other traditional healers and tacitly accede to their care in conjunction with psychiatric care providing the two treatments do not overlap" (p. 313).

Zimbabwe adopted a policy of 'inclusion' after its independence in 1980. Freeman (1988) suggests that a crucial lesson for South Africa can be learned from Zimbabwe's experience that mental health is inextricably linked to socio-economic and political structures. He comments that the task of putting a model of this kind ('inclusion') into practice is extremely complex as it does not just depend on decisions within the discipline of mental health, but that "nonetheless, those working in the mental health field cannot sit back and wait to see what political and economic changes occur before planning mental health structures" (ibid., 1988, pp. 42).

### 1.13 Psychiatric nurses: The interface

Psychiatric nurses participate in both the psychological and medical aspects of the patient's treatment: taking histories, counselling, monitoring vital signs and administering medication (Altschul and Simpson, 1977). They are amongst the most flexible mental-health care workers. Doctors and psychiatrists focus primarily on the medical treatment of patients, psychologists and social workers on the psychological treatment, but nurses stretch across both. This flexibility suggests that nurses' views will reflect issues across the widest range of psychiatric treatments. As Barbee (1986) suggested, they are the pivotal group of biomedical practitioners and "must be involved in any programme that has the goal of collaboration among biomedical and ethnomedical practitioners" (p.75). Nurses are therefore a valuable point of entry into the debate around the implications for change with regard to the marriage of indigenous healing and Western mental health care.

More specifically, Xhosa psychiatric nurses come from the cultural background within which the traditional healing paradigm is embedded, and yet they are trained and work using a Western psychiatric model. In this sense their cultural experience can be expected to reflect both **folk** and **professional** sectors of health-care (Helman, 1990; Kleinman, 1980). They stem from a cultural history that follows a traditional health care

discourse and yet are trained and work within a Western psychiatric discourse. They embody the very interface between these two models and are faced with the dilemma of making sense of this amalgamation. Their views will thus reflect this intersection and house many of the central concerns that surround it.

Barbee (1986) asserts that because of the shared sociocultural system, black nurses are able to communicate and understand black patients in greater detail particularly with regard to traditional healers and the patients' experiences with them (p.77). She explains further that these nurses are at a "critical juncture" in the hospitals because it is they who interpret patients' complaints when other mental-health workers are unable to speak their language.

The nurses hold beliefs about health and illness from two domains, that of their culture and that of western biomedicine. This dual belief system, coupled with the nurses' presence at the critical juncture in the biomedical referral network, places the nurses in the role of primary 'broker' between traditional culture and biomedicine.... The position of broker is an exposed one because brokers must serve some of the interests of groups operating on both the community and national levels. In this exposed position brokers must cope with the conflicts raised by the collision of these interests.... When the two come into conflict, it is these nurses who act as buffers between the two systems. (Barbee, 1986, p.78).

In her study in Botswana, Barbee found that such nurses were "ensnared in a dialectic between traditional and biomedical beliefs" (p.79). The tensions created in this dialectic "serve to make the nurses extremely ambivalent about cooperating with traditional specialists" (ibid.). She found that the nurses mediate the basic contradictions created by the dialectical tensions in two ways. A small number choose to reject their culture in favour of the Western concepts of health and illness. These nurses do not believe they should cooperate with traditional specialists. However, the majority of nurses have adopted a position of peaceful coexistence. Thus most of them believe that there is some value in traditional medicine.

Xhosa psychiatric nurses' views on mental health-care therefore reflect issues across the full range of health-care treatment as well as embody the cultural issues that reflect the interface between the conflicting discourses that often surround the question of accommodation between Western mental-health care and indigenous healing. Their views will thus be central to the debate in this area and will shed light on the cultural dynamics at play here.

There are six types of psychiatric nurses operating in South Africa today. They can be divided into three groups: 1) registered nurses; 2) enrolled (staff) and auxiliary (assistant) nurses; and 3) student nurses. Registered nurses are ranked as Professional Nurse (PF), Senior Professional Nurse (SPN), Chief Professional Nurse (CPN) and Nursing Service Manager (NSM).

Registered nurses require a senior (Std. 10) school certificate to be admitted to training which takes four years to complete (South African Nursing Council, 1988). Enrolled and auxiliary nurses require a junior (Std. 8) certificate to be admitted to training. Training as an enrolled nurse takes two years to complete (South African Nursing Council, 1993a). Training as an auxiliary nurse takes one year to complete (South African Nursing Council, 1993b). Student nurses are nurses who are working in a psychiatric hospital as part of their general nursing training programme.

Marks (1994) explains that the division between registered nurses and enrolled/auxiliary nurses is very distinct. The four-year-trained nurses have become an increasingly different class and are often anxious to distance themselves from the enrolled and auxiliary nurses. She points out that the enrolled and auxiliary nurses have to belong to SANA (South African Nursing Association) and be bound by its laws but they have no voting rights and cannot serve as members of its regional or central boards (pp.201-205).

## CHAPTER 2

### METHODOLOGY

#### 2.1 Population and sampling

The population consisted of all Xhosa psychiatric nurses in a psychiatric hospital. The research used a single hospital as a case example rather than as a sample of all psychiatric hospitals. The hospital selected for this purpose was Fort England Psychiatric Hospital in Grahamstown, Eastern Province. It was selected because of its accessibility and because the hospital is well established with a large population of Xhosa psychiatric nurses (93). The sample unit was a Xhosa psychiatric nurse. Nurses were deemed to be Xhosa if they regarded themselves as mother-tongue Xhosa speakers. The sampling frame encompassed the entire population and therefore no sampling method was required.

#### 2.2 Research instrument

A quantitative methodology was used whereby data was gathered using a questionnaire designed for the purposes of the study. In addition, subjects were given the opportunity to write comments as they progressed through answering the questionnaire. This mechanism was introduced to illicit more qualitative responses from subjects in order to enhance and expand upon the statistical data.

Questionnaire construction followed the guidelines laid out by Nachmias and Nachmias (1987). There are 12 factual questions (p.254) in the questionnaire designed to illicit objective information concerning the respondent's background and some identifying data. The remaining 51 questions are closed-ended, and offer respondents a statement and then a set of answers, from which they are required to choose the one that most closely represents their views (p.256). Answer sets vary in form from two to six item rating scales. In addition, there are 13 open-ended items (p.257) that, as mentioned above, were installed to

provide subjects with an opportunity to elaborate on their responses to the closed-ended questions. Questions are loosely structured in sections that focus on various aspects of the research question and tend to follow a funnel sequence (p.265). Wording of statements for rating fluctuate in preference from one side of the debate to the other so as to avoid response sets (p.267).

The questionnaire (See Appendix A) was constructed in the following way:

- a. A rough draft was created by extracting central questions from literature in the field.
- b. The draft was discussed with Xhosa nurses at the hospital and reworked according to their feedback. As the questionnaire took shape it was repeatedly re-examined by different Xhosa nurses across age, rank and gender. This occurred approximately eight times. The nurses responses and recommendations were used to develop, modify and adapt the questionnaire so as to ensure that the research instrument was relevant, reliable and valid. Linguistic corrections in this regard involved identifying and correcting ambiguous or unclear language, rewording certain questions so as to make them more readable and checking for the correct use of Xhosa terminology where relevant. Content changes involved expanding the questionnaire to include several new questions, reformulating questions to tap for more particular and relevant information and erasing questions that were repetitive, highly ambiguous or problematic to answer.
- c. During this process the researcher repeatedly consulted relevant literature to confirm and develop upon the questionnaire according to the recommendations made by the nurses.
- d. The draft questionnaire was sent to an expert<sup>6</sup> in the field for his opinion and corrections. One further correction was made of a linguistic nature, and a valuable set of additional questions were inserted as per recommendations.
- e. The final draft was examined and discussed in a group with three Xhosa nurses to iron out any final ambiguities.

Throughout the above stages the researcher was guided by research he had previously conducted in this area (Kahn, 1994).

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<sup>6</sup> The expert in question here is Dr. Manton Hirst of the Kaffrarian Museum in King William's Town. He is both an anthropologist and qualified traditional healer and has conducted extensive research in this area.

The process of constructing the questionnaire may be seen as partly hermeneutic (Addison and Packer, 1989), in that whilst immersed in the process, the researcher moved back and forth between the data, the subjects and the literature constantly reflecting, analysing and reworking the instrument in a way that was more circular than linear. Hence the questionnaire was repeatedly reflected upon in a spiralling fashion as it became more and more refined. This process only halted once all the parties involved were in agreement that the instrument was both reliable and valid. This aspect of the methodology was, in part, following the "grounded theory approach" offered by Glaser and Strauss (1967) who explain that in such a methodology the research proceeds according to suggestions and interactions with the participants more so than it does from any strict preconceived framework. The resultant research process is therefore 'grounded' inside of the interaction with the subjects, and in this sense may be considered to be 'closer' to the subjects' experiences.

### 2.3 Data Collection

After permission was granted from the medical superintendent of the hospital, nursing staff were made aware of the research at a general meeting during which the Nursing Service Manager and a representative from the nurses Union offered their support for the study. Questionnaires were disseminated via the zone matrons so that all Xhosa nurses received one. However, only forty three questionnaires were returned via the same channel. Several nurses said that this poor response was due to the "high level of apathy amongst nursing staff because nobody has ever asked us what we think before, and nurses are not used to making their opinion known." It was also mentioned that some Xhosa nurses may not trust the research "because the questionnaire talks about traditional healers and some people are not sure of what the intention is because they are used to hearing that traditional healing and the hospital don't go nicely together." It was recommended that the researcher personally follow up on all the subjects enquiring as to who had not returned their questionnaires. Over a three week period the researcher managed to collect an additional 34 questionnaires totalling 77 from a population of 93. Most of the subjects who had not returned their questionnaires to the zone matrons told the researcher they had forgotten (although they had been

repeatedly reminded by the zone matrons) and approximately 15% said they had not received one in the first place (although they were systematically disseminated).

## 2.4 Data analysis

Once the data was gathered the questionnaires were numbered and the responses entered into a computer. The data was then subjected to statistical analysis. Responses to open-ended questions were collated under relevant headings and appear as Appendix C. This transcript was then summarised under headings, or coding categories (Nachmias and Nachmias, 1987, p.257), that were generated from the questionnaire. This summary appears as Appendix B. The researcher followed principles laid out by Taylor and Bogdan (1984) to reduce the raw data into more succinct language in the following way (pp.139-142):

- a. Data was read and reread to familiarise the researcher with the content.
- b. During this process the researcher kept track of emerging themes which were noted.
- c. These themes were organised under headings.
- d. The themes were then arranged into a more readable format that removed repetition and provided for a concise summary of the data.

From the above a discussion was developed that integrates the results with literature in the area (see Chapter 4). Further statistical and qualitative analysis also occurred at this stage. Finally, conclusions were drawn and recommendations for further research made (see Chapter 5).

## CHAPTER 3

### RESULTS

#### 3.1 Sample characteristics

At the time of conducting the research, there were 93 Xhosa psychiatric nurses working at Fort England Hospital. A total of 77 of these nurses returned completed questionnaires during the data collection, which translates into an 83% response total<sup>7</sup>. Thus it can be assured that the research data faithfully represents the views of the population in question.

Subjects' ages fall across a wide range (21 - 57 years) and are relatively evenly proportioned (20 - 30 years = 22%; 31 - 40 years = 46%; 41 - 57 years = 32%), suggesting a representative sample of views across the full spectrum of ages. Similarly, subjects' years of experience fall across a wide range (1 - 34 years) and are also relatively evenly proportioned (1 - 5 years = 41%; 6 - 15 years = 28%; 16 - 34 years = 31%). Nursing ranks are represented as follows: Auxiliary nurses (43%), professional nurses (21%), student nurses (11%), enrolled nurses (10%) and senior nursing staff (15%). These figures reflect the expected distribution of nursing ranks in a psychiatric hospital in South Africa. There are 15% more female subjects than males, reflecting the dominance of females in the nursing profession. Almost all (99%) of the subjects regard themselves as Christians, 39% of whom said they were 'very religious,' indicating that Christianity has strong predominance as far as religious affiliation is concerned amongst this population.

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<sup>7</sup> There is no reason to believe that there was any systematic reason for the remaining 17% of the subjects to not return their questionnaires.

### 3.2 Quantitative data

The following data tables reflect percentages and frequencies calculated from the results of the questionnaires. Please refer to the questionnaire in Appendix A where necessary for the exact wording of the questions. Further statistical analysis is reported in Chapter 4 during the discussion. Please note, unless otherwise specified, all figures in parentheses indicate number of subjects (n).

#### IDENTIFYING DATA

##### Q1: AGES

20 - 30 yrs	-	21.6%	(16)
31 - 40 yrs	-	46.0%	(34)
41 & older	-	32.4%	(24)
MEAN	=	37.9 yrs	
St. Deviation	=	8.7 yrs	
Range	=	21 - 57 yrs	

##### Q2: NURSES RANKS

Student	-	10.8%	(8)
Auxiliary	-	43.2%	(32)
Enrolled	-	9.5%	(7)
Professional	-	21.6%	(16)
SPN & CPN	-	14.9%	(11)

##### Q3: GENDER

Male	-	42.9%	(33)
Female	-	57.1%	(44)

##### Q4: YEARS OF WORK

1 - 5 yrs	-	41.3%	(31)
6 - 15 yrs	-	28.0%	(21)
16 + yrs	-	30.7%	(23)
MEAN	=	10.2 yrs	
St. Deviation	=	8.5 yrs	
Range	=	1 - 34 yrs	

#### RELIGIOUS BELIEFS

##### Q5: RELIGION

No religion	-	1.3%	(1)
Christian	-	98.7%	(75)
Other	-	0%	

##### Q6: RELIGIOUS COMMITMENT

Very religious	-	38.7%	(29)
Not so religious	-	61.3%	(46)

##### Q7: BELIEF IN QAMATA

Yes	-	70.3%	(52)
No	-	29.7%	(22)

### 3. WORK SATISFACTION

**Q8: DO YOU ENJOY NURSING?**

Yes	-	94.7%	(72)
No	-	5.3%	(4)

**Q9: WORK SATISFACTION**

Satisfied	-	58.7%	(44)
Could be better	-	32.0%	(24)
Not satisfied	-	9.3%	(7)

### VIEWS ON THE EFFECTIVENESS OF TRADITIONAL HEALERS AND PSYCHIATRIC INTERVENTIONS

**Q10: EFFECTIVENESS (Medication)**

Always	-	24.0%	(18)
Usually	-	29.3%	(22)
Sometimes	-	44.0%	(33)
Seldom	-	2.7%	(2)
Never	-	0%	

**Q11: EFFECTIVENESS (Psychotherapy)**

Always	-	20.3%	(15)
Usually	-	25.7%	(19)
Sometimes	-	50.0%	(37)
Seldom	-	4.1%	(3)
Never	-	0%	

**Q12: EFFECTIVENESS (*abathandazeli*)**

Always	-	8.2%	(6)
Usually	-	11.0%	(8)
Sometimes	-	56.2%	(41)
Seldom	-	17.8%	(13)
Never	-	6.8%	(5)

**Q13: EFFECTIVENESS (*amaxhwele*)**

Always	-	3.9%	(3)
Usually	-	11.8%	(9)
Sometimes	-	64.5%	(49)
Seldom	-	14.5%	(11)
Never	-	5.3%	(4)

**Q14: EFFECTIVENESS (*amagqira*)**

Always	-	2.6%	(2)
Usually	-	6.6%	(5)
Sometimes	-	71.1%	(54)
Seldom	-	13.2%	(10)
Never	-	6.6%	(5)

**Q15: EFFECTIVENESS (*amaprofethi*)**

Always	-	4.1%	(3)
Usually	-	6.8%	(5)
Sometimes	-	62.2%	(46)
Seldom	-	16.3%	(12)
Never	-	10.8%	(8)

**Q 12 - 15: AVERAGES**

Always	-	5%
Usually	-	9%
Sometimes	-	64%
Seldom	-	15%
Never	-	7%

**"TRADITIONAL HEALERS CAN PLAY A POSITIVE ROLE IN THE CARE OF THE MENTALLY ILL?"**

<b>Q16: POSITIVE ROLE (<i>amagqira</i>)</b>	<b>Q17: POSITIVE ROLE (<i>amaxhwele</i>)</b>
Agree - 61.3% (46)	Agree - 53.3% (40)
Disagree - 38.7% (29)	Disagree - 46.7% (35)
<b>Q18: POSITIVE ROLE (<i>abathandazeli</i>)</b>	<b>Q19: POSITIVE ROLE (<i>amaprofethi</i>)</b>
Agree - 61.3% (46)	Agree - 54.8% (40)
Disagree - 38.7% (29)	Disagree - 45.2% (33)

<b>Q16- 19: AVERAGES</b>	
Agree -	58%
Disagree -	42%

**"TRADITIONAL HEALERS SHOULD WORK IN HOSPITALS AS MEMBERS OF THE PSYCHIATRIC TEAM?"**

<b>Q20: HOSPITAL TEAM (<i>amagqira</i>)</b>	<b>Q21: HOSPITAL TEAM (<i>amaxhwele</i>)</b>
Agree - 60.8% (45)	Agree - 59.2% (45)
Disagree - 39.2% (29)	Disagree - 40.8% (31)
<b>Q22: HOSPITAL TEAM (<i>amaprofethi</i>)</b>	<b>Q23: HOSPITAL TEAM (<i>abathandazeli</i>)</b>
Agree - 46.6% (34)	Agree - 53.3% (40)
Disagree - 53.4% (39)	Disagree - 46.7% (35)

<b>Q20 - 23: AVERAGES</b>	
Agree -	55%
Disagree -	45%

**"TRADITIONAL HEALERS SHOULD HAVE CERTAIN PATIENTS REFERRED TO THEM AFTER DISCHARGE FROM HOSPITAL?"**

<b>Q24: DISCHARGE REFER (<i>amagqira</i>)</b>	<b>Q25: DISCHARGE REFER (<i>amaxhwele</i>)</b>
Agree - 60.5% (46)	Agree - 53.3% (40)
Disagree - 39.5% (30)	Disagree - 46.7% (35)
<b>Q26: DISCHARGE REFER (<i>amaprofethi</i>)</b>	<b>Q27: DISCHARGE REFER (<i>abathandazeli</i>)</b>
Agree - 53.4% (39)	Agree - 64.5% (49)
Disagree - 46.6% (34)	Disagree - 35.5% (27)

## Q24 -27: AVERAGES

Agree	-	58%
Disagree	-	42%

**"TRADITIONAL HEALERS SHOULD VISIT PSYCHIATRIC HOSPITALS TO CONSULT WITH CERTAIN PATIENTS?"**

Q28: VISIT HOSPITALS (*amagqira*)

Agree	-	62.7% (47)
Disagree	-	37.3% (28)

Q29: VISIT HOSPITALS (*amaprofethi*)

Agree	-	48.6% (35)
Disagree	-	51.4% (37)

Q30: VISIT HOSPITALS (*amaxhwele*)

Agree	-	53.4% (39)
Disagree	-	46.6% (34)

Q31: VISIT HOSPITALS (*abathandazeli*)

Agree	-	63.0% (46)
Disagree	-	37.0% (27)

## Q28-31: AVERAGES

Agree	-	57%
Disagree	-	43%

**"CERTAIN PATIENTS SHOULD VISIT TRADITIONAL HEALERS BEFORE COMING TO A PSYCHIATRIC HOSPITAL FOR HELP?"**

Q32: VISIT BEFORE HOSP. (*amaprofethi*)

Agree	-	46.5% (33)
Disagree	-	53.5% (38)

Q33: VISIT BEFORE HOSP. (*amagqira*)

Agree	-	47.3% (35)
Disagree	-	52.7% (39)

Q34: VISIT BEFORE HOSP. (*amaxhwele*)

Agree	-	39.7% (29)
Disagree	-	60.3% (44)

Q35: VISIT BEF. HOSP. (*abathandazeli*)

Agree	-	43.8% (32)
Disagree	-	56.2% (41)

## Q32 -35: AVERAGES

Agree	-	44%
Disagree	-	56%

**"A REFERRAL SYSTEM WITH THE HOSPITAL AND TRADITIONAL HEALERS SHOULD BE ESTABLISHED?"**

**Q36: REFERRAL SYSTEM**

Agree - 74.6% (53)  
Disagree- 25.4% (18)

**Q42: HOSP. + T.H.<sup>8</sup> vs HOSP.**

Agree - 76.7% (56)  
Disagree- 23.3% (17)

**Q43: JUST T.H. SOMETIMES, NO HOSP.**

Agree - 40.0% (30)  
Disagree- 60.0% (45)

**Q44: T.Hs' PATs SEE MEDS HELP**

Agree - 85.1% (63)  
Disagree- 14.9% (11)

**FUNCTIONS OF TRADITIONAL HEALERS IN PSYCHIATRIC HOSPITALS**

**Q37: T.Hs CAN HELP TAKE HISTORY**

Agree - 65.3% (49)  
Disagree- 34.7% (26)

**Q38: T.Hs CAN HELP DIAGNOSE**

Agree - 58.1% (43)  
Disagree- 41.9% (31)

**Q39: PATIENT'S BELIEVE T.Hs MORE**

Agree - 85.3% (64)  
Disagree- 14.7% (11)

**Q40: PTs SELF-DISCLOSE TO T.Hs**

Agree - 81.7% (58)  
Disagree- 18.3% (13)

**REASONS FOR REFERRAL TO TRADITIONAL HEALERS**

**Q41:**

**A. TROUBLE WITH FAMILY/MARRIAGE**

Yes - 27.4% (20)  
No - 72.6% (53)

**B. AMAFUFUNYANA (Spirit possession)**

Yes - 78.7% (59)  
No - 21.3% (16)

**C. PROBLEMS FROM CUSTOMS**

Yes - 83.8% (62)  
No - 16.2% (12)

**D. DIAGNOSE? (CULTURAL)**

Yes - 81.3% (61)  
No - 18.7% (14)

**E. THWASA (Healer's calling)**

Yes - 88.0% (66)  
No - 12.0% (9)

**F. ALCOHOL**

Yes - 21.3% (16)  
No - 78.7% (59)

**G. UKUTHAKATHA (Witchcraft)**

Yes - 75.3% (55)  
No - 24.7% (18)

**H. DRUGS**

Yes - 12.0% (9)  
No - 88.0% (66)

<sup>8</sup> T.H. = Traditional healers.

**I. SCHIZOPHRENIA**

Yes	-	28.4%	(21)
No	-	71.6%	(53)

**J. ANY KIND OF PROBLEM**

Yes	-	20.0%	(15)
No	-	80.0%	(60)

**"IF YOU DECIDED TO REFER A PATIENT TO A TRADITIONAL HEALER WOULD YOU DO IT IN SECRET?"****Q45: REFER TO T.H. IN SECRET**

Yes	-	25.7%	(19)
No	-	74.3%	(55)

**VIEWS ON THE INTEGRITY AND VALIDITY OF TRADITIONAL HEALERS****Q46: T.Hs TELL PATIENT'S TO STOP MEDS**

None of them	-	16.4%	(12)
Very few	-	15.1%	(11)
Some of them	-	43.8%	(32)
Most of them	-	23.3%	(17)
All of them	-	1.4%	(1)

**Q47: THs JUST WANT MONEY**

None of them	-	4.1%	(3)
Very few	-	12.3%	(9)
Some of them	-	41.1%	(30)
Most of them	-	26.0%	(19)
All of them	-	16.4%	(12)

**Q48: No. T.Hs NEVER FINISHED INITIATION**

None of them	-	2.7%	(2)
Very few	-	20.5%	(15)
Some of them	-	56.2%	(41)
Most of them	-	16.4%	(12)
All of them	-	4.1%	(3)

**Q49: T.Hs ONE CAN TRUSTED**

None of them	-	11.0%	(8)
Very few	-	38.4%	(28)
Some of them	-	39.7%	(29)
Most of them	-	11.0%	(8)
All of them	-	0%	

**Q50: No. T.Hs THAT CONSULT U-I-OF ALCOHOL**

None of them	-	19.4%	(14)
Very few	-	30.6%	(22)
Some of them	-	36.1%	(26)
Most of them	-	11.1%	(8)
All of them	-	2.8%	(2)

**Q51: No. OF T.Hs MENTALLY ILL**

None of them	-	19.4%	(14)
Very few	-	27.8%	(20)
Some of them	-	41.7%	(30)
Most of them	-	8.3%	(6)
All of them	-	2.8%	(2)

**Q52: T.Hs ARE GIVEN POWER BY ANCESTORS**

Agree	-	79.7%	(59)
Disagree	-	20.3%	(15)

**Q53: T.Hs - REGISTERED BOARD**

Agree	-	82.4%	(61)
Disagree-	-	17.6%	(13)

**Q54: MEDICAL AIDS SHOULD PAY T.Hs**

Agree	-	54.8%	(33)
Disagree	-	45.2%	(40)

## SUBJECTS' PERSONAL EXPERIENCES WITH TRADITIONAL HEALERS

### Q55: DO YOU PERFORM CUSTOMS?

Often	-	34.7%	(26)
Sometimes	-	54.7%	(41)
Never	-	10.7%	(8)

### Q56: FAMILY PERFORMS CUSTOMS?

Often	-	41.3%	(31)
Sometimes	-	48.0%	(36)
Never	-	10.7%	(8)

### Q57: NO CUSTOMS = HEALTH PROBS

Agree	-	74.0%	(54)
Disagree	-	26.0%	(19)

### Q58: TIMES CONSULTED *amagqira*.

Zero times	-	35.7%	(25)
1-2 times	-	31.4%	(22)
3+ times	-	32.9%	(23)
MEAN	=	2.6 times	
St. Deviation	=	4 times	
Range	=	0 - 20 times	

### Q59: TIMES CONSULTED *amaprofethi*.

Zero times	-	64.3%	(45)
1-2 times	-	22.9%	(16)
3+ times	-	12.9%	(9)
MEAN	=	1.1 times	
St. Deviation	=	2.3 times	
Range	=	0 - 10 times	

### Q60: TIMES CONSULTED *amaxhwele*.

Zero times	-	47.9%	(34)
1-2 times	-	26.8%	(19)
3+ times	-	25.4%	(18)
MEAN	=	2.3 times	
St. Deviation	=	4.2 times	
Range	=	0 - 20 times	

### Q61: TIMES CONSULTED *abathandazeli*.

Zero times	-	44.9%	(31)
1-2 times	-	34.8%	(24)
3+ times	-	20.3%	(14)
MEAN	=	1.7 times	
St. Deviation	=	2.7 times	
Range	=	0 - 15 times	

### Q58-61: AVERAGES

Subjects that never consulted any healer	-	25.3%	(19)
Subjects that consulted any healer once or more	-	74.7%	(56)
MEAN	=	2 times	
St. Deviation	=	3.3 times	
Range	=	0 - 20 times	

## "WOULD YOU CONSULT WITH A TRADITIONAL HEALER NOW IF YOU HAD A RELEVANT PROBLEM?"

### Q62: WOULD YOU VISIT A T.H. NOW?

Yes	-	63.9%	(46)
No	-	36.1%	(26)

**"DO YOU THINK THAT YOUR TRAINING IN PSYCHIATRIC NURSING HAS MADE YOU DOUBTFUL ABOUT THE VALUE OF TRADITIONAL HEALERS AND THEIR MEDICINES?"**

**Q63: HAS NURSING MADE YOU DOUBT T.H.?**

Yes	-	36.8%	(25)
No	-	63.2%	(43)

**NOTE:** Please consult Appendix B for a summary of the qualitative comments made by subjects on their questionnaires.



## **CHAPTER 4**

### **DISCUSSION**

#### **INTRODUCTION**

The following discussion is comprised of two main sections<sup>9</sup>. Section one explicates in detail the views of Xhosa psychiatric nurses towards traditional healing and its possible role in mental health care in South Africa. Section two discusses the nurses' views in terms of cultural and inter-cultural dynamics.

#### **SECTION 1: VIEWS ON TRADITIONAL HEALING**

##### **4.1 Subjects' personal experiences with traditional healers**

Of the 77 subjects in this study, 75% have consulted a traditional healer at least once before in their lives. National statistics indicate that approximately 80% of South Africa's population makes use of traditional healers (Gumede, 1990; Hopa, Simbayi and du Toit, 1996). This suggests that Xhosa psychiatric nurses use traditional healers as frequently as do the general population of South Africa. In addition, 64% of the subjects said they would consult with a traditional healer now if they had a relevant problem. This suggests that approximately 8 out of 10 subjects who consulted a healer in the past would do so again.

Such statistics reflect a high level of personal participation in the traditional healing system amongst the subjects, and indicate that even though the subjects are trained and work within a Western health paradigm

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<sup>9</sup> In discussing these sections, this chapter offers further interpretation of the results.

they readily make use of the indigenous healing system. The following graph (Figure 1) illustrates the number of consultations the subjects have had with each of the four main types of traditional healers.

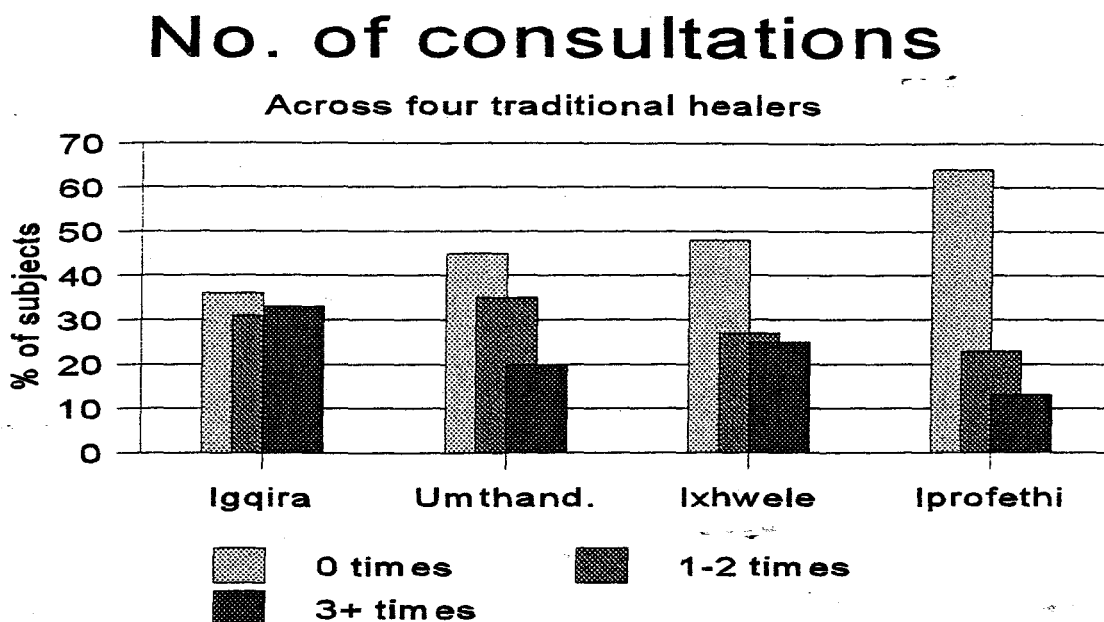


FIGURE 1

The average amount of visits to traditional healers in general was 8. The average amount of visits to any one type of healer was 2, and at least one third of all the subjects have visited any one type of traditional healer more than three times. The most frequently visited traditional healer is the *igqira* with a mean of 2.6 visits per subject, followed by the *ixhwele* with a mean of 2.3, and then the *umthandazeli* with a mean of 1.7. The *iprofethi* has the least amount of consultations with an average of only 1.1. The graph illustrates that although the *umthandazeli* does not have the highest average overall in terms of visits, this healer has the largest percentage of subjects in the '1-2 visits' category (35%). This suggests that a comparatively large percentage of subjects visit this type of healer, but they tend not to return for further consultations. The *igqira* is clearly the most successful of the four healers, with the highest mean amount of consultations and

high percentages of subjects in the '1-2 visits' and '3+ visits' range (31% & 33%) as well as the lowest percentage of subjects in the 'zero visits' range (36%). The *ichwele*, although having the second largest mean amount of visits and a large percentage of subjects in the '3+ visits' category (25%), has a comparatively high percentage of subjects in the 'zero visits' category, and the second lowest percentage in the '1-2 visits' category. This indicates that a comparatively small proportion of subjects consult with this healer, but unlike the *umthandazeli*, those that do tend to make very frequent visits.

In terms of traditional beliefs and practices amongst the subjects, 70% said they believe in *Qamata* (God in traditional Xhosa cosmology), 89% perform traditional customs either 'sometimes' (54%) or 'often' (35%), and 74% believe that Xhosa people who don't perform traditional customs get health problems. In addition, 80% of the subjects agreed with the statement: "Traditional healers are given power to heal by the ancestors." It is therefore evident that even though 99% of the subjects consider themselves to be Christians, the vast majority not only believe in traditional Xhosa cosmology but involve themselves in traditional ritual practices, believe in traditional healing and visit traditional healers as patients. This trend is not unusual. Du Toit (1980) explains that amongst South African blacks, "neither urban residence nor membership in a Christian church necessarily implies a break with traditional supernatural beliefs or religious and ritual practices" (p.21). He found that while more than 90% of urban blacks in a satellite city in South Africa were members of Christian churches, almost half of them had performed traditional rituals for health and success, and as many indicated that they would consult with traditional healers in times of crisis.

#### 4.2 Views on the efficacy of traditional healers

It was found that although nurses believe most strongly in the effectiveness of psychiatric medication followed by psychotherapy, traditional healing methods are not far behind. As much as 78% of the subjects agreed that traditional healing is at least 'sometimes' effective. Figure 2 illustrates these results.

# Traditional Healing

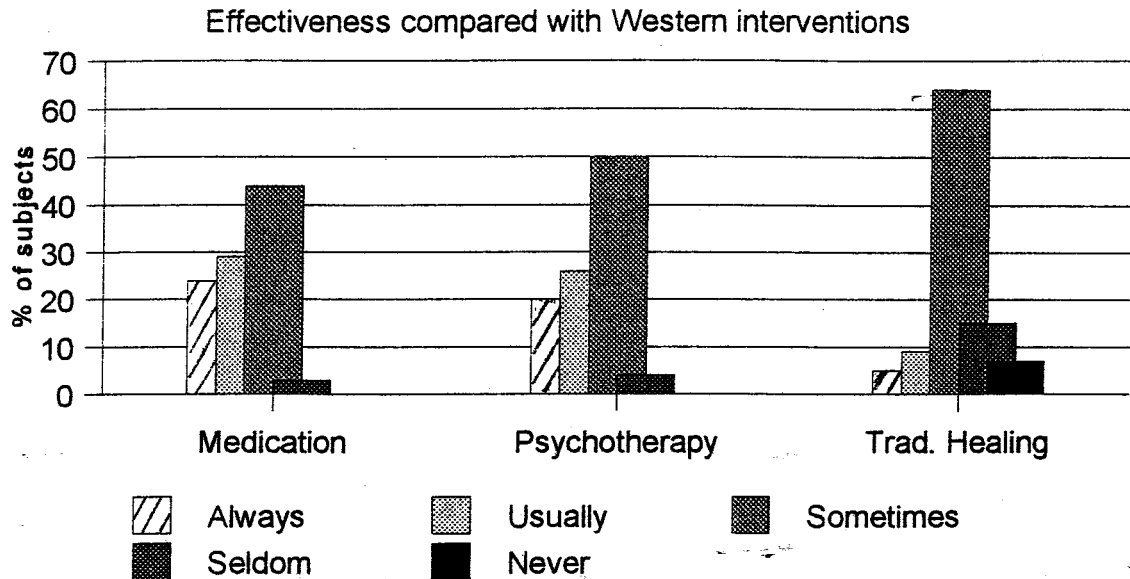


FIGURE 2

These findings are in keeping with previous research conducted in the area of indigenous healing efficacy. Although Swartz (1987) notes that research into the effectiveness of indigenous healing has proved methodologically problematic<sup>10</sup>, he points out that only one of six authors he reviewed suggests that indigenous healing may at times be clinically useless or worse. Many authors (Buhrmann, 1986; Hiegel, 1984; Hirst, 1992; Kahn, 1994; Luckoff et al., 1992; Salan and Maretzki, 1983; Schweitzer, 1977, 1979) imply or state that traditional healing methods may at times be as effective as is Western psychiatry in the treatment of certain conditions. Swartz (1987) reported that there are many clinical accounts of doctors

<sup>10</sup> It is difficult to determine at what level 'helpfulness' can be seen to exist as symptom relief is not necessarily the only level at which healers can effect improvement, as the social and psychological dynamics of the symptoms themselves also play a central role in the experience of the illness (Swartz, 1987).

failing to cure and then traditional healers succeeding. However, reports of failure on the part of healers but subsequent success of "Western" doctors are extremely rare (p.287). Robbertze (1976) went so far as to rate the therapeutic efficacy of indigenous healers as being superior to that of psychiatrists, psychotherapists or medical doctors in the treatment of certain conditions (in Holdstock, 1979, p.120).

The following table illustrates how subjects rated the effectiveness of different types of traditional healers:

**TABLE 1:**  
**EFFECTIVENESS RATINGS OF THE FOUR MAJOR TYPES OF TRADITIONAL HEALERS**

	<b>Always/Usually</b>	<b>Sometimes</b>	<b>Seldom/Never</b>
<i>Umthandazeli</i>	19% (14)	56% (41)	25% (18)
<i>ixhwele</i>	16% (12)	65% (49)	19% (15)
<i>iprofethi</i>	11% (8)	62% (46)	27% (20)
<i>Igqira</i>	9% (7)	71% (54)	20% (15)

Table 1 illustrates that all four healers received the greatest percentage of responses in the 'sometimes' effective category. This indicates that, among the majority of subjects, no particular healer is regarded as significantly more effective than any other. However, further analysis of the data reveals that certain types of healers are more consistently regarded as effective than are others.

The healer who received the highest percentage in the 'always/usually' effective category was the *umthandazeli* with 19%, however a very large percentage of subjects (25%) judged this healer to be ineffective, indicating that opinion as to the efficacy of the *umthandazeli* is spread across the widest spectrum. The *igqira* was most consistently regarded as being 'sometimes' effective (71%) and although the least amount of subjects (9%) rated the *igqira* as 'usually/always' effective, the *igqira* (with the *ixhwele*) received the lowest percentage in the 'seldom/never' effective category. This suggests that the *igqira* is widely regarded as an effective healer in at least some cases. The *iprofethi* has the largest percentage in the

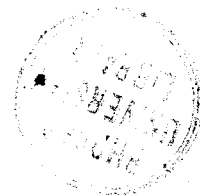
'seldom/never' effective range with 11% of the subjects indicating 'never' effective and 16% indicating 'seldom' effective. The *iprofethi* also had the second lowest percentages in the 'sometimes' and the 'usually/always' effective ranges. This suggests that this healer is generally regarded as having the lowest efficacy amongst the four healers. Overall, the *ixhwele* was most consistently regarded as effective, receiving high percentages in the 'always,' 'usually' and 'sometimes' effective categories and (with the *igqira*) the lowest percentage in the 'seldom' and 'never' effective categories.

In summary then, although there are no significant differences in views with regard to efficacy across healers, analysis reveals that the *ixhwele* is regarded as the most effective of the four healers, followed by the *igqira* and then the *iprofethi*. The *umthandazeli* had an erratic spread of responses, indicating that there is no consistent opinion with regard to the efficacy of this healer. It may be speculated that because the *umthandazeli* and *iprofethi* stem from the more recent development of the independent African churches, their efficacy has not as yet been established. This is as apposed to the *igqira* and *ixhwele* who can trace their history back to the earliest indigenous communities in South Africa. It might also be argued that because the *umthandazeli* and *iprofethi* rely upon a precariously amalgamated cultural matrix (Christianity merged with indigenous cosmology) their healing system's efficacy is jeopardized.

### 4.3 Traditional healing and psychotherapy

It is interesting to note that a chi-square statistical test (P-Value = 0.0339; D.F. = 6), reveals a significant relationship between subjects' beliefs about the effectiveness of traditional healers and their beliefs about the effectiveness of psychotherapy.

Of those subjects who generally viewed traditional healing as 'usually' effective, 50% said psychotherapy was 'always' effective, 25% said 'usually' and 25% said 'sometimes.' However, of those subjects that



generally viewed traditional healing as 'seldom' effective, 13% also said psychotherapy was 'seldom' effective, 53% said 'sometimes,' 13% said 'usually' and 20% said 'always.'

These statistics indicate that there is a tendency for those subjects who generally believe that traditional healing is effective to also believe that psychotherapy is effective, and vice versa. It might be argued then that subjects who believe in the effectiveness of psychological interventions recognise that traditional healers utilise similar mechanisms in their healing system and that they are therefore also potentially as effective as are psychotherapists<sup>11</sup>.

Hirst (1993), comparing two case studies, discusses the divinatory practices of the *igqira* and suggests that "there is inescapable evidence to support the radical conclusion that divination is an indigenous form of Freudian psychoanalysis" (p. 97). He goes on to explain that the healer is "all things to all people; a mirror in which people can readily see the familiar outline of their own subjective refractions."

It was Freud's original discovery that the person is constituted through the symbolic mediation of the self and the other that occurs dialectically in discourse.... By virtue of calling and training, the diviner is spokesman of the shades whose mystical authority takes the form of a supreme social sanction equivalent to law. Through a connected flow of speech, the diviner immediately begins to reflect a "virtual image" of the client.... However the paradox is that the "virtual image" of the self articulated rhetorically by the diviner from the position of the other bears the same tenuous relation to reality as a visual illusion.... This is why conventionally the client intervenes, agrees or disagrees with the diviner and even raises further pertinent questions. Thus instead of engaging the resistance and transference of the client, the diviner immediately triggers the counter transference and provokes the client to work through the truth of his own resistances (p. 110).

#### 4.4 Healing efficacy and playing a positive role in mental health care

It is important to note that although 78% of the subjects tended to express a favourable opinion with regard to the effectiveness of traditional healers, only 58% agreed that they had a positive role to play in the care

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<sup>11</sup> Admittedly however, 20% of the subjects that did not believe in the effectiveness of traditional healing believed that psychotherapy was 'always' effective.

of the mentally ill<sup>12</sup>. This suggests that although Xhosa nurses generally feel that traditional healing may be an effective form of treatment, the same nurses do not necessarily believe that traditional healers have a positive role to play in the care of the mentally ill. This position is perhaps due to the wide range of concerns that subjects hold with regard to the integrity of individual traditional healers, and the possible place traditional healers may take in the established mental health care system.

#### 4.5 Views on the integrity of traditional healers

Most subjects (78%) believe that only 'some' or 'very few' traditional healers can be trusted. This result may at first glance seem incongruent with the predominantly positive views toward traditional healers discussed earlier. However, on further analysis it appears that subjects have a number of concerns with regard to identifying legitimate healers.

Several subjects explained that they were concerned that there are traditional healers in practice who have not finished their initiation process (*thwasa*), and that this makes them dangerous because they are not fully trained. Fifty-six percent of subjects said that at least 'some' healers had not completed their initiation, 16% said 'most' had not and only 21% said 'very few' had not. Some subjects commented that there are healers in practice that never entered the initiation process at all and are practicing without training "just for money." Subjects added that such healers sometimes abuse alcohol and may be mentally ill themselves. Several subjects indicated that healers who had in fact finished their initiation could be trusted, but that it was

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<sup>12</sup> It is interesting to note that herbalists (*ixhwele*) are strongly favoured by males to play a positive role in the care of the mentally ill on a chi-square test (P-Value = 0.0054): Males = 76% in favour; Females = 36% in favour. No reason could be found for this trend.

difficult to establish which of these healers had done so because there is no widely accepted certification process<sup>13</sup>, like there is for Western health care professionals.

Such concerns are confirmed in the literature on this subject. Schweitzer (1979) points out that there are no formal means of distinguishing talented healers from charlatans, because "the traditional method of recognition whereby the name of truly qualified healers spreads by word of mouth, is no longer effective" due to "the breakdown of the traditional system... caused by the effects of industrialization." He explains that this results in "many semi and unqualified practitioners parading as qualified healers and bringing the profession into disrepute" (p. 10). Hopa, Simbayi and du Toit (1996) produced a survey of health professionals' attitudes toward traditional healers and found that "the high rate of charlatanism" amongst traditional healers was one of the primary reasons underpinning many of the negative attitudes toward traditional healers in general (p.18).

In view of these concerns, 82% of the subjects agreed with the statement "Traditional healers should be registered with a government board that has strict rules." Hopa et al. (1996) found similar support for a registering body in their research among other health care professionals, and Green and Makhubu (1984) found in a survey amongst traditional healers in nearby Swaziland that "healers themselves are favourably inclined toward registration." (p.1076).

On the subject of whether or not healers consult under the influence of alcohol, there seemed to be a wide range of opinion. Table 2 shows how the subjects responded to the question: "How many traditional healers consult under the influence of alcohol?"

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<sup>13</sup> Some subjects indicated that certificates from individual healers associations in operation at present would be sufficient for them to accept that the healer had integrity.

TABLE 2

## TRADITIONAL HEALERS THAT CONSULT UNDER THE INFLUENCE OF ALCOHOL

	None	V.few	Some	Most	All
<i>% of subjects</i>	19%	31%	36%	11%	3%

Table 2 illustrates that although responses tend to centre around the 'very few' and 'some' healers category, there is no strong trend with regard to subjects views on this issue. However, deeper statistical analysis offers some explanation as to why this may be so. A chi-square test revealed that subjects who believe that healers consult under the influence of alcohol do not necessarily feel that this is a bad thing. This view became evident when subjects responses to the question of how many healers consult under the influence of alcohol was compared with their views on the effectiveness of traditional healers. The chi-square test revealed that with a P-Value of 0.0063 (Value = 21.338; D.F. = 8), 17% of the subjects that rated traditional healers as 'always' or 'usually' effective also said that 'all' healers consult under the influence of alcohol. This is particularly significant in view of the fact that there were no other subjects that said 'all' healers consult under the influence of alcohol. This strongly indicates that there is a large group of subjects who believe that healers are very effective and at the same time believe that all of them consult under the influence of alcohol. Analysis of subjects qualitative responses confirmed this statistical trend. In their comments, subjects explained that "healers consult under the influence of alcohol because they believe that all the information from the ancestors comes when they have had a few drinks," and "some traditional healers believe they derive power and magic from alcohol." One subject explained that "in most traditional rituals, traditional African beer (*umqomboti*) is used.... It is believed that by brewing you are not just giving to the people but to the ancestors." This explanation is widely confirmed in academic literature which explains that traditional African beer is often used in ritual practices as part of the healing system and that it forms an important part of some traditional

ceremonies (Hammond-tooke, 1989; Hirst, 1990). One subject explained that traditional healers "have a moral code which does not allow them to abuse alcohol." However they do use beer in the form of *umqomboti* as part of some customs<sup>14</sup>.

As to whether or not healers suffer from mental illness themselves, 42% of the subjects said 'some' do, 28% said 'very few' do, 19% said 'none', 8% said 'most' and 3% said 'all'. Several subjects said that healers are sometimes reticent to admit they are mentally ill and may make excuses for their behaviour such as "Its not me. It's the *amakhosi* (spirits) through me." It was explained that sometimes healers do not finish their initiation or are not properly trained and therefore continue to suffer the effects of *thwasa*. It was also suggested that some traditional healers are psychiatric patients who try to deny their illness by calling it *thwasa*, such people were said to never actually qualify but practice as healers anyway. Other subjects said that the healers they have come into contact with have never showed any signs of mental illness, and that in their opinion, healers did not suffer from mental illness more so than any other people, as one subject put it: "Traditional healers are people just like any human beings so they also are prone to any kind of sickness, irrespective of their healing powers."

In research that explores the issue of mental illness among traditional healers, the condition known as *thwasa* (the call to be a healer) has been described as schizophrenia, epileptic psychosis or a psychoneurotic condition (Schweitzer and Buhrmann, 1978). Researchers have pointed out that "a characteristic feature of the traditionalist healing profession is that in the course of suffering an affliction or misfortune, the initiate learns to assist others in managing their afflictions" (Hirst, 1992, p.73). In this sense, mental illness among traditional healers cannot be considered to be uncommon.

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<sup>14</sup> It must be noted that there were other subjects who felt quite differently. One subject said "there should be a law prohibiting traditional healers from consulting while under the influence of alcohol." Another said that "those who consult with their patients under the influence of alcohol cannot be trusted because discipline and good conduct are taught in their initiation period."

Statistical tests reveal that certain factors influence Xhosa nurses decisions about the integrity of traditional healers. With a P-Value of 0.0001 (Value = 22.054; D.F = 3), a chi-square test revealed a significant relationship between beliefs about how many traditional healers can be trusted and belief in *Qamata* (God in traditional Xhosa cosmology). Table 3 illustrates the relationship:

TABLE 3

## TRADITIONAL HEALERS THAT CAN BE TRUSTED

		None	V.few	Some	Most	
<i>Belief in</i>	Yes	0%	44%	44%	12%	(n = 52)
<i>Qamata</i>	No	38%	19%	33%	10%	(n = 22)

Table 3 illustrates that of the subjects who said they don't believe in *Qamata*, 38% (as opposed to 0% who do believe) said that no traditional healers can be trusted. This indicates that there is a strong tendency for those subjects who don't believe in *Qamata* to believe that no traditional healers at all can be trusted. The remaining categories (v.few; some; most) do not reveal as significant a discrepancy between belief in *Qamata* and trust in healers. This is probably because these categories describe attitudes of a more moderate nature as opposed to the strong attitude that is required for the 'none' category ie. the other categories are likely to receive responses from a wider spectrum of subjects representing different belief sets, particularly if one considers the vast number of concerns these subjects hold with regard to the integrity of traditional healers in general. Such a tendency suggests therefore that strongly negative views with regard to the integrity of traditional healers are associated with subjects who do not believe in Xhosa cosmology. This hypothesis seems to be confirmed in another chi-square test (P-Value = 0.0002; Value = 19.510; D.F = 3) which revealed that subjects who have consulted with traditional healers in the past believe they can be trusted more than do subjects who have never consulted a healer. Table 4 illustrates this relationship:

TABLE 4

## TRADITIONAL HEALERS THAT CAN BE TRUSTED

		None	V.few	Some	Most	
<i>No. of</i>	Nil	39%	22%	33%	7%	(n = 19)
<i>Visits</i>	1+	2%	44%	42%	13%	(n = 56)

Table 4 reveals that of the subjects who have never visited a traditional healer, 39% (as opposed to 2%) believe that no traditional healers can be trusted (the general pattern is again similar to that of Table 3 in which other categories do not reveal as strong a discrepancy). This confirms that there is a tendency for those subjects who do not engage in Xhosa cosmology and its practice to have a strongly negative view toward the integrity of traditional healers. It should be noted however, that in both cases (Table 3 and 4), there was a large percentage of subjects (62% and 61% respectively) who did not respond with absolutely negative views toward healers (in fact in some cases - 10% and 7% - they offered strongly positive views) and had also never consulted with one. This shows that subjects who do not believe in Xhosa cosmology and in its practice do not necessarily always hold negative beliefs about traditional healers, but that rather there is a strong tendency to do so. Table 4 also shows that subjects who have consulted a traditional healer tended to believe that more healers could be trusted than those who had never consulted with a healer. This suggests that when consulted, healers generally appear to leave patients with positive impressions, and that those people that are strongly negative toward traditional healers generally have never consulted with one.

The above trends indicate that subjects who are strongly critical of traditional healing tend not to be speaking from personal experience as they generally have never consulted a healer before. Nevertheless, more moderate criticism of traditional healing is certainly prevalent among subjects who have in fact had many

experiences with healers. These criticisms therefore reflect more 'educated' concerns about healers in general, and are probably therefore a more valuable appraisal of traditional healers' integrity.

#### 4.6 Models for healers to work in established mental health care

As mentioned in the literature review, there have been a number of models proposed for the development of working relationships between the established mental health care system and traditional healing. The following list details the various models rated by the subjects in order of popularity (the order of popularity of the various healers for each model is also noted):

1. Healers should have certain patients referred to them after discharge from hospital.  
58% agreed - Abathandazeli (65%) Amagqira (61%); Amaprofethi (53%); Amaxhwele (53%)
  
2. Healers should visit psychiatric hospitals to consult with certain patients.  
57% agreed - Abathandazeli (63%); Amagqira (63%); Amaxhwele (53%); Amaprofethi (49%)
  
3. Healers should work in hospitals as members of the psychiatric team.  
55% agreed - Amagqira (61%); Amaxhwele (59%); Abathandazeli (53%); Amaprofethi (47%)
  
4. Certain patients should visit traditional healers before coming to the hospital for help.  
44% agreed - Amagqira (47%); Amaprofethi (47%); Abathandazeli (44%); Amaxhwele (40%)

The following should also be noted:

- a. There was overwhelming support (75%) for the establishment of a **general referral system** between the hospital and traditional healers.
- b. Most (77%) of the subjects agreed that certain patients would be better off being treated by both the hospital and traditional healers than they would if they were being treated by the hospital staff alone, but only 40% agreed that certain patients would be better off being treated just by traditional healers.
- c. As much as 85% of the subjects agreed that patients who are already seeing traditional healers should also check if psychiatric medication might help them.
- d. 55% of the subjects agreed that medical aids should pay for people to consult with traditional healers when they are ill.

#### **4.7 A referral system**

Subjects in favour of the establishment of a referral system (75%) expressed the view that patients' illnesses were often due to both psychiatric and/or traditional problems and that therefore cooperation between the two sides was desirable. It was suggested that at times patients needed interventions from both traditional and Western health-care workers. As one subject put it: "There are certain illnesses that these people [traditional healers] can see and cure which a doctor cannot see, like a doctor can see and cure illnesses that these people don't see." However, there was again concern about the integrity of certain traditional healers. It was suggested that only "proven" healers be given referrals. A referral system was also seen as desirable in that it would improve cooperation between health-care professionals and therefore be to the advantage of the patient. One subject gave the example of a traditional healer who because of cooperation with the hospital would be able to

identify "seriously ill" patients and therefore refer them for treatment. It was also pointed out that cooperation "would minimize the false beliefs and expectations traditional healers give to their patients," as well as provide for "good relationships and mutual benefits," especially for patients who would then be referred to the appropriate professional promptly and thus avoid developing a more chronic condition.

Several subjects apposed to establishing a referral system held the view that the decision to see a traditional healer remained with the patient and his/her family and that the hospital had no place in being involved in such a decision. Other subjects apposed to establishing a referral system suggested that the hospital would not be able to identify good from bad healers and would therefore be unable to make a confident referral. One subject said that referrals to traditional healers were not desirable because "most patients who visit traditional healers end up coming to the hospital anyway." Another subject stressed that the traditional healer's role in mental health care needed to be evaluated before a referral system be established "because they [traditional healers] are illiterates." Although the above statistics reveal overwhelming support for the establishment of a general referral system there seems to be far less support for more specific working models. Subjects' comments reveal that a number of issues with regard to the specifics of each model may be the cause for this trend.

#### **4.8 Patients referred to traditional healers after discharge**

Several subjects who were in favour of having patients referred to traditional healers after discharge, emphasised the need for the patient's and/or family's consent in the matter. This opinion appeared to be related to the view that it was very important to respect the beliefs of the individual and family and that without their support the referral might be destructive. Those in favour stressed the cultural importance of traditional healing. One subject had the following to say: "Psychotropic drugs can never substitute the inculcated superstitions which are inborn and inheritable from one generation to another." Others pointed out that referrals would be positive in that once patients were stabilised at the hospital they would be more

amenable to treatment for "traditional needs" where necessary. Other subjects repeated concerns about the integrity of traditional healers and were concerned about how to identify "good" from "bad" healers. One subject in favour of referrals explained that "we can encourage the use of psychiatric medication together with those of traditional healers as there is no interaction or reaction between them as I experienced with three patients during the course of my training up to now." Another subject explained that "it is important that the healers work hand in hand with the hospital team. Refer if unable to cure and don't wait until chronicity sets in." Other subjects although not against patients being treated by traditional healers were against the hospital making the referral. One subject explained that "patients should decide for themselves or their families should decide whether they should be referred to a traditional healer after discharge," and another put it simply as "its ones own *indaba* (matter or issue)." A widely emphasised view was that the patient's cultural beliefs should be respected and that if the patient felt it was relevant to consult a traditional healer, then this should not be discouraged.

A common concern was that healers might encourage patients to stop taking their medication thereby risking relapse. In this regard, Table 5 reveals the spread of responses to this question: "How many traditional healers tell patients to stop taking their medication?":

TABLE 5:

**NUMBER OF HEALERS THAT TELL PATIENTS TO STOP MEDICATION**

	<b>None</b>	<b>Very few</b>	<b>Some</b>	<b>Most</b>	<b>All</b>
<b>% of subj.</b>	4%	12%	41%	26%	16%

In Table 5, the greater weight of responses fall toward the right side (in the 'Most' and 'All' categories), indicating that the majority of subjects believe that it is not uncommon for traditional healers to tell patients to stop taking their medication. Only 4% said no healers tell patients to stop medication and only 12% said very few do. Hirst (1992) says that although healers may be expert in traditionalist methods of healing, they differ markedly in their familiarity with and knowledge of Western medicine and social welfare practices. A few

individuals are well informed, but most are badly in need of expert information regarding these and related issues (p. 73). Hence the view that referral to traditional healers will lead to patients stopping their medication is a prominent (and perhaps well-informed) concern amongst the subjects. In this sense, the importance of referral to traditional healers who would not insist on stopping the hospital's medical treatment was emphasised by the subjects. It was therefore again suggested that referrals be made only to "registered" traditional healers. This seemed to be related to the idea that "registered" healers would be "educated" and therefore hold the opinion that the hospital's treatment was desirable.

In summary, several subjects stressed the importance of respecting the cultural beliefs of the patient when deciding whether or not to refer the patient to a traditional healer. It was suggested that the hospital always have the support of the patient and his or her family in such an endeavour. The main apprehension in making such a referral centred around problems in assessing the integrity of the healer in question. The majority of subjects expressed concern that traditional healers might not cooperate with hospital treatment and therefore encourage patients to stop taking their medication. It was therefore suggested that referral be made only to 'registered' traditional healers, who would be 'educated' and therefore in support of the hospital treatment.

#### **4.9 Healers should visit hospitals rather than be members of the team**

Subjects in favour of traditional healers visiting psychiatric hospitals to consult with certain patients generally expressed the view that a combination of traditional healing methods and hospital treatment would be the most effective way of treating patients who believe in traditional healing. One subject put it as follows: "Psychiatric illness is a complex disease emanating from various different factors. Therefore, an inclusive multidisciplinary approach could be effective." It was stressed that if traditional healers were to visit the hospital to consult with

a patient they would have to interact with the hospital team to ensure that there was no conflict between the healer's interventions and the hospital treatment. Subjects again stressed the importance of only allowing credible traditional healers into the hospital. It was suggested that these healers could be identified through recommendations from the community. Several other subjects said that healers should only consult in the hospital if the ward doctor agreed. It was pointed out that visiting as opposed to working full time in the hospital as a member of the team was desirable because it would allow traditional healers to work primarily in their own settings. However, one subject said that although healers understood patient's from a deeply cultural perspective they should still not come to the hospital because they would "cause chaos and disturb other patients." Several subjects emphasised that healers visiting hospitals would be a good idea because it would provide an opportunity for both the hospital and the healer to educate each other about the way they work and understand illness. However, another subject said that healers should only visit hospitals for "health education and orientation" and not to treat patients as they "would confuse patients." Several subjects who were against traditional healers visiting hospitals expressed the view that healers would "disturb" and "confuse" patients, "distort [their] thoughts" and "create conflict" in the hospital. It was also said that patients "wouldn't know who to trust." One subject said that traditional healers "cannot maintain secrets and can therefore not be trusted." Another expressed the concern that healers would "disturb the doctor's duties."

#### **4.10 Patients visiting traditional healers before coming to hospital**

Subjects in favour of certain patients visiting traditional healers before coming to a psychiatric hospital for help emphasised that this was desirable only if the patient and family decided this for themselves. One subject felt that "the family of the patient can choose and see which side has good treatment - the healers or the hospital." One subject said that seeing a traditional healer before the hospital might be a good idea because the patient may then be cured and therefore avoid admission to the hospital. Another subject said that if the traditional healer could not cure the patient s/he would recommend admission to hospital. However, there was generally a

more negative response to this model. Subjects expressed a wide range of concerns. Several subjects said that traditional healers were not able to diagnose the patient's condition and therefore the healers should only be seen after the patient has been to the hospital. Other subjects felt that patients who saw traditional healers first would get worse and inevitably require admission. This was associated with the view that the illness might not be responsive to treatment from traditional healers (diabetes was given as an example). Uneducated traditional healers would not know this and would therefore waste time while the patient's condition got worse. One subject expressed the concern that healers might delay the patient from getting treatment from the hospital because of a need to be seen as "adequate." There was also concern that healers might convince patients that hospital treatment was not necessary thereby delaying admission. Such patients might also be opposed to taking medication once admitted.<sup>15</sup>

#### 4.11 Views on the function of traditional healers in Western mental health

As mentioned earlier, many authors (Buhrmann, 1986; Cheetham and Griffiths, 1982; Hirst, 1992, 1993; Schweitzer, 1977) have likened the traditional healer to a psychotherapist and social worker, and Hammond - Tooke (1989) likened the relationship between the diviner (*iggira*) and herbalist (*ixhwele*) to that of a medical doctor and pharmacist. The question therefore arises as to what function traditional healers will perform if they are to work hand-in-hand with Western mental health care services. Kahn (1994) interviewed psychiatric staff on the question of what function traditional healers could play in a psychiatric hospital. The nursing sister in his study said it would be to the hospital's advantage if healers would visit patients because "their input might aid in diagnosis and they could provide an explanation of the problem that the patient would find more acceptable and easier to understand." She added that "the patient would self-disclose more easily to someone originating from the same world-view" (p.43).

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<sup>15</sup> One subject had the following to say about this debate: "The problem here is that all these helpers [Western and Traditional] do not work together as a team. One condemns the other and this is not right but they could sit, discuss, share ideas. The patient would benefit at the end instead of fighting an endless battle. Education of the community is what must be embarked upon."

In this study it was found that 85% of Xhosa psychiatric nurses agreed that "some patients believe in traditional healers more than the hospital," and 82% of the nurses agreed that "some psychiatric patients would self-disclose more easily to traditional healers than they would to hospital staff." Far fewer subjects (only 58%) believed that "traditional healers could help hospital staff in the diagnosis of certain patients," but slightly more subjects (65%) felt that traditional healers could help hospital staff in taking a history from patients. However, on a more practical level, traditional healers and Western health-care workers will have to begin working together and examining the dynamics of their relationship before any concrete definition of traditional healers' functions can be established (Freeman and Motsei, 1992; Kahn, 1994; Schweitzer, 1979).

It is interesting to note however, that on a chi-square test (P-value = 0.0046; Value = 8.022; D.F = 1), a significant relationship was found between subjects views on whether or not patients would self-disclose more easily to traditional healers than hospital staff and how religious the subjects considered themselves to be.

Table 6 illustrates this relationship:

TABLE 6  
**PATIENTS SELF-DISCLOSE MORE TO TRADITIONAL HEALERS**

		Disagree	Agree
<i>Religious</i>	very relig.	37%	63% (n = 29)
<i>level</i>	not so relig.	7%	93% (n = 46)

Table 6 reveals that almost all (93%) the subjects who regard themselves as 'not so religious'<sup>16</sup> agreed with the statement "Some psychiatric patients would self-disclose more easily to traditional healers than they would to hospital staff," whereas as much as 37% of those subjects that regard themselves as 'very religious' disagreed

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<sup>16</sup>

Bear in mind that 99% of the subjects said they are Christians.

with the statement. This indicates that there is a strong tendency for subjects who consider themselves to be 'very religious' to believe that patients would not find it easier to self-disclose to traditional healers. Such a trend suggests that strong adherence to religious Christian doctrine tends to discredit belief in the depth of relationship that traditional healers have with their patients, or at least it does not credit them with being able to have greater rapport with patients than hospital staff are able. It may be speculated then that staunch Christian education tends to erase positive beliefs about traditional healers' abilities. Such a dynamic points to the possibility of an acculturation process amongst very religious Xhosa nurses within which Christian theology overwhelms indigenous cultural beliefs (the issue of acculturation will be discussed further in Section 2).

#### 4.12 Conditions for which patients may be referred to traditional healers

Table 7 lists the conditions for which subjects indicated they would refer patients to a traditional healer. The percentage of subjects that agree with referral is recorded alongside the condition:

TABLE 7

**Majority in favour:**

1. <i>Thwasa</i> (the 'calling' to be a traditional healer)	-	88%
2. Problems that come from not performing traditional customs properly	-	84%
3. Patients who present diagnostic dilemmas and complain of 'cultural' problems	-	82%
4. <i>Amafufunyana</i> (evil spirit possession)	-	79%
5. The effects of <i>ukuthakatha</i> (witchcraft)	-	75%

**Majority Against:**

6. Schizophrenia	-	28%
7. Family and marriage trouble	-	27%
8. Alcoholism	-	21%
9. Any kind of problem	-	20%
10. Drug abuse	-	12%

Table 7 clearly illustrates that subjects were generally in favour of patients with “cultural”<sup>17</sup> problems being referred to traditional healers and apposed to patients with “psychiatric” problems<sup>18</sup> being referred to traditional healers. This dynamic is an important one because it reflects a central dilemma in this field. Is a “cultural” problem something different from a ‘psychiatric’ problem, or are they different ways of describing the same phenomena, or both? In other words, if researchers are correct in saying that *amafafunyana* is a form of “hysterical psychosis” or schizophrenia (Robertson and Kottler, 1993), and *thwasa* is a kind of existential anxiety, epileptic psychosis or schizophrenia (Luckoff, Lu and Turner, 1992; Robertson and Kottler, 1993), then how will one distinguish a ‘cultural’ problem from a ‘psychiatric’ problem?

Eisenberg (1977) explains that models are ways of constructing reality, of imposing meaning on the chaos of the phenomenal world, and that once they are in place, models act to generate their own verification by excluding phenomena outside the frame of reference the user employs. Kleinman (1980) put it that the modern Western doctor's model of clinical reality assumes that biological concerns are more basic, real, clinically significant, and interesting than psychological and socio-cultural issues. He explains that in psychiatry “there is a tacit professional ideology that exaggerates what is universal in psychiatric disorder and de-emphasises what is culturally particular. The cross-cultural findings for schizophrenia, major depressive disorder, anxiety disorders, and alcoholism disclose both important similarities *and* equally important differences” (Kleinman, 1988, p.22). He stresses that “a more useful model is one in which biological and cultural processes *dialectically interact* (emphasis mine),” and that at times one may become a more powerful determinant of outcome, and at other times the other, but that most of the time it is the interaction, the relationship, between the two which is more important than either alone” (pp.25-26). In this sense, disorder must be viewed as both culturally and biologically constituted and both traditional healer and Western health-care professionals are

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<sup>17</sup> By using the term “cultural” here, the author is referring to ‘diagnostic’ and aetiological descriptions of phenomena that are commonly used in traditional Xhosa discourse.

<sup>18</sup> By using the term “psychiatric,” the author is referring to diagnostic and aetiological descriptions of phenomena that are commonly used in Western mental health discourse.

appropriate in its treatment. Table 7 illustrates that the nurses are operating within two diagnostic paradigms simultaneously in that they view the conditions for referral as either 'cultural' or 'psychiatric' and wish to refer accordingly. In this sense the nurses appear to be trapped within the cultural conflicts of the two healing systems.

## **SECTION 2:**

### **XHOSA NURSES - LIVING IN CULTURAL DISSONANCE**

#### **4.13 Medical pluralism**

The data shows that Xhosa psychiatric nurses exist simultaneously within two healing systems. Although they have been trained and work within a Western mental-health paradigm, they have been raised within and utilise an indigenous healing paradigm. Eighty nine percent of these nurses perform traditional customs and 74% believe that not performing customs will lead to health problems. Seventy five percent have consulted traditional healers, 64% said they would consult a healer now if they had a problem, and 80% believe that traditional healers have been given power to heal by the ancestors. Thus, these nurses live simultaneously within two, often conflicting, health care worlds. This is an example of what Helman (1984) calls "medical pluralism" (p.72). He explains that in a complex society individuals make use of a wide range of therapeutic options, "ill people make choices, not only between different types of healers (popular, professional and folk), but also between diagnoses and advice that *make sense* to them and those that do not" (pp.71-72). As Kapur (1975) found in India:

While the healers themselves were occasionally confused about their conceptual frameworks, the people at large were least concerned with the latter. It seemed that they went to a particular healer not because of the appeal of a particular theory or concept but because of an individual healer's reputation as a man able to cure an illness better than others. They also often followed the treatment of two different kinds of healers

simultaneously and the contradictory nature of the latter's concepts did not dissuade them from this practice (p.288).

The nurses in this study clearly operate within such a pluralistic framework. However, because they are not only consumers of health services but professionals themselves, they are required to operate conceptually and theoretically in making decisions about their patients. It is here then that they are required to mediate between the conflicting discourses of both Western mental health and indigenous healing. In making sense of this malaise they are torn between the basic contradictions created in the dialectical tension between these two healing cultures, and are therefore uniquely and precariously placed at the interface between Western mental health care and indigenous healing.

#### **4.14 Nursing training creates doubt about traditional healing**

The subjects were asked the following question: "Do you think that your training in psychiatric nursing has made you doubtful about the value of traditional healers and their medicines?" Thirty seven percent of the nurses said 'Yes,' and 63% said 'No.' Qualitative analyses of nurses written comments revealed a high level of tension around this question. Three subjects' comments, in particular, illustrated this: one subject commented that "I was made to be doubtful but I am not;" another said "the majority of nurses in government hospitals have been brain-washed by educational institutions, religion and Western culture about their origin, culture, customs etc. and made to believe and perform the Western culture and undermine their own culture and customs," and another said "my thinking has been affected by my training as a psychiatric nurse. I am now leaning more to the Western kind of civilisation and only believing in my customs and ancestors, not traditional healers."

Several subjects explained that as a result of nursing they had been educated about several disorders that could not be healed by traditional healers because these conditions were "inherited" rather than caused by witchcraft.

Epilepsy, mental retardation and schizophrenia were given as examples. As one subject explained: "Now that I have acquired the knowledge about mental illness and the possible causes and the different types of treatment, this gives me doubts about traditional healers. They like to associate mental illness with witchcraft, i.e. blaming somebody else." Other subjects explained that nursing training had made them doubtful about traditional healing because they had seen patients who after being unsuccessfully treated by traditional healers were thereafter successfully treated at the hospital and the reverse was not the case. Other explanations included the view that patients in hospitals "become better soon whereas traditional healers take too long to make [them] better" and that in psychiatry "they check you before they can do anything, in traditional healing they just give you medicines without knowing the full explanation about yourself." Some subjects indicated that nursing had made them strongly doubtful about traditional healers, one person having the following to say: "In my experience in the nursing profession I am 100% sure that traditional healers are dangerous people who fiddle with the patient for something she/he is not sure of, wasting people's time. A problem which would have been identified and diagnosed early will complicate and the patient may die. Their medicines are poisonous and dangerous. They will tell a patient and relatives to buy and slaughter goats for no apparent reason, whilst the patient can be sure with hospital staff."

Subjects who said their training in nursing had not made them doubtful about the value of traditional healers explained that they still believed in traditional cosmology and therefore maintained that traditional healers also had a role to play in the healing of the patient. Several of these subjects expressed the view that not fulfilling cultural duties and customs would result in illnesses which traditional healers are trained to cure. Others added that, therefore, the best treatment would be a combination of traditional and Western therapies. One subject put it that "in actual fact, it [nursing] has given me insight that traditional healing, if followed on proper guidelines and honestly, could simplify some psychiatric problems or rather offer some relevant analysis." Subjects also widely expressed that, in their experience, they had witnessed the effectiveness of traditional healers'

treatments. In addition they said they had seen that when patients were sent to traditional healers after hospitalisation it took longer for them to relapse than if they hadn't been referred.

#### 4.15 Cultural dissonance and acculturation

The above results clearly illustrate that the nurses in this study are ensnared in a dialectic between traditional and Western medical beliefs<sup>19</sup>. The result is a kind of *cultural dissonance*<sup>20</sup> - a state of psychological tension that arises from operating within two cultural discourses that are inconsistent with one another. The concept of *acculturation* is useful here in examining this dynamic. Acculturation is a term that has been defined as culture change that results from continuous, first hand contact between two distinct cultural groups, and *psychological acculturation* refers to changes in the individual that accompany group level acculturation (Berry and Kim, 1988, p.207). "A typical acculturation situation involves an individual of a particular (often nondominant) cultural background being in contact with another cultural group (usually dominant) which leads to that individual having to adapt to his new situation, using a variety of strategies" (p.208). In this sense, the process of cultural change that Xhosa people undergo in becoming psychiatric nurses may be seen as a form of acculturation in that they are required to culturally shift from a traditional (non-dominant) to a Western (dominant) cultural system.

Marks (1994) in her book Divided Sisterhood, points out that historically, the rather rapid emergence of black nurses in South African hospitals has to a large extent been due to the fact that black nurses would not only relieve white woman from the need to look after black men in a racially segregated society, but "in their white

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<sup>19</sup> A very similiar dynamic was found by Barbee (1986) in research conducted with nurses in Botswana.

<sup>20</sup> The author has derived the term *Cultural Dissonance* from the term *Cognitive Dissonance*, as proposed by Leon Festinger (1957). Whereas Festinger used the concept to describe a condition in which an individual maintains two inconsistent cognitions simultaneously thereby causing intrapsychic tension, I have replaced the word 'cognitive' with 'cultural' to describe a similiar process that occurs on a cultural level ie. where an individual functions within two inconsistent cultural systems simultaneously thereby causing psychological tension. *Cultural Dissonance* may thus result in *Cognitive Dissonance*.

uniforms, they would represent the harbingers of progress and healing in black society, a shining light in the midst of its savagery and disease" (p.78). As discussed, prior to colonialism, African societies had their own healing practices, which were intimately bound up with their cosmology and understanding of evil. Upon the arrival of missionaries and, later the colonial authorities, traditional healers came under attack. Marks (1994) gives the example of the establishment of Grey's Hospital in King William's Town which was "explicitly designed to destroy the power of the chiefs and witchdoctors and so win the Xhosa over for 'civilisation and Christianity,' while plans for the training of 'native surgeons' were directly devised so as to 'drive the witchdoctor out of the field'" (p.79). Missionaries trained the first African nurses at the beginning of the twentieth century and, like the colonial authorities, the missionaries saw Western medicine as part of the onslaught against black 'savagery' and 'ignorance' (p.81). The Free Church of Scotland mission doctor who pioneered Western training for African nurses in the Eastern Cape put it that,

...the hospital stood for science against superstition, for fresh air, cleanliness and temperance, as against over-crowding, dirt and... infestation and for Christian helpfulness and simple trust in God as apposed to the fear, the selfishness, the malevolence of heathenism (ibid.).

Marks points out that in this battle, the black nurse had a very special role, she was...

...the 'ally against magic and superstition,' she was to be the model of 'the type of new Native womanhood developing higher than anything to which Native woman have yet attained, strong, reliant, helpful. Young women of good character and education, a real blessing to their people.' They would bring notions of progress, cleanliness and order to a disordered and diseased African society, the Christian answer to witchcraft and filth (ibid.).

Fifty years later the image had not changed much. Writing about the first trained Catholic African nurse, Father Schimlek wrote in 1950:

She blazed the trail for a great many African girls to join in the struggle between orthodox medicine and pagan witchcraft, between the charity of the Good Samaritan and the terror of the powers of darkness (in Marks, 1994, pp.81-82.).

The Star headline in 1943 succinctly captured the issue: "More native nurses needed to stop witchcraft". As daughters of the Christian elite, nurses were to become the self-conscious harbingers of modernity to their own people, 'evangelists for Western medicine.' (ibid.). As Searle (1961) put it: "Scientific medicine had... to

conquer witchcraft and nursing [was] its standard bearer" (in Marks, 1994, p.209). And, as far as support for this initiative from blacks was concerned, by the 1920s, nursing had clearly become an acceptable, and in fact, highly prestigious occupation for the daughters of the now growing Westernised black elite (ibid., p.88). The rapidly deteriorating health of the African population in both town and countryside and the urgent need to organise medical services saw African women, whether fully qualified or with hospital certificates, being employed as nurses on an increasing scale and the demand was outgrowing the supply (Marks, 1994). By the late 1930's, as the status of black nurses began to rise, they began to wield an influence out of all proportion to their numbers in their community. By the late 1940s, unlike the white women who went into nursing at the time, the black nurse probationers came from the best-educated sector of the black population (ibid., p.110).

From the outset, nursing training was not only stringent but the nurses suffered the most intimate regulation of their lives. Black nurses were even taught how to walk and the regimentation of the nursing hierarchy was formidable; "nursing taught you to be ladies" (ibid., p.103). The deeply entrenched ideology of professionalism and the emphasis on status, as well as the middle class aspirations of the fully trained nurses created a gulf between them and their patients (ibid., p.208). From the earliest days, the missionaries deliberately inculcated Western values which served to distance the nurses from their communities, and create a new middle class elite. They were to moralise and save the sick, not simply nurse them. "It is not surprising that these attitudes were often internalised by black nurses. Nursing training 'is not merely a specialized technical training which instills knowledge and skills specific to the occupation of nursing.... It is also a very important socialization process,' initiating African students into a very particular ethos and an entire way of life," and despite the secularisation of training since then and "the lip service paid to cultural difference in apartheid South Africa," many of the older attitudes remain embedded in nursing training (ibid.).

It is clear that in becoming a psychiatric nurse, a Xhosa person is required to shift his or her cultural allegiance from a traditional paradigm to a Western paradigm. In describing the phases of acculturation, Berry

and Kim (1988) explain that in the *contact* phase, the two groups meet, interact and cultural and behavioural exchange and changes begins. They point out that, in principle, the notion of acculturation allows for cultural exchange in either direction, but in practice the balance of flow is usually from one (dominant culture) to the other ('acculturating group'), placing more and more stressors on the non-dominant group. This phase may be seen to have occurred in the development of nursing training, as Marks (1994) points out: "Their entire education from mission school to nursing college was designed to give them a new identity that was far removed from the 'ignorance' and 'superstition,' the 'barbarity' and 'bestiality' of native life" (p.208).<sup>21</sup>

Berry and Kim (1988) explain that a *conflict* phase follows the *contact* phase in the acculturation process. In this phase the non-dominant group experiences a build up of tension, pressure and conflict to change their way of life. When the group relations eventually begin to stabilise in one form or another, the process enters the *adaptation* phase. The authors point out that the varieties of adaptation may or may not bring about an adequate solution to the conflict and crisis, or a reduction in stress for that matter (ibid., p.210). It seems then, that it is at this point, that Xhosa nurses are left to their own devices. They cannot completely reconcile the differences between the two healing paradigms (maybe because they are, at present, inherently incongruent) and are therefore left with unresolved conflicts.

#### 4.16 Do nurses refer to traditional healers in secret?

Subjects were asked the question: "If you decided to refer a patient to a traditional healer would you do it in secret?" Twenty six percent of the subjects said 'yes' and 74% said 'no'. Qualitative analysis of the comments the subjects made in regard to this question revealed various levels of resolve with regard to interaction between the two systems, ranging from outright rejection such as "referring to them [traditional healers] would

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<sup>21</sup> It should be noted here that at least 59% of the nurses in this study have between 6 and 34 years of work experience and were trained before 1990 during the years when South Africa was under the apartheid regime.

be "disgraceful conduct," to complete acceptance such as "we all know that traditional healers are part of the multidisciplinary team. Professionals all know that if you refer a patient to traditional healers you need cooperation on the part of the patient and traditional healer. At the same time you want to win the patient and traditional healer's trust. They must not think that we are against their beliefs." Several subjects who said they would refer a patient in secret were concerned that referring to traditional healers would be viewed as taboo by Westerners, especially doctors, and that "in Western culture people are reluctant and become embarrassed if found in traditional healers places." Another subject said she was concerned that others would "think that you want to bewitch people." Others said they would refer in secret "to avoid embarrassing the patient because this is always kept secret and to avoid conflict with non-believers." It was also explained that "according to our tradition its a family affair to go to a healer, so it's a secret." One subject rationalised that referring in secret would "promote trust with the patient" thereby building the therapeutic relationship. Those subjects who said they would not refer in secret generally answered that being open and honest was the best way of treating patients because it builds cooperation amongst the health-care workers thereby making for better treatment. It was also stressed that traditional healers should be respected and what is required is an open approach so that there would be no shame in making such referrals. One subject pointed out that "traditional healers perform best from openness, unlike confidentiality practiced in psychiatry." Others were afraid to refer in secret because "the doctor might find out about it" and "everyone should know to see who the blame falls on if something goes wrong."

The responses above as well as to the question of whether or not nursing has made the subjects doubtful about traditional healing, reveal a level of uncertainty and a lack of consensus amongst these nurses. In addition, it is clear that these nurses tend to manage the conflict in different ways: some show allegiance to the hospital and its doctors either out of fear, loyalty or both; some hide their actions in secrecy; some stand proud in their beliefs in traditional cosmology; and others remain ambivalent.

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#### 4.17 Modes of acculturation

In viewing the adaptation phase of the acculturation process, Berry and Kim (1988) describe various *modes of acculturation* according to how individuals and groups deal with the two central issues that arise in all acculturation arenas. "The first issue is as follows: 'Is my cultural identity of value and to be retained?,' and the second: 'Are positive relations with the larger (dominant) society to be sought?'" (p.211). These authors identify four modes of response: *assimilation*, *integration*, *separation*, and *marginalization*.

*Assimilation* refers to the decision to relinquish cultural identity and move into the dominant society (ibid.). Nurses who have decided to relinquish their traditional beliefs and wholeheartedly take on Western beliefs about healing and illness may be seen to have taken this option. The following subject's response alludes to this mode: "Now that I have acquired the knowledge about mental illness and the possible causes and the different types of treatment, this gives me doubts about traditional healers. They like to associate mental illness with witchcraft, i.e. blaming somebody else."

*Integration* implies the maintenance of cultural integrity as well as the movement to become an integral part of a larger societal framework (ibid., p.212). Nurses who retain their belief in traditional cosmology but at the same time integrate Western mental health concepts into their conceptual system may be said to be operating in this mode. The following subject's response reflects this mode: "In actual fact it [nursing] has given me insight that traditional healing, if followed on proper guidelines and honestly, could simplify some psychiatric problems or rather offer some relevant analysis."

Both of the above modes are associated with individuals who have decided that establishing and maintaining good relations with the dominant culture is desirable. In the *separation* mode, individuals have decided that the maintenance of one's traditional way of life requires a self-imposed withdrawal from the dominant society

(ibid.). Such individuals would probably not have trained as psychiatric nurses but might well have trained as traditional healers.

The final mode, *marginalisation*, "is an option that is accompanied by a good deal of collective confusion and anxiety. It is characterised by having lost essential features of one's culture, but not having replaced them by entering the larger society. There are often feelings of alienation, marginality, and a loss of identity" (ibid.). Individuals in this mode have lost "psychological and cultural contact with both their traditional culture and the larger society. This is not to say that such groups have no culture, but to claim that this culture may be disorganised and may not be supportive of the individual and his or her needs" (ibid.). It is difficult to establish what level of marginalisation exists for the nurses at present, however it is likely that at least some of the nurses are ambivalent and unsure. This became evident during data collection following a poor response from the nurses in returning their questionnaires. Several vocal nurses mentioned that some Xhosa nurses may not trust the research "because the questionnaire talks about traditional healers and some people are not sure of what the intention is because they are used to hearing that traditional healing and the hospital don't go nicely together, and they may be afraid to make their views known." If this is the case then it is likely that some nurses are being *marginalised* in attempting to manage the tension created in this arena.

→ also plitties.

In summary, the nurses negotiate cultural dissonance in three general ways. Firstly, some *assimilate* into the Western mental health care paradigm, throwing off their beliefs in traditional healing. Secondly, others *integrate*, in one form or another, beliefs from both systems, and thirdly, some remain ambivalent about which way to turn. When viewed in this way, these nurses seem to reside within a cultural milieu that appears to be somewhat unhealthy, but this is not necessarily the case. At one level, these nurses may be maintaining a necessary tension between the two healing systems. Armstrong (1987) warns against adopting an all-encompassing biopsychosocial model toward health. He explains that such an act would effectively neutralise healthy critique of the assumptions underlying Western psychiatry because it would control the

potential threat from "unorthodox" health discourses by 'incorporating' the offensive system into the dominant discourse. In this sense, Xhosa psychiatric nurses who reside within an unresolved health care model may be seen to be 'protectors' of traditional culture in their function as 'containers' or 'managers' of the tension between Western mental health discourse and traditional cosmology. They guard against a situation where regulation and institutional incorporation of traditional healing might result in 'colonialisation' of traditional culture. They are in some sense, hermeneuts who manage the incompatibility of these two systems, and sustain a tension that assures a space for on-going and healthy critique of the assumptions that underlie the discourses involved in this arena.

## CHAPTER 5

### CONCLUSIONS

This study illustrates that Xhosa psychiatric nurses exist at the interface between Western mental health care and indigenous healing in South Africa. Not only do the vast majority of these nurses believe in traditional cosmology, but they also involve themselves in traditional ritual practices and regularly visit traditional healers as patients.

Seventy five percent of the subjects have consulted a traditional healer at least once before in their lives and 64% said they would consult a traditional healer now if they had a relevant problem. Eighty nine percent perform traditional customs and 80% believe that traditional healers are given power to heal by the ancestors. These statistics exist in the face of the fact that 99% of the nurses said they were Christians and all have been trained and work within a Western mental health care system.

The nurses thus operate across two or more healing systems that are at this point not conceptually compatible. They are therefore left with the challenge of negotiating the inconsistencies that arise in this context. However, such a task follows from a nursing education and practice that has historically indoctrinated its trainees with a highly negative view toward traditional healing and its cosmology. This results in deep cultural tension for the nurses as they try and make sense of these inconsistencies. Unlike consumers, who in a pluralistic medical system are not required to make sense of the conceptual conflicts between healing paradigms, nurses are forced into tackling this malaise because as professionals they must make decisions based on a healing model that to them is in some form coherent and supportive. The difficulties involved in succeeding in such a task create cultural and psychological tension for these individuals that is in many senses similar to that which is encountered by groups trapped in a process of acculturation. In being entangled in the dialectical tension created in this context, the nurses manage the incongruencies in three general ways. Firstly, some assimilate

into the Western mental health paradigm, discarding their beliefs in traditional healing. Secondly, some incorporate, in one form or another, beliefs from both systems into an integrative<sup>22</sup> model, and thirdly, some remain ambivalent in the dialectic.

In examining these nurses' views toward traditional healers, two things are important. Firstly, the views emerge out of the cultural tensions arising in this context, and secondly, because of these tensions (ie. because these nurses culturally reside at the interface between the two systems), their views are likely to reflect some of the most important dynamics and concerns involved in bringing Western mental health care and indigenous healing together in South Africa.

In terms of the efficacy of both systems, the nurses believe most strongly in the effectiveness of psychiatric medication, followed by psychotherapy. However, belief in the effectiveness of traditional healing is not far behind. There were no significant differences in views with regard to efficacy across different types of traditional healers.

Although 78% of the subjects tended to express a favourable view with regard to the effectiveness of traditional healers, only 58% agreed that traditional healers have a positive role to play in the care of the mentally ill. One of the central reasons for this rests with the fact that the nurses hold a wide range of concerns with regard to the integrity of many traditional healers. Most subjects (78%) believe that only 'some' or 'very few' traditional healers can be trusted. Three main reasons were given for this. Firstly, 56% of the subjects said that at least 'some' traditional healers had not finished their initiation process, and that such healers were therefore not trained properly. It was also mentioned that some traditional healers were charlatans who had no training at all. Secondly, there was concern that healers abuse alcohol. However, analysis revealed that many nurses make the

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<sup>22</sup> The author uses the term 'integrative' here to refer to a general mode of acculturation. However, as has already been discussed, this does not necessarily imply a 'resolved' model, but rather a model that constantly arbitrates and negotiates (sometimes successfully and sometimes unsuccessfully) the tensions involved in the dialectic between the two healing discourses in question.

distinction between healers using and abusing alcohol, as alcohol in the form of *umqomboti* (traditional African beer) is used by traditional healers in ritual practice as part of the healing system, and is believed to enhance contact with the ancestors. Finally, subjects were concerned that some traditional healers suffer from mental illness themselves, because, as part of their initiation they go through *thwasa*, which has been associated with mental illness. In addition to holding concerns about the integrity of traditional healers, the subjects were also concerned that traditional healers might not cooperate with Western mental health interventions. For example, the majority of the subjects believe that it is not uncommon for traditional healers to encourage patients to stop taking psychiatric medication, especially if they are not educated about the Western mental health model.

The above concerns have resulted in a general belief amongst the subjects that it is very difficult to tell 'good' traditional healers from 'bad' ones. The problem most often mentioned here was that there is no way of assessing the integrity of the healer, unlike in the Western mental health system where a medical board presides over the training and conduct of Western health care professionals. In this regard, 82% of the subjects agreed that healers should be registered with a government board that has strict rules.

Statistical tests revealed that subjects who are strongly critical of traditional healing tend *not* to be speaking from personal experience as they generally have never consulted a healer before. However, more moderate criticism of traditional healing tends to come from subjects who have large amounts of experience with traditional healers, and therefore their views offer a more 'educated' appraisal of traditional healers integrity. Such a trend offers statistical confirmation of the various modes of acculturation that these nurses are operating along. Those nurses most strongly apposed to traditional healing have discarded their cultural heritage and assimilated into an apparently incompatible Western paradigm. However, those nurses more moderately critical of traditional healing still utilise and believe in the traditional healing system, and are therefore operating within an integrative mode of acculturation.

In suggesting ways in which indigenous healing and Western mental health care can work together, 75% of the subjects were in favour of a general referral system between the hospital and traditional healers. Most of the subjects (77%) agreed that certain patients would be better off being treated by the hospital and traditional healers than they would if they were being treated by the hospital alone, and 85% of the subjects agreed that patients who are already seeing traditional healers should check if psychiatric medication might help them. These statistics strongly indicate that the majority of Xhosa psychiatric nurses operate in an integrative model of mental health care. In this model, their beliefs from both Western and traditional healing interact in a way that allows them to manage the conflicts between the two discourses. Although it may appear that such a situation means these nurses operate in an unhealthy cultural context, this is not necessarily the case. At one level, Xhosa nurses maintain an important tension between the two healing systems. They may be seen as 'hermeneuts' who manage and negotiate the incompatibility of these two systems thereby ensuring a space for on-going and healthy critique of the assumptions that underlie the discourses involved in this health care malaise.

### **Recommendations for further research**

The following research options are recommended:

- Action research projects that investigate modes of interaction between mental-health care workers and traditional healers.
- Research that follows the patient between hospital and traditional healer and contrasts and compares the interactions across cultural barriers.

- More widespread investigations into the views of other mental-health care workers toward traditional healers.
- Investigations into the views of traditional healers toward Western mental-health care.

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## **APPENDIX A**

### **QUESTIONNAIRE**

*This questionnaire is part of a Rhodes University research project investigating Xhosa speaking nurses' views toward traditional healers.*

*Please complete the following questions to the best of your ability. Note that your opinions are asked for and **there are no right or wrong answers**. Do **not** put your name on this questionnaire. Your answers will be kept strictly anonymous. This research is intended for academic purposes.*

**THANK-YOU VERY MUCH FOR YOUR TIME AND EFFORT.**

\_\_\_\_\_  
*Mr Marc Kahn (Researcher)*

\_\_\_\_\_  
*Dr Kevin Kelly (Supervisor - Rhodes University)*

*This research is approved by Fort England Hospital:*

\_\_\_\_\_  
*Dr Athol Schultz (Senior Medical Superintendent)*

Please read each question carefully. Then, look at all the options given underneath. Choose the one that best fits your opinion by making a cross over the box next to it.

**Example:** In question number 3, if you are a female, you will make a cross over the second square like this:

Female.

Some questions will ask you to write your answer in the space provided. Other questions will give you space to add any comments you have to your answers. **PLEASE ANSWER ALL THE QUESTIONS.**

\*\*\*\*\*

1. How old are you?

(Write here) .....

2. How many years have you worked as a nurse in psychiatry?

(Write here) .....

3. Are you male or female?

Male

Female

4. What is your present nursing position?

Student Nurse

Staff Nurse

Professional Nurse

SPN

CPN

Other (Write here) .....

5. What is your religion?

No religion

Christian

Other (Write here).....

6. How religious are you?

Very religious

Not so religious

Not religious at all

7. Do you believe in *Qamata* (traditional Xhosa beliefs)?

Yes

No

8. Do you enjoy nursing?

Yes

No

9. **How satisfied are you with the nursing profession?**

- Satisfied                       Could be better                       Not satisfied

10. **How effective do you think psychiatric medication is?**

- Always effective  
 Usually effective  
 Sometimes effective  
 Seldom effective  
 Never effective

11. **How effective do you think psychotherapy is?**

- Always effective  
 Usually effective  
 Sometimes effective  
 Seldom effective  
 Never effective

12. **How effective is the *Umthandazeli* (faith healer)?**

- Always effective  
 Usually effective  
 Sometimes effective  
 Seldom effective  
 Never effective

13. **How effective is the *ixhwele* (herbalist)?**

- Always effective  
 Usually effective  
 Sometimes effective  
 Seldom effective  
 Never effective

14. **How effective is the *igqira* (diviner)?**

- Always effective  
 Usually effective  
 Sometimes effective  
 Seldom effective  
 Never effective

15. **How effective is the *iprofethi* (faith healer)?**
- Always effective
  - Usually effective
  - Sometimes effective
  - Seldom effective
  - Never effective
16. **“Amagqira (diviners) can play a positive role in the care of the mentally ill.”**
- Agree       Disagree
17. **“Amaxhwele (herbalists) can play a positive role in the care of the mentally ill.”**
- Agree       Disagree
18. **“Abathandazeli (faith healers) can play a positive role in the care of the mentally ill.”**
- Agree       Disagree
19. **“Amaprofethi (faith healers) can play a positive role in the care of the mentally ill.”**
- Agree       Disagree
20. **“Amagqira (diviners) should work in hospitals as members of the psychiatric team.”**
- Agree       Disagree
21. **“Amaxhwele (herbalists) should work in hospitals as members of the psychiatric team.”**
- Agree       Disagree
22. **“Amaprofethi (faith healers) should work in hospitals as members of the psychiatric team.”**
- Agree       Disagree
23. **“Abathandazeli (faith healers) should work in hospitals as members of the psychiatric team.”**
- Agree       Disagree

*If you have any comments with regard to your answers in questions 16 - 23 , please write them here:*

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24. **“Amagqira (diviners) should have certain patients referred to them after discharge from hospital.”**

Agree       Disagree

25. **“Amaxhwele (herbalists) should have certain patients referred to them after discharge from hospital.”**

Agree       Disagree

26. **“Amaprofethi (faith healers) should have certain patients referred to them after discharge from hospital.”**

Agree       Disagree

27. **“Abathandazeli (faith healers) should have certain patients referred to them after discharge from hospital.”**

Agree       Disagree

*If you have any comments with regard to your answers in questions 24-27, please write them here:*

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.....

28. **“Amagqira (diviners) should visit psychiatric hospitals to consult with certain patients.”**

Agree       Disagree

29. "Amaprofethi (faith healers) should visit psychiatric hospitals to consult with certain patients."  
 Agree       Disagree
30. "Amaxhwele (herbalists) should visit psychiatric hospitals to consult with certain patients."  
 Agree       Disagree
31. "Abathandazeli (faith healers) should visit psychiatric hospitals to consult with certain patients."  
 Agree       Disagree

*If you have any comments with regard to your answers in questions 28 - 31, please write them here:*

.....

.....

.....

32. "Certain patients should visit the iprofethi (faith healer) before coming to a psychiatric hospital for help."  
 Agree       Disagree
33. "Certain patients should visit an igqira (diviner) before coming to a psychiatric hospital for help."  
 Agree       Disagree
34. "Certain patients should visit an ixhwele (herbalist) before coming to a psychiatric hospital for help."  
 Agree       Disagree
35. "Certain patients should visit the umthandazeli (faith healer) before coming to a psychiatric hospital for help."  
 Agree       Disagree

*If you have any comments with regard to your answers in questions 32 - 35, please write them here:*

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36. **"A referral system with the hospital and traditional healers ( including *amaprofethi*; *amagqira*; *abathandazeli*; *amaxhwele*) should be established."**

- Disagree                       Agree

*If you have any comments with regard to your answers in this question, please write them here:*

.....

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.....

37. **"Traditional healers could help hospital staff in taking a history from certain patients"**

- Disagree                       Agree

38. **"Traditional healers could help hospital staff in the diagnosis of certain patients."**

- Disagree                       Agree

39. **"Some patients believe in traditional healers more than the hospital."**

- Disagree                       Agree

40. **"Some psychiatric patients would self-disclose more easily to traditional healers than they would to hospital staff."**

- Disagree                       Agree

41. Note whether or not you would refer the following types of patients to a *relevant* traditional healer:

A. A patient whose problems come from trouble in their marriage or their family.

Yes             No

B. A patient who appears to be suffering from *Amafufunyana*.

Yes             No

C. A patient whose problems come from not performing traditional customs properly.

Yes             No

D. A patient who is difficult to diagnose and complains of "cultural" problems.

Yes             No

E. A patient who appears to be suffering from *Thwasa*.

Yes             No

F. A patient whose problem is drinking too much alcohol.

Yes             No

G. A patient who appears to be suffering from the effects of *Ukuthakatha* (witchcraft).

Yes             No

H. A patient whose problems come from taking drugs like dagga.

Yes             No

I. A patient who is schizophrenic.

Yes             No

J. A patient with any kind of problem.

Yes             No

*If there are other reasons for which you would refer a patient to a traditional healer, write them here:*

.....

.....

.....

42. "Certain patients would be better off being treated by hospital staff and traditional healers than they would if they were only being treated by hospital staff."

- Disagree                       Agree

43. "Certain patients may be better off being treated just by traditional healers and not by the hospital at all."

- Disagree                       Agree

44. "Patients that are already seeing traditional healers should also check if psychiatric medication might help them."

- Disagree                       Agree

45. If you decided to refer a patient to a traditional healer would you do it in secret?

- Yes                                       No

*Please explain your answer:*

.....

.....

.....

46. How many traditional healers do you think tell psychiatric patients to stop taking their medication?

- None of them  
 Very few of them  
 Some of them  
 Most of them  
 All of them

47. How many traditional healers do you think just want money?

- None of them  
 Very few of them  
 Some of them  
 Most of them  
 All of them

48. **How many traditional healers do you think never finished their initiation (*Thwasa*)?**

- None of them
- Very few of them
- Some of them
- Most of them
- All of them

49. **How many traditional healers can really be trusted?**

- None of them
- Very few of them
- Some of them
- Most of them
- All of them

50. **How many traditional healers often consult with their patients under the influence of alcohol?**

- None of them
- Very few of them
- Some of them
- Most of them
- All of them

*If you have any comments with regard to your answers in questions 46 - 50, please write them here:*

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51. **How many traditional healers do you think are suffering from mental illness themselves?**

- None of them
- Very few of them
- Some of them
- Most of them
- All of them

*If you have any comments with regard to your answer in this question, please write them here:*

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52. "Traditional healers are given power to heal by the ancestors (*izinyanya*)."
- Disagree                       Agree
53. "Traditional healers should be registered with a government board that has strict rules."
- Disagree                       Agree
54. "Medical aids should pay for people to consult traditional healers when they are ill."
- Disagree                       Agree
55. Do you perform traditional customs?
- Often                               Sometimes                       Never
56. Did your family perform traditional customs when you were growing up?
- Often                               Sometimes                       Never
57. "Xhosa people who don't perform important traditional customs will get health problems"
- Disagree                       Agree
58. Please write the number of times you have visited an *igqira* (diviner) with a problem.
- (Write here).....
59. Please write the number of times you have visited the *iprofethi* (faith healer) with a problem.
- (Write here).....
60. Please write the number of times you have visited an *ichwele* (herbalist) with a problem.
- (Write here).....

61. Please write the number of times you have visited the *umthandazeli* (faith healer) with a problem.

(Write here).....

*If you have ever visited any other kind of traditional healer with a problem, please give details here:*

.....  
.....

62. Would you consult with a traditional healer now if you had a relevant problem?

No  Yes

*Please explain why?* .....

.....  
.....

63. Do you think that your training in psychiatric nursing has made you doubtful about the value of traditional healers and their medicines?

No  Yes

*Please explain why?*.....

.....  
.....  
.....  
.....

64. **IF YOU HAVE ANY OTHER COMMENTS WITH REGARD TO THIS QUESTIONNAIRE  
PLEASE WRITE THEM BELOW:**

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.....

***Please make sure you have answered all the questions fully before  
returning this questionnaire.***

*Thankyou very much for your time and effort.*



## APPENDIX B

### Summary of qualitative responses to the questionnaire

*Traditional healers can play a positive role in the care of the mentally ill and should work in hospitals as members of the psychiatric team.*

Several subjects who agreed that healers had a positive role to play in the hospital, emphasised that the patient and/or their family would have to agree that the healer be considered for consultation. This perception appeared to be related to the view that healers would only be appropriate for patients that believe in them. In addition, some subjects said that the healer would only have a positive role to play if the patient's condition required "cultural attention" such as in the cases of thwasa, amafufunyana or where a patient has omitted a custom which is therefore causing illness. It was suggested that healers could play a more positive role in mental-health care if they were educated as to the importance of psychiatric treatment and the workings of the hospital. There was also a suggestion that the hospital staff needs to be educated as to the ways of the healers.

Subjects who felt that healers did not have a positive role to play in the care of the mentally ill expressed concern about the validity of traditional healing methods and the integrity of traditional healers. Views such as "healers are liars", "cannot be trusted" and "are dangerous to the community" were voiced.

With regard to whether or not healers should work in hospitals as members of the psychiatric team there was a wide range of opinion. Some subjects suggested that healers should work full time in hospitals, as patients require both modern and traditional care to be most effectively treated, and "most psychiatric patients have strong beliefs in the positive contributions of customs and traditional healing." Other subjects felt that the healer could be a consultant member of the team, the suggestion being made that the healer visit the hospital once a week to attend to those patients in need rather than join the multi-disciplinary team as a full member. However, several other subjects suggested that it was important that healers work in their own settings and that patients should rather be referred than be seen in the hospital.

There were a number of concerns that emerged about healers working in hospitals. One subject said she agreed that healers should work in hospitals but was concerned about the cleanliness of the healers and their pharmacopoeia, another subject expressed the opinion that healers should not work in hospitals because hospital treatment sometimes contradicts the treatment that traditional healers provide; and several other subjects were concerned that healers might "cause chaos and disturb other patients in the hospital" with their unorthodox methods.

*Traditional healers should have certain patients referred to them after discharge from hospital.*

Several subjects who were in favour of having patients referred to traditional healers after discharge, emphasised the need for the patient's and/or family's consent in the matter. This opinion appeared to be related to the view that it was very important to respect the beliefs of the individual and family and that without their support the referral might be destructive. Those in favour stressed the cultural importance of traditional healing; one subject had the following to say: "Psychotropic drugs can never substitute the inculcated superstitions which are inborn and inheritable from one generation to another." Others pointed out that referrals would be positive in that once patients were stabilised at the hospital they would be more amenable to treatment for "traditional needs" where necessary. In this sense the importance of referral to traditional healers who would not insist on stopping the hospital's medical treatment was emphasised. It was therefore suggested that referrals be made only to "registered" traditional healers. This seemed to be related to the idea that "registered" healers would be "educated" and therefore of the opinion that the hospital's treatment was desirable. Other subjects were concerned about how to identify "good" from "bad" healers. One subject in favour of referrals explained that "we can encourage the use of psychiatric medication together with those of traditional healers as there is no interaction or reaction between them as I experienced with three patients during the

course of my training up to now." Another subject explained that "it is important that the healers work hand in hand with the hospital team. Refer if unable to cure and don't wait until chronicity sets in."

Other subjects, although not against patients being treated by traditional healers were against the hospital making the referral. One subject explained that "patients should decide for themselves or their families should decide whether they should be referred to a traditional healer after discharge," and another put it simply as "its ones own indaba."

A widely emphasised view was that the patient's cultural beliefs should be respected and that if the patient felt it was relevant to consult a traditional healer than this should not be discouraged.

Those against referring patients to healers after discharge were concerned that healers would encourage patients to stop taking their medication thereby risking relapse, and that healers might tell patients that "they shouldn't have gone to hospital in the first place." The view was put forward that if a patient "has been discharged, what is the use of referring him/her because you've managed to control his/her condition, unless uncontrollable." One subject said that traditional healers were dangerous and that referring to them would be considered "disgraceful conduct."

*Traditional healers should visit psychiatric hospitals to consult with certain patients.*

Subjects in favour of this generally expressed the view that a combination of traditional healing methods and hospital treatment would be the most effective way of treating patients who believe in traditional healing: One subject put it as follows: "Psychiatric illness is a complex disease emanating from various different factors. Therefore an inclusive multidisciplinary approach could be effective."

It was stressed that if traditional healers were to visit the hospital to consult with a patient they would have to interact with the hospital team to ensure that there was no conflict between the healer's interventions and the hospital treatment. Subjects also stressed the importance of only allowing credible traditional healers into the hospital. It was suggested that these healers could be identified through recommendations from the community. Several other subjects said that healers should only consult in the hospital if the ward doctor agreed.

It was pointed out that visiting as apposed to working full time in the hospital was desirable because it would allow traditional healers to work primarily in their own settings. However, one subject said that although healers understood patients from a deeply cultural perspective they should still not come to the hospital because they would "cause chaos and disturb other patients."

Several subjects emphasised that healers visiting hospitals would be a good idea because it would provide an opportunity for both the hospital and the healer to educate each other about the way they work and understand illness. However, another subject said that healers should only visit hospitals for "health education and orientation" and not to treat patients as they "would confuse patients."

Several subjects who were against traditional healers visiting hospitals expressed the views that healers would "disturb" and "confuse" patients, "distort [their] thoughts" and "create conflict" in the hospital. It was also said that patients "wouldn't know who to trust." One subject said that traditional healers "cannot maintain secrets and can therefore not be trusted." Another expressed the concern that healers would "disturb the doctor's duties."

*Certain patients should visit traditional healers before coming to a psychiatric hospital for help.*

Subjects in favour of the above statement emphasised that this was desirable only if the patient and family decided this for themselves. One subject felt that: "The family of the patient can choose and see which side has good treatment - the healers or the hospital." One subject said that seeing a traditional healer before the hospital might be a good idea because the patient may then be cured and therefore avoid admission to the hospital. Another subject said that if the traditional healer could not cure the patient, s/he would recommend admission to hospital.

However, there was generally a more negative response to the above statement. Subjects expressed a wide range of concerns. Several subjects said that traditional healers were not able to diagnose the patient's condition and therefore the healers should only be seen after the patient has been to the hospital. Other subjects felt that patients who saw traditional healers first would get worse and inevitably require admission. This was associated with the view that the illness might not be treatable with traditional healing methods (eg. diabetes) and that the traditional healers would not know this and therefore waste time whilst chronicity sets in. One subject expressed the concern that healers might delay the patient from getting treatment from the hospital because of a need to be seen as "adequate." There was also the concern that healers might convince patients that hospital treatment was not necessary thereby delaying admission. There was a fear that once admitted, such patients would be opposed to taking medication.

One subject had the following to say about the above debate: "The problem here is that all these helpers [Western and Traditional] do not work together as a team. One condemns the other and this is not right but they could sit, discuss, share ideas. The patient would benefit at the end instead of fighting an endless battle. Education of the community is what must be embarked upon."

*A referral system with the hospital and traditional healers should be established.*

Subjects who expressed agreement with the need for a referral system expressed the view that patients' illnesses were often due to both psychiatric and/or traditional problems and that therefore cooperation between the two sides was desirable. It was suggested that at times patients needed interventions from both traditional and Western health-care workers. As one subject put it: "There are certain illnesses that these people [traditional healers] can see and cure which a doctor cannot see, like a doctor can see and cure illnesses that these people don't see." However, there was again concern about the integrity of certain traditional healers. It was suggested that only "proven" healers be given referrals.

A referral system was also seen as desirable in that it would improve cooperation between health-care professionals and therefore be to the advantage of the patient. One subject gave the example of a traditional healer who because of cooperation with the hospital would be able to identify "seriously ill" patients and therefore refer them for treatment. It was also pointed out that cooperation "would minimize the false beliefs and expectations traditional healers give to their patients," as well as provide for "good relationships and mutual benefits," especially for patients who would then be referred to the appropriate professional promptly and thus avoid developing a more chronic condition.

Several subjects against establishing a referral system held the view that the decision to see a traditional healer remained with the patient and his/her family and that the hospital had no place in being involved in such a decision. Other subjects against establishing a referral system suggested that the hospital would not be able to identify good from bad healers and would therefore be unable to make a confident referral. One subject said that referrals to traditional healers were not desirable because "most patients who visit traditional healers end up coming to the hospital anyway." Another subject stressed that the traditional healer's role in mental health care needed to be evaluated before a referral system be established because they [traditional healers] are illiterates."

*Other reasons for referral of patients to traditional healers.*

The following conditions were added as possible reasons for referral:

- |       |                     |   |
|-------|---------------------|---|
| (i)   | Epilepsy -          | "A patient who is suffering from epilepsy sometimes has a dirty wind that comes from the stomach then goes up to the brain. Patients like this must see traditional healers."   |
| (ii)  | Cancer              |   |
| (iii) | Disturbing dreams - | "I would refer a patient who is always dreaming that his/her dead parents or relatives were speaking to him/her in their dreams. Sometimes they do not react to treatment - try other means. Maybe something was not done (cultural problems)." |
| (iv)  | To change ill luck  |   |

- (v) To find lost objects

*If you decided to refer a patient to a traditional healer would you do it in secret?*

Subjects who said they would refer a patient in secret explained that "it is our culture not to be seen by everybody because of the belief in witchcraft," and another said she would do it "to avoid embarrassing the patient because this is always kept secret and to avoid conflict with non-believers." It was also explained that "according to our tradition it's a family affair to go to a healer, so it's a secret."

There was also concern that referring to traditional healers would be viewed as taboo by Westerners especially doctors and that "in Western culture people are reluctant and become embarrassed if found in traditional healers places." Another subject was concerned that others would "think that you want to bewitch people." On the more positive side the view was put forward that referring in secret would "promote trust with the patient" thereby building the therapeutic relationship.

Those subjects who said they would not refer in secret generally answered that being open and honest was the best way of treating patients because it builds cooperation amongst the health-care workers thereby making for better treatment. It was also stressed that traditional healers should be respected and what is required is an open approach so that there would be no shame in making such referrals. One subject pointed out that "traditional healers perform best from openness, unlike confidentiality practiced in psychiatry."

Others were afraid that the doctor might find out about it if they refer in secret and that "everyone should know to see who the blame falls on if something goes wrong."

One subject had this to say about the debate: "In primary health care we all know that traditional healers are part of the multidisciplinary team. Professionals all know that if you refer a patient to traditional healers you need co-operation on the part of the patient and traditional healer. At the same time you want to win the patient and traditional healers trust. They must not think that we are against their beliefs."

*Views on the integrity and validity of traditional healers.*

Subjects had several concerns with regard to the integrity of traditional healers. They explained that healers who did not finish their initiation process (thwasa) were dangerous because they were not fully trained. Subjects suggested that a healer might not have finished his training due to poverty (being unable to pay his teacher) or due to family problems. Other subjects suggested that some healers had not even entered into the initiation process and were practicing without training just for the money. These healers were said to use any dried plant as medicine and abuse alcohol. Several subjects indicated or implied that healers who had finished their initiation properly could be trusted. It was also said that healers who held a certificate from the healers association could be trusted.

On the subject of whether or not healers consult under the influence of alcohol there seemed to be a wide range of opinion. Those that felt healers did consult using alcohol did not necessarily agree that this was a bad thing. It was explained that healers consult under the influence of alcohol because they believe that all the information from the ancestors comes when they have had a few drinks, and some traditional healers believe they derive power and magic from alcohol. One subject explained that in most traditional rituals, traditional beer (umqomboti) is used.... It is believed that by brewing you are not just giving to the people but to the ancestors.

However, there were others who felt quite differently. One subject said there should be a law prohibiting traditional healers from consulting while under the influence of alcohol. Another said that those who consult with their patients under the influence of alcohol cannot be trusted because discipline and good conduct are taught in their initiation period. One subject explained that traditional healers have a moral code which does not allow them to abuse alcohol however they do use beer in the form of umqomboti as part of the traditional healing system.

One subject said that the main problem in the above debate is that it is difficult to tell if healers are good or not because there are no papers to prove it. It was stressed that many people pretend to be healers but they "just want money" and "are only familiar with some drugs and rob our people." One subject explained that "the ones who spread hatred in the community are not real traditional healers." It was suggested that healers go through an accreditation process whereby they receive a certificate in order to work with the hospital.

*Traditional healers suffer from mental illness themselves?*

Several subjects said that healers are sometimes reticent to admit they are mentally ill and may make excuses for their behaviour such as "Its not me. Its the amakhosi (spirits) through me." It was explained that sometimes healers do not finish their initiation or are not properly trained and therefore continue to suffer the effects of thwasa. It was also suggested that some traditional healers are psychiatric patients who try to deny their illness by calling it thwasa, such people never actually qualify but practice as healers anyway. Another subject felt that a common problem that healers suffered from was grandiosity.

Other subjects said that the healers they have come into contact with have never showed any signs of mental illness, and that in their opinion, healers did not suffer from mental illness more so than any other people, as one subject put it: "Traditional healers are people just like any human beings so they also are prone to any kind of sickness, irrespective of their healing powers."

One subject had this to say about the above debate: "Critically it is difficult to evaluate this question because traditional healers can be effective to some people and cannot be effective to others. It depends on beliefs of those particular clients of him or her."

*Give details of other kinds of traditional healers you have visited?*

The following other kinds of healers were consulted by the subjects:

- I visited the slum people because they are fortune tellers. I have money problems.
- In our church there are men who are gifted with the Holy Spirit, who can heal you only by laying hands and praying.

Other subjects answered the above question by detailing their experiences with the traditional healers already mentioned in the questionnaire. The following statements were made in this regard:

- I was alright after I visited, and he convinced me, and the problem vanished.
- I visited the traditional healer when I had a problem of seeking a job.
- During my early primary school days I was sick, having nightmares, crying and scared at night so my parents took me to the above mentioned people.
- My problem was solved and I became much better.

*Would you consult with a traditional healer now if you had a relevant problem?*

Several subjects who answered "Yes" expressed the view that they would consult a traditional healer now because they had previously had positive experiences with traditional healers. Subjects also indicated that they would consult a traditional healer now only if their problem was of a cultural nature or if a Western doctor could not find the cause of their problem. One subject explained that "some of our sicknesses cannot be helped in hospital; another put it that "deep down I feel there is something that is culturally hidden from Western medicine;" and another said "there are some specific odd tendencies which are due to not fulfilling a custom - if one visits the traditional healer he will tell one how to do it and results become fruitful." Another subject would only consult a traditional healer that was registered with the Herbalist Council.

Others were not sure if they would consult or not, one subject explained that she is uncertain "because my belief in traditional healers is affected by the fact that most of them are not genuine traditional healers and it is very difficult to get one who one can trust," and another said "I am not sure since I have not yet had a problem that needed a traditional healer."

Those subjects that answered "No" generally said that they do not believe in traditional healing. Some subjects were more strongly apposed to traditional healing as a practice. One subject said she would never consult with a healer because "many people have been burnt who have been diagnosed as witches by traditional healers," and another said: "Now that I have grown up and can make decisions, I don't think (doubt) I can visit them. I don't trust their herbs and I hate the hatred they can instill amongst the people."

Many subjects appeared to hold the view that traditional healing is effective for those who believe in it, but not effective for those who don't. The following statements illustrate this: "Belief in a certain kind of healing can produce therapeutic results;" "Its a question of belief. If you think and believe so would the healer help;" "I believe in Christianity so I don't believe that traditional healers can help me;" "They can help others who believe in it, but not me."

*Do you think that your training in psychiatric nursing has made you doubtful about the value of traditional healers and their medicines?*

Several subjects explained that as a result of nursing they had been educated about several disorders that could not be healed by traditional healers because these conditions were "inherited" rather than caused by witchcraft. Epilepsy, mental retardation and schizophrenia were given as examples. As this subject explained: "Now that I have acquired the knowledge about mental illness and the possible causes and the different types of treatment, this gives me doubts about traditional healers. They like to associate mental illness with witchcraft, i.e. blaming somebody else."

Other subjects said their nursing training had made them doubtful about traditional healing because they had seen patients who after being unsuccessfully treated by traditional healers were thereafter successfully treated at the hospital and the reverse was not the case. Other explanations included the view that patients in hospitals "become better soon whereas traditional healers take too long to make [them] better" and that in psychiatry "they check you before they can do anything, in traditional healing they just give you medicines without knowing the full explanation about yourself." One subject said that nursing has made her doubtful about traditional healing because "it sort of gives answers in a rational, concrete way whereas traditional healing tends to be abstract," and another said "my thinking has been affected by my training as a psychiatric nurse. I am now leaning more to the Western kind of civilization and only believing in my customs and ancestors. Not traditional healers."

Some subjects indicated that nursing had made them strongly doubtful about traditional healers, one person having the following to say: "In my experience in the nursing profession I am 100% sure that traditional healers are dangerous people who fiddle with the patient for something she/he is not sure of, wasting peoples time. A problem which would have been identified and diagnosed early will complicate and the patient may die. Their medicines are poisonous and dangerous. They will tell a patient and relatives to buy and slaughter goats for no apparent reason, whilst the patient can be sure with hospital staff."

Subjects that said that their training in nursing had not made them doubtful about the value of traditional healers explained that they still believed in traditional cosmology and therefore maintained that traditional healers also had a role to play in the healing of the patient. Several of these subjects expressed the view that not fulfilling cultural duties and customs would result in illness that traditional healers are trained to cure. Others added that therefore the best treatment would be a combination of traditional and Western therapies. One subject put it that "in actual fact it [nursing] has given me insight that traditional healing, if followed on proper guidelines and honestly, could simplify some psychiatric problems or rather offer some relevant analysis." The view was also widely expressed that in their experience these subjects had witnessed the effectiveness of traditional healers' treatments. These subjects also said their experience had shown them that when a patient is sent to traditional healers after hospitalization it takes longer to relapse than if they hadn't been referred."

One subject said that her training in nursing had not made her doubtful because it had taught her to be open to a wide range of approaches to healing. However, some subjects indicated that they believed in traditional healers in the face of being educated against them. One person explained it as follows: "I was made to be doubtful but I am not." Another said: "The majority of nurses in government hospitals have been brain-washed by educational institutions, religion and Western culture about their origin, culture, customs etc. and made to believe and perform the Western culture and undermine their own culture and customs."

## APPENDIX C

### ANSWERS TO OPEN-ENDED QUESTIONS

NOTE: The following responses are recorded verbatim

**Comments for Questions 16 - 23:**

*("[Traditional healers] can play a positive role in the care of the mentally ill" and "[Traditional healers] should work in hospitals as members of the psychiatric team.")*

Subj. No.	Response
5.	Amaxhwele (herbalists) should come to the hospital once a week and the patient and family should sign and agree that the herbalist is going to work on them. When the patient is admitted the family should agree, before leaving, that the patient can be referred to a herbalist.
7.	Amaxhwele has got more to do with physical ailments, not psychiatry. Amagqirha can plan an important role to just identify whether a condition needs cultural attention or not, e.g. Ukuthwasa, etc.
8.	The other people mentioned in no. 18, 19 and 20 distort the patient's thoughts further with their beliefs whilst ixhwele treats.
12.	Diviner tells you what is the cause of your illness and how do you feel and when did you start to be ill.
14.	It is true that the traditional healers can play a team role with hospital members because the other patients need to be healed traditionally and hospitalized.
16.	Traditional healers should work in hospitals so that they can attend to those who believe in them.
21.	Depends on incorporation of traditional healers into western medicine, some areas will quickly adapt, others slower, but people are not believing in witchcraft.
24.	All these healers should work hand in hand with hospital but at their own settings.
25.	These people must not be trusted at all. They are dangerous to the community. Hospitals and the staff are the best. They should not work in hospitals because they will put on their so-called uniform and paint their faces white with beads and feathers on their heads. This will cause chaos and disturb other patients who were at a stable condition.
26.	Clients should be allowed to attend herbalists, etc. They are healed psychologically but herbalists and others should be educated about the importance of treatment. Diviners examine and treat clients differently with the hospital routine. Their presence can cause chaos and confusion on the part of the hospital doctors and psychologists.
30.	Most psychiatric patients have strong beliefs in the positive contributions of customs and traditional healing to their illness.
33.	Traditional healers should be part of the psychiatric team in cases where the patient is suffering from thwasa and amafufunyana.

35. I agree to some extent. They can all play a role in the care of mentally ill patients but they must not be allowed to work in the hospital full-time. They should only come in to visit.
38. I think the amagqirha and amaxhwele, plus the psychiatric team, should work together.
39. If they can be clean and their medicine clean them properly.
42. It's because some patients believe in the above and see them as their healers.
44. Nursing profession could be better if they are combined with herbalists and diviners. Some of the faith healers can play a positive role and some of the faith healers are good (true ones).
48. Yes, they can work together as a team to help the community.
52. If the above mentioned people can come forward and have a referral system to the psychiatric units, because most black people go to them before going to professional people (i.e. hospital).
53. Culture does play a part in shaping one's like so it should not be ignored.
54. In some cases one is mentally ill because of some certain custom and that can be cured by a herbalist.
56. Not very much in favour or agree with faith healers. There is no true faith healer nowadays.
62. Hospital treatment is sometimes contradictory with the above healers.
63. Herbalists, faith healers, diviners should come together with the health team and teach one another about psychiatric illness, causes, treatment, side effects, complications, removal of stigma attached, chronicity.
64. I agree that these people should be involved to complete the multi-disciplinary team and to respect the belief of Xhosa patients who believe in their rituals and customs.
65. Few patients need attention from herbalists and faith healers.
66. No comments except that a person becomes better for a short while and then starts to be ill again.
69. It is impossible for them to be included in psychiatric team because they are not always effective and some people have disbelief in them. Partly others are liars so there is mistrust developed towards them.
74. Some patients believe that they have been punished by God for their sins. Some are resistant to voice out their problems but can reveal easily to faith healers.

**Comments for Questions 24 - 27:**

*("[Traditional healers] should have certain patients referred to them after discharge from hospital.")*

1. They work same like psychologist except for the water.
5. Referrals can be made with the patient and family's permission.
7. If one has been discharged, what is the use of referring him/her because you've managed to control his/her condition, unless uncontrollable.

14. Certain patients can go to traditional healers after discharge because patients can be cured with medication of hospital at the same time he/she needs traditional help.
16. Patients should decided for themselves or their families should decide whether they should be referred to a traditional healer after discharge.
21. What if the faith healers tell them it was not necessary to have gone to hospital in the first instance.
25. These people are trained in magical skills. If a patient has belief in their dancing and throwing of bones and shells, he/she can visit them as long as they will continue with treatment and follow-up.
26. If a patient has been educated about the important of medication, there is no need for further referral to a herbalist or faith healer because herbalists discourage patients from taking hospital medication. Their treatment is so dangerous. They do stomach wash-outs and induce vomiting as they believe that there is a poison or patient is bewitched. Patients can die in the hands of herbalists and if there is a history that the patient was referred by a professional, it can be disgraceful conduct.
30. Psychotropic drugs can never substitute the inculcated superstitions which are inborn and inheritable from one generation to another.
33. Patients should be referred to traditional healers after discharge in cases where the patient is suffering from thwasa and amafufunyana.
34. The people can be referred to amaxhwele, amaprofethi and abathandazeli because in the community where they live they believe in those people.
35. It's one's own indaba.
37. Faith healers have a psychological role to play to mentally ill patients.
38. They can work together. It will help the country.
41. They can be referred to the above healers if their illness is due to our customs or due to superstitions.
42. This could do them good at times.
44. I disagree because if a patient is discharged well, he is fit for the outside world. Doctors should work hand in hand with diviners and herbalists until the patient is cured.
45. It is difficult to answer the questions concerning amaxhwele and amagqira because sometimes they are good and sometimes bad.
48. Yes, they can work together as a team to help the community.
52. All traditional healers should be registered. Then if an individual after discharge wants to see a traditional healer he/she should be referred.
53. Referrals should not be made to these disciplines. Seeking such advice should be left to patient's relatives and patients themselves to decide about.
56. Patients can be referred to faith healers and diviners only if they believe in such and the faith healer or diviner should not stop the patient's medical treatment without consulting the doctor.

63. It is important that the healers mentioned above should work hand in hand with the hospital team. Refer if unable to cure and not to wait until chronicity sets in. Refer patients whilst still acute for further assessment and treatment in order to prevent chronicity.
64. I agree because some of the patient's believe in the aforementioned healers so I think it could be proper to respect their point of view, and if one believes in something that should be respected as we all come from different backgrounds with different beliefs.
65. Patients can be referred to the herbalists and faith healers because they can heal the patients. Not the other two.
66. I agree because sometimes they help those people who are from the hospital.
69. It must depend on the individual and his or her family to see or attend them. What we can encourage is the use of psychiatric medication together with those of traditional healers as there is no interaction or reaction between them as I experienced with 3 patients during the course of my training up to now.

**Comments for Questions 28 - 31:**

*("[Traditional healers] should visit psychiatric hospitals to consult with certain patients.")*

1. They have power to remove the witches bewitching people.
5. Orientation to psychiatric hospitals would help make them aware of some of their wrong diagnoses.
8. The amagqirha reinforce the distorted thoughts of the patients and most of the time create conflicts within the family.
12. Faith healer tells you what is going to happen in future.
14. Both teams should meet each other and share views with each other about the patients, so that they can see the diagnosis of the patients.
16. Traditional healers should visit hospitals because there are patients who still believe that if they can be brought in these people could feel better.
21. If there is acknowledged interaction with the multi-disciplinary team.
24. There is no need to refer patient to diviners on discharge because they have been treated and they can see for themselves the results - no need for further enquiry.
25. They can communicate with disturbed people. At least they have that intimate knowledge of their customs and beliefs of their people. They must not be allowed to consult their patients in hospitals, as this can cause chaos and disturb other patients.
26. The abovementioned people should visit hospitals only for health education or orientation purposes. They will confuse the already confused patient.
30. Psychiatric illness is a complex disease - emanating from various different factors. Therefore an inclusive multidisciplinary approach could be effective.

35. The herbalists and faith healers must conduct or do their therapies outside the hospital premises. They must not be allowed into the hospital premises.
41. If and only if the above healers are qualified, not chance takers, which means they must be recommended by the community.
42. This could be helpful to some patients.
44. They should first consult the doctor to get a full history of the patient and then to the patient and see what can be done.
48. Yes, they can work together as a team to help the community.
53. These practices should be done in own institutions or relevant places, e.g. home of a diviner or a faith healer.
56. This would cause a problem to the already confused patient as to who to have trust in.
63. Apparently all the above mentioned people are working towards one goal, i.e. that of getting the patient better. Therefore they must work hand in hand. One must not condemn the others. They must sit and discuss the psychiatric problem of a patient and get a solution to cure the patient.
64. I agree that the abovementioned should visit the hospital to maintain the contact with the patient and to advise about the medication they have commenced and to share their expertise with the multidisciplinary team.
65. The abovementioned people will disturb the doctors' duties in the hospital.
69. Amongst us Black people there is a belief that if somebody is using herbal medication all his or her demons will interfere with one who is not using it. They cannot maintain professional secrets as it is most important for the patient to develop a feeling of worth and trust.

**Comments for Questions 32 - 35:**

*("Certain patients should visit [traditional healers] before coming to a psychiatric hospital for help.")*

2. Because of time consuming, some patients get worse because of these therapists mentioned above. It is better to take the patient for psychiatric treatment first.
5. The patient can see the therapists mentioned before coming to hospital if they believe in them.
7. These people should work hand-in-hand with each other, it is not necessary that patients must visit them before going to a psychiatric institution.
8. Patients should only visit an ixhwele after coming to a psychiatric hospital for help.
14. I disagree with points 33 and 34 because it can be the hospital illness and then they don't know that is why the patient must come to hospital first.
16. Patients should go to the doctor (medicine) first.
21. This would probably delay proper intervention and the faith healer would want to be seen as "adequate". (I would rather phrase no.34 as "would visit".)

25. If you allow them to visit these people it would be difficult for you to change his mind for your medication. Health education is very important; importance of regular visits, check-ups and treatment.
26. I personally discourage clients from going to herbalists before going to hospital because by the time they come to the hospital they are already worse. Sometimes psychiatric patients are also suffering from diabetes, etc. In that case they will be worse. In my experience in nursing we've seen people attended to by herbalists with no effect. Instead they worsen the situation.
30. Referral to a mental institution is usually viewed as a second opinion because mental illness is associated with witchcraft and customary related illness.
36. I am not sure about the role of amaxhwele.
40. Patients can't visit ixhwele first without knowing the cause of the illness because the ixhwele has got herbs only.
41. In so much that the family of the patient can choose and see which side has good treatment - the healers or the hospital.
42. Some patients should visit traditional healers because they could have been cured before they had been admitted to an institution.
44. The patient must go to a hospital before the herbalist because he/she can be a danger to themselves and to the community.
53. Use of "should" implies a matter of "must" which I disagree with.
56. I agree because some of the herbalists (trained with certificate) had previously referred patients to the psychiatric doctors or medical doctors.
63. The problem here is that all these helpers do not work together as a team. One condemns the other and this is not right but they could sit, discuss, share ideas. The patient would benefit at the end instead of fighting an endless battle. Education of the community is what must be embarked upon.
69. It is important to encourage and educate community to come to hospital first because my experience during 2 years training in psychiatry and 1 year as professional nurse if they abuse patients and about 80% ended up in psychiatric hospitals from them. Their care is based on punishment like they work as slaves throughout the day, they assault them saying they bit amafufunyana, not thinking patients are human beings.

**Comments for Question 36:**

*("A referral system with the hospital and traditional healers should be established.")*

2. Disagree. Some people become sick because of failure to get their traditional customs and treatment.
7. (same as no.32 - 35) Agree. These people should work hand-in-hand with each other, it is not necessary that patients must visit them before going to a psychiatric institution.
8. Agree. But only with certain "amaxhwele" because others are liars which practice ubexhwele only for money - only to the ones with proven results.
14. Agree. So that they can share the views to each other about the patients and see what or which medication or herb they must use.
16. Agree. So that there could be better co-operation between the patient and the healers.

22. Disagree. Patient can't visit all these people before coming to a psychiatric hospital. Most of the patients who visit all these people end up coming to the hospital.
24. Agree. Preferably before a patient is treated on both side in case the illness needs to be attended by the other.
25. Disagree. They are illiterates. Their role needs to be evaluated.
26. Agree. It can be established so that if the herbalist is quite aware that the client is seriously ill, they must not fiddle with the client but must refer them immediately.
42. Agree. This can serve a good cause to the benefit of the patients in question.
44. Agree. If he/she does not become better he can be referred with the help of the hospital/doctors with strict supervision.
52. Agree. The referral system can enhance good relationships and co-operation between the two worlds. One would respect each other and the patients will benefit.
53. Disagree. Decision should be left to parents/relatives or to patient himself.
56. Agree. This would give a chance to the "others" (traditional healers) to have an insight as to what a psychiatric patient is and this will minimize the false beliefs and expectations they give to patients.
62. Disagree. If the person would like to visit the above healers, should decide for himself or referral can be made by family members.
63. Agree. This referral system would help to eliminate chronicity as patients will be treated in their acute stages and would get better treatment using the team work approach.
66. Agree. There are certain illnesses that these people can see and cure which a doctor cannot see, like a doctor can see and cure illnesses that these people don't see.
69. Disagree. It must depend to that particular individual and his or her family. It is their choice because some of the community members are non-believers or before they experienced negative attitudes towards them which led to mistrust amongst them. As I said before some are liars.

**Comments for Question 41:**

*(Reasons for referral of patients to traditional healers.)*

5. For Thwasa a patient must be referred to a special igqira who has good training, not any igqira who wants a bottle of alcohol first.
12. Traditional healers can not cure people taking drugs.
14. What I can talk about a patient who is suffering from epilepsy because sometimes its a dirty wind that's come from the stomach then goes up the brains so the patients like that must see traditional healers.
16. They help sometimes.
21. No. J - Would depend on the kind of problem and what cultural beliefs the patient believes in. The answer would probably be YES and NO.

25. Some of these conditions need counselling, e.g. abuse of alcohol and marriage problems. Because of these cultural beliefs some conditions can be reviewed by these traditional healers, e.g. Thwasa cultural problems, to undergo their training but if this doesn't help they must come back to hospital for professional help and treatment.
26. Clients with something traditional or cultural can be referred to the traditional healers to sort out Thwasa. A patient with amafufunyana needs hospital treatment, i.e. sedation and counselling. In my experience in nursing, these patients can be seen by the herbalist and others but eventually they come to the hospital. Since now the psychologists and psychiatrists are aware about the problems, they can be treated psychologically with a lot of counselling. Hospital doctors must follow up the patient after discharge so as to build that relationship.
44. I would refer a patient who is always dreaming that his/her dead parents or relatives were speaking to him/her in their dreams. Sometimes they do not react to treatment - try other means. Maybe something was not done (cultural problems). For marriage or family problems a social worker can be consulted.
45. A patient can be referred to a traditional healer, like for cancer they can get help and those who are suffering from amafufunyana.
46. I think they will help and play a big role in the care of mentally ill patients.
48. No other reasons, only they can work together as a team.
69. My suggestion is that no patient can be referred to relevant traditional healers as hospital will not know who is the best healer or relevant one.

**Comments for Question 45:**

*("If you decided to refer a patient to a traditional healer would you do it in secret?")*

1. Yes. It is our culture not to be seen by everybody because of the belief of witchcraft.
2. Yes. Because of the western culture people are reluctant and become embarrassed if found in traditional healer's places.
5. Yes. People tend to think that you want to bewitch people.
7. No. If I see that none of the psychiatric/modern medicine works/improves the situation and history of patient presents symptoms of cultural problem.
8. Yes. To avoid embarrassing the patient because this is always kept secret and to avoid conflict with non-believers.
12. No: I would not do it in secret because the patient will tell doctor that so and so have taken me to the healer when patient is sick.
14. No. It cannot be a secret because you wouldn't know whether the patient needs help from both people and sometimes both help to such cases.
15. No. Everybody or members of your family must know about everything in order whatever outcome may come should be blame.
16. No. So that there is not overdosage in medicines.

21. No. Traditional healers perform best from openness, unlike confidentiality practised in psychiatry.
24. No. If I see that the illness does not need hospital interference I will explain to the doctor, then ask him to discharge patient.
25. No. It must be known. In the first place psychiatric staff do invite these people to their meetings and workshops. There should be an agreement and must be in writing, so that if it happens that you refer a patient to the healers you are on the safe side because anything may happen whilst treated by these traditional healers.
26. No. In primary health care we all know that traditional healers are part of the multidisciplinary team. Professionals all know that if you refer a patient to traditional healers you need co-operation on the part of the patient and traditional healer. At the same time you want to win the patient and traditional healer's trust. They must not think that we are against their beliefs.
30. No. Traditional healing is now an open approach which one can voluntarily decide to follow unapprehendedly.
33. No. If he has thwasa, amafufunyana, traditional customs or complaint of cultural problems, these need to be diagnosed.
34. No. Simply because there are traditional healers who are recognized, even by the hospitals.
37. Yes. Because it is seen as taboo by Western society/doctors.
38. No. Because traditional healers and hospital work together.
40. Yes. According to our tradition it's a family affair to go to a healer, so it's a secret.
41. No. It is not something which must be hidden, it's not a disgrace, it's just like visiting any surgeon.
42. No. Traditional healing should be respected.
44. No. If traditional healers can work hand in hand with the hospitals and be educated or workshopped and no secrets about that (the way forward).
45. No. A patient can be referred to a traditional healer through the agreement with the doctor.
47. No. Traditional healers are part and parcel of our black society, e.g. if a young Xhosa boy is to go for circumcision he first visits a healer.
48. No. You should consult the doctor first.
49. No. If the patient believes in a traditional healer I would tell him/her that I'm referring him/her to a traditional healer. It won't be a secret.
51. No. Traditional healers are no secret. They exist in our society and it's no shame to see them.
52. No. If the traditional healers can all be registered and the Department of Health find a way of co-operation between them, I think that can help.
53. No. Attending a traditional healer for cultural purposes (like rituals) is no shame.
56. No. I feel that the traditional healers and doctors should work hand in hand. That is why they should be openly referred.

59. No. There is no need to hide if you believe in a traditional healer.
63. No. I feel they should also receive recognition as health team members who want to help sick people to get better. Therefore referring some patients to them would motivate them to do the same with their patients, i.e. refer them to the hospital team or invite hospital staff to see patient and decide after discussing patient how to meet the patient's problem instead of waiting too long, encouraging chronicity.
66. No. Because I am trying by all means to get him or her a better health.
69. Yes. Maintaining secret promotes, establishes and maintains trust relationship with the patient which is most important in therapy of patient's condition.
74. No. Some patients have social and cultural problems which need the consultation of a traditional healer and I feel that traditional healers are also members of health providers.
75. No. Because in psychiatry we work as a team and so that we can all see how effective medication of the traditional healer is.

**Comments for Questions 46 - 50:**

*(Views on the reliability/integrity/validity of traditional healers.)*

5. Most traditional healers don't finish their initiation because of poverty, e.g. they are unable to buy all these goats and cattle demanded by some traditional doctors. Some are sexually abused, get divorced and along the way don't finish their initiation. Most healers consult under the influence of alcohol because they believe that all the information from ancestors comes when they have had a few drinks.
8. Most traditional healers don't even "thwasa" because healing was not their "call", but because they want money. They take any plant and make medicine out of it after drying and grinding it - disguise. If you bring money they don't bother re influence of alcohol.
14. Traditional healers need the money because they are using money for the things that are using for healing. Some of them are not after money - they after the patient's life.
21. Some traditional healers believe they derive power and "magic" from alcohol.
24. It is difficult to know whether or not a traditional healer has finished his/her initiation because there are no papers or any documents to prove it.
25. These people cause hatred, families are broken, other children are orphans and homeless because of them. Quoting from "Sunday Times" - there are kids who were crying for their mother who was burnt into ashes because they believed she was a witch. Certain family consulted a sangoma who allegedly told them that their mother was responsible for the death of a certain member of that community.
26. Most traditional healers discourage patients from taking hospital treatment. The aim of these people is money only. I'm not interested in them.
42. There should be a law prohibiting traditional healers from consulting while under the influence of alcohol.
44. Those who finished their initiation can be trusted. Those who consult with their patients under the influence of alcohol can not be trusted because discipline and good conduct are taught in their initiation period.
47. As stated in question 45, e.g. in most traditional rituals traditional beer (umqomboti) is used not for the question of drinking. It is believed that by brewing you are not just giving to the people but to the ancestors.

51. There are people who pretend to be real traditional healers whilst they are not. They are only familiar with some traditional drugs. These tend to go for money. It's them who rob our people.
52. Some of the traditional healers are just looking for money and only spread hatred among the family members and even the community at large and do not help the psychiatric patient at all.
56. Traditional healers do have a moral code which does not allow them to abuse alcohol - should mostly take "umqombothi".
69. It is difficult to answer these questions because it needs individuality who experienced or engaged or involved to these influences.

### **Comments for Question 51:**

*("How many traditional healers do you think are suffering from mental illness themselves?")*

5. Some traditional healers suffer from mental illness but they don't want to admit mental illness and say they've amakhosi; they've killed a lot of people through this amakhosi. They'll stab a person and when asked will say "No! It's not me. It's the amakhosi through me."
7. Very few traditional healers are suffering from mental illness. Some of them didn't finish the period of "ukuthwasa" as they were greedy only for the money.
14. Those who suffering mental illness are those who didn't finish to be healed and the forefathers wants them to be finished and they cannot and then landed there.
24. It is difficult to tell because I have never come across one whose mentality was being questioned.
25. They are all mentally ill. How can a traditional healer help somebody with depression? These healers use herbs.
26. Most of them are mentally ill and I wonder how can you treat a depressed patient or other illnesses. For example, King Gcaleka with a skull is also mentally ill.
42. When they are not properly trained by the igqirha, they do suffer from mental illness sometimes.
44. I would say that very few traditional healers are suffering from mental illness. If all other methods have been tried, try the other side of the coin.
47. Traditional healers are people just like any human being so they also are prone to any kind of sickness, irrespective of their healing powers.
52. Some of them suffer from grandiosity.
56. A few of these traditional healers are actually mental patients who try to deny mental illness by running to "thwasa" and they never get qualified.
69. Critically it is difficult to evaluate this question because traditional healers can be effective to some people and cannot be effective to others. It depends on beliefs of those particular clients of him or her.

### **Comments for Questions 58 - 61:**

*("If you have ever visited any other kind of traditional healer with a problem, please give details")*

1. For assistance.
26. No, I don't believe the traditional healers. They make things worse.
31. I was alright after I visited and he convinced me and the problem vanished.
42. Some are chance takers.
44. I visited the slum people because they are fortune tellers. I have money problems.
46. I visited the traditional healer when I had a problem of seeking a job.
51. I didn't actually go to the faith healer, but in our church there are men who are gifted with the Holy Spirit, who can heal you only by laying hands and praying.
52. During my early primary school days I was sick, having nightmares, crying and scared at night so my parents took me to the above mentioned people.
53. Personal problems are points to remember.
62. Prophets are more effective than other types of healers.
66. My problem was solved and I became much better.

**Comments for Question 62:**

*("Would you consult with a traditional healer now if you had a relevant problem?")*

1. Yes, because he helped.
2. Yes, because there are Xhosa problems which need traditional way of treatment. Because medical doctors cannot refer me for a custom.
7. Yes, if I knew for a fact that it involves something of tradition.
8. Yes, I would consult ixhwele who will treat the problem without telling me lies as who caused my problem like igqirha.
14. Yes, I can because there are dirty witchdoctors that can separate your family asunder so that you can't be together at all.
15. Yes, if I have a problem with my self through which the doctor couldn't find what caused it.
16. No, the first option when somebody is sick is a medical doctor.
21. Yes, I feel deep down there is something that is culturally hidden from Western medicine.
24. Yes, if I notice that the problem does not need a doctor at all.

25. No, I have no belief in them. They are trained in magical skills.
26. No, many people have been burnt who have been diagnosed as witches by traditional healers.
28. Yes, because I do believe in traditional healing. Some of our sickness cannot be helped in hospital.
30. Yes, there are some specific odd tendencies which are due to unfulfillment of a customary trait - if one visits the traditional healer he will tell one how to do it and results become fruitful.
31. Yes, because he did a wonderful job for me and it worked.
33. Yes, because they do help sometimes.
36. No, I am not quite sure because my belief in traditional healers is affected by the fact that most of them are not genuine traditional healers and it is very much difficult to get one who one can trust.
37. I am not sure since I have not yet had a problem that needed a traditional healer.
40. Yes, according to our custom there are problems which need traditional healers.
41. Yes, because I believe in their treatment and you can feel when the problem you have needs the doctor or the traditional healer.
42. Yes, some problems are only solved by traditional healers, e.g. ill luck.
44. Yes, if I had a dream of my family that I don't understand I will consult or cultural problems.
45. No, it is always good to consult a doctor before a traditional healer.
47. Yes, it's a question of belief. If you think and believe so would the healer help.
48. Yes, if the problem is related to traditional customs.
49. Yes, if I feel that the problem needs a traditional healer.
51. No, I believe in Christianity so I don't believe that traditional healers can help me. They can help others who believe in it, but not me.
52. No, now that I have grown up and can make decisions, I don't think (doubt) if I can visit them. I don't trust their herbs and I hate the hatred they can instil amongst the people.
54. Yes, if that problem can't be solved by someone else, maybe I need some special herb.
56. Yes, if the problem is relevant to a traditional healer, e.g. customs related - not medical problem. The medical doctors can do very little to help me. Of course, only if he is registered with the Herbalist Council.
59. No, I don't believe.
62. Yes, belief in a certain kind of healing can produce therapeutic results.
63. Yes, if for example I have lost valuables in my house and a traditional healer is able to tell me exactly where they are. There are those that can help with such problems but not for health problems.
65. Yes, because it is my belief and my tradition.

66. Yes, because I've got a belief in traditional healers.
69. No, it is important to involve yourself in problem solving as to prevent dependent disorder.
74. Yes, but it depends on the kind of problem I am having and only if it is a social or customary problem.
75. Yes, if the problem concerns a traditional healer.

**Comments for Question 63:**

*("Do you think that your training in psychiatric nursing has made you doubtful about the value of traditional healers and their medicines?")*

5. Yes, because I've learnt and seen that in some cases mental illness is inherited and no traditional healer can cure that, e.g. schizophrenia, mental retardation. You can slaughter many goats with no improvement, e.g. epilepsy.
7. No, I still strongly believe that as a black African (Xhosa) we have our long history, e.g. If you can do a research to so called "Blacks" Witnesses of Jehovah, you will find out about 50% of their population is mentally disturbed. Why? Because they don't do their custom. Mostly the youth, because fathers and mothers have done their customs before joining witnesses of God.
8. No, because I was treated more than four times by my ixhwele and it took seven days to heal a three month old ulcer on the leg - spreading ulcer - and one day to treat my father who was bleeding frank blood every third hour when he goes to toilet.
12. Yes, because if you take a patient to psychiatric hospital he became better soon whereas traditional healer takes too long to be better - instead he becomes worse.
14. No, because both medication and traditional healers can work together.
15. Yes, I think the better offer is from psychiatric nursing because here they check you before they can do anything, in traditional healers they just give you medicines without knowing full explanation about yourself.
16. No, they are helping in certain problems.
21. No, in actual fact it has given me insight that traditional healing, if followed on proper guidelines and honestly, could simplify some psychiatric problems or rather offer some relevant analysis.
22. Yes, because in the first place I've nursed many patients from traditional healers who came to the psychiatric hospital very ill. After some few weeks in the hospital the patients get better. So I don't believe in traditional healers.
24. No, recently a relative of mine developed an acute headache and confusion. We took him to hospital and at the same time consulted a traditional healer. The medication we gave him helped to treat the confusion but still he had to be operated on. He is now fine but is still using both hospital and traditional healer's medication.
25. Yes, some of the traditional healers made me doubtful about them.
26. Yes. In my experience in the nursing profession I am 100% sure that traditional healers are dangerous people who fiddle with the patient for something she/he is not sure of, wasting people's time. A problem which would have been identified and diagnosed early will complicate and the patient may die. Their medicines are poisonous

and dangerous. They will tell a patient and relatives to buy and slaughter goats for no apparent reason, whilst the patient can be sure with hospital staff.

28. No, traditional healers are also playing an important role. They are needed by our families.
30. No, training in psychiatric nursing does not change one's beliefs, it rather explores one's unilateral approach to mental illness to include the modern trend of psychotherapy.
31. No, because traditional healers are also there to help and their medicines are effective to those who believe in them.
33. No, because when an individual is sent to them after hospitalization it takes time to be hospitalized again.
34. No, there isn't doubt about training in psychiatric nursing simply because the training in psychiatric hospitals is more advanced and well planned. It gives a nurse a positive attitude towards a patient, as compared to traditional healers.
36. Yes, my thinking has been affected by my training as a psychiatric nurse. I am now leaning more to the Western kind of civilization and only believing in my customs and ancestors. Not traditional healers.
37. Yes, it sort of gives answers in a rational, concrete way whereas traditional healing tends to be abstract in healing.
39. Yes, I am doubtful because those people who have been treated here get better and after leaving hospital they worsen.
41. No, as I have said there are traditional healers who are not qualified who need money and they tell lies, and this is what causes the misunderstanding between these people. Let me tell you this, those who are not chance-takers do not recommend themselves, they are quiet.
42. No, from experience I know that some patients do need traditional healers' treatments.
44. No, I was made to be doubtful but I am not.
47. Yes, I have experienced that not all cases of mentally ill people are due to witchcraft but one can be born mentally retarded.
48. No, some of the traditional psychiatric problems are originating from traditional problems, like ukuthwasa.
49. No, they work hand in hand because other patients are cured or feel better. This depends on the patient's belief about traditional healers.
51. No, I'm certain that traditional healers, especially amagqirha, can play an important role and must be included in the therapeutic team. They are the only people who can deal with amafufunyana, thwasa, witchcraft and cultural disobedience-linked psychiatric illness.
52. Yes, now that I have acquired the knowledge about mental illness and the possible causes and the different types of treatment, this gives me doubts about traditional healers. They like to associate mental illness with witchcraft, i.e. blaming somebody else.
53. No, with training I still recognise the work of traditional healers.
54. I don't know because my training hasn't started yet.

56. No, faith healers have always been part of our community. Even before the medical doctors were introduced to the blacks, these people were always there and they did a lot of help for the people of those days health-wise (excluding the fake or false ones).
63. Yes, many patients who started by being treated by traditional healers have reached the hospital already in the chronic stages of mental illness and they end up being in hospital for years whereas if they came to hospital earlier, early treatment would prevent chronicity. Discussion of causes, treatment and prevention should be emphasised as well as the importance of working together. The importance of referring could also be stressed.
65. No, because some of the patients need attention of traditional healers.
66. Yes, because in nursing people are helped by tablets and injections, whereas the traditional healer gave them some kinds of roots and herbs and they also become better or cured.
69. No, because sometimes they are effective.
74. No, traditional healers medication has been of good help to some psychiatric patients and we cannot shift it aside.
75. No, there are those traditional healers that help the people and also those people who believe mostly in them and then they should not be discouraged.

**Comments for Question 64:**

*(Any other comments with regard to the questionnaire.)*

1. It is good and can assist the psychiatric team to understand some problems not resolved by them.
7. Qamata is God - before missionaries we knew that there is God who is invisible and powerful and our ancestors act as a link before God and us.
8. I think the ways of selecting of any of the traditional healers should also be included.
12. I was interested and I have learnt a lot.
21. I would be pleased if the questionnaire could be fully utilized, as the input of Xhosa-speaking nurses would be most helpful.
25. This person is psychiatric orientated. It is difficult for one who is not trained in psychiatry to say Yes or No. This questionnaire should be given to all races because they all know about these questions, especially the Coloureds.
26. This questionnaire is focussing on psychiatry, mentions a little about psychotherapy and yet some problems are marriage and financial who need counselling and some people resort to traditional healers.
30. It is not the effect brought by psychotropic treatment that heals the mental illness, but the curing of the belief that one has before he was even admitted to a mental institution.
37. Some answers cannot be given in a Yes / No fashion, especially when one has never experienced the item in question.
41. Every time I visit the surgeon or the traditional healer I ask God to be there and give this treatment His power to heal me or to solve my problem, because God is above all things on earth. That is why most of the doctors do not want to perform abortions. It's not that they cannot but they are afraid or respect God, which is good. In everything which a person does God comes first.

42. What I think is that traditional healers should go through a test and be issued with certificates in order to enter psychiatric institutions.
44. Traditional healers should be given a chance to work with hospitals and be educated. I am sure things might change with all these diseases that are incurable in this world of ours.
47. It's brain opening. It's challenging, it gives one insight. It's education, it's democratic in that it does not confine one to answer what is relevant. It is a good combination of good and constructive ways of seeing things.
53. Use of "should" in many questions makes the sense of the statement to appear as if the ..... must be used.
63. How about organizing workshops, symposia etc. where all types of healers are invited to attend and participate in such as no-one feels inferior or even superior than the other. It would be nice to have these healers during ward rounds where a patient with a certain type of mental illness is discussed by the health team so that they can also bring their ideas and teach and learn at the same time.
69. Research done by not Xhosa speaking people cannot be effective on investigation because research needs individuals who engaged, experienced these in community and we tried in our best answering questions but cultures differ even amongst us Xhosa speaking people concerning traditional healers. Community must be involved in the research as they know better. Take for instance I am born in non-believers of traditional healers.
74. The majority of nurses in government hospitals have been brain-washed by educational institutions, religion and Western culture about their origin, culture, customs etc. and made to believe and perform the Western culture and undermine their own culture and customs.
75. For the belief of the patient that plays an important part to quick or speedy recovery, whatever the person believes in should be considered and not be undermined and the patient is educated to use both hospital and traditional healer's medication.

