

Does the evidence support collaboration between psychiatry and traditional healers? Findings from three South African studies

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Abstract

It is estimated that 70% of South Africans consult traditional healers, who include diviners, herbalists, faith healers and traditional birth attendants. Calls from the new democratic South African government for medical practitioners to collaborate with traditional healers escalated during the nineties, and the draft Traditional Health Practitioners Bill of South Africa was unanimously approved by parliament in September 2004. The author felt that there is a significant lack of information about the contribution of traditional healers in South Africa to mental health, and over recent years conducted three studies designed to fill some of the gaps. The combined data of the studies suggests that, while traditional healers provide a valued mental health service to certain types of clients, they resemble faith-based practitioners and counsellors more than medical practitioners. The author concludes that collaboration should be promoted, but further knowledge and debate is needed about the best way for mental health practitioners to collaborate with traditional healers, and on what basis it should be founded.

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Introduction

The draft Traditional Health Practitioners Bill of South Africa was unanimously approved by parliament in September 2004. This was the long-awaited official recognition of the country's approximately 250,000 traditional healers and their advocates. It is estimated that 70% of South Africans consult traditional healers, who include diviners, herbalists, faith healers and traditional birth attendants.¹ The Bill is the first step in the process to register traditional healers with the Health Professions Council, to subject their medicines to control by the Medicines Control Council, and to accommodate them in medical aid schemes.

Calls from the new democratic South African government for medical practitioners to collaborate with traditional healers escalated during the nineties. The motivation put forward was that traditional healers have been serving indigenous communities since time immemorial, and enjoy a respected place in their society. Despite the development of excellent medical services in South Africa, traditional healers continue to be consulted, even when clients are under medical treatment. Many consider traditional healers to provide more holistic care than medical practitioners, to be more accessible, and to have an approach that is more appropriate and therefore more acceptable to the community. In addition, there are more traditional than medical practitioners in South Africa. Finally, it has been felt that traditional healers are not understood or accepted by the medical profession, and are being excluded from many of the benefits of the health system.

During the past few decades, members of our research group have been involved in various cultural mental health projects, and several of us were interested in the issue of collaboration between mental health professionals and

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traditional practitioners. It was felt that it would be easier to support the call to collaborate if more was known about what collaboration entails. There is a relative lack of knowledge among the general public about traditional healing, due, among other things, to secrecy and lack of documentation. Although the public image of traditional healers may be generally positive, awareness of reported instances of 'malpractice' or even fatal outcomes following traditional healing, suggested a cautious approach to collaboration.

To a lesser or greater extent these issues influenced the planning of the three studies providing the data for this article. It was felt that effective collaboration needs to be based on a mutual understanding of the principles, practices and knowledge base of the parties involved. More specifically, there was an awareness of the significant lack of information about the contribution to mental health of indigenous African healers in South Africa. These studies sought to answer questions that would fill the current gaps in existing knowledge. All the studies were carried out among Xhosa-speaking Africans in Cape Town, mostly in the informal settlement of Khayelitsha. All interviews were conducted in Xhosa.

Biomedical and indigenous African diagnostic systems

The first study started with a pilot study to document common indigenous categories of distress and dysfunction in children seen by traditional healers.² Interviews with ten diviners, herbalists and faith healers in the township of Guguletu yielded five putative categories. In the main study, these were explored further with sixteen diviners in Khayelitsha by means of semi-structured questionnaires designed for the study, as the pilot study suggested that diviners had the most experience in this field. The study found that each of the categories was well known to the diviners and had an indigenous name, the first three occurring commonly among adults as well as children. Their English meaning is given in parentheses:

1. Ukuthwasa (calling to be a healer)
2. Amafufunyane (possession by evil spirits)
3. Ukuphambana (madness)
4. Isinyama esikolweni (bewitchment at school)
5. Ukuphaphazela (episode of fearfulness)

According to the nomenclature of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, 4th Edition (DSM IV), the first three categories would be termed culture-bound syndromes, as they cannot be related to any one DSM IV disorder.³ Each has a heterogeneous presentation including elements of anxiety, depression, aggression, dissociation and antisocial behaviour. Although *ukuthwasa* is not strictly speaking a disorder or illness, reportedly it can 'deteriorate' into an illness like *amafufunyane* or *ukuphambana* if the calling to be a healer is disregarded.

The other two categories would be termed by the DSM IV cultural variations of DSM IV disorders. *Isinyama esikolweni* meets the DSM IV criteria for Conversion Disorder with sensory deficit, having similarities to the Brain Fog syndrome, whereas *ukuphaphazela* meets the DSM IV criteria for Sleep Terror Disorder.

However, it is important to recognise the essential

difference between the two diagnostic systems. The DSM IV categorises behaviour phenomenologically within a bio-psycho-social framework, whereas the African indigenous healers categorise according to the meaning of the behaviour. This meaning is usually interpreted in the context of relationships with the ancestors, or of bewitchment. Traditional healing uses an intuitive approach within an existential paradigm, whereas western Medicine uses an evidence-based approach within a dualistic (mind/body) paradigm.

The study confirmed that traditional African belief systems recognise and categorise unusual or pathological symptoms and behaviours in children and adults, some of which are defined as mental disorders in the DSM IV. However, in the purest sense, the two diagnostic systems cannot be integrated.

Beliefs and experiences of consumers of African indigenous healing and psychiatric services

In the second study, interviews were conducted following first hospital admission for serious mental illness of a random sample of psychiatric patients and their families.⁴ An adapted version of Weiss's Explanatory Model Interview Catalogue (EMIC) was used, together with a questionnaire exploring satisfaction with services.⁵ African indigenous healers had been consulted by 61% of the patients during the previous 12 months. On the whole, patients and their families were satisfied with herbalists and psychiatric services, had mixed feelings about faith healers, and were dissatisfied with diviners. They reported that diviners were very expensive, and had not been able to cure the illness. They did not like the diagnosis given, as it almost invariably pointed to bewitchment: which in their culture has frightening and serious implications, for both patient and family. One patient was physically beaten by a diviner.

Even though half of the patients and their families considered their (psychiatric) illness to be an African traditional illness like *amafufunyane*, they believed in multifactorial causation. These included both traditional causes such as jealousy and bewitchment, as well as psychosocial causes like stress and conflictual relationships, and causes expressed in christian religious terms.

The study strengthened the impression of local psychiatrists that diviners cannot cure serious mental illness, despite their assertion to the contrary. There was no evidence that indigenous healers provide a more holistic treatment than psychiatrists. Indigenous healers do not give their clients any information about the prognosis of their condition or the effects of treatment, and do not concern themselves at all with the social circumstances of their clients. In fact, diviners appear to have potentially adverse effects on patients with serious mental disorders by increasing their already dire financial straits, by increasing anxiety and stigmatisation through the diagnosis of bewitchment, and by not referring timeously for psychiatric treatment. The study revealed that consumers use multiple explanatory models for their serious mental illness, even when they give it an indigenous name.

Beliefs and experiences of consumers of African indigenous healing and community mental health services

The data for this study (the third) have been analysed but not yet published. Mental health screening instruments, which

included the Self-Reporting Questionnaire and questionnaires covering substance use, life events and social functioning, were administered to random samples (n=349) of adults living in Khayelitsha, Cape Town.⁶ The samples were derived from the general community, from primary health care clinic attenders, from traditional healer clients (diviners, herbalists and faith-healers), and from a community psychiatry clinic. Respondents who screened positive for mental health problems were administered the EMIC, as in the second study, regarding their beliefs and treatment experiences.⁴ Only findings related to the traditional healer sample will be discussed here. The full data are currently being written up for publication in three parts.

Although almost all traditional healer clients screened positive for mental health problems, most clients did not consult traditional healers explicitly for mental health problems. For instance, they consulted about job loss, or disturbing dreams. Healers almost always gave a traditional explanation for the presenting problem, but frequently gave different explanations for what appeared to be similar problems. For instance, one client consulting for job loss was told he had *amafufunyane*, whereas another client consulting for the same reason was told he was suffering from *umgqwaliso* ("bad luck"). A client consulting for alcoholism was diagnosed as having *amafufunyane*, whereas another was told poison had been put in his beer, making him lose control over his drinking (*idliso*).

Healers frequently prescribed similar treatments for what appeared to be different problems. For instance, a diviner gave snuff to the client who had lost his job, a woman with fits, and a woman with headaches. A faith healer gave holy water to drink or sprinkle to a man with sores on his legs, and to a man consulting because of his violent behaviour.

Some of the treatment measures prescribed by healers made 'medical sense', whereas others appeared to work on suggestion. For instance, a woman with disturbing dreams was given a bottle of herbs to drink before sleeping, and the man with sores on his legs was advised to bathe in dettol. However, a man who was having recurring dreams was told to bathe in muti, drink another muti which would make him vomit, and then bury his vomit in the ground. A woman who wanted her estranged husband to return to her, was instructed to boil a given powder in water, and then blow the steam out of her front door, calling her husband's name three times.

Two-thirds of the clients felt that the treatment they received from traditional healers was fully effective, and over 90% reported that they were satisfied and would consult healers again. The degree of satisfaction did not differ between types of traditional healer. Both these positive response rates were considerably higher than for those returned by the respondents in the community, primary health care and psychiatric samples, despite the fact that healers' fees were reportedly as much as ten (faith healers), fifty (herbalists) or one hundred times (diviners) more than medical fees.

In their individual interviews the healers claimed competency to treat many physical illnesses, and all mental illnesses. On further questioning, some agreed that they couldn't cure all mental illnesses, and would refer those cases to medical practitioners. However, our experience was that many families of patients with severe mental illnesses referred

themselves to medical facilities after years of expensive and unsuccessful treatment by traditional healers. In their individual interviews the healers reported that their healing skills are not usually recognised by medical practitioners, and they are not regarded as partners in health care. They feel that they are entitled to a comparable status. They would be reluctant to share their knowledge of healing unless doctors are prepared to share theirs.

Discussion

The limitations of the studies need to be recognised before discussing the implications of their findings. The respondents sampled in the hospital and community studies are representative of those particular populations only, and traditional healers were selected by convenience sampling. Therefore findings cannot be generalised to South African Xhosa-speakers or Africans as a whole, or to traditional healers as a national group. Although most of the research instruments have been tried and tested in previous studies on similar populations, none have been standardised for the populations sampled in these particular studies. Although every effort was made to ensure the validity and reliability of the responses, including the use of anthropology students rather than medical researchers for the interviews, it is possible that language and cultural factors, and a wish to give an 'acceptable' answer to questions, may have exerted undue influence. Despite these limitations, a high level of coherence was apparent between the findings of the three studies.

As nearly all their clients screened positive for mental health problems, and the overwhelming majority expressed satisfaction with the treatment received, traditional healers are clearly providing a valued mental health service to the population sampled in the third study. It would have been preferable to know if the clients still felt satisfied after a further 6 or 12 months, but they did all report that they would gladly consult a traditional healer again in the future. This high level of satisfaction is in stark contrast to the dissatisfaction expressed, particularly about diviners, by the psychiatric sample of the second study. As similarly large consultation fees for traditional healers were reported in both studies, this difference cannot be attributed solely to cost of treatment. Although the methodology of the two studies does not allow us to be definitive about the underlying reasons for the differences in satisfaction expressed, the nature of the client's illness seems one of the likely factors. The presenting problems reported in the community study ranged from seeking a love potion to alcoholism with family violence, involving some degree of anxiety or depression in most clients, (as reflected in the Self-Reporting Questionnaire).⁶ On the other hand, the presenting problems in the hospital study were, by selection, serious mental illnesses ranging from severe depression to schizophrenia and bipolar disorder. Broadly speaking, the former problems can be considered as problems of daily living and lifestyle problems, whereas the latter are biological or brain disorders. As the treatment measures employed by the traditional healers appear to be limited to relatively non-specific, low potency homeopathic medications combined with suggestion, we should not be surprised that they are effective with the former, but not the latter mental health problems.

According to the information received in the three studies,

traditional healers interpret their clients' behaviour and significant experiences in the context of relationships with the ancestors, or of bewitchment. Their interpretation is intuitive, rather than being based on phenomenological or physiological evidence of dysfunction. Apart from homeopathic medications prescribed, they operate largely in the spiritual and existential sphere. With regard to medications, they do not generally apply the natural sciences to their art, such as monitoring doses and side-effects, although this may be changing. Therefore, they would seem to resemble faith-based practitioners and counsellors more than medical practitioners. This is the major conclusion drawn from the data obtained in these three studies.

Conclusion

The implications for collaboration between mental health practitioners and traditional healers are significant. While collaboration should be promoted, as between all members of the multi-disciplinary mental health team, there is little evidence from these studies to support collaboration between the two groups as fully-fledged medical partners. While it may be necessary for the medications used by traditional healers to be subject to the requirements of the Medicines Control Council, is it appropriate that their costs, unlike other homeopathic medications, are reimbursed by medical aid schemes? When traditional healers are registered with the Health Professions Council, will they, but not ministers of

religion, feel entitled to request patients' confidential information from mental health practitioners?

Collaboration with traditional healers should urgently be promoted, as they are clearly providing a significant mental health service to certain sectors of the population. However, much more knowledge needs to be gained, widely shared, and debated, about how traditional healers practice, and what form of collaboration would be most appropriate. To proceed in any other way, would be a disservice to our clients and to the health profession generally.

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