

**A study of how a sangoma makes sense of
her ‘sangomahood’ through narrative**

by

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SUMMARY

This study can be described as a journey into the discourse of ‘sangomahood’. It focuses on the narrative of a female sangoma in South Africa and how she experiences her ‘sangomahood’ and gives meaning to it in her specific cultural context. By qualitatively exploring her narrative an attempt was made to understand and illuminate the experiences informing her ‘sangomahood’.

This journey starts with an introduction to the two discourses of health namely the dominant, scientific discourse of Western medicine and the alternative discourse of traditional healing. In this part of the journey the historical, anthropological and sociological perspectives on medicine are discussed, as well as the different views of Western medicine and traditional healing to healers, practices, illness and patients.

The methodology and context of the research is then explained. Narrative analysis is used to explore the themes in the sangoma’s narration.

The sangoma’s narrative is then introduced by means of five letters that I, as the researcher, write to her. In these letters I also reflect on the difference between her experience and mine, as well as the impact of her narrative on me as a psychologist trained in the Western perspective.

This journey was undertaken to create a greater understanding of the culture and experience of ‘sangomahood’. This research also intends to make psychologists aware that the telling of a narrative is never a neutral process and that their clients’ stories always have a certain impact on them as listeners. Each individual experience is shaped through time, by a specific cultural context which becomes the lens through which we experience and shape the world.

KEY TERMINOLOGY

Western medicine, traditional healing, historical perspective, anthropological perspective, sociological perspective, healer, practices, illness, patients, experience, narrative, history, culture, narrative analysis, qualitative research.

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CHAPTER 1

A JOURNEY INTO ‘SANGOMAHOOD’

Dear reader

You have embarked on a collaborative journey into ‘sangomahood’. This journey started for me more than a year ago when I decided to get to know and understand more about the path of traditional healing that sangoma’s are travelling in South Africa today. This path is part of a discourse that is lived by so many South Africans, and yet, is not well-known to mainstream Western society. As a healer-to-be, I was interested.

On this journey into ‘sangomahood’, I have made use of the guiding metaphor of sangoma healing practices. In any interaction with a healer, be it a therapist or doctor in the Western tradition, or a sangoma in the field of traditional healing, there is almost always a ‘question’, ‘problem’ or ‘illness’ that needs to be identified, addressed and attended to. Embarking on what the issues are for sangomas and where they currently stand in South Africa, is thus where my journey truly began.

1.1 THE PROBLEM OF THIS JOURNEY

When I started reading about the issues surrounding healthcare in the South African context, I realised that it is imperative that we know and understand more about sangomas’ experiences and ways of meaning-making. In my interaction with the reading material, as well as speaking to other people about these issues, I started shaping certain ideas and insights into aspects of a rich culture and an approach to health that is only now beginning to be formally recognised in South Africa and the country’s health system. New legislation will soon recognise the practice of South Africa’s indigenous healers. The Traditional Health Practitioners Bill (www.hst.org.za) that regulates the practice of South Africa’s indigenous healers, was unanimously approved by Parliament in 2004. About 200 000 traditional health practitioners are set

to benefit from the legislation. The Bill recognizes the unique circumstances of traditional healers, sets professional and ethical norms and standards, and seeks to empower traditional health practitioners to regulate their practices. Once the new Bill becomes law, traditional healers will be able to apply for registration and to claim fees from the medical aid schemes of their patients. Only registered healers will be allowed to practice medicine. These healers are, however, barred from the diagnosis and treatment of terminal illnesses such as HIV/AIDS and cancer. From a conventional scientific perspective, traditional healing is not supported by research and therefore the scope of its value to patients is questioned by the dominant paradigm. Furthermore, the Department of Health is going to develop regulations in collaboration with traditional healers through an Interim Traditional Health Practitioners' Council, which will regulate the four kinds of practitioners. These categories are: destructive and evil (wizards and witches), diagnosticians or diviners (sangomas and smellers), therapeuticians (medicine men and herbalists) and specialists (rainmakers and disease specialists). These categories sometimes overlap (Gumede, 1990; Matomela, 2004).

In South Africa peoples' health is shaped by two discourses – the one, dominant, Western and medical and the other alternative, African and spiritual. I view traditional healing not as an opposing discourse, but as a different perspective to health than that of Western medicine. Traditional healing is a distinct discipline that in my view must not be adapted to, or integrated with Western medicine. Although there is often tension between Western medicine, that focuses on material causation for illnesses, and traditional healing, that looks at a spiritual origin, these two systems both have something unique to offer and must rather aim at working collaboratively in future. In South Africa the two roles are often combined, as in the case of black medical nurses, of whom an estimated one percent are also traditional healers (Pretorius, 1989). Various researchers have come to the realisation that modern and traditional systems are devoting their energies to different facets of the process of healing. Modern medical practitioners diagnose and treat disease (scientific), whereas the traditional healers treat illness or the human experience of disease, viewed as pre-scientific (Pretorius, De Klerk & Van Rensburg, 1993). Although there have been calls for the

integration of Western and African paradigms (Seedat & Nell, 1990), there are, however, researchers that believe that these differing worldviews – scientific and pre-scientific - are irreconcilable and totally incompatible (Gumede, 1990). Holdstock, however, (1979, p.123) holds a different opinion concerning science:

Before all else, science must be comprehensive and all-inclusive. It must accept within its jurisdiction even that which it cannot understand or explain, that which cannot be measured, predicted, controlled or ordered.

Furthermore, the Western discourses of fear, suspicion and scepticism that surround sangomas, in my opinion indicate our lack of knowledge and understanding. Medical practitioners, for instance, either totally disbelieve (49%) or are indifferent (51%) to traditional healing (Peltzer, 2001). The popular media in South Africa also often carry horror stories of traditional medicine and its healers, while sensationalist articles have escalated with the rise of the HIV/AIDS epidemic. Stories of the prescription of mysterious herbal treatments, healers who claim to have found the cure for HIV/AIDS and unethical and unsavoury behaviour relating to treatment of patients, can often be found in the pages of newspapers or magazines, strengthening the stories of suspicion and marginalization. Many of these traditional healers have deserved the negative publicity generated by their disreputable conduct, but unfortunately these stories have contributed to a negative sentiment held towards all traditional healers and their practices. This has also meant that the role that ethical and well-educated traditional healers can play in South Africa's health care system, has largely been ignored (Richter, 2003).

The World Health Organisation (WHO) already in 1978 formally recognised the importance of collaboration with traditional healers (Gumede, 1990). The year 1978, in which the Alma Ata Conference on primary health care was presented by the WHO, was thus, in many respects, a watershed in respect of interest in traditional medicine on the entire African continent (Pretorius *et al.*, 1993). Currently limited cooperation between these two discourses exists, but before any cooperation on a large scale can be

attempted a mutual understanding of the two cultures needs to be established. This understanding is paramount, as health views determine how health care systems develop and at the core of these views are culturally determined beliefs and values. Through socialization and experience people learn what to think, believe and do in terms of appropriate health behaviour (Muller & Steyn, 1999).

Traditional healers play an influential role in the lives of predominantly African people and can be important role players in a comprehensive health strategy. These healers are cheaper, culturally appropriate for the largest population in South Africa and can also offer psychological support to sick patients in African communities, where psychological services have not yet been fully recognized or used to their full potential. It is therefore important to demystify these traditional healers and hopefully aid in eradicating the marginalizing discourses that surround them. Traditional healers are a vital link between the community and Western practitioners in that they are affordable, accessible and mostly well informed about basic and advanced health care. Without them the poorly resourced community clinics will be even more overwhelmed than they are (Campbell, 1998).

Until now the discourse of Western medicine has received a great amount of attention in contrast to the work and experiences of sangomas and traditional healing. In my view this attention has been due the fact that the Western discourse, with its positivistic epistemology, has created a lot of knowledge through quantitative research whereby hypotheses and assumptions have been validated. The constructions of scientific validity and generalisability have thus created a scientific power. Orthodox medicine has thus been legitimized under the auspices of a scientific discipline and has been able to have the scientific paradigm of medical care accepted as ‘the’ paradigm, accusing alternative practitioners of invoking magical beliefs without scientific basis (McKee, 1988). Modern Western medicine is also viewed as the legally and culturally dominant form of medicine in probably every country in the world. It is socially constructed by its knowledge and social relations, especially professional self-regulation of qualifications, practice and ethics backed by government licensing and international

corporations (Worboys, 1997). On the other hand, however, traditional healers view Western medicine as too scientific and clinical and are often of the opinion that these practitioners should approach their patients in a more holistic manner, thus not only taking into account the patient's body but also aspects of the soul (Gumede, 1990).

Furthermore, the taken-for-granted assumptions of Western medicine, about how the world is and ought to be, often conceal patterns of domination and submission over the narratives of traditional medicine and their healers. Certain discourses are viewed as more important in certain contexts than others, which suggests that what counts as 'knowledge' is often closely related to power (Gergen, 1994). Up to 80% of the indigenous African people consults indigenous healers as their first point of reference. These statistics show that although most African people have accepted this scientific Westernized medical discourse, they nevertheless continue to retain traditional concepts and discourses to give meaning to their experience (Hammond-Tooke, 1989; Sodi, 1996). It therefore seems that ties to one's culture and sensitivity to the value and belief systems of a person's cultural background seem evident in the selection of health care services (Broad & Allison, 2002). In terms of the number of people who are served by traditional health services worldwide, one cannot but deduce that traditional medicine has an important role to play in primary health care (Pretorius *et al.*, 1993).

Rudnick (2002, p.51) argues that regardless of their compatibility, both approaches "appear to be firmly rooted within the national infrastructure, and it behoves practitioners from all camps to be well informed about their alternative colleagues". He furthermore states that in the key divide between orthodox and traditional healing, perhaps being purest is seldom an answer. Healers can need medicine and doctors can need healing. "In essence health care works best when it can draw on the best of everything" (2002, p. 182).

I would like to conclude this first part of my journey with an extract from Engel (1977, p.135):

Nothing will change unless or until those who control resources have the wisdom to venture off the beaten path of exclusive reliance on biomedicine...In a free society outcome will depend on those who have the courage to try new paths and the wisdom to provide the necessary support.

In the light of the above discussion, it seems that traditional healing and sangomas are still marginalised in South Africa. Also, as Western healers and psychologists we know and understand very little of traditional healing and sangoma's. It is therefore important that their unique experiences and voices be heard to create a greater understanding of 'sangomahood' before we can take the first authentic step to working collaboratively with these healers. The next steps towards creating greater understanding on this research journey, is to look at the question, goals, structure and thus the 'map' of this journey.

1.2 THE QUESTION OF THIS JOURNEY

After careful consideration, I decided that the question of this research journey will be: "How does a sangoma make sense of her 'sangomahood', through narrative?"

1.3 THE GOALS OF THIS JOURNEY

1.3.1 General goal

The general goal of this research project is thus to try and understand how a sangoma makes sense of her 'sangomahood', through narrative.

1.3.2 Specific goals

The specific goals of this research journey are to:

- 'Listen to the ancestors' - do a literature review.

- Choose certain rituals - describe the research methodology.
- ‘Throw the bones’ - conduct the research project.
- Interpret the thrown bones - write the research report.

1.4 STRUCTURE

Each journey needs a certain amount of structure to make it easier to follow and more understandable. This journey will be structured in the following way to guide the reader more comfortably: In Chapter 2 we will be ‘listening to the ancestors’ by taking a look at how literature describes traditional healing and Western medicine and their respective histories, as well as looking at the different perspectives on medicine. In Chapter 3, we will be choosing certain ‘rituals’ where I will be discussing the research position of this journey, namely that of narrative psychology and analysis. This will then be followed by ‘the throwing of the bones’ in Chapter 4 and thus an analysis of the interviews with the sangoma, which will be done by writing five letters to her, discussing my analysis of her narrative and its effect on me. In the final chapter, Chapter 5, I will interpret the ‘thrown bones’ by reporting my interpretation and findings based on the interviews with the sangoma.

CHAPTER 2

‘LISTENING TO THE ANCESTORS’

In this chapter we will be listening to what the ‘ancestors’ have to say about the different perspectives and aspects of Western medicine and traditional healing. Listening to, engaging and mediating with the ‘ancestors’ is paramount and primary to any journey into ‘sangomahood’. They add guidance, structure and insight to this journey. The ‘ancestors’ in this part of my journey, are thus used as metaphors for the literature with which I engaged and which added a certain amount of structure and understanding to the journey. Clatts and Mutchler (1989) state that metaphor works by association, by comparing two non-associated entities with each other and by doing so it “shapes perception, identity and experience, going beyond the original association by evoking a host of multiple meanings” (1989, p.106-107). There are mainly two ‘ancestral voices’ or discourses, namely Western medicine or biomedicine and traditional healing.

‘THE ANCESTORS SPEAK’

2.1 PERSPECTIVES ON MEDICINE

2.1.1 Historical perspective

The first perspective that I will discuss is the historical perspective on medicine, which focuses specifically on the historical development of Western medicine and traditional healing.

This perspective can give the researcher an indication of how Western and traditional medicine has developed through time. It also gives us insight into the functioning of these two discourses and therefore how and why they work the way they do. A historical perspective can also help us to see, in hindsight, how easily we take for

granted certain traditions without deconstructing their usefulness or creating alternatives. This perspective can also shed light on how power works and how it produces certain forms of knowledge (Worboys, 1997).

Furthermore, history provides a perspective which is able to show that the conventions of Western biomedicine are no more ‘scientific’ or ‘objective’ than medical systems in other cultures or in other times (Lupton, 2003). Also, this perspective gives us a chronological approach, with a sense of continuity as well as change, and the ability to interweave different levels of interpretation in its analysis of medical and public health issues. Historicity allows for insight into social issues and shows that the taken-for-granted features of the present should be challenged (Berridge & Strong, 1991). “We use the past to shake confidence in the ‘obvious’ appearance of medicine today; not in order to sanctify it as has so often happened in histories of medicine” (Wright & Treacher, 1982, p.2).

Without the historical perspective, the behaviour and beliefs of people in response to health issues will sometimes appear irrational and self-defeating. This perspective can for instance cast light on why certain diseases are stigmatized and provoke widespread fear and moralistic judgements (Berridge & Strong, 1991). Brandt (1991, p.211) states that “in studying the history of medicine we learn about the constraints and prospects of the human condition across time and cultures.”

The historical writings of Foucault (Foucault, 1967) have been very important in the reshaping of the histories of medicine. He called into question the truths of historical interpretations and showed how networks of power produce medical experiences and knowledge. Foucault for example questioned the diagnostic processes that developed in psychiatry in the seventeenth and eighteenth century and which created mental illnesses by labelling some behaviour as normal and other as abnormal. He thus saw mental illness as socially constructed, while he viewed psychiatry as a system of knowledge exerting disciplinary power on the minds and bodies of those who were defined as ‘mad’. The Foucauldian perspective has inspired radically different ways of

viewing the role played by medicine, particularly in seeking to identify the discourses that shape ways of thinking about the human body and the relations of power that are part of the medical experience (Lupton, 2003).

Before the ‘ancestors’ go on to guide the journey through the discussion of the respective histories of Western medicine and traditional healing, it is important to mention that medicine and culture are inseparable entities and together make up a complex world or set of worlds. Medicine itself is a culture and a world of its own, with institutions and sub-institutions, and with rites of passage, forms of education, standards of behaviour and sets of norms that have their own history and development (Rothman, Marcus & Kiceluk, 1995).

- **History of Western medicine**

Documentary evidence exists that Hindu physicians prescribed kindness and consideration some 3400 years ago in alleviating mental suffering. Some 1000 years later the Greeks appeared to have introduced the idea that natural forces, and not only supernatural or magic forces, played a role in the world. Healing practices thus became inspired by a balance of rationalism and supernaturalism. Hippocrates, the most celebrated of Greek physicians’ disparaged charms and amulets, and believed that nature was ultimately responsible for causing and curing illnesses (Bromberg, 1963).

The time of the Enlightenment (late 17th to late 18th century) is believed to be the period in which many of the ideologies, practices and discourses of contemporary biomedicine developed and became dominant. This period thus brought with it major developments in philosophy, literature, art, mathematics and architecture and this new spirit of rational enquiry led to a decline in the reliance of supernatural explanations. Until the mid-seventeenth century causes of illness were related to the corruption of air and the corruption of morals which, in turn, was related to the will of God - viewed as the ultimate cause of illness. Then, divine intervention determined the outcome of illness. During the Enlightenment, however, ideals changed and there was great faith in the

progress of society through developments in science and technology and belief in the power of reason (Herzlich & Pierret, 1987). Furthermore, the invention of the microscope and new-found understanding of chemistry gave impetus to medicine in general. Medicine based on scientific principles was seen as the solution for the ills of humankind. The printing press also fuelled the scientific revolution by distributing new knowledge (Bromberg, 1963).

It seems however that the rise to power of the medical profession in Western societies is historically recent. Before the Enlightenment physicians and surgeons were seen as a little more than trades people. Surgeons had contact with blood (seen as a poisonous residue) and were engaged in the blasphemous dissection of bodies and therefore they were seen as impure and polluted. As little as a century ago the medical profession had much less power, influence and prestige. As late as the eighteenth century individuals medicated themselves and tended not to seek the help of medical professionals, for they were not considered appropriate to deal with witchcraft or divine intervention (Lupton, 2003). When ill people did seek a practitioner's help, treatment and cure depended on the sick person's self-report, and all aspects of emotional and spiritual life, as well as the physical state, were emphasized. The ill selected their practitioners, making use of their own personal assessment of the practitioner's moral integrity and therefore the consultative relationship was based on the basis of personal empathy between the parties (Worboys, 1997).

An important factor in the rise of status of biomedicine was the growing acceptance in the nineteenth century that diseases were caused by certain entities within bodily tissues, of which the ill person was unaware. From the late 1800's onwards the dramatic discoveries in laboratories of the causes of diseases such as tuberculosis, cholera and typhoid made front page news, glorifying the progress of scientific medicine. Professional excellence came to be associated with scientific skill and laboratory research rather than library-based knowledge and empathetic bedside skills. There was a shift away from the person-centred cosmology to an object-centred cosmology (Jewson, 1976).

Although Western medicine had become more scientific, in the second half of the nineteenth century Western white healers were still reasonably tolerant of traditional healers and did not treat them with the same disdain and arrogance evident in later years. These Westernized medical healers were well aware of the limitations of Western medical science as illustrated by Dr. David Livingstone's consultation of traditional healers on drug treatment for fevers (Etherington, 1987).

However, decades of colonialism, cultural imperialism, and the power of the multinational pharmaceutical industry have all assisted in slowly marginalizing the discourse of traditional healing (Richter, 2003). Discourses of the legal system have also contributed to marginalizing the views and practices of sangomas, such as the previous Witchcraft Suppression Act of 1957 and the Witchcraft Suppression Amendment Act of 1970 (www.doj.gov.za) which prohibited the diviners or sangomas of practising their trade. This was prohibited as early as 1891 in colonial Natal (Jolles & Jolles, 2000). Other factors that strengthened the campaign against traditional medicine were Western methods of education and the integration of African subsistence economies into the world capitalistic system which led to new values, preferences and patterns of behaviour and eventually to the disintegration of traditional African cosmology and culture. Yet, traditional medicine survived because most Africans follow a dualistic pattern of consumption, which accommodates both the conspiracy theory of witchcraft and the scientific theory of modern medicine (Pretorius *et al.*, 1993).

Medicine did, however, ultimately succumb to rationalism and the Western medical epistemology remains scientifically based. Methods and medicine which have not undergone empirical testing and rigid scientific scrutiny are generally disregarded by adherents of this approach. These kinds of parameters shape the disciplines which dominate the Western medical world and influence the way in which Western practitioners attend to their various crafts (Benjamin & Baker, 2004).

In the light of the above discussion, the next step on this journey will be to listen to what the 'ancestors' have to say about the historical path of traditional healing.

- **History of traditional healing**

The origin of contemporary traditional healing is speculative. One view is that it is reasonable to trace back the origins 10,000 years and suggests that many San healing rituals evolved from this time (Katz, 1982). Another view is that our traditional healing originated from Arabic Sahara countries around 6000-4500 years ago, when that region was the centre of African trade and learning. From here the art of healing was disseminated northward and southward (Gumede, 1990).

It is, however, not possible to understand the traditional healer and traditional healing without first looking into the concepts of African traditional religion. For centuries the Africans have always been a highly religious people. They left no shrines, temples or monuments because they never (here or in the Sahara) worshipped inanimate objects such as stones, trees or forests as the objects of their beliefs. Their religion was for everyday living. They believed in someone, a supreme being, which they could not see. He is known by different names in African societies, namely Tixo (among the Xhosa), Tilo (Tsonga), Modimo (Sotho) and Umvelinqangi (among the Zulus). In African culture there is interdependence between the African people and their ancestral spirits and it is therefore natural that this bond will also be apparent in their practices of healing. The living and the dead have a duty towards each other. It is mandatory to continually make sacrifices to the dead to maintain this bond of friendship with the spirits of the departed. There are three basic tenets of a proper sacrifice. First, there must be the correctly chosen beast, secondly there must be beer brewed before the slaughter day and thirdly, there must be frankincense. If certain customary rites are not performed, the spirits of the ancestors will show their disapproval through visitations which often takes the form of ill health and disease. It is done to remind the off-spring of the errors of their ways. Health and ill health are held in a state of fine balance through this bond of friendship between the living and the dead (Gumede, 1990).

Our journey will next take us to a second perspective that cannot be overlooked, namely the anthropological perspective, as it has caused the Western and traditional

medicine discourses to develop fundamentally differently as a result of certain cultural views.

2.1.2 Anthropological perspective

The focus of the anthropological perspective is thus on culture and how it shapes the different faces of medicine. From this perspective a person's culture will determine how he or she views illness and experiences it. Illness, the experience and treatment thereof are social and cultural processes. It, therefore, makes sense that individuals in the Western culture view physical illness in terms of the germ theory as there is a culture of scientific proof and expert knowledge. On the other hand, traditional communities, whose culture is embedded in the spiritual world, will automatically link the ancestors to the practice of medicine and treatment (Rosaldo, 1993).

Traditionally medical anthropologists have been concerned with the interpretation and lived experience of illness. They recognize that the culture, in which a patient operates, influences the patient's illness experience. This approach therefore views illness as a form of communication – the language of the organs – through which nature, society and culture speak simultaneously. Recent approaches of this view have been interdisciplinary, incorporating political economy concerns with the structural economic features of society and how they impinge on health status, with a social constructionist interest in language use, as well as an interest in the experiential aspects of the medical encounter (Lupton, 2003). From this perspective, the human body is understood as a product of social and cultural processes, and of biology and is, therefore, simultaneously totally biological and totally cultural. These concerns are identical with sociological and historical approaches that adopt a social constructionist perspective (Guarnaccia, 2001).

Furthermore, social constructionism is an approach which questions claims to the existence of essential truths. What is asserted to be 'truth', can be considered the product of power relations, and is therefore never neutral but acts in the interest of

someone or some ideology. All knowledge is thus, inevitably, the product of social relations, and is always subject to change. One of the primary focuses of social constructionists is examining the social aspects of biomedicine, the development of medico-scientific and lay medical knowledge and practice. This approach does not call into question the reality of disease or illness states. It merely states that these conditions and experiences are known and interpreted via social activity and therefore should be examined using social and cultural analysis (Guarnaccia, 2001).

According to this perspective, Lupton (2003, p.12) states that:

medical knowledge is regarded not as an incremental progression towards a more refined and better knowledge, but as a series of relative constructions which are dependent upon the socio-historical settings in which they occur and are constantly renegotiated.

This approach therefore allows for alternative ways of thinking about the truth claims of biomedicine, showing that they are as much social products as lay knowledges of medicine. Furthermore, there is a range of political positions taken by the social constructionist approach. One position views medical knowledge as neutral, while others emphasize the social control function of dominant discourses such as Western biomedicine, arguing that such knowledge and its practices reinforce the position of powerful interests to the exclusion of others. Although social constructionists recognize a multiplicity of sites of power, the notion that medicine acts as an important institution of social control has remained. The emphasis, however, has moved from examining medical power as an oppressive, highly visible sovereign-based power to a conceptualization of medicine as producing knowledge which changes in time and space. According to this view it is thus argued that medical power not only resides in institutions or elite individuals, but is deployed by every individual to accept certain norms and values by way of socialization (Worboys, 1997; Freedman & Combs, 1996; Wright & Treacher, 1982).

Furthermore, it is rarely claimed by the social constructionist approach that fleshly experiences are simply social constructs without a reality based in physical experience. This approach acknowledges that experiences, such as disease and pain, exist as biological realities, but emphasize that such experiences are always inevitably given meaning and therefore experienced and understood through cultural and social processes. Social constructionism exposes the social bases of medicine, health care and illness and by doing so renders these phenomena amendable to change, negotiation and resistance. “At their most political, social constructionist perspectives may be brought to bear to challenge the inequalities that exist in health care provision and health states” (Lupton, 2003, p.14).

Having discussed the anthropological approach above, this journey will take us to a third and final perspective, namely the sociological perspective, which comprises of the functionalist and political economy approaches to medicine.

2.1.3 Sociological perspective

○ Functionalist approach to medical sociology

This approach sees the medical profession as a profession of social control that has to distinguish between normality and deviance. Medicine and the medical model are used as mechanisms to control the disruptive nature of illness. The focus of this approach is thus based on control.

The classical functionalist position is to view illness as a potential state of ‘deviance’, which is failure to conform to societal norms in some way. Illness is considered an unnatural state, causing physical and social dysfunction, and therefore a state that must be alleviated as soon as possible by medical control. The patient is placed in the role of the socially vulnerable supplicant, whereas the role of the doctor is seen as socially beneficent. In turn, the doctor-patient relationship is viewed as inherently harmonious and consensual, even though it is characterized by an equal power relationship (Lupton,

2003). There is a constant struggle for power between doctors and their patients and that they have different, and often, conflicting interests. Negotiation is therefore necessary at every step of the encounter. It is also argued that there are organizational constraints in the medical setting and external factors influencing the behaviour of doctors and patients when they meet, which go beyond the dynamics of the sick role model (Turner, 1995; Gerson, 1976). The functionalist approach has thus become unpopular in medical sociology because of these critiques, but has nevertheless made important contributions in terms of the emotional relationship between doctor and patient, and the needs and drives that underpin it (Lupton, 1997).

- **The political economy approach**

This approach emphasizes societies' marginalization of individuals who do not contribute to the production and productiveness of society.

The medical system therefore exists to ensure the health of individuals to enable them to remain productive. The focus of this approach is thus based on production. Like the functionalists, political economists see medicine as a moral exercise, used to define normality, punish deviance and maintain social order and productiveness. Political economists, however, differ from functionalists in that they believe that the power of the medical model is harmful, rather than benevolent and that it is abused by the medical profession. Political economists refer to the cultural crisis of modern medicine in which health care under capitalism is perceived as largely ineffective, overly expensive and inequitable. The high status of the medical profession and the faith that is invested in doctors' abilities to perform miracles has resulted in other social problems being inappropriately redefined as medical problems. As medical jurisdiction has widened, more social resources have become directed towards illness and thus the medical profession's power and influence increased markedly in the twentieth century, with little scope to question its use of resources or activities (Freidson, 1970; Wright & Treacher, 1982).

There are two major facets to the political economy approach. The first largely accepts that biomedicine is a politically neutral good and seeks to provide more and better services to the underprivileged, while the second, more radical critique, has questioned the value of biomedicine and highlighted its role as an institution of social control, reinforcing patriarchy and racism. Both these approaches conform, however, to the use/abuse model of medical knowledge, which tends to accept the objectivity and neutrality of medical knowledge, but questions the use to which it is put in the interests of doctors and the wider capitalist system (Ehrenreich, 1978). Furthermore, the political economy approach calls for:

a mass social movement to change dependency upon medical technology, decommodify medicine, challenge the vested interests of drug companies, insurance companies and the medical profession, and redirect resources towards ameliorating the social and environmental causes of ill health (1978, p.25).

Some sociologists see this as idealistic and unrealistic, especially in the light of the perceived symbiotic relationship between capitalism and medicine. The political economy approach has therefore been criticised for its unrelenting nihilism and its failure to recognise the advances in health status and increased life expectancy which have occurred over the past century, associated with reforms in sanitation, a rise in standards of housing, better contraceptive technologies and progress in medical treatment and drug therapies. The latter are intrinsically linked to the requirements and demands of the capitalist economic system. The political economy approach, however, still remains an important perspective of the social aspects of health and illness. Continuing problems of access to health care and the larger environmental and political issues surrounding the question as to why certain social groups are more prone to ill health still remain important points of discussion for this approach (Hart in Lupton, 2003).

In the light of the above perspectives of medicine, the next part of the journey will entail looking at the different practices and viewpoints of Western medicine and traditional healing.

2.2 ‘THE TWO ANCESTRAL VOICES’ – WESTERN MEDICINE AND TRADITIONAL HEALING

As mentioned above, the health of South Africans’ is currently shaped by two discourses or, on this journey, two ‘ancestral voices’ namely that of Western medicine and that of traditional healing. I will first take a look at the dominant discourse of Western medicine, and how this discourse has shaped the concepts of healer, illness, medical practices and patients, before I take a look at these concepts from the viewpoint of the alternative discourse of traditional healing.

2.2.1 ‘The dominant ancestral voice’ - Western medicine

o Healer

On this research journey I would conceptualize that the Western health care system distinguishes between different types of healers and that there are relatively rigid territories in the health sector, such as the physical healer or medical doctor, the psychological healer or psychologist and the spiritual healer or pastor. The emphasis of the physical healer is on the application of scientific methods, knowledge and technology, whereas the psychological healer concerns him- or herself with personal history, experience, perceptions and existential issues. The pastor, on the other hand, focuses on the spiritual issues of the patient.

The Western doctor mostly sees his job as the application of knowledge and technology to diagnose and treat causes and symptoms of illness. Although the distinction of the different healers can have certain drawbacks, such as the fact that some doctors may

exclusively focus on the patient's physical ailments, there are also advantages to the Western approach. It allows for the creation of specialist and expert knowledge in each of the fields of healing, as well as a multi-disciplinary approach where specialists of different fields can come together and share their knowledge. The patient is then viewed holistically from a team perspective (Felhaber & Mayeng, 1999).

When looking at the ways in which doctors approach their work as healers, it is important to understand the socializing processes by which individuals achieve the official credentials to practice medicine. The training is based on the positivist scientific method, centring on the rapid accumulation of facts - spanning six years, including an internship year - with little space devoted to consideration of human communication. Emotional problems are not seen to be in their scope of work and patients with these problems are referred to psychologists. Furthermore, medical students are taught that there is a diagnosis for every condition and that every condition has a set of treatment strategies (Simmons, 2002). The good doctor is expected to be able to make instant judgements and to get the job done quickly. Spending a long time with patients and encouraging questions is not valued in the hospital or public clinic setting. Also authority and depersonalization is seen as functional for both medical professionals and patients (Stein, 1990).

In spite of the above, modern medicine is increasingly moving in the direction of a comprehensive approach by putting the focus on the total patient in his total environment. A growing number of Western medical practitioners do have an understanding of the aetiology described by their black patients and they can communicate with them effectively (Pretorius *et al.*, 1993)

- **Illness**

The central premise of Western medicine is the germ theory. This theory states that germs (viruses and bacteria) are *inter alia* seen as the causes of physical symptoms and disease. Germs are seen to have personalities. They are expressed in, and can be recognised by the various symptoms they cause. Illness is no longer predominantly

seen as caused by evil forces, but rather as a microscopic invader (Lupton, 2003; Chauvet & Tomka, 1998).

As the field of psychology makes use of metaphors, I have decided to illustrate with the use of well-known metaphors used by certain researchers how the Western world often perceives disease or illness. When referring to illness, the language of warfare and the military metaphor is extremely common in modern medical and public health discourses, especially illnesses such as AIDS, cancer and other infectious diseases. Furthermore, there is also a frequent use of metaphor in the medical context, as metaphor is used in all areas of verbal communication as an epistemological device, serving to conceptualize the world, define notions of reality and construct subjectivity (Lakoff & Johnson, 1981).

Lupton (2003, p. 65) illustrates the use of metaphor in illness in the medical context and states that:

the immune system, for example, is commonly described as mounting a 'defence' or 'siege' against the 'invasion' of 'alien' bodies or tumours which are 'fought', 'attacked' or 'killed' by white blood cells, drugs or surgical procedures.

Also, research with oncologists and their patients found that they both constantly referred to the disease as 'the enemy' and 'the aggressor' and saw themselves as allies against cancer. As this suggests, in Western societies giving up, fear and denial are not socially acceptable ways of dealing with disease. A coping attitude, strength and cheerfulness are required, and dying bravely becomes a victory. Also, the physician must respond with military-like leadership, authority, precision, little emotion and an aura of control (Erwin, 1987).

The military metaphor has also been particularly dominant in patients' description of living with HIV/AIDS. One patient had described his illness in the following way (Brown in Lupton, 2003, p.67):

My personal war began two years ago when I was mobilized by AIDS. All the pleasures of peacetime and my carefree life were suddenly banished, as if an orchestra had stopped playing to let the theatre manager announce that war had just been declared, that Pearl Harbour had been bombed. Since then I have devoted myself exclusively to the war effort, because the futility of civilian life (my thirty-six years of good health) is absurd when survival itself has become the main imperative.

Furthermore, in modern Western societies, the emphasis on individuals' responsibility for preserving their health and avoiding their risk has come to dominate explanations of illness. Self-indulgence, stress and lack of self-discipline are viewed as reasons why people become ill with diseases such as heart disease, diabetes and lung cancer, which have strongly been linked to diet, weight and use of tobacco. Currently, the emphasis on diet and attitudes towards food enter firmly into the world of morality. What we eat is about making choices between illness and health. If the behaviour is viewed as socially deviant, such as smoking or excess alcohol consumption, then the ill person is seen as courting illness (Sontag, 1989). For example surgeons in the late 1980's in Britain that refused heart bypass operations to people who smoke, arguing that these patients would benefit less from the surgery and thus implying that people that smoke are less deserving of medical care (Coward, 1989).

Also, the modern tendency to view illnesses such as cancer as the result of internalised stress or anger constitutes:

a powerful means of placing blame on the ill. Patients who are instructed that they have, unwittingly, caused their disease are also made to feel that they have deserved it (Sontag, 1989, p.57).

In the light of the above it is clear that the germ theory has had a great impact on how illness is perceived. The next step on this journey will be to take a look at Western medical practices and the treatment of diseases, which stem from the germ theory.

○ **Practice(s)**

The result of the Western mechanical and materialistic approach is a nearly exclusive emphasis on the practices of clinical diagnosis and physical treatment through the application of pharmaceutical and other technologies.

The practice of Western medicine has made significant technological and scientific advances in the last few decades which has contributed to the shift away from models of person-centred medical care to models which depersonalize the patient. The gap between medical knowledge and patient knowledge continues to increase, strengthening the reliance of medical practice on scientific theories to measure its success. Although medical practice is based on scientific methods and is designed to produce the healthiest possible human beings, the practice of medicine is first and foremost an ethical practice (Clifton-Soderstrom, 2003). In this regard Western doctors practice medicine based on the following ethical principles (Kubsch, Hankerson & Ghoorahoo, 2005):

- Autonomy, as medical practitioners make most of the decisions themselves;
- Non-maleficence, seen as the principle to do no intentional harm, as there are significant risks of harm associated with drug usage, surgery and medical errors;
- Beneficence, necessary to judge claims of benefits and hopeful cures related to use of treatments prescribed by physicians; and
- Justice, seen as the principle that promotes fairness, equality and access to medical care.

Furthermore, the practice of Western medicine has contributed significantly to the health, well-being and longevity of human beings. An example is that of new genetics, that has now become an integral part of contemporary biomedicine, promising great advances in alleviating disease and prolonging human life (Finkler, 2005). Also, biomedicine is focusing more and more on quality of life, where the specific needs of

patients are given attention. An example is an article by Fisher (2004) concerning the needs of parents, lifestyle modifications and stress factors when dealing with allergic children.

Also, the language of the modern healer is scientific approach, aetiology, symptomatology, diagnosis, epidemiology, curative, preventive, prognosis and mortality. This must be understood in the context of medical training which entails a set of beliefs and knowledge, based on the scientific model, which structure the ways in which doctors diagnose illness and respond to patients (Gumede, 1990). For interventions doctors also make use of the well-known Cochrane Library, which is an electronic collection of over 2000 high quality systematic reviews. This is a good first port of call for doctors when looking for evidence on interventions. In South Africa the Cochrane Library is accessible to doctors after registering (Swingler, 2005).

Medical doctors are taught to believe that there is a scientific basis for disease and diagnosis. Although the disease processes can be correctly explained, the important existential question ‘Why has this happened to me?’ is not explained (Muller & Steyn, 1999). The discourse of modern medical care in Africa is criticised because it is crisis-orientated and financially constrained, it provides symptomatic treatment, it depends on technology, it exhausts resources, it is not always available, and, if it is, it lacks understanding of the people whom it serves (Pretorius, 1989).

The practice of doctors is also closely related to power. “See the routine clinical techniques: the rash displayed, the hand applied to the abdomen, the stethoscope placed gently on the chest. This is the stuff of power” (Armstrong, 1987, p.70). In medical examinations individuals are “located within a field of visibility, subjected to a mechanism of objectification, and thereby to the exercise of power” (Smart, 1985, p.87). Each individual is marked as a case and therefore the individual is constituted as the subject, as well as the object of knowledge.

It is important to bear in mind that power enables doctors to act in the competent role demanded of them by most patients and which is legally and professionally prescribed. Thus, doctors are not necessarily behaving in a deliberate attempt to oppress their patients. They are behaving in a way which is expected of them by their co-workers and patients and they cannot easily decide to break the frame of their professional game without serious consequences. The medical discourse can therefore not be understood simply in terms of unnecessary or causal forms of convenient domination or arrogance. As the experts in the medical encounter, doctors must advise patients how to behave, direct their bodily movements in clinical examinations, prepare them for surgical procedures and advise them about behaviour relating to their health problems and treatment regimes, for as non-experts the majority of lay people do not know what to do (Maseide, 1991).

Furthermore, it is important to mention that medical practitioners themselves sometimes make use of metaphors to describe their work and patients. A medical anthropologist working in an American hospital, documented his research and found that doctors repeatedly described themselves as being ‘on the front line’, in need of ‘getting aggressive’ and using ‘shotgun therapy’ and ‘magic bullets’. They commonly described working in the emergency room as being ‘in the trenches’. The doctors in this study did not only battle against disease, but also against the masculine world of the medical system, attempting to master their work as winners, never allowing themselves to lose control (Stein, 1990).

Lastly, I will be taking a look at how the Western medical world views the patient.

- **Patient(s)**

As mentioned above, doctors often view their patients in terms of a scientific approach, which means the patient is viewed mechanically. The focus is on the human body and its organs and the medical practitioner focuses almost exclusively on this physical aspect. The Western approach has created distinct boundaries in the health sector and

one cannot expect doctors to offer quality psychological and spiritual support in which they were not trained (Stein, 1990).

The mechanical metaphor has been used in discourses on the body, since the industrial revolution. Even pre-industrial revolution metaphors adopted “the imagery of the body as a workshop full of instruments and tools, including the lungs as blacksmith’s bellows” (Lupton, 2003, p. 62). The mechanical metaphor includes the idea that individual parts of the body, like parts of a plumbing system or car may ‘stop working’ and can sometimes be replaced. The metaphor thus has the effect of:

separating mind and body, of valorising medical techniques which focus upon locating a specific problem in a part of the body and treating only that part, and devaluing healing relationships which rely upon spirituality, personal contact, intimacy or trust (Helman, 1985, p.322).

This correlates with the description of a patient of her experience with the doctor in hospital (Kleinman, 1988, p.116):

It is a voice that won't falter if the moon falls out of the sky, a voice completely stripped of emotion. When he uses that voice, I know I am just a piece of machinery to him, that his disinterest in my feelings is complete.

The routine employment of organ transplants and artificial organs or parts such as pacemakers and hearing aids in high technology medicine is supported by and reinforces this image. It was therefore a logical leap to imagine the body as a computerized system in the late twentieth century. There developed a symbiotic metaphorical relationship between humans and computers. Computers were said to have a memory, while humans have increasingly been portrayed as ‘organic computers’ (Stein, 1990). With the discovery of RNS and DNA the human body began to be represented in medical and scientific texts as a complex chemical factory, manufacturing chemical building blocks using blueprints. These metaphorical systems thus reduce individuals to their DNA codes (Nelkin & Tancredi, 1989). Sickness becomes viewed as the product of biological destiny, located within the individual and requiring the intervention of technology to correct the faulty code and in this way

detracting the attention from the examination of the social context of illness, such as poverty (Conrad, 1999).

Sacks (1984, p.28) describes his experience of depersonalization, of becoming a patient from the perspective of a physician:

One's own clothes are replaced by an anonymous white nightgown; one's wrist is clasped by an identification bracelet with a number. One becomes subject to institutional rules and regulations. One is no longer a free agent; one no longer has rights; one is no longer in the world-at-large. It is strictly analogous to becoming a prisoner, and humiliatingly reminiscent of one's first day at school. One is no longer a person – one is now an inmate.

There are thus powerful emotions present in illness and the patient role, where even doctors who are trained to deal objectively with illness of others succumb to anxiety and uncertainty when it is their own bodies that are involved. For many doctors the experience of being ill dramatically changes their perspective and the way in which they practice medicine (Lupton, 2003).

As we have listened to what the 'ancestors' have had to say about Western medicine, the next step on this journey will be to listen to the alternative ancestral voice of traditional healing.

2.2.1 'The alternative ancestral voice' - Traditional healing

o Healer

Griffiths and Cheetham (1982) consider the term traditional healer a misnomer, as well as inadequate. It will, however, be a commonly used term in this research report. Healers are considered to be analogous in the Western world to a cross between psychotherapist, medical doctor and mystic. In general traditional healers carry the same respect as medical doctors in the Western world. Whereas the Western medical

world focuses on the individual and individual empowerment, the traditional healer focuses mostly on the contributions to the community (Hammond-Tooke, 1989). The African way of recovery is through and within the community by means of consultation and actively involving others. The traditional healer is therefore evaluated by the community in terms of his interventions and the restoration of social harmony. Although these healers do not emphasize elements such as warmth and empathy the client is the centre of attention in the healing process. Their clients have great belief in the expertise and rectitude of the traditional healer (Gumede, 1990).

The traditional healer is thus seen as a spiritualist and a healer of physical ailments. Unlike biomedicine, their alternative therapies can provide satisfactory explanations for the questions ‘Why me?’ and ‘Why now?’ replacing the world of sterile biologic facts with a readily understood moral system in which the right attitudes and behaviours are rewarded with good health (Gumede, 1990). Traditional healers make their diagnosis (and therapeutic combinations) with the aid of ‘spirits’ or ancestors and under the control of the ‘spirits’. Most traditional healers are ‘called’ by the ‘spirits’ or ancestors to become healers (Thindisa & Seobi, 2004).

Becoming a traditional healer rarely happens out of choice and *bona fide* healers are called to their jobs by the ancestors, often in the guise of a dream or an illness that won’t go away. This sickness is characterized by a range of symptoms which include various aches and pains, anxiety, irritability, insomnia or sleepiness. Another sangoma of standing must then be consulted to determine whether the symptoms are a calling or not (Faure, 2002).

Their training mostly comprises of an apprenticeship, of which the length varies, depending on the skill of the trainee and the cooperation of the ancestors. The normal range for training is 12 to 24 months, although gifted students will train in less time. In some cases it could go on for 5 or 6 years. During the training the trainees live with their trainers and are taught under close observation until they have mastered their calling. Training then ends in an initiation ceremony after which one can work

independently (Louw & Pretorius, 1995). In some cases, training even occurs under water and is given by a crocodile (Ngubane, 1977).

There is furthermore not a precise use of terminology for traditional healers within the same language group or across cultural groups. Campbell (1998) uses the terms *inyanga* and *isangoma* interchangeably.

Pretorius *et al.* (1993, p.10) state that a traditional healer, according to the World Health Organization (WHO), is:

Someone who is recognized by the community in which he or she lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as the prevailing knowledge, attitudes and beliefs regarding physical, mental and social well-being and the causation of disease and disability in the community.

Traditional healers thus have a specific way in which they view and treat illness, which will now be discussed.

- **Illness**

The concept of illness differs in the traditional communities from Western communities. Causes are not sought at a mechanical level, but rather at a spiritual level. Illnesses are a community affair that involve the living and the dead and engages the person as a whole, as attempts are made to find meaning in suffering by linking peoples experiences at an external level with their own deepest belief systems and cosmology. Illness is also linked to the morality of the community and fear of physical ailments is used as a way of keeping the conduct of community members within acceptable bounds. This approach thus seems comparable to the way in which the concept of sin has been used by the church and other religious institutions over centuries (Gumede, 1990).

Witchcraft and sorcery play an influential part in African cosmology, similar perhaps to the role which Satan plays in the Christian world. A witch or sorcerer is thought to have the power to harm others. They are believed to have the power to send mythical animals or to change shape to do harm to those of whom they may be envious. The so-called 'night-sorcerers' are the most feared and are likely to be elderly women or men. They are believed to be indiscriminately evil and place harmful medicines on objects that others are going to use or where others are going to pass by. On the other hand, day sorcerers only operate in response to someone with whom they are in conflict. Family members from the same lineage should therefore not quarrel, because this upsets the ancestors. Sometimes it is possible for someone to persuade the ancestors to withdraw protection from their other descendants, leaving them vulnerable to distress and misfortune (Campbell, 1998). This is known as lineage sorcery (Ngubane, 1977).

Good health, in the African tradition, is conceptualized within a broader frame than Western models. While the Western link between body and mind is considered to be reciprocal in the African world there is an indivisible unity of body and mind. The traditional African healer adopts a dual approach to explain illness. On the one hand illness can be due to primary causes, such as predisposing factors that cannot be explained in physical terms, for example coming from supernatural forces such as spirits or from stresses, caused by the individual contravening communal morality. These supernatural causes are not seen as a violation of scientific principles, as the healer will also work on a physical level and take secondary causes into account. Secondary causes are thus also recognized, involving direct causal connections comparable to Western medicine's germ theory (Sogolo, 1995).

Furthermore, a distinction is made between natural and unnatural causes for disease. Natural causes of sickness and disease include old age, injury, poison and exposure to heat or cold. Illnesses such as the common cold, chicken pox, measles, mumps and whooping cough are all regarded as natural. They are usually treated by a wide variety of herbs. On the other hand, unnatural, supernatural or magical causation of disease is invoked in cases where the ancestral spirits disapprove of certain behaviour and an

intervention by a traditional healer is then seen as essential. The decision to consult with a healer is mostly not taken by the people themselves, but by the head of the household (Faure, 2002; Gumedede, 1990).

The unnatural causes of illness can be due to the following:

- Wizards and witches, who delve into black magic, and cast spells;
- Evil spirits that cause catastrophes like earthquakes;
- Visitations from the ancestral spirits for wrongdoing and thus punishment include congenital malformations such as hare lip, spina bifida, Siamese twins, dwarfs and albinos;
- Ancestors and other ghosts who feel they have too soon been forgotten or not recognised;
- Wanton spirits, which are not family ancestral spirits, but spiteful and destructive spirits who act in an unpredictable manner without rhyme or reason. They are believed to be spirits that died with a grudge against society. They make cows barren, women infertile and turn field barren and unproductive. These spirits or *spooks* are believed to make home visits at night. Patients report that their child was crying all night and on waking the parents noticed burnt spots on the child's body. The Western doctor diagnoses kwashiorkor with skin lesions (Gumedede, 1990).

A study by Hacking, Gudgeon and Lubelwana (1988) among Xhosa women with breast cancer identified three main perceived causes of disease: disapproval of ancestral spirits, actions of enemies prompted by jealousy or hatred, and contravention of a taboo. Cancer is seen as a reflection of stress or conflict, particularly in social relationships.

Furthermore, there are certain 'polluted' states in which a person is vulnerable to ill health. These states can be the result of a miscarriage, death or a long journey. Illness, in these cases, is caused internally and is not sent by another and thus differs from

having a curse from a witch or sorcerer. Individuals, however, open themselves up to admonishment from ancestral forces if they do not adhere to the rituals surrounding these states of pollution. Two main polarities of pollution are birth and death. There are also everyday occurrences associated with life and death which can incur states of pollution like breast-feeding, menstruation and sexual intercourse. Infant children, who are for example close to the birth process, are placed under the protection of the patrilineal ancestors by means of a goat sacrifice (Hammond-Tooke, 1989). Furthermore, it is believed that someone travelling around outside the local area is susceptible to absorbing foreign elements from the atmosphere through breathing. This is because sorcerers, people and animals leave invisible tracks behind which can 'pollute' unwary travellers. To resist these dangers people need to be in harmony with their environment, people, ancestors and other mystical forces (Ngubane, 1977).

Lastly, there are more than 50 conditions that traditional healers deal with, which range from skin problems to stomach ulcers. They also deal with five cultural-bound syndromes for which biomedicine has few answers, namely ancestral wrath, spirit possession, sorcery, defilement and neglect of cultural rites (Pretorius, 1999).

The practices of traditional healers will be discussed next and go hand in hand with how they view themselves and the concept of illness.

- **Practice(s)**

The practice in the traditional African approach is holistic and combines biological, religious, social and magical factors. In their practices sangomas engage *inter alia* in the throwing of bones, the making of *muti* from natural extracts, the telling of stories and the engagement of ancestors. Healers make use of a diversity of methodologies, for instance, not all healers make use of throwing bones. Whereas in Western medicine patients come to see doctors with the reason for their consultation, traditional healers tell their patients why they have come (Ngubane, 1977).

Sangomas engage primarily with the ancestors and operate as mediums for them. Traditional healing involves a form of triangulated mediation between the ancestors, the healer and the patient. The ancestors are part of a large cosmology, and are seen as the most accessible to their families. The healer is able to consult the ancestors about the patient's woes. The ancestors have the power to make patients sick and to help them recover. Besides helping with sickness, the ancestors assist the healers and descendents in warding off evil (Gumede, 1990). Ancestors are fundamentally the spirits of deceased relatives and for many individuals they are the primary religious entities. They are however not spirits to be worshipped, but rather to communicate to. There is a tightly woven interdependence between the living and the dead and that it is mandatory for the living to pay homage through rituals to their deceased ancestors. In addition to make their presence known through illness, ancestors also have the ability to materialize in different forms like birds, baboons, certain snakes such as the highly poisonous mamba and wolves (Hammond-Tooke, 1989).

The WHO defines the practice of traditional African medicine as:

The sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or societal imbalance, and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing (Pretorius *et al.*, 1993, p.15).

While Western science is marked by a distinction between theoreticians and practitioners, within the context of traditional healing the practitioner tests his own theories as they develop. Science and traditional healing processes both attempt to systematize past observations and future predictions with their knowledge, but they do this in very different ways. In the Western paradigm the dominant mode of diagnosis is to establish causality through interpreting symptoms, while in traditional healing the mind-body is not a complex machine, but a self, embedded in social interactions. The evidence of this efficacy is the establishment of harmonious relationships (Barsh, 1997). Traditional healing does not embrace science to validate its effectiveness. Efficacy is experientially determined by the community. For these healers and patients

across the board certain models seem to work best when all parties collude in accepting the same myths (Dow, 1986).

As mentioned in the introduction above, it is estimated that traditional healers are used by 80% of South Africans, and that about 60% of South African babies are delivered by traditional birth attendants. Herbal medication is the most common therapeutic method used by traditional healers. Other methods include psychosocial counseling, simple surgical procedures, rituals and symbolism (Pretorius *et al.*, 1993).

Traditional healers are also regarded as an important national health resource. In some parts of the country, they are available where Western trained personnel are lacking. They share the culture, beliefs and values of their patients. They are widely accepted and respected. In addition, many are skilled in interpersonal relations and counseling. Traditional healers cater for the complete person, within the family and community context (Faure, 2002).

- **Patient(s)**

In the light of the above discussion of traditional healing, it is clear that sangomas engage their patients more holistically than medical practitioners in the Western tradition typically do. The mind-body divide, which is seen in the Western worldview, is rejected by these healers. Furthermore, the dynamic between patient and healer is, on the one hand strongly influenced by power dynamic where the patient believes that the sangoma has some or other supernatural power over him. This contrasts with the Western tradition in which the practitioner mostly has expert power. On the other hand, however, there seems to be more intimacy between a healer and his/her patients, as in some cases the patient stays with the healer until the healing process has been completed (Hammond-Tooke, 1989).

Rudnick (2002) states in his research that healers and their patients appear to be highly spiritual people who are deeply connected to their beliefs in everyday life. He adds that

“with healing, spirit is central and unequivocal... healing empowers the ecology around the individual by harnessing the resources of spirit” (2002, p. 170).

I will now go on to introduce you to certain rituals that will guide and give more shape to our journey of ‘sangomahood’.

CHAPTER 3

CHOOSING CERTAIN RITUALS

The next part of this journey will entail choosing certain ‘rituals’ to further shape and enhance this experience of ‘sangomahood’. I will make use of the narrative analysis proposed by Riessman (1993) to shape the journey in this chapter, as it leaves the process of analysis open and prefers not to give specific structural guidelines.

There are thus five kinds of representations or rituals on this journey, with porous boundaries between them, namely:

3.1 RITUAL 1: ATTENDING TO THE JOURNEY

By attending to experience, certain phenomena are made meaningful. On this first level of representation there is a choice in what a person notices, a selection from the totality of one’s primary experience (Riessman, 1993). Attention to this journey started within a certain context, with certain participants and from the position of narrative psychology. These aspects will be discussed to set the scene for the research journey.

3.1.1 Context

This part of the journey was undertaken with much anticipation and excitement as it led me to interviews with the sangoma which took place at the University of Pretoria. The sangoma lives in Soweto, Gauteng, where she practices as a full-time sangoma. The interviews were held in October 2005.

Part of this research journey into ‘sangmahood’ began within the context of the academic community of the University of Pretoria (UP) in general, and specifically

within the Department of Psychology, which, of course, influences how I narrate this journey.

The UP is a leader in higher education which is recognized internationally for academic excellence and a focus on quality and is known for international competitiveness and local relevance through continuous innovation. It is a university for students, staff, employers of graduates and those requiring research solutions and has a value-driven organizational culture that provides an intellectual home for the rich diversity of South African academic talent. It is the premier university in South Africa that acknowledges its prominent role in Africa, is a symbol of national aspiration and hope, reconciliation and pride, and is committed to discharging its social responsibilities.

Furthermore the university encourages academically rigorous and socially meaningful research, particularly in fields relevant to emerging economies. It is locally relevant through:

- its promotion of equity, access, equal opportunities, redress, transformation and diversity;
- its contribution to the prosperity, competitiveness and quality of life in South Africa;
- its responsiveness to the educational, cultural, economic, scientific, technological, industrial, health, environmental and social needs of the country;
- its active and constructive involvement in community development and service; and
- its sensitivity to the demands of our time and its proactive contribution towards shaping the future (<http://www.up.ac.za>).

I will now introduce the participants on this journey, which are the sangoma and I, as the researcher.

3.1.2 Participants

The sangoma that met with me on this collaborative journey is a 29-year old Zulu woman, who grew up in Soweto, Gauteng. She has completed her formal training and has been practising as a sangoma for some time. She has finished grade 12 and also has working experience in the corporate world.

My own journey of inquiring and curiosity about the world, began 35 years ago in the Free State where I was born into a white, middle-class English and Afrikaans speaking background. I grew up in the Free State, studied law and worked as a journalist before I started my studies in psychology. People's lives, stories and their meaning-making have always fascinated me. I also have an interest in the mystical and cultural aspects of people's narratives and this is why I chose to embark on a journey into the life story of a sangoma. I did not know anything about the sangoma and her culture beforehand. My interaction with her has led me to a greater insight of other cultures, paradigms and individuals – which, in my view, is paramount to any future psychologist working in the South African context. It has also enriched my own life story and spiritual growth. This journey has also helped me to look at individuals' narratives more carefully and attentively, listening for their uniqueness, while embarking on the collaborative journey. Gallavan and Whitemore (2003) state that we are rarely afforded the opportunities to investigate parallel paths and communicate honestly with individuals who seem far away and foreign. Seldom can we truly experience multiple perspectives and cross-cultural relationships in our own journeys. I have viewed this journey as such an opportunity.

It is, however, important to state that I have approached this journey from a post-modern position or context of 'not knowing' what 'sangomahood' entails. I was however not totally unbiased, as I am schooled in the Western way of thinking. I did not do any research about sangomas and their beliefs and practices prior to my interviews with the sangoma. The interviews were thus approached from a position of naïveté. By doing this I left open the possibility of creating an alternative narrative or

unique outcome (White & Epston, 1990) for myself, as I attempted to limit my preconceived ideas of how sangomas 'should be'. Through collaborative social interaction with the sangoma I wanted to construct a new, enriching reality for myself as a white healer, schooled in the Westernized way of thinking, as well as for people reading this research narrative.

I will now go on to discuss the position I have chosen to work from on this journey.

3.1.3 Position

This part of the research journey will entail looking at the research position of narrative psychology, which will include the constructs of experience, narrative, history and culture. Narrative psychology focuses on the narratives that people construct in interaction with the world around them. This position is thus interested in the experiences of people within their social settings through time in order to understand them better. The narrative mode leads not to certainties, but to varying perspectives across time (Morgan, 2000; White & Epston, 1990).

o Experience

Experience is the living of life itself. This journey is such an experience, for me as researcher, the sangoma and you as the reader. This experience, the ways in which we subjectively interpret it, always take place through time -the past, the possible future and the present – and within a certain space, namely our culture or social contexts. Our experiences are therefore not something we experience in isolation, but are negotiated and constructed through time and in interaction with one another (White & Epston, 1990).

Experience comes to us, not in discrete instances, but as part of an ongoing life, our lives. 'Now' is not atomistic, but variable, depending on one's perspective. It is equally this moment, this day, this year and this life. Experience is an ever unfolding

richness before our reflective grasp. We can never say enough about it (Kerby, 1997). In Husserlian terms we can say “that it has expansive internal and external horizons. And there is a sense in which it is correct to say that we are this richness, this expanse” (1997, p.128).

Furthermore, through our experience of life, we construct and shape our identities. Finding a place for oneself in the world means, on the one hand, to find a social identity, a place in the social order, and on the other hand to maintain a personal identity, in the sense of biographical uniqueness. Whereas social being is a problem for marginalized individuals, such as immigrants who have no established place in the social order, personal identity can be difficult for people who find it hard to distinguish themselves from their careers and thus their social order (Harré, 1983). Furthermore, Harré’s work on personal being “reflects the paradox that a sense of self is gained only through social meanings. This paradox is resolved in the way social meaning is *lived*” (Murray, 1989, p.180). However, the Western world views identity in a different manner. Geertz (in Sampson, 1989, p.1) states that:

The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgement and action is...however incorrigible it may seem to us, a rather peculiar idea within the context of the world's cultures.

Various theories have challenged the above idea of unique and individual or personal identity. Cross-cultural studies have uncovered less individuated alternatives to identity (Heelas & Lock, 1981), while feminist re-conceptualizations of the patriarchal of psychological, social and historical life have introduced very different views of personhood (Lykes in Sampson, 1989). Social constructionism has argued that selves, persons, as well as the idea of individual psychological traits, are social and historical constructions, and that systems theory gives ontological primacy to relations rather than individual entities. Social constructionism argues that reality is created in interaction with the world and that people constitute, create and produce themselves and their

worlds through their conversational activity. Meaning and knowledge are co-constructed through interaction (Shotter, 1993). Also, deconstructionism has challenged all notions that psychology's subject is a naturally occurring reality (Freedman & Combs, 1996). Deconstructionism is the 'taking apart' and examining of the taken-for-granted beliefs, ideas and practices of the world and broader culture in which a person lives and that often sustain certain problems (Morgan, 2000). Deconstructionism "presents a very unsettling picture of the world and undoes the security which the current North American ideal presents" (Derrida in Sampson, 1989, p.2). The Western conception of personhood thus emphasizes individuals as more or less integrated universes and distinctive wholes. However, the 'subject' of writing does not exist if we mean by that some sovereign solitude of the author. The subject is:

a system of relations between strata: the Mystic Pad, the psyche, society, the world. Within that scene, on that stage, the punctual simplicity of the classical subject is not to be found (1989, p.15).

In my view the identity of 'sangomahood' from a narrative point of view fits more comfortably in the alternative Derridian view that speaks of an identity that is multi-dimensional, multi-levelled and without centre. This type of identity is a process and a paradox, but never a beginning or end. The Western logic of identity is a logic of either/or, whereas Derrida's more post-modern logic of identity is a logic of both/and (Sampson, 1989).

I will now take a look at the constructs of experience and narrative.

o **Experience and narrative**

By sharing this journey with you as the reader, I am shaping my experience and making sense of this journey by means of a narrative, which is fluid and open to interpretation. Narratives are thus the ways in which we shape our experiences of ourselves and our lives and through which these experiences are made meaningful. In my opinion narratives are interpretations of our subjective experiences through time (history),

within a specific culture. These experiences, which are shaped through narratives, form our identities. Furthermore, in my opinion, narratives are not objective realities that exist and that must merely be accessed or conveyed through language. Narratives are created in an inter-subjective and interactional manner and are negotiated in the social realm and in turn construct experience. A narrative is like a thread that weaves events together, forming a story (White, 1995; Morgan, 2000).

The study of narratives has gained new momentum in recent years. Concern with narratives and narrativity originally goes back to Aristotle's *Poetics*. This renewed interest in an old topic relates to the increased awareness of the role storytelling plays in shaping social phenomena (Jovchelovitch & Bauer, 2000). The concept of narrative provides a new "root metaphor" for the field of psychology as a whole (Sarbin, 1986). Furthermore, narrative modes of knowing privilege the particulars of lived experience rather than constructs about variables and classes (Bruner, 1990).

Narratives are ways of organizing experience, interpreting events and creating meaning, while maintaining a sense of continuity (Bruner, 1986). Narrative thus emphasizes the active, self-shaping quality of human thought, the power of stories to create and refashion personal identity (Mancuso & Sarbin, 1986). According to Josselson (1995, p.33) "narrative is the representation of process, of a self in conversation with itself and with its world over time." Narratives are not records of facts, of how things actually are, but of "a meaning-making system that makes sense out of the chaotic mass of perceptions and experiences of a life" (p.33). Narrative is thus the means by which we, as participants and as researchers, shape our understandings and make sense of them.

Narrative is "a primary act of mind, the primary scheme by means of which human existence is rendered meaningful" (Hardy, 1987, p.1). It is a specific cultural system, the "organizing principle" by which "people organize their experience in, knowledge about, and transactions with the social world" (Bruner, 1990, p.35). There is no human experience that cannot be expressed in the form of a narrative. Barthes (1993, p.251) points out that:

Narrative is present in every age, in every place, in every society; it begins with the very history of mankind and there nowhere is nor has been a people without narrative...Caring nothing for the division between good and bad literature, narrative is international, trans-historical, trans-cultural: it is simply there, like life itself.

The narrative metaphor allows people to make sense out of their everyday experiences and to see their lives as a narrative, unfolding through time (history) and in space (culture) (White & Epston, 1990). Using a narrative metaphor leads me to think of people's lives as stories and to work with them to experience their life stories in ways that are meaningful and fulfilling (Freedman & Combs, 1996; White & Epston, 1990). That narratives are closely linked to peoples' identities and even more precisely that narratives *are* peoples' identities is an idea that is at the forefront of the social studies today. In the telling, they become more part of the creation of how the teller sees himself or herself, rather than to objectively reflect reality (Lieblich, Tuval-Mashiach & Zilber, 1998).

One of the areas of interest in psychology has therefore been the role of narrative in establishing identity. One's personal story or personal identity is a recollected self out of the past and a depth dimension of the self that gives the self character. "A self without a story contracts into the thinness of its personal pronoun" (Polkinghorne, 1988, p.107). 'Selves' are socially constructed through language and maintained in narrative. "We think of a self not as a thing inside an individual, but as a process or an activity that occurs in the space between people" (Freedman & Combs, 1996, p.34)

Identity, however, consists not simply of a self-narrative that integrates a person's past events into a coherent story, but it also includes the construction of a future story. Some researchers prefer the construction of a narrative as "telling a past, constructing a present, dreaming a future" (Human, 2004, p.6). It is also argued that personal identity is an idea that a person constructs. It is not an underlying substance to be discovered. The development of a personal identity is an ongoing process that involves the synthesis of many different ideas about oneself and its multiple facets. Furthermore,

the human disciplines attribute the development of personal identity and the self to symbolic and physical interaction within the social environment. The concept of self is, in this view, thus not the discovery of an innate “I”. It is a construction built on interaction with the social world and is subject to change.

The realization of the self as a narrative in process serves to gather together what one has been, in order to imagine what one will be, and to judge whether this is what one wants to become (Polkinghorne, 1988, p.154).

Furthermore, human identities are considered to be evolving constructions. They emerge out of continual social interactions in the course of life (Scheibe in Sarbin, 1986).

The next step on this journey will be to look at how the experiences that we share and narrate are shaped through time in certain cultural or social settings.

- **Experience, narrative, history and culture**

- **Experience, narrative and history**

The experiences that we narrate are our experiences through time and thus through history - of the past, the possible future and the present. In my view, time can not be seen as linear (Slife, 1995). The past and the future exist and come together in the present and create a certain context for the present. Important factors to take into account are our memory and imagination. Without memory we would not be able to recall our experiences through time and our narratives and our identities would thus have no coherence. Furthermore, our stories are in some way the product of creative imaginings, because the way in which we organise our memories of life events and therefore which events we choose to be marginal or central, is partly an imaginative process. Memory and imagination are, however, also language constructions which we use to shape our narratives (White & Epston, 1990).

A case has been made for the non-linear construction of time in which the historical act is not primarily a past event, a dead event that has to be recovered from the grave. It is alive in its present. The real historic event, the event in its actuality, is when it is going on now. ‘Lived time’ can vary in its qualities. The three dimensions of time can co-occur in any particular ‘now’. “The past as memory and givenness, and the future as anticipation and possibility, exist in and provide a vital simultaneous context for the present” (Slife, 1995, p. 541). This recognition of times’ three dimensions as simultaneous, rather than successive, “permits any particular moment to be itself as a temporal whole” (p. 543). Knowledge of the present is thus an integrated knowledge of all three temporal dimensions, as a full understanding of the now implies some understanding of the past (memories), as well as the future (possibilities). The construction of time as non-linear is the way to incorporate history and culture into any observation. Traditional methods that ‘freeze’ events in the ever-receding present are inadequate for the authentic study of living beings (Sarbin, 2000).

We thus experience ourselves in the present time, but with a memory of the past, and an anxiety for the future. A narrative brings past-lived experiences and future imagined experiences into present consciousness. A present narrative is therefore a construction of an experience, and not the expression of an experience (Ochs, 1997).

Furthermore, when we record people’s narratives over time, we can observe the evolution of the life story, rather than see it as a text in a fixed and temporal state. As a novel leads to its end, personal narrative describes the road to the present and points the way to the future. The as-yet-unwritten future cannot be identical with the emerging plot and so the narrative is revised (Josselson, 1995).

The future expressed in narratives contains the loose ends, the beginnings that expire, the desires that fade or fall by the wayside. Continuity and change are emplotted in narrative form. A ‘good-enough’ narrative contains the past in terms of the present and points to a future that cannot be predicted, although it contains the elements out of which the future will be created (1995, p.35).

Our culture and social realities shape our experiences and therefore our life narratives. This will be discussed in the next part of the journey.

- **Experience, narrative and culture**

Culture has to do with the basic assumptions of a community, which influence the feelings, thoughts and behaviours of that community and which manifest in for example symbols, rituals and processes. Meaning of our experiences is negotiated and interpreted from our unique space in time, namely from our culture. Culture thus provides the building blocks for us to build and shape our stories. When a person has an experience and it is narrated, the culture in which he or she lives has a profound influence on the construction and shaping of the present narrative (Weisner & Millet, 2001; Human, 2004).

Furthermore, the validity of a psychological inquiry is questioned in which cultural meanings are not taken into account as people are essentially cultural products. All human understandings are value-laden and therefore we need to acknowledge the cultural, traditional and experiential origins of these values. In its quest to understand human behaviour, psychology thus needs to work within an interpretive, hermeneutic framework (Gergen, 1994; Smith, 1994).

Also, all human conduct is culturally mediated. No domain of life is more or less cultural than another. “Culture shapes the ways that people eat their meals, do politics and trade in the marketplace as much as it forms their modes of poetry writing” (Rosaldo, 1993, p.196). Furthermore, not only do people act in relation to a perceived reality, but it makes no sense to speak of reality independent of culture.

Therefore, when a narrative is constructed, not only history (the past and the future) is taken into account, but also culture. According to Cushman (1995, p.17-18):

Culture is not indigenous 'clothing' that covers the universal human; rather it is an integral part of each individual's psychological flesh and bones ...

the material objects we create, the ideas we hold and the actions we take are shaped in a fundamental way by the social framework we have been raised in.

Thus, when a person narrates a particular story, the culture in which this person's experiences are imbedded will profoundly influence and shape that narrative. Culture has to do with the basic assumptions of a community, which influence the thoughts, feelings, and behaviours of that community and which manifest in for example rituals, symbols and processes (White & Epston, 1990). Culture also refers to locally shared meanings and interpretive vocabularies that participants use to construct the content and shape of their lives (Gubrium & Holstein, 1995). Through narratives we therefore have access, not only to the individual's identity and its systems of meaning, but also the teller's culture and social world (Lieblich *et al.*, 1998). Furthermore, the stories we tell in turn have an influence on and shape our culture. The stories we tell through our conversations, art and technology form and re-form our ways of being together and apart and therefore also shape the community and culture at large (Carter & Everitt, 1998). Over time "we become the autobiographical narratives by which we 'tell about' our lives" becoming to some degree "variants of the culture's canonical forms" (Bruner, 1986, p.14).

Furthermore, understanding the narrative and contextual dimensions of individuals can "lead to new insights, compassionate judgement, and the creation of shared knowledge and meanings that can inform professional practice" (Wetherall & Noddings, 1991, p.8).

3.2 RITUAL 2: TELLING ABOUT THE JOURNEY

The next part of this journey will entail the telling and thus the performance of a personal narrative. In the telling there is an inevitable gap between the experiences as the person lived it and the communication about it. Meaning is also constructed on this second level of interpretation in a process of interaction. The story is told to certain people and might have taken a different form if it were told to someone else. "In telling

about an experience, I am also creating a self – how I want to be known by them...My narrative is inevitably a self representation” (Riessman, 1993, p.11).

The telling of the story thus entails that data be gathered about ‘sangomahood’ by means of an interview, which in this case will be a narrative interview.

3.2.1 Data

o Gathering information about ‘sangomahood’

In order to put the ‘narrative ritual’ in place, this part of the journey entailed collecting information and, finally, narratives, which were based on the experiences of the sangoma and her ‘sangomahood’. I did this by meeting the sangoma for three one-hour interviews, which I audio-taped. These interviews entailed getting to know each other, exploring ‘sangomahood’ and, eventually, reflection and feedback. The reflective interview was arranged to offer feedback to the sangoma on my own meaning-making and to hear whether this was congruent with the story she wanted to convey, as well as to invite further comments, corrections or observations. These conversations were therefore the context for the construction of meaning, rather than mere vehicles for carrying or representing prefabricated formulations of meaning of either the researcher or the participant (Emerson & Frosh, 2004).

When we work in communities we must be prepared to be ‘profoundly touched’ by our encounters with clients. Stories change the storytellers and the listeners and they not only impact on our relationships with each other, they *are* our relationships. What food is to the digestive system, so stories are to the soul (Lifschitz & Oosthuizen, 2001).

Furthermore, Witherall and Noddings (1991, p.280) advocate the use of life stories in research and suggest that:

telling our stories can be cathartic and liberating. But it is more than that. Stories are powerful research tools. They provide us with a picture of real people in real situations, struggling with real problems. They banish the indifference often generated by samples, treatments and faceless subjects. They invite us to speculate on what might be changed and with what effect. And, of course, they remind us of our persistent fallibility.

The gathering of information was done by means of a narrative interview, which allows for flexible and rich talk, while targeting a research question.

- **Narrating ‘sangomahood’ – the narrative interview**

After getting to know each other, the sangoma and I started to engage in a way that allowed her enough space to thoughtfully talk about her ‘sangomahood’. This is most commonly achieved through a relatively ‘open’ form of interviewing. When doing research one can make use of different interviewing techniques. In my conversation with the sangoma I made use of the narrative interview, which is seen as a form of an unstructured, in-depth interview wherein an individual can tell her life story. The idea of narrative interviewing is motivated by a critique of the question-response schema of most interviews. In this latter mode the interviewer imposes structures by selecting the theme and the topics, by ordering the questions and by wording the questions in his or her own language. In the narrative interview, however, the influence of the researcher is minimal. It is an attempt to go beyond the question-answer type of interview and it uses a specific kind of everyday communication, namely storytelling and listening, to reach this objective (Emerson & Frosh, 2004; Jovchelovitch & Bauer, 2000).

The narrative interview has a particular narrative schema of which the underlying presupposition is that the perspective of the interviewee is best revealed in stories where she is using her own spontaneous language in the telling of the events. Storytelling thus follows a self-generating schema with three main characteristics (Jovchelovitch & Bauer, 2000):

- Detailed texture – which refers to the need to give detailed information to account for the transition from one event to the other. The less the listener knows the more detail will be given. Storytelling is close to events – it will among others, account for time, place and motives.
- Relevance fixation – the storyteller reports features of the story that are relevant according to his perspective of the world. The account of events is necessarily selective and unfolds around thematic centres that reflect what the narrator considers important. These themes represent her relevance structure.
- Closing of the Gestalt – which refers to a core event in the narration which has to be reported completely with a beginning, middle and end. This threefold structure makes the story flow.

Gaskell (2000) states that for reasons of practicality and economy the interview is a useful method. Becker and Geer (in Gaskell, 2000) offer certain issues for consideration to sensitize researchers to the problems and to act as a catalyst for better interviewing skills. Firstly, I realised that I should not take anything for granted. Secondly, at times I probed for more detail than the sangoma offered as a first reply to my questions, and lastly, it was in the accumulation of insights from a set of conversations that I came to understand the life world of the sangoma. Gaskell (2000) further states that an in depth interview is chosen when the researcher wants to explore the personal experience of the interviewee in detail. “While such personal views reflect the residues or memories of past conversations, the interviewee has centre stage. It is their personal construction of the past” (Gaskell, 2000, p.46). Furthermore, when a narrative is under construction, some of the elements are well remembered, but sometimes details and interpretations are voiced which may even surprise the interviewee himself. Perhaps it is only by talking that we know what we think.

Storytelling comprises two dimensions, namely the chronological dimension, which refers to the narrative as a sequence of episodes, and the non-chronological, which involves the construction of a whole from successive events or the configuration of a plot. The plot is very important to the constitution of a narrative structure. It is through

the plot that smaller stories within the big story in the narrative acquire meaning. Jovchelovitch and Bauer (2000, p. 59) are further of the opinion that:

narratives live beyond the sentences and events that form them; structurally, narratives share the characteristics of the sentence without ever being reducible to the simple sum of its sentences or forming events. In the same vein, meaning is not at the 'end' of the narrative; it permeates the whole story.

The next ritual on this journey is writing about it.

3.3 RITUAL 3: WRITING ABOUT THE JOURNEY

3.3.1 Putting the journey to paper

Transcribing is like the previous two levels of attending and listening: incomplete, partial and selective. Transcribing discourse is thus an interpretive practice. Different transcription conventions lead to different interpretations and they ultimately create different worlds (Riessman, 1993).

This part of the journey thus entailed that the conversations with the sangoma were put in writing for detailed analysis. A transcription can be seen as a theoretical entity. It does not stand outside an analysis, but is part of it (Emerson & Frosh, 2004). According to Mishler (1991, p. 264) the act of transcription:

is not a matter of striving for a text more accurate or objective than another but an activity driven by and reflecting the assumptions of the researcher, that is, it is an interpretive practice carrying evaluative connotations.

Detailed transcription should be expanded to bring the interviewer into the analysis of personal narrative. This allows for “the examination of power relations in the production of personal narratives” and helps to show “how meaning is interactionally

accomplished” (Riessman, 1993, p.20). Certain themes can then be identified in the narrative.

Methodological choices have a significant impact on the ways in which the narrative material is interpreted and that this in turn affects how or whether the ways “the culture speaks itself through the individual’s story” (1993, p.5) may be heard. Although it is the researcher’s responsibility to select areas of interest from the text, the researcher should “find ways of working with texts so the original narrator is not effaced, so she does not lose control over her words” (Riessman, 1993, p.34).

The next step is the analyzing of the journey.

3.4 RITUAL 4: ANALYZING THE JOURNEY

3.4.1 Narrative analysis

In the analyzing of experience, values, politics and theoretical commitments are elements that enter into the research process once again. As Behar (in Riessman, 1993, p.14) states:

Although a kind of betrayal, it is also necessary and productive; no matter how talented the original storyteller was, a life story told in conversation certainly does not come ready-made as a book, an article or dissertation. The stop-and-start style of oral stories of personal experience gets pasted together into something different.

Furthermore analysis cannot easily be distinguished from transcription. Close and repeated readings, coupled with methodic transcribing, often leads to insights that in turn shape how we choose to represent our text. The researcher must look at aspects like how the narrative is organised. Also, why does a teller develop his or her narrative in a specific way in conversation with a specific researcher? Riessman (1993) prefers to start her analysis from the ‘inside’, from the meanings encoded in the form of talk,

and then expand outward, identifying for example underlying propositions that make the talk sensible. “The strategy privileges the teller’s experience, but interpretation cannot be avoided” (1993, p.61). However, ultimately, the features of a narrative account that a researcher chooses to write about are linked to the evolving research question, as well as to theoretical or epistemological positions the researcher values.

Textual analysis is the process whereby meaning and interpretation are negotiated from the mass of texts that have been collected in this qualitative research study. For purposes of this project I made use of a narrative analysis which focuses on the teller’s interpretation, experiences and meaning-making. This analysis makes room for the creation of different ‘knowledges’ and stories and is linked to social discourses. Narrative analysis is therefore part of the process of negotiation of possible lives, particularly in the context of dominant discourses, where the possibility for alternative narratives may serve to warrant new meaning-making and social practices. The purpose of the narrative analysis from a post-modern viewpoint is therefore to look at how history and culture is used to build a narrative, through which people make sense of their experiences (Emerson & Frosh, 2004). It can furthermore be seen, in Geertz’s words as “an interpretive science in search of meaning, not an experimental science in search of laws” (1973, p.5).

When referring to analysis, Crabtree and Miller (1992) recall Shiva, the androgynous Hindu Lord of the Dance and of Death. According to them (1992, p.10) an inquirer:

enters an interpretive circle and must be faithful to the performance or subject, must be both apart from and part of the dance, and must always be rooted in context.

This research is concerned with gathering and analyzing discursive forms, talk and text. Constructionist theory argues that reality is relationally constructed. Because ways of talking construct our worlds, the discursive forms that emerge and gain viability in particular communities become our primary texts. Research in this context becomes centred on narratives of various kinds, in this case on the sangoma’s narratives. The analysis of people’s talk and text can:

demonstrate the discourses they draw upon, how these construct or constitute available identities or subject positions and prevent or marginalize others, and what issues of power and social practice are bound up with them (Emerson & Frosh, 2004, p.6).

It is however important to remember that analysis is not purely a mechanical process. It also hinges on creative insights, which may occur when the researcher is talking to a friend or colleagues or in moments of contemplation, when driving or taking a bath. As the interpretation develops it is also important to return to the raw material. It is vital to check that any interpretation is rooted in the interviews themselves (Gaskell, 2000).

- **Choosing a narrative analysis**

The use of narrative methodology results in rich and unique texts that cannot be obtained from experiments, questionnaires and observations. Narrative materials can also be analyzed along a myriad of dimensions such as the content, structure, style of speech, motives, attitudes and beliefs of the narrator. Furthermore, the texts are influenced by the interaction of the interviewer and the interviewee, as well as other contextual factors (Lieblich *et al.*, 1998). Working with narrative material requires dialogical listening to at least three voices namely, the voice of the narrator as represented by the text or on tape, the theoretical framework, which provides the tool for interpretation and a reflexive monitoring of the act of reading and interpretation, that is self-awareness of the decision process of drawing conclusions from the material. There are therefore usually no *a priori* hypotheses, and hypotheses and theories are thus generated while reading and analyzing the narratives (Bathkin, 1981). “Thus the construction of an identity by an autobiographical story, and the process of theory building by empirical research, parallel each other” (Lieblich *et al.*, 1998, p.10).

This leads me to narrative analysis as a qualitative approach that “takes as its object of investigation the story itself” (Riessman, 1993, p.1-2). The process of ‘storying’ is always linked to social discourses and takes place in a firmly interactional or inter-subjective context. Narrative analysis typically takes the perspective of the teller,

rather than that of society. This method of analysis offers a way of counteracting the tendency to impose upon or ascribe to texts pre-given meanings arising out of professional or expert discourses. It is also an approach that negotiates ‘possible lives’, particularly in the context of dominant discourses or canonical (widely shared) narratives where possibilities for alternative narratives may serve to warrant new meaning-making and different social practices (Emerson & Frosh, 2004).

Furthermore, narrative analysis does not use a sampling procedure, but asks specific questions about particular lives. It is founded on the detailed investigation of very small numbers of research ‘subjects’ whose process of accounting and making sense of their experience is seen as being of intrinsic interest, rather than a source for generalizations. In other words, how does the sangoma see her sense of self, make sense of her world and work as a healer in interaction with her environment, her ancestors and other individuals. This particular field of research thus makes room for different questions and the possible generation of different ‘knowledges’ (Emerson & Frosh, 2004). Also, Denzin and Lincoln (1994, p.479) state that “the processes of analysis, evaluation, and interpretation are neither terminal nor mechanical. They are always emergent, unpredictable and unfinished.”

The next, and one of the last phases of the journey, is to read and thus encounter the journey of the researcher.

3.5 RITUAL 5: READING THE JOURNEY

The fifth and final level of representation is what you, as the reader, are doing at this very moment – encountering the journey. This will bring other meanings to bear. All texts stand on moving ground and there are thus no master narratives. Clifford (1988, p.112) states that the ‘truths’ we have constructed “are meaningful to specific interpretive communities in limiting historical circumstances”. Any finding, a depiction of a certain culture or social structure, exists in historical time, between subjects in relations of power. Ultimately, we cannot speak, finally and with authority

for others. Clifford (1986, p.10) states it so eloquently when he says our subjects “do not hold still for their portraits”.

Before I conclude this chapter, two further rituals need to be discussed, namely the quality of this research journey and the ethics that were involved.

3.6 RITUAL 6: THE QUALITY OF THE JOURNEY

The quality of this journey refers to the question of whether it is of value to a certain community and society. Also, whether the journey enhances and contributes to knowledge in a meaningful way. The quality of this journey, furthermore, refers to the trustworthiness thereof and can thus be enhanced by collaboration and reflection with one’s supervisors and the sangoma.

Psychology has historically predominantly been linked with the positivist epistemology of the natural sciences and quantitative research which, with its criteria of objectivity, reliability, validity and generalisability, has been the privileged form of research within psychology (Mason, 2002). However, changing social science assumptions - about the contextuality of knowledge and the inevitability of interpretation - underwrite increased attention to subjectivity and the validity of subjective knowledge. An interest in personal narrative and the co-construction of subject-to-subject meaning-making is imbedded in such assumptions. Psychosocial studies have thus ingrained in them an effort to recover or construct meanings. They therefore work in a terrain in which interpretive work is given priority. This involves an assertion of the value of interpretive, qualitative methods despite difficulties in establishing generalisability and stability of findings (Gergen, 1994). Qualitative research is part of a major shift affecting psychological and social sciences which has contributed to the erosion of traditional empirical science in determining what counts as knowledge (Emerson & Frosh, 2004). Clinical scientists sometimes find it difficult to accept qualitative research “where the generation of hypotheses often replaces the testing thereof,

explanation replaces measurement, and understanding replaces generalisability” (Labuschagne, 2003, p.100).

The utility of the researcher’s findings is the criterion of a successful model rather than their replicability. Ultimately the utility of our constructions has more value than their accuracy or truth. Lieblich *et al.* (1998, p.172) argue that they:

do not refer directly to the truth-value of a narrative study but propose that a process of consensual validation – namely sharing one’s views and conclusions and making sense in the eyes of a community of researchers and interested, informed individuals – is of the highest significance in narrative inquiry.

In qualitative research “reliability refers to the trustworthiness of observations or data”, whereas “validity refers to the trustworthiness of interpretations or conclusions” (Stiles, 1993, p.601).

The quality of my research was enhanced by using the following strategies, as proposed by Stiles (1993):

- Firstly, during my research, and specifically my analysis, I continually disclosed my specific orientation as that of a psychologist, working from a Western perspective. During this research I was always aware of the fact that this is interpretive work and thus a very personal and subjective process grounded in my own cultural and social context. I also disclosed my goals and theoretical allegiance, being that of narrative psychology, for the research study.
- Secondly, I clarified the context of the research by describing the social and cultural contexts of myself, being part of an academic community in the Western world, and that of the sangoma, as a traditional healer from the Zulu culture.

- Thirdly, my research was also enhanced by the fact that I described my internal processes, reflections and the impact that the sangoma's narrative had on me throughout my analysis of the text.
- I furthermore engaged with the material by reading and re-reading the text, and had a collaborative relationship with the sangoma in which I could reflect on my processes with her.
- Reflection and discussion of the text also took place on a monthly basis with my supervisor, dr. Lourens Human, who has completed his doctorate in narrative psychology and has also completed his studies in theology. Reflection in supervision thus helped me shape my research and interpretation of 'sangomahood'.
- Finally, as a result of these processes, I believe this research has reflexive validity, as my way of thinking about sangomas and traditional healing was profoundly enhanced and changed by the data as I engaged in collaborative conversation with the sangoma and my supervisor.

3.7 RITUAL 7: THE ETHICS OF THE JOURNEY

3.7.1 Consent

As this research is part of my MA degree in psychology, it was approved by the Faculty of Humanities and the Ethics Committee of the University of Pretoria.

Fully informed consent was also obtained from the sangoma in respect of the recording, transcription and publication of the conversations with her, as well as for the analysis of this journey into her 'sangomahood' by me.

3.7.2 Anonymity

An undertaking was made to the sangoma that her identity will not be disclosed for publication purposes.

CHAPTER 4

‘THE THROWING OF THE BONES’

In this phase of the journey, the sangoma metaphorically ‘throws the bones’ in interaction with me as the researcher, which are then left open to interpretation. When a sangoma throws bones in an encounter with a patient, these bones, in interaction with the ancestors, the sangoma and the patient, shape certain narratives and experiences. On this collaborative journey with ‘the ancestors’ (the literature about healing), the sangoma and myself a narrative of ‘sangomahood’ unfolded, which in turn comprised of certain narratives. I will now go on to tell the different stories that were shaped in our interaction on this journey in the form of an introductory letter, followed by five letters I have written to her. It is, however, important to bear in mind that the impact her story had on me and my interpretations thereof are not ‘truth’ statements. They are merely interpretations based on my experience and interaction with her and might differ from your interpretation, as the reader.

4.1 Introductory letter

Dear S

You and I met three times during the course of this journey in which you told me about your life and experiences of your ‘sangomahood’. The telling of a narrative is never a neutral process and always has a certain impact or effect on the person listening to or reading the story. As the researcher, I listened to your narrative of ‘sangomahood’ from a Western perspective. From this perspective I view life and the way in which I live it as an ongoing set of choices and that as an individual, I have, to a great extent, control over my destiny. In the telling of your story of ‘sangomahood’, different narratives of having ‘no choice’ unfolded. In the letters I am going to write to you, I would like to tell you what your story did to me.

The different narratives that unfolded on this journey of ‘sangomahood’ which I have chosen to write about are the following:

- i) Becoming a sangoma;
- ii) the training;
- iii) loneliness and isolation;
- iv) a vehicle and messenger for the spiritual world; and
- v) the material world.

4.2 Letter 1: Becoming a sangoma

Dear S

You told me that becoming a sangoma was not your choice, but that it is a calling that had chosen you. You could not refuse it, without dire consequences. The aspect of not being able to choose your own career path is emphasized in your words:

- (A)
1. My grandfather, also a sangoma, knew that I was going to be a
 2. sangoma, but as a child he never told me. He always taught
 3. me about *muti*'s, but I never knew why...
 4. I was 18 when I heard for the first time that I had to be a
 5. sangoma. I heard it from a man from Zimbabwe. He was a
 6. prophet. I was sick and then my mother took me to him. And
 7. the man said, that is why I am sick, because I have to be a
 8. sangoma. There was nothing he could do for me. I was having
 9. these headaches. Very badly, for two weeks. The headaches
 10. never go away. They always come again. As we speak, I have
 11. a headache now. I did finish school and then I had my first job.
 12. But I never lasted in any of my jobs because of this thing. But
 13. I had to work because I had two children at that time. I had to
 14. work to support my children. I didn't know that it was serious
 15. that I had to be a sangoma. I had luck with jobs, got one after
 16. the other, but they never lasted, because I was fighting with my
 17. boss. Always because of this thing. Last year for the first time
 18. I realized it was serious. Another man told me that my husband
 19. was going to die because of me. It was a man from Natal – he is
 20. also a sangoma. He said my husband is going to die, because
 21. I don't want to take the job of sangoma. So I realized that they were
 22. serious. I started my training three months later. It was so difficult.

Analysis

The sangoma starts by placing her narrative of 'sangomahood' in a historical context by referring to her grandfather knowing about her 'sangomahood' when she was just a

child (A 1-3). ‘Sangomahood’ was thus already present in her childhood. From this paragraph it seems that, as a child, she did not know about her calling and constructs this by narrating that her grandfather knew about her ‘chosenness’ and that he taught her about *muti*’s, but that she “never knew why” (A3). This construction of her experience subtly introduces the aspect of ‘no choice’. Her grandfather was already teaching her about *muti*’s and thus preparing her for a calling she was unaware of. The sangoma constructs this ‘chosenness’ within a certain cultural context as it appears that ‘sangomahood’ is introduced through her paternal lineage via her grandfather and is inherited. This inheritance further highlights her inability to choose as it is culturally ‘bestowed’ on her.

The sangoma then places her experience in a historical context once again, by narrating that she heard for the first time that she had to become a sangoma when she was a young adult. “I was 18 when I heard for the first time that I had to be a sangoma” (A4-5). She also places her experience of being told of her ‘sangomahood’ in a certain cultural context. She narrates that a Zimbabwean prophet, whom she went to consult because of chronic headaches (A 6, 8-9), told her about her ‘sangomahood’. In my literature study I stated that becoming a traditional healer rarely happens out of choice and *bona fide* healers are called to their jobs by the ancestors, often in the guise of a dream or an illness that won’t go away. This sickness is characterized by a range of symptoms which include various aches and pains and a sangoma or prophet must then be consulted to determine whether the symptoms are a calling or not (Faure, 2002).

From this narration the sangoma thus also constructs her inability to choose by telling the listener that she was told to become a sangoma by a culturally respected prophet. This prophet interpreted her illness or headaches as a sign that ‘sangomahood’ had chosen her as she narrates “the man said, that is why I am sick, because I have to be a sangoma. There was nothing he could do for me. I was having these headaches. Very badly, for two weeks” (A 7-9). Her inability to choose comes to the fore once again in her narration of the prophet’s words “there was nothing he could do for me” (A8). The headaches were simply a sign, imbedded in the cultural context of traditional healing, of ‘chosenness’ to become a sangoma. She furthermore constructs her experience of

these headaches by using the words ‘always’ and ‘never’.”The headaches never go away. They always come again. As we speak, I have a headache now” (A 9-11). These headaches thus appear to be constant companions and reminders of her ‘chosenness’ and lack of choice.

Furthermore, it seems however that the sangoma was reluctant to listen to this calling as she entered into the job market after school. She constructs her experience by saying that, after school, she had to work to support her children and that she “didn’t know that it was serious that I had to be a sangoma” (A 14-15). This calling into ‘sangomahood’ did however not loosen its grip on her as she narrates that her jobs never lasted, “always because of this thing” (A17). The sangoma then goes on to narrate the inevitability of ‘no choice’. She constructs this experience by telling of a sangoma from Natal, once again a healer within her cultural context, that gave her a warning that her husband would die because of her unwillingness to listen to her calling and ‘chosenness’. She is then, perhaps for the first time, confronted with her true inability to choose as she states: “So I realized that they were serious” (A 21-22) and starts her training within three months. She constructs this experience as “so difficult” (A22).

Furthermore, the sangoma narrates her experience of a career in the Western, corporate world. She constructs this experience by narrating that she “had luck with jobs, got one after the other, but they never lasted because I was fighting with my boss” (A 15-17). She thus seemingly constructs her experience in the Western job market as ‘having choices’ as she could leave one job and go to another. In the corporate world, she works for another human being. She could also argue with her boss and speak her mind. This is in stark contrast to a career as a sangoma where she cannot leave or choose another path. As a sangoma she works for the ancestors and cannot argue with other sangoma’s, prophets or her ancestors about her calling.

It seems that tradition and culture are primary discourses in your life and must be adhered to above all else. ‘Sangomahood’ is bestowed on you, via your ancestors, and must be respected. In these discourses, personal narratives of power and choice have

no place. If you dare to choose another path you will have to face tragedy. It seems to me that you surrendered to ‘sangomahood’ out of fear of wrath and loss. I cannot help but wonder what this lack of choice toward your own destiny did to you.

Listening to your story, there were times when I felt extremely powerless. I wonder how it felt to be forced fearfully into something you seemingly did not choose or seem ready for. I find it very frustrating not to have a choice over my own life. I have continually had a choice to exert personal power over my own life, which I believe has taught me the lesson of taking responsibility for my choices and has gently shaped me into the person I imagine to be. I would like to tell you more about my story of being able to choose in order for you to understand the lens through which I view the world. After school, I chose to study law. I was young and starry eyed, but this choice soon proved to be less satisfying. I nevertheless practised law for more than a year, before choosing to make a shift towards journalism, as writing had always been a personal passion of mine. This choice opened up a whole new world to me and had a profound effect on how I view society, the media and the individual. However, after five years in the newspaper industry I was disillusioned by negativity, sensationalism and the lack of depth in the industry. I was at a crossroads. I had to choose once again – this time between continuing as a writer or researcher in the media world and pursuing something completely different which would mean starting my studies all over again. I opted for the latter choice and ended up studying psychology – which to me has been an ever unfolding mystery. Choice in my life has thus shaped me, giving me a continuous chance to refine and reinvent myself. It has given me the chance and freedom to experience and explore the world and myself fully and to make mistakes. I find it extremely sad that you do not have the same opportunities because of a lack of personal choice.

There was however a stage that you did have a choice when you pursued different jobs after school. If a job was not working out, you left and pursued something else. I wonder what that freedom and sense of choice did to you and how that was different from what you are experiencing now. There is thus an apparent difference between a

career in the Western world and a career as a sangoma. In the Western world you worked for a boss, could choose to resign and then pursue something else. You could always leave. In the world of the sangoma, however, you work for the ancestors and they make the choices for you. You cannot choose another calling, cannot leave or resign unless you are willing to face tragedy. It makes me wonder whether there is room for narratives of self-exploration and personal responsibility or could it be that this type of surrender has created a different path of exploration and growth for you?

4.3 Letter 2: The training

Dear S

In this letter I would like to address the aspect of training. It seems that your training is not only an initiation into ‘sangomahood’, but also an initiation into a life and narrative of ‘no choice’. This initiation, in your following words, seems to be fraught with physical and emotional difficulty and sacrifice:

- (B)
1. When you hear of people in training for sangoma, it is so
 2. difficult, you see. It's not easy. They never wear shoes,
 3. never wear bras. They have to wear a skirt only - the whole
 4. day - until you are finished training. And you have to wear
 5. this mud, red mud, over your whole body, for six months.
 6. That's why I was scared. Some, maybe for two years, three
 7. years. But for me, it was six months. It depends on the
 8. person that trains you...
 9. They (the ancestors) tell the man (the trainer) what he must
 10. do with me. He must give me certain things to eat and I
 11. must wear this and this. We wear a red skirt, nothing else,
 12. only a red skirt with the red mud all over our body. Nothing
 13. else. You sleep like that too. Even if it's cold. It doesn't
 14. matter. We may only wear skirts, not pants, because we
 15. may not show our bum. In the training, we must also wash
 16. our bodies with the cold water, 3 o' clock in the morning.
 17. It's very difficult. That's why everybody, they are scared,
 18. because of this training...
 19. The ancestors are eating this red mud. It is to feed them.
 20. We wear it all the time until you are finished training and
 21. then you eat *ikobong* at 3 o' clock in the morning. It's like
 22. a *muti* in a 5 litre bucket. And you are feeding the
 23. ancestors too. It's made with everything, including herbs.
 24. It tastes horrible. We will eat pap. But no meat. No
 25. chocolates, no milk. We do not eat these nice things.
 26. Because it is not you that is eating, it is them...
 27. At the end of our training, we slaughter the goat and wear

28. red mud which we wash with the blood of the goat, and
29. we take the bones and put it on. And you drink the blood.
30. You must drink three glasses from three goats.

Analysis

It appears from this narrative that ‘no choice’ is manifested in the physical reality of her training. She firstly narrates her experience of ‘no choice’ by referring to the clothing that she had to wear during the training. The sangoma constructs this experience of ‘no choice’ by making use of the words ‘never’ and ‘have to’: “*never* wear shoes, *never* wear bras. They *have to* wear a skirt only - the whole day... And you *have to* wear this mud, red mud, over your whole body” (B 2-5). She goes on to construct her experience by narrating that the ancestors *tell* her trainer what he *must* do with her (B 9-10). She uses the word ‘must’ to emphasize the lack of choice: “He must give me certain things to eat and I must wear this and this” (B 10-11). Also in line B 15: “we must also wash our bodies with the cold water, 3 o’ clock in the morning.” Furthermore, she uses the words ‘nothing else’ and ‘only’ which seems to give the impression that her physical reality is not negotiable, irrespective of the weather. “We wear a red skirt, nothing else, only a red skirt... Nothing else. You sleep like that too. Even if it’s cold. It doesn’t matter. We may only wear skirts, not pants, because we may not show our bum” (B 11-15). Note her construction of ‘may not’ in this last sentence, which strongly indicates prohibition.

The sangoma constructs the extent of her experience of ‘no choice’ by referring to the clothing that she is allowed to wear. She narrates that in training one can never wear shoes nor bra’s. One has to cover your body with red mud and wear a red skirt only “the whole day - until you are finished training” (B 3-4). No pants are allowed, as one may not show your bum. She also has no choice when she goes to sleep: “You sleep like that too. Even if it’s cold. It doesn’t matter” (B 13-14).

The aspect of ‘no choice’ is further underlined by her narration of the duration of the training. She constructs this by saying that the length of the training “depends on the person that trains you...” (B 7-8). The duration of training is thus dependent on the trainer, who works for the ancestors. The length of training seems to be chosen by the

ancestors and is, as I understand from the literature that I have read, determined by the sangoma's giftedness. This gift or talent also seems to be pre-determined by your ancestors.

The sangoma then goes on to indicate her lack of choice by narrating what she is allowed to eat and not allowed to eat during her training: "you eat *ikobong* at 3 o'clock in the morning. It's like a *muti* in a 5 litre bucket... It's made with everything, including herbs. It tastes horrible. We will eat pap. But no meat. No chocolates, no milk" (B 21-25). Note how the sangoma uses the word 'no' to construct her experience of 'no choice'. She also constructs her experience by contrasting the food she has to eat as 'horrible' to the food she is not allowed to eat as 'nice'. At the end of her training a goat is slaughtered and she narrates that she "must drink three glasses from three goats". Once again she constructs her experience of no choice by using the word 'must'.

When I interact with your narrative, it seems that you have no choices during your training as a sangoma. You do not have a choice as to what clothing you can wear and are told very specifically by the ancestors, via your trainer, that you may only wear a skirt, irrespective of the weather. It is also decided for you that you may not wear pants and thus show your bum. Even intimate choices, such as wearing underwear, is not made by you. As a woman, I cannot help but wonder what this did to you. Furthermore, you are required to cover your whole body in red mud, which seems to be a symbolic submission and offering of your body as a vehicle to the ancestors. Even this offering is chosen by the ancestors and it seems that the surrender of personal choice and power is complete from this moment on. In this moment there seems to be complete loss of ownership and control of your life, body and destiny.

The aspect of 'no choice' is secondly underlined by the fact that you have no say in the length or duration of your training. It further seems that at the outset of the training you have no idea for what period of time you have to prepare yourself. From your narrative it appears that in some cases it could take years for the training to end. I wonder what effect this had on you, as you had to leave your three young children and husband to

undergo unspecified training, and whether you were relieved when you realised that the ancestors had chosen to train you for only six months.

When I read this narrative, I was astounded by the vast difference between your training and mine. This narrative of yours creates immense frustration and disempowerment in me, as my training as a psychologist is so far removed from the experience you describe. When I chose to study psychology and was accepted into the Masters course, I knew that there would be certain rules that I would have to adhere to, such as the content of the course, the hours spent in class and doing a year of internship at an institution recognised by the Health Professions Council of South Africa. I also knew that my training would entail a minimum study of two years for which I, as the mother of a young child, could prepare for. It was, however, for the greatest part of my training, a journey which contained narratives of personal exploration and self-discovery, dictated by the narrative of self-reflection, in interaction with others, as well as my own willingness to learn. It appears that it is unlike your journey, in which you seem to surrender personal power and choice and thus become less, whereas, during my training I shaped a narrative of ‘becoming more’. Furthermore, during my training I had the choice to what extent I wanted to change or allow the narrative of growth into my training. I could adhere to the minimum academic requirements and pass, or I could engage on a personal level with my work and classmates and gain so much more. I was always faced with a choice.

Furthermore, I find that your training narrative creates a lot of helplessness in me because it appears that your body is ‘taken’ as a vehicle by the ancestors through which they speak and operate. It appears that your body is utilised so that the ancestors can shape and interact with your environment. But where are you in this process and what does this do to you? I would feel that my body had been hijacked and that my opportunity to a right of life had been taken away. This is also illustrated by the further description of your training and interaction with the ancestors in the following words:

The aspect of ‘no choice’ and being a vehicle to the ancestors is furthermore highlighted here by the fact that you cannot choose what you eat and drink. When you do eat or drink, it is done in service of the ancestors. This reminds me of a part of my training when, as a group we had to attend a week of adventure therapy in Oudtshoorn in the Western Cape. Although the attendance was compulsory, during this week we were continually faced with choices. Various activities were planned for each day, such as the exploration of eco-caves, canoeing, hiking and obstacles on high ropes courses. We were never forced to participate in any of these activities and the choice was ours whether we wanted to challenge ourselves or not and take responsibility for the possible consequence of learning less. Also, the food during this week was catered for by a chef and we received five star meals to nourish our exhausted bodies after hours of adventure and the discovery of ourselves and nature. The only ‘ritual’ we had, in contrast to your drinking of goats’ blood and the washing of your body with blood, was writing and reflecting about our daily experience in a diary and sharing this in group therapy every evening. We could also choose to what extent we wanted to share our experiences with our classmates and how much we wanted to invest in this group therapy. Each choice would have a different outcome. I wonder what this freedom of choice that I have does to you.

4.4 Letter 3: Loneliness and isolation

Dear S

In this letter I would like to discuss the loneliness and isolation that entered into your life with your calling into 'sangomahood'. Loneliness and isolation thus chose you as part of your 'sangomahood'. In our first interview, you introduced your narrative in the following words:

- (C)
1. When I was little, I was always sick. I had headaches. I wanted
 2. to be alone. I never played with other children. I wanted to be
 3. alone all the time. I felt different from other children, because
 4. I never had many friends. I never liked people. I didn't know
 5. why, but I knew that I was different. Always quiet, on my own.
 6. Never liked school. I was always sick at school, had headaches.
 7. Never listened to the teachers, what they were teaching about.
 8. I always forgot my studies. It was the ancestors but I didn't know...
 9. My mother doesn't accept that I am a sangoma. But I don't blame
 10. her. I blame her family, because they are controlling my mother.
 11. My great-grandmother is turning everybody against me because
 12. I am a sangoma. It's like she is jealous of my life, because her
 13. children are not like me. I am the only one that has luck at home.
 14. But I don't believe I'm the only one. I do believe they have luck.
 15. It's just because they don't focus on the ancestors. They think I've
 16. got money, they think I know everything. That's why I think she
 17. hates me. It's because I listen to the ancestors...
 18. Like I had a friend, and when I went to training, I never told
 19. her that I am going to training. You never tell anyone when you
 20. go to training, you just go. So when I came back, she never said
 21. 'hello' like before, you know. It's like she doesn't know me
 22. anymore. She knows that I am a sangoma, she sees the way I
 23. dress, but I'm like a stranger to her. So, it's killing me. She
 24. never comes to visit, because you have to respect sangomas,
 25. you don't visit like before. Your friends can't just come and visit.
 26. You don't have friends. Just me, my kids and my husband.
 27. My friend will come, but she will never feel comfortable like

28. before. Because they know that I can see everything that they are
29. doing. They are scared...

Analysis

The sangoma starts this narration of loneliness and isolation by putting it in a certain historical time frame: "When I was little" (C1). This narrative of aloneness thus started when she was a child. She then goes on to construct her experience as a child by narrating that she wanted to be "alone" (C2) and "alone all the time" (C3), as well as "always quiet, on my own" (C5), because of chronic headaches. In the literature that I read it was clear that a sangoma is called to 'sangomahood' by the ancestors, often in the guise of an illness or pain that won't go away (Faure, 2002). These headaches thus seem to be indicative of the sangoma's calling into 'sangomahood'. She refers to these headaches by narrating that she was "always sick. I had headaches" (C1). She first states that she was sick (in general) and then becomes more specific about her illness, namely headaches. These headaches thus isolated her ("I had headaches. I wanted to be alone" - C 1-2). The sangoma then goes on to narrate this isolation and constructs this experience by using the word 'never' in relation to different social contexts of her life as a child, for example: "I *never* played with other *children*. I wanted to be alone all the time. I felt different from other children, because I *never* had many *friends*. I *never* liked *people*. Always quiet, on my own. *Never* liked *school*. I was always sick at school, had headaches. *Never* listened to *the teachers*, what they were teaching about. I always forgot my studies. It was the ancestors but I didn't know..." (C 2-8). In this paragraph she firstly narrates her alienation in her social context as she says that she never interacted with other children. She then goes on to state that she never had many friends and then generalises that she never liked people. She secondly narrates her alienation in the educational context as she constructs this experience by saying that she never liked school, never listened to the teachers and always forgot her studies. Her use of the words 'always' and 'never' appears to indicate the intensity and extremity of her experience of alienation.

The sangoma then goes on to narrate her experience of isolation and alienation in the cultural or social context of the adult world. In this world she constructs her experience

by firstly referring to her isolation from family and secondly isolation from friends. When she narrates her isolation from her family she starts by referring to her mother that does not accept her 'sangomahood'. Her narration extends to her mother's family who "are controlling my mother" (C 10). The sangoma then narrates that her great-grandmother is turning 'everybody' against her because she is a sangoma. She thus constructs her experience of loneliness and isolation by using the phrase 'everybody against me', which indicates total exclusion. She also says "I am the *only one* that has luck at home" (C13). Her construction of the words 'only one' further indicates her experience of isolation. She also tries to make sense of her experience of isolation by attributing it to 'luck' and 'jealousy'. Both these aspects are related to her 'sangomahood' as she constructs her experience of luck as listening to the ancestors, for example: "I do believe they have luck. It's just because they don't focus on the ancestors" (C 14-15). She also says that she thinks her great-grandmother hates her "because I listen to the ancestors" (C17).

The sangoma then narrates her experience of isolation from her friend. She constructs this by narrating that, with her going into 'sangomahood', she *never* told her friend (line C18). She states that: "you never tell anyone..." (C19). It is almost as if this prohibition on sharing this journey into 'sangomahood' in itself creates isolation and estrangement. The element of not being able to choose what she shares with people around her is also highlighted here. She then goes on to construct her experience of isolation from her friend by saying that when she came back from training her friend *never* greeted her like before (lines C20-21), "never comes to visit" (C24) and "will never feel comfortable like before" (C27). Her continuous use of the word 'never' seems to portray the sangoma's feeling of a lack of options. This lack of choice can also be seen in her narration of "your friends *can't* just come and visit" (C25). The sangoma also constructs her estrangement from her friend further by saying that "it's like she doesn't know me anymore" (C21-22) and "I'm like a stranger to her" (C23). The sangoma goes on to construct this estrangement as "it's killing me" (C23). It thus seems that she experiences this isolation and lack of choice or options as stifling and deadly.

From your narration it thus appears that isolation and loneliness started in your childhood, when headaches were your constant companions and gentle reminders of your ‘chosenness’. I find it interesting how our different cultural contexts shape our experiences and meaning-making of events in our lives. I have also been a sufferer of chronic headaches since I was a teenager. In my cultural context I visited numerous doctors and was told that my headaches were caused by factors such as stress, a high sugar intake and hormonal imbalances. This explanation made sense to me. I grew up in a home where Western healing practices were the norm, as my father is a paediatrician. I could, however, choose to end these headaches by living a healthier life, eating correctly and exercising. Although you have the same symptoms, it is interpreted completely differently within your specific cultural and social setting by sangomas and prophets as a sign of your ‘chosenness’. Furthermore, it seems that you cannot choose to make these headaches go away, as they seem to be lifelong reminders of your calling and occupation. I wonder what this does to you that we experience the same symptoms, but that I can choose to end my pain by choosing a different lifestyle, whereas you seemingly can not. From my perspective, I find it frustrating and even unfair.

You narrate your experience of this isolation and loneliness in different contexts. It started at school when your constant headaches seem to have kept you from meaningful social interaction. As an adult it has extended to your broader family and friends. Narratives of jealousy and hatred appear to be shaped when your family interact with your ‘sangomahood’. At this point I cannot help but wonder if your loneliness and isolation is not perhaps due to the fact that you have internalised the discourse of ‘sangomahood’ to such an extent that you *are* your ‘sangomahood’ and do not exist as an individual outside this discourse. If this is the case it would seem impossible to choose intimacy within a family which seemingly interacts only with your ‘sangomahood’ – a discourse which they seem to perceive with hostility. Defining yourself in these terms alone must, in my view, render you extremely powerless and one-dimensional.

The narratives of isolation and loneliness further extend to your friendships. I wonder what it does to you that you can never put your ‘sangomahood’ aside in your personal life and that you are constantly perceived as a sangoma. You describe your experience of isolation and estrangement as something that is ‘killing’ you. You seem to experience this in a very traumatic way, by shaping it with the language of death or murder. It is almost as if the closeness and intimacy of friendship has been killed and done away with, with the introduction of and presence of ‘sangomahood’ in your life. It further seems as if a part of your ‘old self’ and old interactions died or had been killed by this new identity of ‘sangomahood’. ‘Sangomahood’ and the ancestors seem to demand the utmost loyalty. This identity of ‘sangomahood’ thus appears to leave you stuck as you do not have the freedom to engage with others as an ordinary human being. This inevitably creates greater loneliness and isolation as your very identity of ‘sangomahood’ creates narratives of fear, respect and distance in those that interact with you.

I find the thought of having to live your life in this way very stifling and limiting. My identity is not limited to my occupation as a psychologist. When I spend my time with friends and family I can choose to leave my role as a psychologist behind and in my social environment create greater intimacy with people close to me. In this environment I do not act as a psychologist, but merely as a human being. Although I believe that loneliness is part of the human condition and that each human being experiences loneliness, I also believe that we can choose to alleviate this loneliness by interacting with and taking part in the world around us. I wonder what it does to you that your very identity stops you from having a real choice to create less loneliness and isolation.

4.5 Letter 4: A vehicle and messenger for the spiritual world

Dear S

In this letter I would like to discuss your narrative of being a vehicle or medium for the ancestors and spiritual world. ‘Sangomahood’ goes hand in hand with your ‘chosenness’ to be a messenger for the ancestors, and contact with the spiritual world starts after your training, as seen in your words:

- (D)
1. The dead people only started coming to me after my training.
 2. You have to eat these things to make you and the spirits strong
 3. and then they start coming...
 4. When I heard for the first time I had to be a sangoma, I was
 5. scared. It’s very scary. I was so scared, because there
 6. was this lady (a sangoma) I didn’t know. She was always telling
 7. me that when she wakes up at 2am in the morning she will
 8. see a monkey in her yard. So it was scary, you see, that
 9. I am going to see those things too. And I’m beginning to see
 10. those things. It’s, it’s frightening. Like maybe a person died
 11. a long time ago – I’ll see him standing there. It’s scary.
 12. Like I’m sitting here now, I will see a person that is dead, standing
 13. there. They don’t talk to you. They just look at you and that is not
 14. nice. I don’t always know what it means. I find out later. Last
 15. year my two cousins died, two brothers. The one died in February
 16. and the one in March. So, when we finished burying the first
 17. one on the Saturday, on the Monday, he came to me and told
 18. me that he is hungry. So I said to him ‘why are you telling me,
 19. why don’t you tell your mother that you are hungry?’ And he said ‘no,
 20. I wanted to tell you that I am hungry. So get up and go and make
 21. some food for me in the kitchen.’ So I refused, because I knew
 22. you don’t have to get up when these spirits come to you and say
 23. ‘let’s go.’ So I refused and he tried to pull me from my bed. I
 24. fought him and then he left. He came the next day. The same
 25. thing. He was trying to tell me that I must tell his mother that
 26. he is not happy where he is now, because his mother does not
 27. believe in the spirits. So he was telling me that I must tell his



28. mother that he was not happy. And then they came again,
29. now, the two brothers and tell me the same thing – that they are
30. hungry. I fought with them again. I'm trying to tell their mother
31. 'your sons now, they are not happy.' But she doesn't listen to me.
32. She must slaughter a goat and wash her body and speak to them.

Analysis

From this narration the sangoma constructs her experience with the spiritual world by using the word 'only' in line D1 when she states that "dead people *only* start coming after my training". The training seems to be a rite of passage and initiation into the spiritual world. She places her first contact with the spiritual world in a historical time frame by narrating that the dead people come to her *after* her training. She then goes on to narrate that "you *have to* eat these things" in line D2, to construct her experience of preparing oneself for the role of a messenger or vehicle in her cultural context. These words once again indicate the theme of 'no choice'.

The sangoma then constructs her experience when she heard for the 'first time' (she places this narration in historical context) that she "*had to be* a sangoma" in line D4. She refers to this experience of 'no choice' as "I was *scared*", "*very scary*" and "*so scared*" in the same sentence (line D5). With the use of this word over and over again she seems to construct the intensity of her experience and fear of having no control over her life. She also uses the word 'scary' again in lines D8 and D11 and uses the word 'frightening' in line D10.

The sangoma also brings in another sangoma from her cultural context to construct her experience of this fear of having to deal with the spiritual world. This sangoma is "always telling" (D6-7) her, thus a constant reminder of her connection to the spiritual world, that she sees a monkey in her yard in the early hours of the morning.

In this narration the sangoma also narrates her experience by initially giving the listener or reader a general description or background to the spiritual world (from lines D1 –

D14). From line D15 onwards her narration becomes more specific as she refers to her experience with the spirits of her two deceased cousins. She narrates this experience with these spirits as an event that takes place again and again by saying “...on the Monday, he came to me” (D17), “he came the next day” (line D24) and “then they came again” (D28). It thus appears from this narration that she has no choice when or how often the spirits come to her.

What is furthermore important to mention, is the sangoma’s use of the words ‘tell’ and ‘telling’ throughout this paragraph. With these words she constructs her experience of ‘being a messenger’, as the word ‘tell’ indicates the conveying of a message from the sangoma to her, from the spirits and from the sangoma to the spirits. The words ‘tell’ and ‘telling’ are used in lines D6, D18-20, D25, D27 and D30.

Your training seems to be an initiation and the start of ‘being a vehicle or messenger’ to the spiritual world. It seems to me that the training is also a ritual of strength, during which you have to eat certain foods to prepare you for your contact with the deceased. Together with your ‘sangomahood’ a story of unchosen spiritual torment and fear seems to unfold as you narrate being a vehicle for restless and troubled spirits, such as the spirits of your two deceased cousins. They come to you with certain messages and you must try and solve their anguish. From this narration it seems to me that your patients are not only limited to the physical world, but that you have ‘patients’ that come to you from the spiritual realm. It seems that these patients from the spiritual world make contact with you whenever they please – even at night when you are asleep. As a sangoma and vehicle for the spiritual world you are thus never ‘off duty’, which to me emphasizes that ‘sangomahood’ is a way of life, rather than an occupation. You have no chance or choice of a private life, as you are called on by tormented spirits, such as your two deceased cousins, who seemingly have no boundaries or respect for your time or personal space. It seems, from your narration, that these two spirits were trying to get a message across to their mother via you that they were ‘spiritually hungry’ and unhappy because their mother would not feed them with the ritual of slaughtering a goat. You then become part of their turmoil and even have to

endure physical battles with them. Besides the fact that you have no time for yourself, it must be extremely upsetting and frightening to have to deal with another realm that people around you do not understand or have access to. I wonder if this does not enhance your narrative of isolation and loneliness. You can also seemingly not choose who your patients will be, as they seem to choose you.

I find this narration of the spiritual world very intimidating. As a psychologist it seems foreign to me that you do not have a private life and personal space outside of your 'sangomahood'. It seems that, to some extent, this has to do with the fact that I do not work with troubled spirits in the spiritual realm. However, I know from my literature study that sangomas allow their patients to stay with them at their homes until they have been helped. Although I do not view being a psychologist as purely an occupation, I do believe in creating certain boundaries that allows me the time to pursue other interests. In my work I create definite boundaries. My patients, or clients as I prefer to call them, make one hour appointments to see me during the day and are only allowed to contact me after hours in a case of emergency. They do not know anything about my private life or where I live. This is also part of an ethical code of conduct in my profession. Also, I can choose my clients and can thus refer individuals whom I have difficulty working with to another psychologist. Family and friends are also not allowed to become my clients as, from a psychological perspective, one cannot be 'objective' enough to deal with their problems. Although I become emotionally involved in my clients' lives and I am a facilitator on their journeys, I do not become actively involved in their private lives. It is their responsibility, outside of therapy, to take control of their destiny. Thus, from my perspective, I find your narrative of being a vehicle and messenger for the spiritual world frightening and intrusive. Once again it touches on the discourse of 'not being able to choose'.

4.6 Letter 5: The material world

Dear S

In my final letter I would like to discuss the narrative of your material world. Your material world also seems to reiterate your narrative of ‘no choice’ as seen in your words:

- (E)
1. The ancestors are giving you money to eat, to feed yourself and
 2. your children, to buy things in your home. To buy their things they
 3. want...*muti* ,...The ancestors want you to use the money properly,
 4. not just waste it. Especially the kids. They don't want to see
 5. them hungry. The kids have to have everything they want. If
 6. you use the money wrongly, the ancestors will take your patients
 7. away. They are watching you all the time. Like if you want the
 8. furniture, you go and take *mpepo* and light it and speak to them.
 9. You tell them you saw that furniture you want, maybe a sofa,
 10. maybe something else, you want that thing. They'll give you the
 11. money – the cash - not via instalment. I told them I wanted a house.
 12. They are the ones that choose the house. I did like a house before.
 13. I was going to buy that house. It was very nice, very big. But they
 14. didn't like it. And I waited for about three months that the man must
 15. phone me and tell me I can come and sign the papers. And when I
 16. went there and asked him what's happening, why he doesn't phone
 17. me. He said, no, the people don't want to sell the house anymore.
 18. So I know, they didn't like the house, because the lady of that
 19. house, she wasn't the good one. She was the bad one. So I was
 20. going to suffer in that house, because I have to clean all the evil
 21. things out of there. So they choose a house now for me and it's
 22. very nice. I think they are happy. .

Analysis

The sangoma constructs her experience of the material world by narrating that the ancestors are providing her with material goods. Firstly she refers to money: “The

ancestors are giving you money” (E1). This money is given to her for food and to buy ‘things’, seemingly referring to material objects in her home. The sangoma then goes on to construct her experience of ‘no choice’ in the material world when she narrates that the money is given to her by the ancestors “to buy *their things they want*” (E2-3). Here it appears that money is viewed by the sangoma to come from the ancestors and objects in her material world thus belong to the ancestors as they dictate to the sangoma what they choose. She further narrates that the ancestors “*want* you to use the money properly” (E3). Here it seems to be about the needs of the ancestors to spend her money wisely which she constructs as looking after her children. The sangoma also shapes her experience in the material world by narrating that the ancestors watch over her “all the time” (E7) to make sure that she spends the money in the way they wish. She narrates in lines E 5-7 that “if you use the money wrongly, the ancestors will take your patients away”. This once again indicates her lack of choice and freedom and the authority that the ancestors have over her life and choices.

She goes on to construct her experience of lack of choice by telling the story of buying a house. She narrates clearly in line E12 that “they are the ones that choose the house”. She goes on to clarify this statement by saying that she did like a house before, but the owners of the house eventually decided that they did not want to sell this house. The sangoma constructs this event as the ancestors “didn’t like it” (E13-14). She finally narrates that “*they choose* a house now for me...I think they are happy” (E21-22). In this latter narration she again constructs her experience to tell a story that the ancestors choose her material world. This is clear even in mundane matters, such as buying furniture like a sofa. The sangoma narrates that when she sees furniture that she likes, she has to light *mpepo* and “speak to them” (E8) before they provide the money (E10-11). It thus again seems that she cannot make her own choices without consulting the ancestors.

Your narration illustrates that the ancestors not only dictate your spiritual world, but also seemingly every aspect of your material world. Your material world is thus interpreted in terms of and dictated by the spiritual world. At this point I wonder if the

ancestral discourse of ‘sangomahood’ has not taken all your individual power away and marginalized you as a unique human being. Does this not sometimes frustrate you or has it perhaps become comfortable to not take responsibility for your world?

The ancestors seem to provide you with money via your patients. They then keep watch over how you spend it. If you do not obey them and spend your money wisely, the ancestors will take your patients away and you will lose your money. This image of the ancestors ‘keeping watch’ over you creates the impression of a punitive parent-child relationship. Even though you are an adult, you are seemingly never given full responsibility or allowed the room to make mistakes without being punished. I sometimes wonder if you do not live in fear and how it feels to always do what is wise because someone else is watching over you. Power in your world thus seems to be externalised and does not come from within yourself. Looking at the world from my perspective, I embrace my humanity and often allow room for mistakes and unwise behaviour as this, to me, creates a greater intimacy with the wholeness of life. The fact that I am allowed to choose and make mistakes allows for personal power to enter into my life. Power is thus not something that is externally forced into my life.

Further, the ancestors also choose your other material possessions, such as your furniture and house. I find it interesting what this story of your material world does to me. It creates a sense of helplessness in me that you have so little control and choice over your own life. It stifles me to think that you have no input in the process of choosing your material world and that the ancestors are continually choosing on your behalf. I cannot help but wonder what this interaction with the world around you does to you. It seems as if you cannot exert any power over, or influence your world, even when it concerns your most intimate possessions such as furniture. I have a choice of what furniture I prefer and which house I want to live in. From my perspective my home and choice of furniture is an expression of my individuality and creativity. I can also choose to change this world as my taste and personality change and develop. Not being able to express myself in my own chosen way, via my material world, would be utterly frustrating and limiting to me.

4.7 Reflection

The dominant discourse which I chose to highlight in my analysis of the text of ‘sangomahood’ and which, in my view, was the most prominent was the theme or discourse of ‘no choice’. I chose this theme because, in my reading and re-reading of the text, I found myself - viewing life as a set of choices - utterly frustrated with the sangoma’s lack of choice and the small role that she as an individual has to play in her own life and destiny. My frustration with her different narratives of ‘no choice’ was profound and thus made me decide to write her a set of letters, telling her, and you as the reader, about the impact that it had on me. In this way, I felt, the research would have more integrity as I could be open and honest about what my interaction with her text did to me. The text might have had a different impact on you as the reader and you might have chosen to focus on an entirely different discourse. You may also have given different meanings to my analysis of ‘no choice’.

In my opinion the discourse of ‘no choice’ within her ‘sangomahood’ leaves the sangoma stuck, as she is unable to write her own unique narrative in her chosen way. This narrative of being stuck begins when she starts her training out of fear that her husband will die if she does not accept her calling. During the narration of her training I became particularly aware of her inability to make choices and the profound influence and control that the ancestors have in making choices for her. As the narration unfolded I became aware of the fact that this extends to her material life, outside of the training, her inter-relational world with friends and family, as well as her spiritual world. Her whole life becomes defined by her ‘sangomahood’ and there is little, if no room for a personal, individual narrative or life outside of this calling.

At this point I wonder what influence time has on the sangoma’s narrative. Will her narrative be more pro-active and less fearful as time progresses? And will time allow her to surrender to her ‘sangomahood’ to such an extent that she will start telling an alternative story, with different meanings and even perhaps a story of more choice within her limitations?

There are many more narratives that I could have introduced to you on this journey. I have only highlighted my main impressions in the discourse of ‘sangomahood’ and thus connected certain events of ‘no choice’ to tell a certain story. This, unfortunately, leaves many untold narratives around the sangoma’s text. These untold narratives are, however, not less meaningful or less important to the one I chose to tell you.

CHAPTER 5

‘INTERPRETATION OF THE BONES’

5.1 MAKING SENSE OF THE JOURNEY

We have now reached the final stage of this journey and I would like to use this chapter to firstly reflect on the experience that has taken place.

The question at the outset of this journey was: “How does a sangoma make sense of her ‘sangomahood’ through narrative?” Along this journey, I looked at what the ‘ancestors’ and literature had to say about ‘sangomahood’. In my discussion of the literature, the dominant discourse of Western medicine, as well as the alternative discourse of traditional healing, were highlighted. I referred to different perspectives such as the historical, anthropological and sociological perspectives on medicine, which illustrate that the social context or position from which we view reality has an impact on how we see and interact with the world and thus shape our experiences and stories. Each of these perspectives had different ways of viewing and interacting with the world. Also, the two discourses of medicine broadly gave you as the reader an idea of the different realities that came together in this research journey – being the alternative healing world of the sangoma and the Western scientific based reality of me as the researcher.

The rituals that I introduced in the next part of the journey created a broader picture of the social and academic context from which I was going to conduct my analysis. I experienced these rituals as guidelines in a creative process where I could make my own voice, as well as the sangoma’s voice heard.

However, at this point in the journey, it seemed that the literature and academic context only partly answered the question of this journey. It was therefore necessary to analyse

the sangoma's narrative and her experience through time within her specific cultural context to fully answer the question.

During the analysis of the sangoma's text it became clear to me that she made sense of her 'sangomahood' by telling a story of 'no choice'. She starts this story by narrating how she had 'no choice' when she was called into 'sangomahood' and that this was an occupation that had chosen her. Refusing it would only lead to tragedy entering into her life. Secondly, she tells of her training as an initiation into 'sangomahood' and her lack of choice during the training. The sangoma narrates how she had no choice as to the duration of her training, which clothing she had to wear or what she could eat, as this was always determined by the ancestors. Thirdly, the sangoma goes on to narrate a story of loneliness and isolation, which had chosen her and entered into her life as part of her calling into 'sangomahood'. She narrates how this loneliness and isolation started in childhood when she had to deal with chronic headaches. This isolation did not only manifest in her social context, but also in her educational context as she had difficulty focusing on her studies. As an adult she narrates how her 'sangomahood' caused a rift of jealousy and hatred between her and her family, as well as estrangement from her friends. The sangoma then narrates a further narrative of 'no choice' which entails being a messenger or vehicle for the spiritual world. Within this narrative she tells of spiritual torment and fear as troubled spirits enter into her life without her having any control or choice over these happenings. Lastly, the sangoma emphasizes her lack of choice as she narrates her experience of her material world. She tells how the ancestors provide her with money and how they keep watch over the way in which she spends this money. She has to consult them when she buys furniture and they ultimately choose the house that she has to live in.

From this narration a dominant story of 'no choice' seemed to unfold. This narrative highlighted the sangoma's lack of control and thus choice over her occupation and calling of 'sangomahood'. Entering into 'sangomahood' had a snowball effect on the shaping of the rest of the sangoma's reality as the discourse of 'sangomahood' dictates that she is a vehicle for the ancestors and must obey them. The fact that the ancestors

had chosen her introduced chronic headaches, loneliness and isolation into her world. The ancestors, furthermore, not only chose how she was to be trained, what she was to eat and wear and what house she was to live in, but they also dictate her spiritual world. From this analysis it became clear to me that the sangoma defines herself in terms of her ‘sangomahood’ and that it has become her identity. As she has no opportunity or choice to express herself outside of this discourse of ‘sangomahood’, no individual identity could be created. Thus, she did not choose her identity either, it chose her. The answer to the question of how the sangoma makes sense of her ‘sangomahood’ through narrative, according to my meaning-making, is that she makes sense of this calling by constructing a narrative of ‘being an instrument’ of the ancestors and ultimately having no choice in any sphere of her life.

As I reflected on the impact that her story had on me, I was profoundly frustrated by her powerlessness. I wonder if ‘sangomahood’, ruled by the ancestors, is not just another way of marginalising her humanness. Where did she have the chance to freely express herself and make choices pertaining to her destiny and environment? Who would she be if she were not called into ‘sangomahood’?

It is, however, important to point out that my frustration with the text does not lie in the wrongness of her narrative, but merely in the different views of my culture. I cannot imagine a life without choice, self-determination and self-actualisation. If I did not have choices, I wonder if I would really want to be alive. Choices give me hope for the future as I am constantly aware of the fact that I can always choose to change aspects of my life that I do not like. I am not merely a puppet on a string, working with a prescribed text. Making choices, taking responsibility for these choices and learning from them is paramount to personal growth and self-expression. Even this research is symbolic of my right to choose as narrative research enables me to interpret the text in my own unique way.

This discourse of ‘no choice’ is merely one of the discourses that surround ‘sangomahood’. I would thus like to encourage you, as the reader, not to be attentive to

this discourse alone, but to go on discovering other discourses and meanings and allow them equal space and significance.

5.2 FURTHER RECOMMENDATIONS

Lastly, I would like to make a recommendation for further research, as well as look at the value this research might have for psychologists and others who find themselves in conversations with sangomas or individuals from different cultures.

A further recommendation for this research would be a journey where I share my story as a psychologist from the Western perspective with the sangoma and then analyse what impact it has on her. If this research was done again, I would have interviewed more sangomas to see whether their experiences of ‘sangomahood’ were similar.

Finally, I hope that this research journey offers psychologists a better understanding of the impact that culture and our social contexts have on our experiences and interactions with others. It is important to remember that as psychologists our clients’ stories always have a certain impact on us and thus on the way we ask questions and conduct our therapy as we are rooted in certain social and cultural contexts. Culture is not ‘indigenous clothing’ that covers the universal human, but is thus personal and unique to every human being. This research journey has therefore hopefully contributed to a greater understanding of the sangoma culture. It has made me realise how much we still have to learn about other cultures and the world around us to truly understand one another and allow space and tolerance for the creation of narratives that differ from ours.

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