Introduction

Even a cursory reading of the extensive literature dealing with therapeutic practices in Africa reveals that in many, if not most, societies there is a wide variety of systems of healing in existence, among which patients may choose. What has variously been termed "Western" or "cosmopolitan" medicine, or biomedicine "coexists everywhere", as Charles Leslie (1978:xiv) has noted, "with other systems of practice forming more or less pluralistic, more or less integrated, and more or less syncretic regional systems". This is to be expected given the fact that in many parts of Africa people participate in both traditional and Westernized culture. T.F. Johnson (1977:230), for example, writes with reference to Tsonga girls in South Africa: "the strong present-day belief in witchcraft, by adolescents attending a European-type school, suggests that such beliefs are not dissonant with modernization and on-going social change." He notes that his findings are consistent with those of Gustav Jahoda (1970), who found that among Ghanaian university students traditional Africa and Western ideas and beliefs co-existed.

With regard to healing systems, then, beliefs and ideas from diverse sources are held and compete for attention, as do the purveyors of therapies of different types. How, then, do sufferers, and their kin, decide where to go for help? What does each of the various systems have to offer? Are they in direct competition or are there occasions when more than one is utilized, and do they then complement each other? Such situations have been reported from many other parts of the world, including Taiwan (Kleinman, 1980), India (Kakar, 1981), Mexico (Finkler 1986) and the United States (Pattison, 1974).

John H. Janzen (1978) has described in considerable detail the operation of a complex pluralistic regional system in the Lower Zaire. This system consists of at least three traditional types of practice or, more precisely, groups of types, in addition to Western medicine available in
Another example of a contemporary church, this one with its associated community, is that of the prophet Ancho and the Bregbo community in the Ivory Coast, which has been very fully described by C. Poullet et al. (1975). In this case, we learn that many of the patients approached the prophet with self-accusations of witchcraft, "fetish" worship, and sexual transgressions. It is this public confession of evil which is basic to the prophet's therapeutic approach. Here, healing, rejection of traditional religious practices, reinforcement of some aspect of traditional morality, and social control, are all linked.

The Problem

The examples cited above raise a number of different issues that need to be considered if we wish to understand the role played by such diverse therapeutic systems in contemporary African societies and their relationships to each other as they deal with the presenting problems of their clients. For example, a division of labor may exist among several traditional approaches. Thus, in many African societies diagnosis may be separated from therapy. Diagnosis is in the hands of the diviner, who is generally a man, and who is not necessarily himself a healer, but who, by virtue of his discovery of the causes of problems will refer patients to those who can take the appropriate actions. This is the case, in the instances already cited, such as the Yoruba of western Nigeria (Prince 1964) and the Moundang of Chad (Adler and Zanoleni 1976). On the other hand, therapies of different types will be conducted by particular kinds of specialists. Those that involve spirit possession will, for the most part, concern women cult leaders as well as a group of women, often former patients, as ritual participants. This, too, is the case among both the Yoruba and the Moundang.
Still another type of healing activity is likely to be carried out by
syncratic or neotraditional religious leaders. Examples of these that we
have already cited are Yeboa and his church in Ghana (Beckman 1978) and the prophet
Atcho on the Ivory Coast (Floult et al. 1973). And, finally there are various
institutions of cosmopolitan biomedicine. In the psychological domain,
however, asylums are the most prominent and these are reserved for only a
small minority of those most seriously affected by severe mental disorders.

To understand the division of labor between these and other therapists
and therapeutic institutions, and the manner in which people in need of help
decide where to find relief, we shall need to consider a number of specific
questions, such as the following: How does an afflicted person, or those
close to one afflicted, decide where to turn for help? Who actually makes the
decision? What are the criteria by which such choices are made? Is there
what has been termed a "hierarchy of resort", that is, are there clear
sequences of where one goes first, and, if not finding relief, where one turns
next, and so forth? Underlying all of this, however, is the question
concerning the similarities and differences between the various therapeutic
systems and traditions of healing. And it is to these questions that we shall
turn next.

Healing traditions and their explanatory models

As Arthur Kleinman (1980) has pointed out, both patients and healers have
their own "explanatory models", that is, their particular understanding of
what a human being is and how disorders that may appear are to be accounted
for. Sometimes patients and healers share a common explanatory model and
sometimes they do not. In some cases, part of the healing process is
concerned with the therapist's effort to teach the patient the explanatory
model which he holds, and on the basis of which he expects healing - and also
prevention of future illness - to occur. Indeed, the physician, nurse or
other health worker who teaches patients about bacteria, infections and
hygiene, is doing just that: explaining disease in terms of micro-organisms
and contagion and teaching this conception to patients and communities.
Similarly, the psychoanalyst finds it necessary to explain basic Freudian
collapses to patients in order to be able to teach the method of free associa-
tion and to analyze the meaning of symptoms, of dreams or "Freudian slips",
socalled. The prophet or preacher who explains illness on the basis of sin
operates his healing ministry, at least in part, by means of converting
patients to his system of beliefs, so that they will, indeed, be able to
recognize and identify those of their actions for which they are, he tells
them, being punished, so that they may repent and not relapse into their old
ways.

An important, indeed a basic, part of the explanatory system of various
healing traditions is their conceptualization of how healing fits into the
larger pattern of the society, and indeed, of the world. Related to this is
the question of how they conceptualize the human person. This requires us to
look at the explicit and implicit conceptions involved in cosmopolitan
biomedicine as well as those of traditional and neotraditional systems.

Cosmopolitan medicine, including its psychiatric and psychological
specializations, perceives itself in the context of science; indeed, we often
see references to "scientific medicine" in contrast to other types of
practices, which may be rejected as "unscientific". Medicine in Western
societies sees itself as having both a preventive and a curative function. It
is, however, independent of other special institutions of society, such as
those of the law, religion, education, or the family. Indeed, Western,
industrialized societies are highly compartmentalized in their various
functions.
Quite in contrast to the situations in Western societies, traditional African societies were highly integrated, so that a single institution could and did fulfill a variety of functions. In particular, diagnosis and healing were often intimately involved with the ancestors and the family, with religious ritual and legal rules and prescriptions. Indeed, the very separation made here is an artificial taking-apart of what really belongs together. It is then not surprising that many neo-traditional religious movements and churches concern themselves with healing, as well as with sin, and impose legal as well as religious sanctions and penalties. Given this situation, we should also not be surprised to find persons brought up with an integrated world view who find themselves unsatisfied by the "scientific" medical explanatory model and feel that the religious aspects of their problems have been neglected when only the needs established by the model of cosmopolitan medicine have been satisfied.

We may now turn to the question of how the human person is conceptualized in the various healing systems. We must do so because a therapeutic system always stands in a close relationship to its etiological conceptions and these, in turn, are intimately tied to its underlying views of the human being and the relationship that is thought to exist between human beings and other entities.

The question we ask here requires us to look at the conceptualization of the human person in cosmopolitan biomedicine, as well as in traditional and neotraditional, or syncretic, healing systems. There is a long-standing Western tradition that considers the human being as consisting of several parts; in religion, it is the body and the soul, and in medical thinking, this has become the body and the mind. This distinction is shown in the very existence of various medical specialization, such as internal medicine, gastro-enterology, ophthalmology, and many others on the one hand, and psychiatry and clinical psychology on the other. Since this is so, the body-mind distinction is emphasized and reinforced in the training of physicians, in spite of the fact that much theoretical writing of the last half-century has stressed the psychobiological unity of the human individual and that much has been said about psychosomatic and somatopsycho health problems.

The issue of "somatization" is also directly relevant to this discussion. Kirmayer, who has reviewed this topic in two important articles (1984a, 1984b), notes that although it has often been argued that somatization is found more frequently in Third World countries, this is not the case. Rather, he writes, "worldwide, somatic symptoms are more common that emotional complaints as a way of presenting psychosocial distress" (Kirmayer 1984a:161).

He points out that the term somatization is used with three rather distinct meanings in the current psychiatric and psychological literature: (1) somatization is assumed to exist if the examining physician finds little or no organic basis for the complaints the patient presents; (2) patient presents somatic complaints instead of psychological or emotional complaints, for as Kirmayer (1984a:159) says: "help seeking in many cultures is organized around the presentation of bodily complaints rather than explicit mention of emotional disturbance or family conflict", and (3) the view - primarily among psychoanalytic writers - that emotions can give rise to bodily dysfunctions, the so-called psychosomatic disorders. For Western-trained physicians, who work in Africa, two factors militate in favor of seeing only the organic basis of patients' complaints. On the one hand, there may exist infections, various so-called tropical diseases, and other organic disorders directly amenable to biomedical intervention. If these are present in addition to emotional disturbances, they will attract physicians' attention and receive priority in therapy. The patient may feel relief - particularly at first - following such treatments. On the other hand, unfamiliar cultural features of patients'
lives may often make it difficult for the physician to recognize the psychosocial problems that may exist together with the physical complaints which are presented. However, if the underlying psychosocial problem has not been dealt with there may be a feeling that cosmopolitan medicine is incompetent to deal with what ails the patient. A major aspect of cosmopolitan medicine then is its traditional tendency to separate the mind and the body, reinforced by professional specialization on the one hand and on the other by therapists' frequent unfamiliarity with the reality of patients' lives and the cultural milieu in which psychosocial problems arise and must be resolved.

Since, in spite of various attempts, it is difficult to generalize broadly about African conceptions of the human person, we shall instead turn here to some specific examples to illustrate the differences between Western biomedical and African traditional conceptions, which underlie therapeutic systems. We shall therefore consider instances of healing which reveal the thinking on which they are based. Curley (1973), writing of the Lango of Uganda, notes a case in which a man suffered from impotence, with the result that his wife had not conceived so that their marriage was threatened. A woman who has been initiated as an adept in spirit possession is consulted and explains that the man's impotence is caused by the shade of his dead grandmother. Impotence is then seen as either a physical or an emotional problem but one involving relations with ancestors - a tool used by the deceased to express their anger at their descendants. The concern is not so much with the man's dysfunction but rather with its reproductive, that is, familial, consequences. The human being, here, is conceived of as intimately integrated into a familial and social system, and it is the social relations - with ancestors, spouses, and descendants - which are investigated in cases of illness, rather than either physical or emotional disturbances.

This social dimension appears to be primary in much African traditional thinking and many examples may be cited. For instance, Victor Turner (1964) describes a case he observed among the Ndembu of Zambia. The patient complained of physical symptoms such as palpitations, fatigue, and back and chest pains as well as pains in arms and legs. He also had bad luck in hunting, claimed others were speaking against him and withdrew from social relations. The diviner diagnosed attack by his dead grandfather, and his own dead father who was angry at him, but there was also sorcery and witchcraft at work. As Turner terms it, the causes were "mystical". In order to deal with this, a series of curing ceremonies had to be held. Significantly, these ceremonies involved the airing of grievances between the patient and various categories of relatives. Physical manipulations of the patient were also involved but Turner sees these as being primarily symbolic. "I felt strongly", he writes, "that what was being drawn out of this man...was, in reality, the hidden animosities of the village" (Turner 1964:260). The community was, in fact, reorganized, and a follow-up visit several years later showed that the patient was enjoying life and was reintegrated into his group.

Again, this case indicates a conception of the individual as intimately tied into the group, both the contemporary group of living kin, affines and neighbors, as well as the continuing group including dead ancestors, and perhaps the unborn as well. The diagnostic process is concerned with interpersonal relations, in a large scope, so that we may speak here of religion and law as well as kinship. And the healing process involves the re-establishment of harmony in a disturbed system. Parenthetically we may note that, although this seems very different from the general trend of cosmopolitan biomedicine, certain areas of psychology and psychiatry, specifically family therapy as it is practiced by some specialists in the United States, offer many parallels. Salvador Menchikin, et al. (1978), for instance, see
the disturbed child, such as the young girl suffering from anorexia nervosa, as expressing in her behavior and suffering the disturbances of a family group. Thus, the traditional African concern with interpersonal relations is quite alien to the modern distinction of what can only be called "traditional" biomedicine, but is in some respects very close to newer trends in family, and even community, therapy in the West.

Studies of syncretic religious groups, which include healing among their various functions, show both similarities and differences with traditional practices and with cosmopolitan medicine as well. Mullings (1984) has made specific comparisons between these three types of psychological therapy in a study of traditional healing and health in a spiritualist church in Ghana. (Spiritualist is the term used for churches which involve in their rituals the direct participation of the Holy Spirit, churches of the type often also called pentecostal or apostolic). For the spiritualists as for the biomedical healer, the unit of therapy is the individual, in contrast to traditional healing which, as we have noted, emphasizes the kin group. Indeed, Mullings suggests that spiritual healing may become a means by which people can break kinship ties which they find too cumbersome. This is particularly likely to be the case of migrants who come to urban centers from rural areas. Healing is related to personal salvation, which is obtained through conversion, confession of sin, and a new way of life in the context of the church. Indeed, while healing is concerned with the individual, the church group provides the former patient and now convert with a new group, and a new authority figure in the person of the church leader. This corresponds quite closely to the other examples of syncretic cults that we have referred to earlier (see Beckman 1975, Rhaut et al. 1975). While there is an apparent contrast between the traditional and the syncretic healing groups in that attention is shifted from the group to the individual there is continuity with regard to concerns with morality, living up to the demands of the spiritual or mystic powers - ancestors and divinities in one case, Jesus and God in the other. In both cases, there are directions for, and rules of, living and changes in behavior that are imposed, and authority is reinforced. In the case of the church, there is also a vigorous rejection of the ancestors and of traditional religious practices. In both cases, there is concern over witchcraft and sorcery as causes of illness, pointing to jealousy and fear of jealousy, competition and interpersonal hostility in the new circumstances of life.

As in the traditional belief structures, in the syncretic churches, the human being is seen as a spiritual being, who must be in harmony with the demands of higher powers, and whose illnesses are the result of infractions and sins. These higher powers can also provide defense against the attacks - supernatural attacks - by hostile beings and persons.

**Etiology and its Philosophical Basis**

It is clear from this comparative discussion that conceptions of the human being are directly related to etiological thinking. Where the human being is divided into an organic and a psychological portion, with the organic given priority, causes of disturbances will be looked for in biological and physical factors, ranging from infections to hereditary dispositions. Where the individual is seen, as in traditional belief structures, as deeply rooted in the kin group and the community, it is these groups that will be turned to as the locus of the disturbance. And, finally, where new institutions have arisen from the contact of cultures, in the form of syncretic churches, which reflect contemporary social relations, two types of explanations of illness and misfortune are found: on the one hand, the individual is likely to be responsible for his own troubles, for disorders are punishments from God for a
sinful life. On the other hand, a different explanation is also to be found: interpersonal hostility, as seen in social rivalry and economic competition is expressed in symbolic terms in the forms of witchcraft and sorcery. The churches and prophet movements also find ways of dealing with such spiritual attack through prayer, exorcism and other rituals.

Etiological Theory and Therapeutic Choice

In both the traditional and the syncretic, or neotraditional, systems of healing, a recurrent distinction may be noted with regard to the causes of "disease", which, in turn, affects therapeutic choice. Thus, Janzen (1978), in his study of Lower Zaire, notes a distinction between "diseases of god", amenable to biomedical healing, and "diseases of man", only traditional healers know how to treat. Edgerton (1971) has noted such a distinction earlier among the Hahe of Tanzania. A similar distinction is described by Mullings for the people of Labadi, in Ghana, who differentiate between "natural" and "spiritual" illnesses, with the latter amenable to treatment by either traditional or spiritualist healers. In this connection, Mullings (1984:40) observes that the problems people bring to traditional and spiritualist healers are remarkably similar, with both dealing with issues of witchcraft and sorcery.

If, then, the illness is thought to be "of god", or "natural", and biomedical treatment is available, this will be the first resort. Here, rapid results are generally expected. If little progress is perceived, the patient and those concerned, such as relatives, may decide that either there are "spiritual" complications, or that the initial diagnosis was altogether in error. As a result, either the patient will be withdrawn from biomedical care or supplemental spiritual care will be sought. Thus, Mullings (1984) notes that in Labadi, the Ghanaian community of this study, utilization of biomedical facilities was high, but patients used other systems as well. In my sample, she writes, "the majority of patients participated, often serially, in all these systems" (Mullings 1984:50). There may be dissatisfaction with traditional healing, as well as with cosmopolitan medicine. In that case, other sources of care will be sought, and these then may be either in a neotraditional setting or in cosmopolitan medicine. For example, N.C. and E. Ortigues (1966) report a psychoanalytic practice within a hospital context, in Dakar. Here patients seek help who have found traditional therapy wanting in cases of both psychoses and neuroses. The perceived effectiveness of treatment is linked on the one hand, to the initial decision regarding "natural" versus "spiritual" illnesses, and on the other hand, to past experience.

Traditional healers and church leaders are likely to encourage use of biomedical facilities in conjunction with their own therapies, in areas - particularly urban areas - where these are available. However, they stand in direct competition with each other.

A first step, then, in the therapeutic process, is an identification of the type of illness the patient is suffering. As Janzen (1978) points out, such an initial decision is made by what he terms a "therapy management group". In his detailed study, he finds that such groups range in size and composition from one person - the patient - to complex groups, including the sufferer, kinship factions, non-kinship factions and, finally, the specialist. In all, he distinguishes eight different types. The composition of the therapy management group depends on a number of factors. Important from our perspective is the observation that members of this group may be of different opinions with regard to the decisions to be made. Final decisions will, therefore, depend on the resolution of differences among them, and this in turn may depend on factors of influence and power. Mullings (1984), for
example, cites a case in which a depressed and delusional young woman was taken by her mother and her mother's sister to a traditional healer. It so happened that this healer was the husband of the mother's sister. The healer's wife was able to influence the choice of therapy because she had contributed to the upbringing of her niece. The patient's paternal relatives, who had not been supportive, were not given a voice in this matter.

Divination and Diagnosis

A major aspect of the decision-making process concerns the consultation of a diviner. Divination may be a first step in the therapeutic process, as in the Ndembu case (Turner 1964) cited earlier. Or it may be a step in the choice of therapeutic strategies, as among the Moundang (Adler and Zempleni 1972), where the diviner proceeds first to discover the causes of an illness and then the means of dealing with it. In this prescriptive phase of divination the discovery of the causes of illness lead to the identification of the type of specialist who must deal with it: specialists in disarming witchcraft, specialists in various kinds of medication, etc., who are men, operating individually, or, specialists in possession, who are women, working as a group. Healing for men in this case involves specific treatments, for women it involves initiation into the association (the authors say "college") of possession specialists. Such a differentiation between male and female healing is, indeed, very widespread in Africa (cf. for example for the Hausa: Mounfouga-Nicolás 1971, Besmer 1983).

Mendoas (1982) has studied divination among the Sisala of Northern Ghana. In the case of illnesses of various types, anger of ancestors may be identified by the diviner as the cause. This, then, becomes an occasion for the airing of interfamilial conflicts. In the case of insanity, which is considered to be an illness, supernatural attacks of two kinds may be identi-

fied. In the one case, the demand of shrines to be taken up, the diagnosis in fact states that the illness is to be treated by initiation into a religious cult. It is, then, to be seen as an "initiatory illness".

Conclusions

Mullings (1984) argues that in most parts of Africa biomedical intervention is not considered suitable for mental illness, because both patients and their families believe it necessary to examine the patient's social matrix. This is so because "one of the tasks of psychotherapy is that of transmitting a specific version of the social order" (Mullings 1984:56). Ortigües and Ortigües (1986) have shown that a European-based psychotherapeutic system, namely psychoanalysis, must be modified to be useful in working with patients living in an African social milieu, under conditions of social and cultural change. This last point is of particular importance. Both the biomedical and cosmopolitan psychotherapeutic systems, and the syncretic religious movements and churches reflect a situation in which a lineage and community-based social order has been modified and where the focus is on the individual and the individual's problems.

It is then from a perspective of social and cultural change that we must consider the current utilization of mental health resources in Africa, and indeed its distinctiveness. Several features are noteworthy, both in the traditional and the neotraditional or syncretic system: first of these is the key role of the diviner-diagnostician and his control over the therapeutic process as well as the important role and the variable composition of the therapy management group. Both of these involve decision-making functions, so that, despite of increased individualization and changing social structures, it appears that, for the most part, it is not the patient but others on his or her behalf who are primarily concerned in making therapeutic choices and
assuming financial and personal risks and responsibilities. Note, also, that clearly sex-differentiated healing systems are frequently in operation. The observation that women predominate among patients is, however, not unique to Africa (see e.g. Finkler 1985). There is no evidence in what we have been able to find of any clear hierarchy of resort, or sequence of therapeutic choices. It is, instead, often the case that more than one kind of therapeutic agency may be treating a patient at the same time. There may, therefore, be reason to speak of both complementarity and competition in African psychotherapeutic practice.

Notes

1 Such a distinction is found in Afro-American cultures also, e.g. in Haiti.

2 I observed such double simultaneous therapies in Haiti, for example in the case of a child who was being treated by a vodou priestess for an attack by “evil winds”, while a physician was dealing with the child’s respiratory disease.

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