Cultural Tensions in Psychiatric Nursing: Managing the Interface Between Western Mental Health Care and Xhosa Traditional Healing in South Africa

Marc S. Kahn
Cape Town, South Africa

Kevin J. Kelly
Rhodes University, South Africa

Abstract: The views of a sample of Xhosa-speaking psychiatric nurses on traditional healing and its role in mental health care in South Africa are examined. We explore how the nurses manage apparent incompatibilities between their practice of Western psychiatry and the use of traditional healing services. Under normal circumstances this incongruity appears unproblematic for the respondents; these systems co-exist pluralistically in their experience. However, when questioned about the possible cooperation of these systems, respondents give views inconsistent with their pluralistic world-view and promote psychiatry's hegemony. Implications for healthcare planning are discussed.

Key words: culture • healthcare planning • nursing • psychiatry • traditional healing

Introduction

This study examines how Xhosa-speaking psychiatric nurses in South Africa view their dual allegiance to apparently competing, and largely

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incommensurate, mental health paradigms - Western psychiatry and traditional healing - and how they mediate interpretive tensions between these systems. Using their experience as an interpretive lens, we offer an insight into the irony of trying to engineer systems of co-existence between systems already co-existing.

Marks (1994) states that the emergence of black nurses as a professional class in South Africa was part of the drive for cultural hegemony by Western colonial belief systems. Black nurses ‘would represent the harbingers of progress and healing in black society, a shining light in the midst of its savagery and disease’ (p. 78). Colonial policies aimed to replace indigenous healthcare systems, with nursing as a standard-bearer of Christianity, Western social values, and scientific medicine (Marks, 1994).

South African psychiatry is largely hospital based with community outreach programmes radiating from central services. There are typically four types of nurses in a South African psychiatric ward: registered, enrolled (staff), auxiliary (assistant), and student. Registered nurses require a 12th grade school certificate for admission to a 4-year training course, which includes a psychiatry module. Enrolled and auxiliary nurses require a 10th grade certificate for admission to training, which takes 2 years and 1 year respectively. Student nurses work in a psychiatric hospital as part of their general training. The training model is standardized nationwide. The general practice model is the multidisciplinary team headed by psychiatrists and comprising nurses, clinical psychologists, occupational therapists, and physiotherapists. Nurses are responsible for day-to-day patient care and practice in uniform.

The psychiatric nurse performs activities covering basic functions of psychiatric care: one may call her a generalist practitioner mediating tensions between roles in the multidisciplinary team. For example, tensions between custodian of order and empathic psychotherapist are represented in the nurse, who must factor out incompatibility between these otherwise distinctive roles.

In this study, we focus on nurses’ mediation of medico-cultural tensions. In the hospital in which our research was conducted, psychiatrists and psychologists are mostly white. Xhosa-speaking patients perceive themselves and Xhosa nurses as being ‘of a kind’. Yet, although the nurses are primarily African, they also belong to ‘the Western psychiatric institution’. In attire, access to resources and association with the psychiatric team, nurses are points of access to the hospital’s power. So from the patient’s perspective the nurse is not entirely ‘one of us’. From the psychiatric institutional perspective the nurse is ‘one of us’, but also ‘one of them’ in familiarity with Xhosa patients’ culture. Being Xhosa means subscribing to a general culture of social practice, and a culture of health and healing. Studying how nurses manage this dual allegiance can teach us more about how mental health cultures interact.
As Barbee (1986) suggests, psychiatric nurses must be part of programmes with ‘the goal of collaboration among biomedical and ethno-medicinal practitioners’ (p. 75). South African nurses are entry points into the debate around seeking models of association between traditional and Western healing practices. Speaking from another Southern African context (Botswana), Barbee (1986) says:

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

Barbee found that nurses were ‘ensnared in a dialectic between traditional and biomedical beliefs’ (p. 79). Tensions in this dialectic make nurses ambivalent about cooperating with traditional healers. Nurses mediate contradictions created by dialectical tensions in two ways: some reject socio-cultural beliefs for Western concepts, but most adopt a position of co-existence. In the sections that follow, we attempt to extend this analysis, and examine how nurses view the interaction between these systems, in the context of models of collaboration.

The Context of Traditional Healing

The South Africa Health Act (1974) forbade healers not registered with the South African Medical and Dental Council from performing ‘medical’ acts. Yet traditional healing has persisted: about 80% of the population uses traditional healers (Gumede, 1990; Hopa, Simbayi, & du Toit, 1996).

There are various types of traditional healers known to Xhosa speakers. However, the generic term ‘traditional healer’ is commonly used to refer to all of them. In our research, when we used the term ‘traditional healer’, we ensured that respondents understood it to refer to the generic category. Otherwise we used specific terms for the different types of healers.

The coherence of the term ‘traditional healer’ rests on what it achieves in the context of comparing Western medical models with healing systems with foundations in African cosmology. ‘Traditional healer’ acquires coherence through the exclusion of this group from official recognition, rather than by shared ground. Use of the term ‘traditional’ rests as much on practices being alternative to Western psychiatry as on any historical origin.
We examined traditional healing specifically in relation to the psychiatric context. This introduced cultural bias, because at the outset we define the field from the perspective of Western mental health and specifically psychiatry. Were we to consider how the mental health field is defined from within Xhosa culture, we would need to dispense with ‘mental’, and possibly also recast ‘health’. However, we found that respondents themselves subscribed to the distinction made between ‘psychiatric, institution-based mental health practices’ and ‘traditional practices’. In the context under study, tensions inherent in psychiatry’s relation to culture and Xhosa culture’s relation to Western biomedicine become paramount in defining these categories.

**Traditional Xhosa Healers**

Broadly speaking, there are three main types of healers in traditional Xhosa culture: ‘diviners’ (amagqira), ‘herbalists’ (ixhwele) and ‘faith healers’ (umthandazeli). ‘Prophets’ (umprofethi) might be considered a sub-type of faith healer.

Central to the diviner’s work is mediation of the relationship with izinyanya (shades/ancestors), who can cause illness and misfortune if displeased. Treatment usually involves ritual and may include herbs and remedies (Buhrmann, 1986; Hirst, 1993). Diviners are spiritually ‘called’ to their profession through an illness of their own. This is called thwasa. Once the calling is accepted, the person begins initiation under a diviner’s guidance. Training usually takes 3-5 years. Diviners use supernatural powers to explain misfortune and illness and offer guidance on appeasing the shades. They often act as community arbitrators and are aware of social order and cohesion. It is common for the patient’s family to attend consultations (Buhrmann, 1986; Cheetham & Griffiths, 1982; Hammond-Tooke, 1989; Hirst, 1992, 1993; Schweitzer, 1977).

Although diviners have extensive knowledge of medicines, more often patients obtain medicines from herbalists (Ngubane, 1977). Herbalists, sometimes called ‘traditional doctors’, use African medicinal plants, animal products, patent medicines and prepare concoctions, some of which have protective functions. To this extent herbalists share some of the functions of diviners, but their concern is mainly with healing illness. Unlike diviners, herbalists are not necessarily ‘called’ to their profession.

In South Africa, membership in a Christian church does not necessarily imply a break with traditional African beliefs. The context of African faith healing is an amalgamation of traditional cosmology and Christianity. The Independent Separatist Churches of Southern Africa, often called Zionist or African Independent churches (Gumede, 1990), retain some customs and views of traditional rural society, but have abandoned certain of its role boundaries and authority structures. Faith healers are imbedded in
these churches and are seen as outstanding persons with clairvoyant and healing powers, operating from within ‘African’ church cosmology (Edwards, 1983; West, 1975).

Prophets are foretellers of droughts, disease and other major events rather than healers, but are consulted for guidance about illness or misfortune. They receive revelations from God or ‘the spirits’ and are considered to be of higher status and rarer than faith healers. They may work independent of formal African churches (Gumede, 1990; F. N. Mthotywa & M. Sandi, personal communication).

Further clarification of ‘healer’ is necessary here, as practitioners may practice witchcraft, in which case they are classed as witches. ‘Witch’ (igqwirha) and ‘sorcerer’ (umthathathi) are anti-social people motivated by jealousy to harm others (Hirst, Cook, & Kahn, 1996). Beneficent ‘shades’ (ancestor spirits) and malevolent ‘witches’ represent important polarities as explanatory causes of misfortune and illness.

**Method**

**Setting and Sample**

The Eastern Cape is one of South Africa’s three poorest provinces. Grahamstown is a small educational centre of about 90,000 people in the interior of the province. The area has little industry. About 80% of the Eastern Cape’s population is rural, with an urbanization rate of about 2% per annum. The unemployment rate is the country’s highest – about 25% (Southall, 1992).

The study (Kahn, 1996) was conducted in Fort England Psychiatric Hospital, Grahamstown, a 470-bed general psychiatric hospital with wards including custodial wards for geriatric patients and patients with chronic or intractable problems, a high therapy ward, an acute ward, an admission ward, and a ward for patients committed through the law courts. The hospital services 40 rural clinics and the total patient number (inpatient and outpatient) exceeds 6000. The Eastern Cape population is mainly Xhosa-speaking; over 80% of admissions to the hospital are Xhosa-speaking. The hospital is not a training facility, although some training modules for student nurses are conducted there.

The study population consisted of all 93 mother-tongue Xhosa-speaking nurses working in Fort England Psychiatric Hospital.

**Research Instrument**

A combined quantitative and qualitative methodology was used, whereby data were gathered using a questionnaire designed for the study. Respondents could also write comments as they went through the 63-item
questionnaire. Questionnaire construction followed the guidelines of Nachmias and Nachmias (1987), and the following steps were taken to ensure reliability and validity: (i) A rough draft was created by extracting central questions from relevant literature. (ii) The draft was discussed with the nurses and reworked according to their feedback. The questionnaire was re-examined by nurses across age, rank and gender. This process was repeated nine times. (iii) An anthropologist/traditional healer, who has extensively researched Xhosa traditional healing, reviewed the questionnaire. This led to further revision.

Data Collection

After permission had been granted by the hospital’s medical superintendent, nursing staff were informed of the research project at a meeting in which the nursing service manager and a nurses’ union representative offered support for the study. Questionnaires were disseminated to all Xhosa nurses. A total of 77 questionnaires were returned from a population of 93, reflecting an 83% response rate and indicating strong interest for and co-operation with the project among the respondents.

Responses to open-ended questions were collated under coding categories (Nachmias & Nachmias, 1987) using thematic analysis principles described by Taylor and Bogdan (1984).

Results and Discussion

This section begins by reporting nurses’ personal experiences and perceptions of using the services of traditional healers. A presentation of their views on various possibilities of association between traditional and psychiatric practitioners follows, leading to discussion of their views on the need to regulate traditional healing so as to manage its interaction with institutional psychiatry.

Respondents’ Personal Experiences with Traditional Healers

As well as subscribing to traditional Xhosa cosmology, most of the nurses perform traditional rituals and customs (89%) and visit traditional healers as patients (75%). Eighty per cent of respondents believe that the ancestors have given traditional healers healing powers. These statistics are interesting, considering that 99% of the nurses said they were Christians, and all trained and work in a Western mental healthcare system. Du Toit (1980) found that among South African blacks, ‘neither urban residence nor membership in a Christian church necessarily implies a break with traditional supernatural beliefs or religious and ritual practices’.
He found that while over 90% of a sample of urban black South Africans were members of Christian churches, almost half had performed traditional rituals, and as many indicated that they would consult traditional healers in a crisis. So this trend is not unusual in the general population; however, it is striking among Xhosa nurses and raises interesting cultural questions.

It is germane to consider how the nurses responded to the question 'has nursing made you doubt traditional healers?' Thirty-seven per cent answered 'yes' and 63% 'no'. Interviews with nurses corroborated the view that while they acknowledge the contradictions of subscribing to different systems, awareness of incompatibility and doubts about legitimacy only really arise in response to questioning on the topic: this forces them to recognize and reconcile their contradictory beliefs, which they would otherwise not typically do. This suggests that the questions are either not usually asked or the nurses do not have the need to integrate these facets of life experience into a unitary system. As will be seen, in response to questions about models of interaction between the systems, the nurses voiced awareness of the problems associated with bringing the two models together. It might be extrapolated that the public, unschooled in Western psychiatry and not generally having to answer questions related to healthcare planning, is well disposed to straddle both worlds without needing integration. Medical pluralism (Helman, 1990), the tendency to simultaneously subscribe to disparate healthcare systems, is more the rule than an exception in most societies, and the need for integrated models is arguably more a concern of planners and academics than of the public.

The Perceived Efficacy of Traditional Healers

The nurses rated the effectiveness of traditional healing, psychotherapy, and medication as modes of intervening in mental illness. A small proportion (22%) of nurses see traditional healing as 'seldom' or 'never' effective; most nurses (64%) see it as 'sometimes' effective; and the smallest percentage (14%) see it as 'always' or 'usually' effective. However, only 58% of respondents agreed that traditional healers could play a positive role in mental health care. Medication and psychotherapy efficacy were rated highest (50%) in the 'always' or 'usually' effective categories, alongside a very large percentage (47%) in the 'sometimes' effective category. We might conclude here that the nurses would not endorse traditional healing as a replacement for psychiatric medication or psychotherapy, but as an adjunct to these.
Relation of Traditional Healing to Psychiatric Services

Freeman and Motsei (1992) and Suryani and Jensen (1992) outline options for models of interaction between Western health services and traditional healing practices. Respondents in this study gave their views on three models proposed for developing working relationships between the official mental healthcare system and traditional healing: traditional healers as part of the multidisciplinary team; healers visiting hospitals as consultants; and the establishment of referral systems. Responses to specific questions on the role of traditional healers are summarized in Table 1.

As will be seen below, there is a fairly high degree of support for some form of the two health systems working together, and recognition that both have something to offer. As one respondent put it: ‘There are certain illnesses that these people [traditional healers] can see and cure which a doctor cannot see, like a doctor can see and cure illnesses that these people don’t see.’ There is less explicit support for any specific interaction model and no model emerges as a building block for developing models of interaction. Whereas there is positive general sentiment, when examining specific models, optimism about interaction between the two systems is dampened by lack of a convincing and prevailing vision.

In general, nurses feel that interaction with traditional healers would benefit patients. As one respondent said: ‘Their input might aid in

TABLE 1
Xhosa nurses' views of traditional healing

<table>
<thead>
<tr>
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<th>% Agreement</th>
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<tr>
<td>Certain patients would benefit more from being treated by both the hospital and traditional healers than by hospital staff alone.</td>
<td>77</td>
</tr>
<tr>
<td>Certain patients would benefit more from being treated only by traditional healers and not by hospital staff.</td>
<td>40</td>
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<tr>
<td>Patients already seeing traditional healers should also check if psychiatric medication might help them.</td>
<td>85</td>
</tr>
<tr>
<td>Medical insurance should pay for consultations with traditional healers.</td>
<td>55</td>
</tr>
<tr>
<td>Healers should have certain patients referred to them after hospital discharge.</td>
<td>58</td>
</tr>
<tr>
<td>Healers should visit psychiatric hospitals to consult with certain patients.</td>
<td>57</td>
</tr>
<tr>
<td>Healers should work in hospitals as members of the psychiatric team.</td>
<td>55</td>
</tr>
<tr>
<td>Certain patients should visit healers before seeking help at the hospital.</td>
<td>44</td>
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diagnosis and they could provide an explanation of the problem that the patient would find more acceptable and easier to understand. It was also said that ‘the patient would self-disclose more easily to someone originating from the same world-view.’ Recognition of the need to provide a more culturally familiar psychiatric milieu appears to be a strong motivation for nurses favouring traditional healers working with the hospital.

Eighty-five per cent of nurses agreed that ‘some patients believe in traditional healers more than the hospital,’ and 82% agreed that ‘some psychiatric patients would self-disclose more easily to traditional healers than they would to hospital staff.’ Fewer respondents (58%) believed ‘traditional healers could help hospital staff in the diagnosis of certain patients.’ Sixty-five per cent of respondents felt traditional healers could help hospital staff take patient histories.

Many authors (e.g. Buhrmann, 1977; Kruger, 1974; Ngubane, 1977; O’Connell, 1980) have suggested that the diviner’s practice derives from deep knowledge of social system functioning and intervention. ‘A great deal of the informal helping that diviners provide to clients falls into the general category of manipulating social networks . . . the healer is, very often, in possession of highly specific and relative local knowledge which may take the average professional a lifetime to assimilate and master’ (Hirst, 1992: 73–74). Some nurses who are aware of this appear ambivalent about whether this aspect of healing can be ‘delivered’ as a health service or whether it belongs in the context of the community.

The hospital already practices a multidisciplinary approach, and on one level adding traditional healing alongside occupational therapy, clinical psychology, physiotherapy, pastoral care, and social work models appears to pose no problem. Eclecticism as a theoretical framework appears to accommodate diversity in much the same way as the nurses do in their private lives. This fits the pluralism model, which is a culturally tolerant way to address diversity, and is consistent with the eclectic model, which is part of institutional psychiatric culture in this hospital and possibly worldwide. Armstrong (1987) noted that in attempting to pursue a biopsychosocial paradigm the incommensurability of separate paradigms is glossed over in favour of an ethos of practical working together.

Most concerns about the inclusion of traditional healers in the culture of psychiatry relate to the maintenance of the integrity of the institutional psychiatry system. These concerns are about issues that challenge regulated running of the institution of psychiatry and ancillary professions. Concerns about including traditional healers were phrased in terms of concerns about their training standards. It is suggested that these concerns are based on the realization that integration of a fundamentally incompatible system into psychiatric terrain requires the ability to regulate that system. Only an internally well-regulated system is open
to the possibility of itself being well regulated – hence concern about training standards.

Healers Visiting Hospitals

Respondents in favour of traditional healers visiting psychiatric hospitals to consult generally felt that a combination of traditional healing and hospital treatment would be the most effective way to treat patients who believe in traditional healing. Nurses generally appeared unaware of the dissonance between theories of causality underlying Western psychiatry and traditional healing. Being themselves comfortable to draw on available health resources, they showed no need to identify or reconcile incommensurabilities between healthcare models. Many felt that traditional healing could be added to the repertoire of methods used in the hospital.

However, some nurses were more cautious about the idea of traditional healers visiting hospitals as part of the team. One respondent said that healers should only visit hospitals to receive ‘health education and orientation’ and not to treat patients, as they ‘would confuse patients’. Several respondents who were against healers visiting hospitals thought they would ‘disturb’ and ‘confuse’ patients, ‘distort [their] thoughts’ and ‘create conflict’ in the hospital. Patients ‘wouldn’t know whom to trust.’ Another concern was that healers would ‘disturb the doctor’s duties.’ Cultural conflicts between the norms of traditional healers and psychiatry also came to light. One respondent said healers ‘cannot maintain secrets and can therefore not be trusted’, suggesting that they would not respect patient confidentiality.

Several respondents said that healers should only consult in the hospital if the ward doctor agreed. This relates to concerns that functioning of the multidisciplinary team is presently contingent upon vicissitudes of individuals rather than on a system. This suggests that while cultural tensions prevail within the psychiatric team, which is likely as long as authority is vested in white doctors, there is cause for pessimism about the possibility for close interaction between traditional healing and psychiatry.

Discourse about healers working in the hospital was strongly connected to notions of order and control. The presence of traditional healers in the hospital with their unorthodox (from a Western psychiatric perspective) ways was seen as potentially causing chaos. The possibility of visiting as opposed to working full-time as a team member was thought desirable, given that traditional healers’ work was seen to belong in a particular cultural context that cannot be translocated into the existent culture of a psychiatric hospital.

There was strong support (75%) for establishment of a ‘general referral system’ between the hospital and traditional healers. Several advantages
were cited by nurses with regard to setting up a referral system between psychiatric services and traditional healers: (i) traditional healers would be a first line of contact with the community and well placed to identify ‘seriously ill’ patients and refer them for treatment; (ii) co-operation ‘would minimize the false beliefs and expectations traditional healers give to their patients’; (iii) the system would operate as an early detection system for mental illness; (iv) a referral system would include patients’ cultural worldview in the healing process. This would not otherwise be addressed in the psychiatric milieu and particularly not by psychotropic drugs.

Nurses also noted several disadvantages of setting up a referral system between psychiatric services and traditional healers: (i) the hospital would be unable to identify ‘good’ from ‘bad’ traditional healers and would therefore be unable to make a confident referral; (ii) poor literacy and education of healers would make communication between the two health sectors problematic; (iii) a belief prevails that the decision to consult healers ‘should only come from the person or the person’s family’. It appears here that consulting a healer is seen as belonging to a context outside the Western medical worldview and thus referral is deemed inappropriate. One respondent explained that ‘patients should decide for themselves or their families should decide whether they should be referred to a traditional healer after discharge.’

A common concern was that healers might encourage patients to stop taking medication. In response to the question, ‘How many traditional healers tell patients to stop taking their medication?’, 83% of respondents indicated that ‘some’, ‘most’, or ‘all’ healers would do so. Hirst (1992) says that although Xhosa healers may be expert in traditional healing methods, they differ markedly in their knowledge of Western medicine and social welfare practices. Hence the concern that referral to healers will lead to patients stopping medication may be well informed. It was therefore again suggested that referrals be made only to ‘registered’ healers. This seemed related to the idea that ‘registered’ healers would be ‘educated’ and therefore consider the hospital’s treatment to be inviolable.

The conditions for which the majority of respondents indicated that they would refer patients to a traditional healer included: thwasa – the illness that calls one to become a traditional healer (88% agree with referral); problems arising from not performing traditional customs properly (84%); patients that present as diagnostic dilemmas or have ‘cultural’ problems (82%); amafufunyana, evil spirit possession (79%); and the effects of ukuthakatha, witchcraft (75%). Conditions for which the majority of respondents would not refer patients to a traditional healer included: schizophrenia (only 28%), family trouble (27%), alcoholism (21%), any kind of problem (20%), and drug abuse (12%).

The data suggest that respondents were generally in favour of patients
with ‘cultural’ problems being referred to traditional healers, but not patients with ‘psychiatric’ problems. This dynamic reflects a central dilemma in this field: is a ‘cultural’ problem different from a ‘psychiatric’ problem or are they different ways of describing the same phenomenon? In other words, if researchers are correct in saying that amafufunyana is a form of ‘hysterical psychosis’ or schizophrenia (Robertson & Kottler, 1993), and thwasa a kind of existential anxiety, epileptic psychosis or schizophrenia (Luckoff, Lu, & Turner, 1992; Robertson & Kottler, 1993), how does one distinguish ‘cultural’ and ‘psychiatric’ problems? The nurses in this study answer this question through a form of radical pluralism. When it is called schizophrenia it should be referred to a psychiatrist. When it is called amafufunyana it should be referred to a traditional healer. They rule out the possibility of psychiatry treating amafufunyana and traditional healers treating schizophrenia, which would be possible in a more integrated system.

The Regulation of Traditional Healers

Training of traditional healers is not subject to central regulation; the community determines who is appropriately trained. It is interesting then that nurses are in favour of externally imposed registration standards, at least in response to possible cooperation between traditional healers and psychiatric practitioners.

Most respondents (78%) believe that only ‘some’ or ‘very few’ traditional healers can be trusted in the sense of acting in their clients’ interests. This may at first seem incongruent with the predominantly positive attitudes toward healers discussed above. However, on further investigation it appears that the incongruence arises because respondents believe that many healers are not properly trained.

Fifty-six per cent of respondents said that at least ‘some’ healers had not completed initiation, 16% said ‘most’ had not, and only 21% said ‘very few’ had not. Several respondents indicated the difficulty of evaluating healers’ credentials, because there is no widely accepted certification process. Concerns included that there are healers who were never initiated or trained and practice ‘just for money’.

Other criteria nurses apply in finding problems with traditional practice relate to alcohol abuse, unresolved ‘mental illness’ among healers, and the eccentric conduct of many healers. These ‘problems’ seem to have meaning in terms of psychiatric mental health constructs or contexts, but may not carry the same weight at a community level.

Hopa et al. (1996) carried out a survey of health professionals’ attitudes toward traditional healers and found that the perceived ‘high rate of charlatanism’ among healers was a primary reason for negative attitudes toward
them (p. 18). They found that health professionals saw the need for a registering body of traditional healers. Consistent with this, 82% of respondents in the present study agreed with the statement ‘traditional healers should be registered with a government board that has strict rules.’ Green and Makhubu (1984) found in a survey of traditional healers in Swaziland that ‘healers themselves are favorably inclined toward registration’ (p. 1076). This finding is contentious, and one could argue that healers may be in favour of a registering body because it could allow them access to medical institutions, rather than because it has intrinsic value for the vocation. However, we are not in a position to comment on the motivations of traditional healers.

**Conclusion**

Describing the phases of acculturation, Berry and Kim (1988) explain that in the ‘contact’ phase of two cultures interacting, a fairly open process of interchange is possible. They point out that in principle the notion of ‘acculturation’ (becoming dis-identified from one’s primary cultural background) allows for cultural exchange in either direction, but in practice the balance of flow is usually from one dominant culture to the other ‘acculturating’ group, with pressure on the non-dominant group to conform to the dominant group. Berry and Kim (1988) explain that a ‘conflict’ phase follows the contact phase in the acculturation process. In this phase the non-dominant group experiences a build-up of tension and conflict about changing their way of life. When group relations eventually begin to stabilize, the process enters an ‘adaptation’ phase. The authors point out that the varieties of adaptation may or may not bring about an adequate solution to the conflict and crisis, or even a reduction in stress.

Looking at Xhosa nurses in terms of this schema, we might say that they have ‘adapted’ and bypassed possible conflict in a situation in which they have little power. Despite adopting a Western model of biomedicine, however, they have not rejected their own ‘traditional’ health practices. They subscribe to a pluralistic system and draw on both cultural worlds in an adjunctive way without a single core set of principles of mental health. In thinking about mental health services, they tend to give priority to the psychiatric model. When asked about the re-organization of health services towards a more culturally inclusive model, the psychiatric institutional model tends to be the centre around which they imagine various possible forms of association with traditional healing. As a result, concerns about regulation and standardization, and the need for an integrative, cohesive healthcare model emerge as key problems to be addressed. However, their radical pluralism – demonstrated by their personal use of ‘excluded’ traditional systems – suggests that traditional systems have value for them.
There is widespread interest in contemporary South Africa in exploring possible ‘cultural inclusion’ and ‘multiculturalism’ in the health field. However, there is need for caution, because as shown above, regulation and institutionalization of excluded resources apparently require changes subject to requirements of the already institutionalized and more centrally organized system of psychiatry.

Ironically, the idea of inclusion may jeopardize the protection afforded to cultural practices by being kept separate from the psychiatric model. In engineering and managing models of association between institutional and traditional healthcare paradigms, consideration should be given to finding that even when a particular model is formally excluded it can continue to have a strong presence. Indeed, traditional health practices that already exist parallel to mainstream practice may have an appeal, identity and coherence by virtue of their exclusion from the dominant psychiatric institutions.

Regulation cannot but change ‘traditional’ systems, which are accountable to – and determined by the beliefs and attitudes of – the public they serve. Considering these nurses’ perceptions, we wonder if even the loosest forms of association, based on patient referral, could be accommodated without requiring a change in the character of traditional healing through stricter regulation (the most likely outcome), or a shift away from the dominance of psychiatry. This seems to suggest that attempts at interaction will result in traditional healing being treated, and treating itself, as an ancillary to Western mental health care rather than as a parallel system. These arguments suggest a need for cautious and critical appraisal of the motives of programmes of inclusion, and recognition that inclusion, with its regulatory demands, may inadvertently undermine what it strives to accommodate.

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Marc S. Kahn, M.A. (Clin. Psych.), is a Clinical Psychologist, Psychotherapist, and Consultant in private practice in Cape Town, South Africa. He is particularly interested in medico-cultural dynamics, and is currently completing a Ph.D. in this area through the Department of Psychiatry at the University of Cape Town. Address: 129 Beach Road, Mouille Point, Cape Town, 8005, South Africa.

Kevin J. Kelly, Ph.D., is a Clinical Psychologist and a Senior Lecturer in the Psychology Department at Rhodes University, South Africa. He has a long-standing interest in psychology and public health, and works as an action researcher in the community health field in South Africa. Address: Psychology Department, Rhodes University, P.O. Box 94, Grahamstown, 6140, South Africa.