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# Representations and Restitutions of African Traditional Healing Systems

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FRENCH INSTITUTE OF SOUTH AFRICA

# **Bodies and Politics**

*Healing rituals in the  
Democratic South Africa*

Véronique FAURE  
(Sous la direction de)  
(Co-ordinated by)

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Healing Rituals in the Democratic South Africa

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# **African Traditional Healing Systems: Representations and Restitutions**

Michael Urbasch

## **Introduction**

The capacity of traditional approaches to mental health to deal with the well being of populations in the developing world, has been compromised by the incorporation of a limited model of scientific knowledge into the administrative structures of social health provision. Some have suggested that science has also been mobilized both as a method and as a metaphor to reduce the power of those cultures and peoples who do not recognize it, or who order their ways of life around those cultures' metaphysical implications (Nathan 1995; Fernando 1995a, 1995b; Horton 1967). As such, these arguments go, governments or state-legitimated health bodies tend to accept science as an ideological counterpoint to their power and influence, providing justification for the disregard of other forms of cultural practices and ways of life. The biomedical scientific approach to health thus tends to be seen as being at odds with other cultures that have a more holistic awareness of the human condition (Fernando, 1995a: 38). In the wake of the early and mid-twentieth century influence of logical positivism and its offshoots (Ayer 1936/1971; Russell 1926; Whitehead and Russell 1913/1962; Quine 1953), the biomedical model of health replicates that tradition's insistence that only scientific knowledge can be considered to be knowledge at all.

Under this approach, still influential but not as widely held as previously, other forms of "knowledge" are considered as non-sense: mere belief, speculation, metaphysics, or superstition. In this sense the scientific basis for the biomedical approach becomes the ground for replacing lore and craft as cultural markers, allowing for the exclusion of knowledge based on cultures – and their attendant ways of life – that are not based on scientific norms (Nathan, 1995; Horton 1967; Fernando 1995a, 1995b). The associated demands for empirical method and testability have led to formal medicine adapting the biomedical approach to mental health and healing (Edwards, 1986; Engel, 1977; Fernando, 1995 a). Although not hegemonic in its application, this approach assumes that mental health can be dealt with like somatic disease. The model "has become structurally dominant, creating a rift between it and more culturally relativistic, humoral, functionally strong traditional healing approaches" (Edwards, 1986; 1273).

In this paper, I review some of the limits that this places on other forms of healing. In the following section, I sketch the relationship between institutions of learning and the biomedical model. Next, I provide an outline of how the legitimacy of the biomedical model underpins the relationship between the South African state and traditional or customary healing practices. Thereafter I give an overview of some of the ethnographic data and analysis on traditional medicine, with an emphasis on the extent to which such healing relies on a different world-view to that which underpins the biomedical approach. The next section examines some of the discussions that have taken place about the extent to which the practices of both biomedical and traditional healers actually overlap in practice. I conclude that contemporary circumstances in South Africa justify exploring the ways in which elements of traditional practice might be accorded professional recognition that matches their widespread popular legitimacy.

### **Health Care and Professional Legitimacy**

In much of the world, including southern Africa, the professional health sector is almost synonymous with western biomedicine (Swartz 1998: 78). The impact of the medical model on *physical* illness is, for the most part, quite apparent. For mental illness, however, the linkage is more problematic. Mental illness has been viewed through a nexus of physical, mental, and increasingly environmental and social explanation. This expanding of the problem does not, however, change the fundamental “illness model” in which a person’s problem is conceived as a disorder or illness specific to the mind instead of some other cause (Engel, 1977; Fernando 1995a; Nathan, 1995). As a rule, those trained in the context of modern biomedical theory, psychological or psychoanalytic, will evaluate human mental problems in terms of illness. The practitioner intervenes by identifying a “change” (from a hypothesized norm), giving it a name (diagnosis), evaluating the causation (aetiology) and finally making a judgement on interventions (treatment) that are likely to counteract or alleviate the condition” (Fernando, 1995a; 15).

With some modification we can follow Fernando (1995a:12) in arguing that the biomedical model of psychology conforms to a number of dominant concepts commensurate with scientific materialism and dualism. Among these, argues Fernando (1995a: 12), are mind-body dualism; the mechanistic view of life; a materialist concept of mind; a segmental

approach to the individual; and that illness is to due to biomedical change or natural causes. These lead to the situation in which diagnosis and treatment of mental disorders is the province of trained practitioners alone. This training must take place in an approved institution, and must provide expertise in the methodology, theory, and practice that conform to biomedical norms. Even theories and practices that are not typically dualistic in thinking, such as psychoanalytic and psychotherapeutic theories, partake of the legitimising “glamour” of this medical model (Nathan, 1995: 9).

There are a number of ways to explain mental health and illness within the biomedical model. Psychodynamic explanations seek problems in the process of psychological development, or at the level of the wider environment, family or social level. In this way, theories based on psychoanalysis escape many of the assumptions of dualism and materialism. Neurological explanations view pathology in terms of bio-chemical or physiological disruption either through chemical, organic, traumatic, or heredity dynamics. More eclectic practitioners evaluate illness in terms of a number of biological, psychological and social factors (Fernando, 1995a). Such a list, although not exhaustive, indicates some of the methods that practitioners within its authority have developed to escape the limits of the biomedical model.

The basic premise of the systems, what Nathan (1995: 9) calls “*scientific psychotherapies*”, regardless if they are Freudian, anti-Freudian or neo-Freudian, Kleinian or Lacanian” (Nathan 1995: 9 my translation), is that the patient is ill and alone. Subsequently, it would follow, the illness resides in the subject. Nathan (1995: 9, my translation) argues that this is the major premise of “all the theoretical systems, which have seen the light of day since the second half of the nineteenth century.” The task of modern western medicine then is to return the patient to harmony with the self. The different methods all have their detractors and supporters. However, more importantly for the support of the ideas developed in this paper, they all have extensive literatures and are formally taught as required courses in psychology and medicine at various South African Universities.

The positioning of these disciplines within the academy, therefore, and their recognition through formal teaching, is perhaps one of the most important

indications of their recognition and intellectual and social cachet. Bove (1986) reminds us that universities are not simply teaching institutions, but are also centres of power and legitimisation. By being positioned within the legitimising nexus of academic study these disciplines find not only a place to propagate and expand theory and methodology, but also occupy positions that allow their reproduction and projection into the wider social, political, and ideological context. Such disciplines become part of the ideological apparatus of society, becoming recognized as bearers of knowledge and, more problematically, as *truth*, thereby escaping the designation of belief or superstition.

For all that the biomedical model still receives such widespread administrative support, there has been a parallel anthropological understanding of traditional and customary health practice that makes a different interpretation possible. In the following section, however, I will review some of the salient interventions that have ensured the structural marginalization of traditional and customary healing in South Africa.

### **South African Indigenous Healing and its Practice**

It has been estimated that there are “200, 000-traditional healers in South Africa, and up to 60% of South Africans” regularly consult these healers (Van Wyk et al., 1997: 10). This number stands in contrast to Swartz’s (1998: 79) estimate of the number of biomedical practitioners; psychiatrists 290, psychologists 2420, clinical psychologists 1060, psychiatric nurses 7000 and social workers 7300 (Swartz, 1998: 79). Clearly, a majority of South Africans uses the services of traditional healers. A study at Mogopane hospital in the then North Eastern Transvaal, calculated that “nine out of ten patients who come to the out-patients ward first consult traditional healers” (Oskowitz 1991: 21).

For all that a majority of people in the country continue to use their services, however, we have already seen that traditional healers themselves are excluded from entry into institutions sanctioned by the South African Medical and Dental Council (SAMDC) are sanctioned to train registered health professionals. This is codified into South African law, and finds expression in the association of the practices of traditional healers with



“witchcraft”. Healers were (and to some degree remain) governed by a number of laws and subsequent amendments:

- The Transvaal Crime Ordinance Act of 1904, Ordinance 26, made it illegal for “any person who for purposes of gain pretends to exercise or use any kind of supernatural power witchcraft sorcery enchantment or conjuration or undertakes to tell fortunes or pretends from his skill or knowledge in any occult science”.
- The Natal Code of Black Law 1891, section 19, made it illegal for traditional healers, hereafter called *izangoma* and *izinyanga* (singular *sangoma* and *inyanga*) to practice.
- Subsequently, the Witchcraft Suppression Act 50 of 1957 and amended by Act no 50 of 1970, made it an offence for “any person to exercise supernatural powers, to impute the cause of certain occurrences to another person”.
- The Amended Act of 1970 is still current and, although South African *izangoma* or *izinyanga* are covered under the Associated Health Service Professional Act (No 63 of 1982), they are also, still, covered under the Witchcraft Suppression Act.

In 1974 the SAMDC forbade non-registered healers to practice or perform any act pertaining to the medical profession. “Registered healers were even forbidden to work in collaboration with non-registered healers” (Edwards, 1986: 1275). Despite being under review the ruling of 1974 still defines the Councils’ attitude, with the consequence that traditional healers remain excluded from the status and professional cachet associated with practising beneath its umbrella. The result of this history is the ongoing representation of traditional healers as witches and agents of darkness. Traditional healers supposedly practice what the prominent African doctor, Nthato Motlana, in a speech given at medical graduation ceremony at the University of the Witwatersrand, calls “*mumbo jumbo*”. In the same article Motlana attacks those who would reassess the role of indigenous healing with a resounding condemnation of traditional in these words:

Here at home there are men and women who want to take us back to the dark ages by romanticizing the half-naked drummer of the night. They choose to forget that the so-called advanced nations of the west also passed through age when they believed that diseases

were also caused by mists arising from the marshes; they too believe in witchcraft, and it took centuries of turmoil, conflict of rejecting scientific discoveries to eradicate it (Motlana, 1991: 3).

It is therefore hardly surprising that traditional healers' methods and practices are not included in the training of SAMDC-sanctioned mental health practitioners. Although there are numerous effects resulting from this exclusion, for our purposes two main consequences are hypothesized.

- First, practitioners trained under the SAMDC regime remain ignorant of how the country's majority represent mental health, thereby denying practitioners insight into patients from the indigenous population; and, secondly,
- it keeps traditional practice outside the realm of what is sanctioned as knowledge by the dominant institutions in the country, thereby perpetuating the representations of indigenous knowledge already referred to.

The SAMDC's exclusion of traditional methods from university training for health professionals is evidence not only of the general administrative denial of the cogency of indigenous thought in general, but also of how biomedical discourse has monopolized knowledge in the health field generally. Indeed, it might even be correct to say that indigenous belief systems are an absence, an exclusion seldom challenged or debated. Reasons for the separation of western and indigenous healing systems have in part been already suggested. An important adjunct is that by being positioned within institutions these systems can organize both training, access to budgets, as well as structure degrees, and gain legitimacy by experts (Swartz, 1998: 78).

Nevertheless, traditional and customary healers do enjoy some protection under the law:

provision [is] made for their practice in the Code of Zulu Law for example. Also in the Associated Health Service professional Act (No 63 of 1982) the Council of Associated Health Professions, a separate statutory body not affiliated to the Medical and Dental Council, has provided for the registration and control of healers (Edwards, 1986: 1275).

## **Understanding indigenous healing systems**

The biomedical view contrasts with Asian and African patterns of health that emphasize integration, harmony, balance and the community (Edwards, 1986; Nathan 1995; Ngubane, 1977). The latter approaches view mental and physical health as essentially intertwined with religious, social, cultural, moral as well as physical and medical concerns. (Edwards, 1986; Fernando, 1995a, 1995b; Nathan, 1995; Ngubane, 1977; Swartz, 1998; Turner, 1967). African indigenous healers, therefore, regard the human organism as a whole, which is integrated within a total ecology of the environment and with the interrelated spiritual, magical and mystical forces surrounding him/her. Likewise, their conceptual model of health is couched in terms of a balance between a healthy body and a healthy situation and that set of circumstances that surrounds them (Cheetham & Griffiths, 1982: 954).

Evidence to counter the simplistic view of the African traditional thought has long been available from a number of sources. Although it is by no means clear that these writers have dispelled all prevailing prejudices, their lucid accounts of custom, myth and rites provided ways of re-socializing and re-investing the ways of life of Africa and its peoples. Of particular note was Victor Turner's (1967) seminal work *The Forest of Symbol*, with its particularly impressive account of Ndembu symbol and ritual. Turner developed methodological tools to understand the power and cogency of ritual, even going so far as to conduct the patterns of his daily life around them. More importantly, however, Turner's analysis showed that ritual has a politically integrative function, often serving as a vehicle for solidarity in the face of heightening social and public conflict. Turner develops the Ndembu understanding that diviner sickness arises not only from some spiritual or physical sources, but also as a result of disturbances in the social field. In this context, then Turner refers to "divination as 'social analysis' and says that Ndembu believe a patient will not get better until all the tension and aggression in the groups inter-relations have been brought to light and exposed to treatment" (Horton 1967: 54).

Practices of the Zulu and Ndebele *izangoma* of Southern Africa offer a similar model of social analysis. These practices are based on the concept that

good health involves the person within the total universe, and that disease represents a disturbance of this balance (Ngubane 1977). The task of the healer lies in *restoring balance*, which “is a pivotal ideology around which revolve practically all of the notions that constitute African disease” (Ngubane 1977: 27). The logic of traditional healing allows for a variety of causes for illness. Zulu practice recognizes two distinct categories of illness: natural causes, and those related to the community’s cosmology. The latter covers sorcery; ancestral interventions or invocations; those related to pollution; and possession (Ngubane 1977).

The first category, *umkhuhlane*, consists of illnesses that just happen, like common colds or epidemics such as smallpox or influenza. Old age and other natural process are also understood as affecting one’s health and general condition. The malfunction of certain organs can cause illness resulting in excessive bile and giving rise to conditions such as headaches. Some diseases are also associated with development and growth, like measles and mumps in children. Seasonal changes can also bring on diseases, as when summer brings on hay fever. It is also recognized that certain problems run in families (Ngubane, 1977: 23).

The second category, associated with a community’s traditional cosmology, is idiomatically known as *ukufa kwabantu* (diseases of the African people). This is the category that covers the conditions most western practitioners recognize as ‘mental illness.’ Non-comprehension of the rationale behind the thinking encountered during these states can cause of confusion for the biomedical therapist; indeed, here is where one meets a logic totally at variance with that of biomedical practice. Although different societies may have their own ways of describing these problems, on the other hand, healers nevertheless accept an affinity between the various cultures’ approaches to this kind of illness (Ngubane 1977: 24). *Ukufa kwabantu* may result from a number of sources: sorcery (*ubuthakathi*); illnesses connected with the ancestors; illness connected with pollution; and problems of self connected with spirit possession (which is more often than not associated with an individual’s initiation as a diviner).

*Ubuthakathi* practitioners can utilize either substances or familiars, and are divided into three types:

- First is the “*night sorcerer*”, most closely allied to the notion of a “witch” in European tradition, who has an evil heart by nature and who harms people for no other apparent reason. Night sorcerers ride on baboons, and keep dwarfs called *imikhovu* who are under his control (Ngubane, 1977; 33).
- The second type of sorcerer is called a *day sorcerer*, who acts not as a matter of habit but only in cases of personal animosity, in situations rife with jealousy and competition (Ngubane, 1977: 34). Their preferred method is using poisons, either adding them to the victim’s food or scattering them within his immediate environment. This category of sorcerer may include men, but is normally comprised of women because their movements at night tend to be restricted.
- *Uzalo*, the third category of sorcery, is “*lineage sorcery*” and can be practised only by men who are heads of homesteads. In *uzalo*, a man persuades his ancestors to favour him at the expense of his other family members. It involves the use of black medicines and acts to deprive the victim and his descendants of the protection of the ancestors and thus make them susceptible to all kind of misfortune, misfortune that can continue down the generations (Ngubane 1977: 37).

The ancestors are believed to be primarily concerned with the welfare of their descendants, who are vulnerable to all kinds of misfortune without this protection. Not all ancestors have the power to punish or reward. Misfortune or illness due to the ancestors can arise under several different conditions. One is when a member of the family or some other person has acted in such a way to disturb the social order (Swartz, 1986: 282). Another arises when a family member has not included the ancestors in some decision, or has simply ignored them. These oversights may result in the individual or family being denied ancestral protection, making them more vulnerable to witchcraft, or the ancestral spirits can actively act against them (Ngubane 1977).

*Umnyama* (pollution) literally means darkness and represents an imbalance or a slipping between the boundaries of this world and the world of

darkness, between life and death, and as such is particularly associated with birth and death. *Umnyama* is conceptualised as a force that diminishes resistance to disease, creating conditions like poor luck, misfortune (*amashwa*), disagreeableness and repulsiveness (*isidina*). People associated with *umnyama* patients take a dislike to them without any provocation, and is contagious in its worst form (Ngubane 1977: 78). Sufferers are known as *ukuzila* and are required to behave in prescribed ways: they must withdraw from social life; abstain from pleasure (including sexual intercourse); they must avoid fighting and must speak in a low voice; and they are permitted to eat only small quantities of sloppy food (Ngubane, 1977: 78). Appropriate behaviour during pollution is thus aimed at controlling imbalances caused by the stress of major life events (Ngubane, 1977: 82). Ignoring correct behaviour may result in neurosis designated as *ukudlula* (derived from the verb *dlula* – ‘to pass’ or ‘to surpass’). This surpassing by not observing the prescribed conduct, can result in sexual perversion or the person becoming aggressive. *Dlula* can sometimes include *iqungo* (bloodlust), resulting in homicide (Ngubane 1977; 82).

Harriet Ngubane (1977) distinguishes between three types of spirit possession. The first is the traditional possession of a *sangoma*, which is seen as beneficial, when she is able to hear the voices of her ancestors. These are from the healer’s own descent group and are spirits who have reached a desired state of spiritual perfection (Ngubane, 1977; 142). This type of possession is closely allied to Buhrmann’s (1981) description of *thwasa* possession among the Xhosa. *Thwasa* results from the calling of the ancestors and Buhrmann’s Jungian analysis leads her to distinguish between *thwasa* and bewitchment. *Thwasa* means the emergence of new aspects of the personality through the acceptance and integration of unconscious material (Buhrmann, 1981: 877). Bewitchment is associated with mental illness and is a result of the individual having a negative attitude to unconscious material.

*Indiki* (plural *amandiki*) is the second form possession, which seems to have emerged at the beginning of the twentieth century and is closely related to South African industrial development. *Amandiki* are believed to be the spirits of persons who were never given the necessary sacrifice to insure their integration with their other ancestors. Such spirits are often the spirits of

foreigners who become a menace to local people. They enter through the chest and the patient “bellows with a deep voice and speaks in foreign tongues” (Ngubane, 1977: 142-143). Treatment consists of a short period of initiation into a spirit cult, removing the spirit, and replacing it with the spirit of a male ancestor. Because the ancestral spirit is being induced to supersede the alien spirit, the patient is required to observe conduct similar to that of a traditional neophyte: withdrawal from society; observing abstinence; wearing special coloured medicines and clothing; and engaging in ceremonies. The object is to regain health, however, and not to become a *sangoma* (Ngubane, 1977: 143). A third type of possession is called *ufufunyane* or *izizwe* possession, a form that also derives from the 1920s. Whereas *indiki* is contracted by mere chance, *ufufunyane* is on the contrary due to sorcery (Ngubane, 1977: 144). The afflicted person is seen as mentally deranged, and does not derive any diagnostic or healing powers from the condition.

Ngubane’s ethnography serves as a foil for the tendency of studies to focus on the purely mystical aspects of indigenous healing practice (Swartz, 1986: 278). It is also important to distinguish between the *nyanga* (doctor) and the *sangoma* (Ngubane, 1977). The *nyanga* is usually male, and becomes qualified to dispense herbal medicines after having apprenticed to another *nyanga* for not less than a year. *Izangoma*, on the other hand, are predominantly women who, chosen by their ancestors and after a period of spirit possession, undergo training to develop their clairvoyant powers. Bernard’s (1999) description of Zulu spiritual healers’ initiation provides an insightful analysis of both the spiritual and political aspects of *sangoma* practice, which falls firmly within the mystical tradition of the shaman (Cheetham & Griffiths, 1982: 957). While both *izinyanga* and the *izangoma* are able to treat patients with herbs and with colour symbolism, it is only the *sangoma* who can use the ancestors to heal. “In addition to traditional healers in the black groups there is a strong emphasis on healing in the African independent churches” (Swartz, 1986: 286). These churches are for the most part offshoots of the Christian Pentecostal movement, employing a complicated theology that mixes traditional healing practice with Christian theology.

Some aspects of traditional healing practice clearly contrast dramatically with the biomedical method’s emphasis. A question is, therefore, how do we

understand the methodology of the *sangoma*? What are its connections, if any, with western practice? There is both a system and rationality at the heart of the diviner's practice, but it is one that can easily escape the western gaze:

The emphasis on non-rational aspects of healing in many aspects of folk practice, and in African healing in particular, can lead to the mistaken impression that there are no rules or rational procedures in such practices. Many studies have shown very clearly that rationality does play an important part in decision-making and treatment in African indigenous healing (Swartz, 1998: 86).

### **Rethinking the dichotomy**

The "ethno psychiatrist" Tobie Nathan (1995) argues that to understand the indigenous healer, it is necessary to distinguish between two ways of thinking. The first is that of communities who think that the universe is ontologically heteroglossic and pluralistic. In this world-picture, there are multiple layers of beings and powers who possess various levels of agency, what Nathan calls "*les sociétés à univers multiples*" (Nathan, 1995: 10-11). This is in contrast with those communities –usually associated with 'the West'– who occupy an ontologically monoglossic universe in which matter is dead and without agency, what Nathan calls the "*univers unique*". The former universe is that of the diviner, while the latter is home to the biomedical fraternity.

Nathan (1995) illustrates the distinction between these world-views by examining the fate of a person (almost invariably a woman) who once would have been labelled as an 'hysteric'. In the biomedical tradition the *problem* (the illness) is given a name, thus hysteria. The woman would be *referred* to what Nathan calls the master of rational knowledge (in this case a psychoanalyst). The *aetiology* of the problem is then identified, for arguments sake we imagine the hysteric is suffering due to unconscious sexual desire. An *intervention* of some kind is thus decided upon, in this case the unravelling of unconscious sexual desires. Accompanying the procedure is a *representation* of the patient: she is understood as infantile, her behaviour is read as regressive. The *therapeutic aim* is to help the patient towards a more mature understanding. The *means* at the therapist disposal is the psy-



choanalytic technique, the *mise en scène* of the analysis, transference, interpretation, the *agon* with the self. In conclusion Nathan repeats the leitmotif that runs throughout all his work, the *outcome* of the treatment is that the patient is alone, “alone in face of the savant alone, even against the state” (Nathan, 1995: 11.my translation).

In the other form of society, a woman presenting the same symptoms is considered very differently. The *cause* of the problem is considered to be an attack by spirits. The woman is thus *referred* to someone who has knowledge of this layer of the universe, most often as the result of the diviner’s own attachment to the spirit world. The diviner also draws on a practice of *intervention*, in this case identifying the spirit to gain knowledge of its intention, to enter into negotiation and dialogue with it. The *representation* of the patient is thus that she is seen as a door to the spirit realm: an ambiguous person, a sorcerer, perhaps, or a prophetess. In other words, she is represented as already an expert (Nathan 1995: 22). The healer’s concern is not the woman, therefore, but the hidden realm and the spirit possessing the woman. Finally, the *outcome* is often the patient’s attachment to a society of women who are connected to this class of spirits. The woman by definition is not alone but part of a community and has a social place, her problem understood through her connection to others (Nathan, 1995: 13).

Nathan’s model clearly has parallels with the models identified by Ngubane (1977), and also with Buhrmann’s (1977a/1977b) and Turner’s (1967) analyses of the role of the *sangoma*. The diviner’s role is to restore a natural balance and order (Ngubane, 1977: 27) by bringing the patient into a new order of being. Cheetham and Griffiths (1982: 958) take this a step further, concluding that divination and psychotherapy result in a set of universal outcomes. These outcomes include:

The rationalization of fears of unknown origin, projection, displacement, penance and undoing. This intriguing list of ‘ego defence mechanisms’ may be seen to have some plausibility as a proposed set of outcomes of the activities of the traditional healer and the psychotherapist, i.e. rationalizations involving the invocation of familiars, sorcery or the id-superego conflict; projection onto ancestors, deities or id impulses; displacement onto witchcraft

or parental deprivation; penance by ritual slaughter, fees or the relinquishing of defences; and undoing through ritual observance, appointments regimes or the talking through of problems (Cheetham and Griffiths, 1982: 957).

This suggests that although there are distinctions between the theory and world-views of the biomedical and traditional methods of healing, the two positions also share a number of similarities.

Edwards (1986: 1275) emphasizes the coherence and consistency of traditional Zulu approaches as well as confirming the universal components of the two systems. To show this, Edwards (1986: 1274) undertook to study the effect of the various methods on a number of patients diagnosed as suffering from a range of problems, including, anxiety, depression, epilepsy, mental retardation, physical disorder of natural causation and schizophrenia. Both traditional healers and clinical psychologists examined the patients who, when asked to assess the interventions of the two kinds of practitioner, rated both the clinicians and traditional healers as “being more or less helpful” (Edwards, 1986: 1275). On this basis, Edwards (1986: 1275-6) argues for greater co-operation and integration between the two realms (Edwards, 1986:1275-6). This would require continuous research to identify the ethical and legal implications of traditional and modern healers working together, the impact of this on training, and related issues.

## **Conclusion**

The paper has attempted to show that there is ample evidence to support the value of indigenous healing, but that the academy and the Medical and Dental Council continue, for the most part, to ignore its rationality and value. Although the SAMDC intends to review the status of traditional healers, it will be interesting to see if any future review changes the representation or status of such healers, or if the methodology of traditional healers will ever become a part of the training of health professionals. Yet the attributes required of the diviner are in fact similar to those required of the western psychotherapist (Cheetham & Griffiths 1982: 957). Following the work of Fuller Torrey (1972), Cheetham and Griffiths (1982) suggest a number of points of similarity between the diviner and psychotherapist.

First, both possess their own consistent world view. Second, both the diviner and therapist show a particular *savoir-faire*, in other words a set of personal qualities. Third, both the *mise-en-scene* of the therapeutic situation and the status of the therapist are vital to the outcome. Fourth, the technique must be acceptable and recognizable to the patient (Cheetham & Griffiths, 1982: 957). Frank (1972, cited in Cheetham and Griffiths 1982: 957) has shown that there is a series of underlying themes that are shared by psychotherapists all over the world, similar to those suggested by Nathan (1995). In summary, these themes include: an intense emotional and confiding relationship; and a rational myth offering a cause for the problem and simultaneously offering powerful emotional reassurance to the sufferer. Further, the offering of new information to the client, the status of the therapist, and the *mise en scene* of the setting, are vital to the treatment. Of final interest is the expectation of success offered by the treatment, and the deep emotional arousal that provides the motor for change (Cheetham & Griffiths, 1982: 957-958).

In conclusion, then, there is clearly a need for further study into the ways in which the mental health profession in South Africa – and the developing world in general – can benefit patients from marginalized groups by adopting methods that do not privilege the biomedical model to the exclusion of other existing traditional and customary practices. Although there may be radical *philosophical* differences between the means of explaining and justifying them, these two forms of practice have many pragmatic and empirical elements in common. In South Africa it would not be too much to say that the legacy of apartheid includes a significant population of post-traumatic stress sufferers for whom biomedical interventions are simply out of reach. By the same token, biomedical theory's focus on the individual limits its capacity to deal with entire communities of suffering. This paper has outlined some evidence to suggest that sufficient common elements are present between biomedical and traditional practice to justify an examination into those areas in which a combination of both can open up a whole new realm of community healing. Given the revelations of people's experiences during the Truth and Reconciliation Commission, there is ample need for some way to institutionalise such an intervention.

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