ELSEVIER

Social Science & Medicine 65 (2007) 1260–1273

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

How healers manage the pluralistic healing context: The perspective of indigenous, religious and allopathic healers in relation to psychosis in Uganda

Joanna Teuton[a,*], Christopher Dowrick[b], Richard P. Bentall[c]

[a]*Glasgow, Scotland*

[b]*School of Population, Community and Behavioural Sciences at the University of Liverpool, Liverpool, UK*

[c]*School of Psychological Sciences, University of Manchester, Manchester, UK*

Available online 22 May 2007

Abstract

This paper examines the relationships between service providers involved in caring for people with 'psychosis' in Uganda. Data from qualitative research investigating conceptualisations of 'madness' held by indigenous, religious and allopathic healers in urban Uganda are used to explore the attitudes of these different service providers towards each other. Case-vignettes of individuals with a diagnosis of a psychotic disorder were discussed by the healers and real cases were discussed by allopathic doctors, and their discourse was analysed. The healers varied in their attitudes towards other parts of the healing context. The indigenous and religious healers were tolerant of allopathic medicine, although the religious healers were inclined to explain its success in terms of a Christian or Islamic framework. In contrast, the allopathic healers made little reference to religious healers and were ambivalent towards indigenous healers. Finally, the relationship between the religious and indigenous healers emerged as one of conflict. The religious healers negated the beliefs and methods of the indigenous healers, whilst the indigenous healers regarded indigenous spirituality and evangelical Christianity as incompatible. Historical and social psychological perspectives are used to understand these differences. There appear to be opportunities for greater dialogue between indigenous and religious healers and allopathic doctors and this could contribute to a more integrative model of care for individuals with psychotic experiences in Uganda.

Keywords: Uganda; Indigenous healing; Religious healing; Medical pluralism; Psychosis

Introduction

In Uganda and other African countries, people who experience 'psychotic symptoms' access indigenous, religious and allopathic healthcare systems (Ensink & Robertson, 1999; Patel, 1993; World Health Organisation (WHO), 2001). Proponents of social and psychological approaches to 'psychotic' experiences suggest that non-medical explanations and treatments can provide meaning for patients and families and can have a positive impact on the nature and course of these experiences (Bracken & Thomas, 2001; Kirmayer & Corin, 1998; Romme & Escher, 2000). In Uganda, clients may benefit from aspects of all the various healing systems, but there

*Corresponding author.

E-mail addresses: joanna@teuton.wanadoo.co.uk, jltbangla@hotmail.com (J. Teuton), Cfd@liverpool.ac.uk (C. Dowrick), richard.p.bentall@manchester.ac.uk (R.P. Bentall).

0277-9536/$ - see front matter © 2007 Elsevier Ltd. All rights reserved.
doi:10.1016/j.socscimed.2007.03.055

is little liaison between them (World Health Organisation (WHO), 2001). If a more integrated approach is to be pursued, it is important to examine the attitudes of service providers towards each other. In this paper we report on the discourse of indigenous, religious and allopathic healers about other healing systems.

Healthcare systems

Health systems can be defined in terms of the 'social organisation of health and illness in… society' (Helman, 1994, p. 7). They are dynamic and reflect the social organisation and structure of societies as well as particular beliefs, practices and theories (Hacking, 1999; Horwitz, 2002).

In most African countries, healing systems for mental health problems are pluralistic and include indigenous, religious and allopathic theories and practices (Beckerleg, 1994; Ensink & Robertson, 1999; German, 1987; Mutambirwa, 1989; Obbo, 1996; Ovuga, Boardman, & Oluka, 1999). The informal sector, including both indigenous and religious healing systems, remains the largest sector (Ensink & Robertson, 1999; Patel, 1993; World Health Organisation (WHO), 1996, 2001). Which system sufferers access is partly influenced by the wide ranging and complex explanatory models they hold of these experiences (Ensink & Robertson, 1999; Lund & Swartz, 1998; MacLachlan, Nyirenda, & Nyando, 1995).

Indigenous healing systems

Indigenous spiritual healers use spiritual forces to determine the cause of ill health and misfortune (Ensink & Robertson, 1999; Teuton, Bentall, & Dowrick, 2007; van Duijl, Cardena, & de Jong, 2005). Within these systems, 'madness' is variously seen as a sign that the family has deviated from cultural norms, a form of harm instigated by a jealous third party, a form of social justice, or a physical problem (Edgerton, 1966; Good, 1987; Jacobsson & Merdasa, 1991; Orley, 1970; Patel, 1995; Teuton et al., 2007). The 'witchdoctor' or sorcerer, often differentiated from the indigenous healer, is construed as malevolent because of their ability to 'cause' illness (Hogle, 1990; Teuton et al., 2007).

Religious healing systems

In East Africa, the influence of Islam in the 19th and 20th century resulted in the emergence of Muslim healers who often combine Islamic and indigenous practices (Teuton et al., 2007; Whyte, 1991). The introduction of Christianity similarly led to a group of healers. Within these religious health systems 'diagnosis' is often undertaken under the guidance of spiritual forces and 'madness' is attributed to the influences of Satan or the *Jinnh*. Interventions include prayer, deliverance and counselling (Al-Issa, 2000; Ensink & Robertson, 1999; Jacobsson & Merdasa, 1991; Odejide, Oyewunmi, & Ohaeri, 1989; Sharp, 1994; Teuton et al., 2007). These approaches are increasingly popular in Africa and research suggests that religious leaders are often sought out for help with 'mental health problems' (Ensink & Robertson, 1999). Nonetheless, they have rarely been the subject of research.

Allopathic healing systems

Allopathic medicine is endorsed by and receives investment from governments and development partners. Mental health is not usually prioritised and receives little funding, and consequently psychiatric services have few resources and provide limited services (Ovuga et al., 1999; World Health Organisation (WHO), 2001). Treatment is commonly limited to psychotropic medication, custodial care, restraint and electro-convulsive therapy (MacLachlan et al., 1995; World Health Organisation (WHO), 2001). Access to services outside the major conurbations has been minimal. Recognition of the need to decentralise health care and the impact of psychiatric morbidity (Murray & Lopez, 1996), has led to mental health being incorporated into some primary care programmes (World Health Organisation (WHO), 2001).

Rationale

We have previously argued that aspects of indigenous and religious healing may be helpful to people with psychotic experiences and could be incorporated into a holistic service model (Teuton et al., 2007). Generally, however, these approaches fall outside the formal psychiatric systems, are not regulated, and do not have any formal links with psychiatric services. World Health Organisation (WHO) (2001) note the need to develop systems that allow greater integration and dialogue between all service providers delivering care for people with mental health problems. A first step in this process is to examine and attempt to understand the relationships between providers.

Both social and personal factors potentially play a role in this understanding. Ian Hacking (1995) suggests that ideas or theories about 'kinds' of people are formed within a matrix comprising material and social aspects of the world. This can be seen in the historical development of psychiatry in the UK over the last 100 years (Horwitz, 2002; Pilgrim, 1990; Scull, 1979). The historical and current socio-political context of healing and spirituality in Uganda must therefore be considered when attempting to understand the relationships between the healers. An alternative but not necessarily incompatible perspective considers the psychological motivations of the healers, both as individuals and as 'professionals' in explaining the findings.

The aims of the current study were twofold:

- to analyse the discourse of respondents from different parts of the healing system to establish how they view each other;
- to examine the explanatory power of socio-historical and social psychological perspectives in understanding these relationships.

It was felt that this would further our endeavour to develop more effective dialogues between services.

Methodology

Design

We draw on data from a two-phased qualitative study undertaken in and around Kampala, Uganda. Pragmatic considerations—in particular, providing a focus for the interviews and optimising respondent engagement in the interviews—resulted in different approaches being adopted in each phase.

In phase one, *religious* and *indigenous* Baganda (the people of Buganda, the central region of Uganda) healers were shown case vignettes depicting individuals with symptoms of schizophrenia and bipolar disorder, and interviewed about them using topic guides. This method provided the healers with a common point of reference and enabled the interviewers to conduct a more informal and less structured interview consistent with the cultural context. In the second phase, more structured in-depth interviews were undertaken with psychiatric staff from the national psychiatric hospital about a specified clinical case with a diagnosis of a psychotic disorder using the Explanatory Model Interview Category (EMIC) (Weiss, 1997) adapted to the Ugandan context.

Context

Uganda is in East Africa and has a population of approximately 26 million. There are roughly 30 different tribal groups; the Baganda, based in the central region, including Kampala, being the largest. The healing systems in Buganda include those based on western medicine, indigenous beliefs, Christianity and Islam. These sources of healing are potentially available to individuals experiencing psychotic disorders. At the time of the study the number of indigenous or religious healers treating people with psychotic disorders was not known. Psychiatric services were limited to the national psychiatric hospital and general hospital, both in Kampala. All six Ugandan psychiatrists worked in these services.

Phase one: indigenous and religious healers

Twenty respondents were drawn from two groups living within a 30-km radius of central Kampala: 10 Baganda *indigenous* healers using indigenous spiritual paradigms and practices and 10 *religious* healers whose practice was based on Christianity and Islam. The snowball technique was used to access as diverse a group as possible; however, only one female could be recruited. Only Baganda were included to minimise cultural variations between tribal groups and to reduce the need for interpreters. The healers were given the choice of conducting the interviews in Luganda (the vernacular) with English translation, or in English. Nine indigenous healers and one religious healer completed the interview in Luganda, the rest preferred to be interviewed in English.

Two case vignettes, based on real Ugandan cases and designed to reflect the western concepts of schizophrenia and bipolar depression, were developed by the first author with Ugandan and local expatriate psychiatrists. These were blindly reviewed by six psychiatrists in the UK and amendments made in light of these comments. A storyboard depicting the main aspects of the vignettes was created as a memory aid to assist in their presentation (Teuton et al., 2007). Each respondent was interviewed by the first author (a British clinical psychologist) covering identification and classification of the experiences described in the

vignettes; conceptualisations of these experiences; interventions and expected change; and the role of western medicine. Interviews were not confined to the vignettes, and respondents were encouraged to draw on their own experiences. The interviews were audio-taped and transcribed. Where Luganda was used, a research assistant acted as an interpreter; the English translations were transcribed and the Luganda dialogue was blindly back-translated and compared to the original English. Interviews lasted between 1 and 3 hours, over one or two meetings.

Phase two: psychiatric staff

The pool of psychiatric staff working at the national psychiatric hospital included five psychiatrists and nine qualified and one trainee Psychiatric Clinical Officers (PCO—Psychiatric nurses with additional training to diagnose and prescribe medication). Six team members were available to take part in the study: two psychiatrists and four PCOs. Other members of staff had either been involved in the development of the study or were not resident in the hospital at the time of the study.

The EMIC (Weiss, 1997) is a semi-structured interview format which covers the same areas as the topic guide used to interview the *indigenous* and *religious* healers. It was adapted for the research on the basis of the first author's experience of the clinical context in Uganda, information derived from interviews with the healers and the existing literature on conceptualisations of mental illness in Africa. The interview comprised open-ended questions concerning patterns of distress; perceived causes and explanations of illness; help-seeking behaviour; treatment; general illness beliefs; and disease-specific beliefs. Probe questions were used to elicit aspects that had not been previously mentioned and to allow elaboration of areas of particular interest. The guidelines provided by Weiss (1997) were followed.

For each interview, the first author and the respondent identified a client with a diagnosis of a psychotic disorder who was known to and currently being treated by the respondent. The participant was then asked to review the relevant case notes to re-familiarise themselves with the case. They were then interviewed by the first author about this client. When the participant found it difficult to discuss a particular issue, they were asked to draw on their experience of similar cases. A brief profile of all the respondents is given in Table 1.

Analysis

The process of coding and analysing qualitative data is inevitably influenced by the social and research context and the a priori assumptions and values of the researchers. In order to counter the tendency to impose western concepts and values, the authors developed a coding system based on the data from the indigenous and religious healers and used this to examine the data derived from the allopaths.

A sample of transcripts from the indigenous and religious healers was coded line by line by the first author and memos were written to capture central ideas. These codes were agreed on by the research team and used to code the remaining transcripts. Extracts of transcripts were independently coded by the authors using the coding index. Disagreements were resolved by consensus and amendments made to the coding system.

Selective coding was then initiated to develop a formative theory of how the healers managed the pluralistic healing context. Discourse about the respondents' own healing practices and those of other service providers was identified and re-analysed, and additional codes concerning the pluralistic context were developed. Following discussion by the team, these were incorporated into the coding index. Extracts of transcripts were then independently coded by the authors using the revised coding index.

The coded data was placed into eight categories describing the strategies the healers used to discuss other parts of the healing systems. These strategies contributed to four higher-order *processes*; two reflected tolerance of other healing systems and two reflected conflict with other healing systems (see Figs. 1 and 2).

Data from the interviews with the members of the psychiatric team were analysed in relation to the model that had been developed for healers in order to compare the strategies the staff used to manage the pluralistic healing context.

Results

Respondents who were tolerant of another healing system defined their and other service providers' areas of expertise and thus differentiated themselves from the other types of healers (*Define area of Expertise*), and/or accommodated aspects of different healing systems into their discourse on

Table 1
Profile of indigenous healers (IH), religious healers (RH) and psychiatric staff (PS)

Code	Age	Background	Healing	Illness/misfortune
IH01	64	Hajji in a peri-urban area	Buganda and Islamic spiritual medicine	Health problems and bring fortune
IH03	70	Elder in an urban community	Buganda spiritual healing	General
IH04	45	Muslim who has established an in and out-patient service in high-density urban area	Buganda spiritual and herbal approaches	Mental health
IH05	41	Specialist, peri-urban community	Buganda spiritual healing	*Eddalu* (madness) caused by witchcraft
IH06	57	Specialist	Buganda spiritual healing	*Eddalu* and *nsimbu* (epilepsy)
IH07	50	Healer in a peri-urban area	Buganda spiritual healing	General
IH08	34	Female healer	Buganda spiritual healing	General
IH10	70	Healer in a peri-urban area	Buganda spiritual healing	General
IH11	47	Specialist	Herbal medicine and Buganda spiritual healing	Witchcraft
IH14	56	Muslim living in a urban community	Islamic and Buganda healing	Witchcraft
RH03	67	Catholic brother running a clinic in an urban area	Herbal medicine	General
RH04	45	Evangelical Christian	Deliverance and the power of God	General
RH05	38	Imam in a peri-urban area	Koran	General
RH06	45	Pentecostal Christian minister in a peri-urban area	Deliverance and the word of God	General
RH07	56	Catholic priest in urban area	Herbal medicines and spiritual healing	
RH08	60	Imam	Koran	Mental health
RH09	44	Catholic Charismatic priest in a peri-urban area	Deliverance, laying on of hands and counseling	Mental health
RH10	29	Born again pastor in large urban church	Spiritual healing and counselling	Health and psychosocial problems
RH11	31	Catholic Charismatic revival priest in urban church	Faith healing	General
RH12	32	Pentecostal minister in urban church	Counselling and spiritual healing	Youths with health and social problems
PS01	39	Male psychiatrist—practising for 8 years		
PS04	39	Female second year trainee Psychiatric Clinical Officer (PCO)		
PS08	44	Male psychiatric clinical officer—8 years experience		
PS09	40	Female psychiatric clinical officer—4 years experience		
PS18	40	Female psychiatric clinical officer—5 years experience		
PS23	38	Female psychiatrist-practising for 10 years		

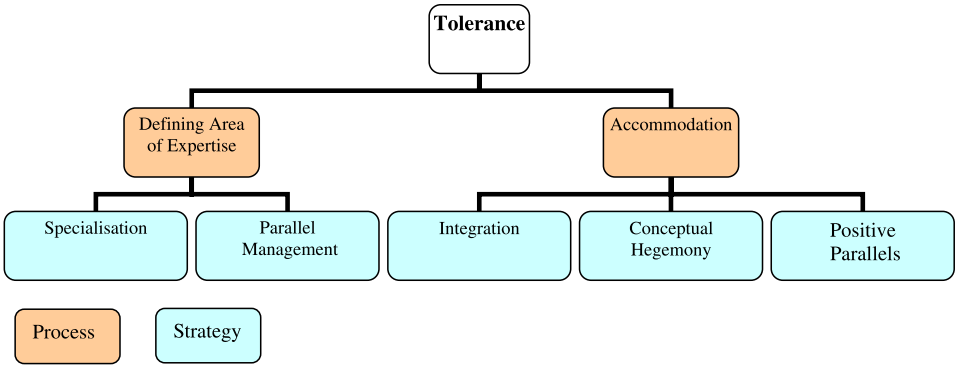

Fig. 1. The processes and strategies indicating tolerance towards different healing groups and practices.

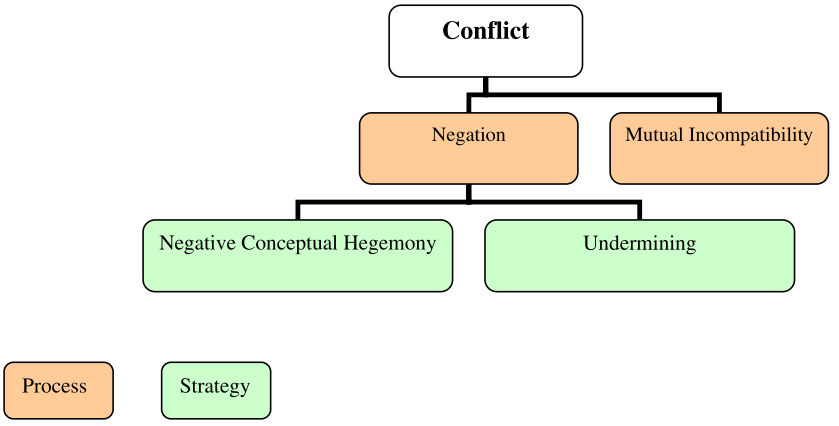

Fig. 2. The processes and strategies indicating conflict towards different healing groups and practices.

'madness' (*Accommodation*). In contrast, healers who did not tolerate alternative systems made statements in which they negated other healers' beliefs and practices (*Negation*), or indicated that they regarded an allegiance to an alternative worldview as damaging to the client's well-being (*Mutual Incompatibility*). These four processes and the eight strategies contributing to them are described with illustrative extracts in Table 2. The extent to which different processes and strategies are used by the healers varies in relation to different healing groups is described in Table 3.

The relationship between indigenous healers and allopathic healers

The dialogue of the indigenous and religious healers suggests that they are tolerant of allopathic medicine. The majority of the indigenous healers defined their area of expertise and that of allopathic doctors using the strategy of specialisation. Specialisation is operationalised by the indigenous healers in terms of the perceived expertise and skills deficits of allopathic doctors, and an acceptance of the limitations of indigenous healers. Indigenous healers commonly perceived allopathic doctors as having expertise to identify and treat 'madness' caused by non-spiritual factors such as AIDS, fever/malaria, syphilis, and problems with the head or brain, nerves and blood vessels (Extract 9). They acknowledged that indigenous healers lacked the knowledge and skills to treat these illnesses, but also indicated that allopathic healers lacked knowledge of spiritual forces and were unable to treat problems that the indigenous healers believed were spiritual in nature.

Extract 9

> In case ….. it's neither of the two causes (witchcraft or culture), I could then refer him to the government hospital where further diagnosis could be done and they may discover that this individual's brain is being affected by …..fever of the brain (IH05).

Table 2
The processes and strategies used by respondents to discuss alternative healing systems including definitions and quotations from the transcripts illustrating the strategies

Process	Tolerance		
	Strategy	Explanation of strategy	Example of strategy
Defining area of expertise	Specialisation	Discourse indicating that different healing practices are appropriate for different problems	*Extract 1*: "Like I told you about the other two girls that ran mad, they decided to take them to hospital, they spent there six months and they came back and we simply constructed the shrine and as it was constructed, they recovered. You see that car, it has got many nuts, there are a number of spanners, there's 14, and there could be a nut that could be driven by a spanner of 7. And although the spanner of 14 is big, it can't open this nut of 7. Therefore everything has its own 'solution'. First take her to where you think that they are very wise and when they've failed, you come to realise 'Ah it need 7, 14 has not been appropriate" (IH 07)
	Parallel management	Discourse indicating that different healing practices can simultaneously contribute to helping the problem	*Extract 2*: "Sometimes, yes, sometimes, some of them keep one leg with the traditional healer and another with the treatment facilities. So the two may be ongoing" (ST01)
Accommodation	Integration	Discourse in which concepts and healing practices associated with an alternative healing system are integrated into their own practices	*Extract 3*: "I will say "In the name of Jesus Christ, I rebuke any physical sickness which may be in this person…….. I stand against them in the name of Jesus Christ, I command them to leave, I proclaim healing to this person in the name of Jesus" and then I would pray a prayer against any mental sickness, so I would pray against schizophrenia, I would pray against paranoia, I would pray against neurosis of various kinds and just say a prayer rebuking them and commanding them to go" (RH09)
	Conceptual Hegemony	Explanatory models and healing practices based on different worldviews are attributed to mechanisms congruent with the respondent's own worldview	*Extract 4*: "Yes there is no *musawo* (healer) in the world that heals. Except that they give out medicine because you may find that this one has taken poison and recovers and the other one uses a lot of medicine—let's say he has been told to swallow one tablet and instead takes two and he dies. Therefore you'd expect the person that has taken two tablets would recover soon/easily but has instead just died. Yet the one that took poison has recovered, therefore curing is in the hands of God. There is no musawo that cures" (RH08)
	Positive parallels	The healers discuss their beliefs and practices using analogies with other healing practices drawn from different healing paradigms	*Extract 5*: "They (IH) don't ask them (spirits), as a machine is not asked. You can't ask a machine, if you put a blood sample in it, it indicates to you what is right" (TH07)
Process	Conflict		
	Strategy	Explanation of strategy	Example of strategy
Negating other healing systems	Negative conceptual hegemony	A form of conceptual hegemony in which concepts from one worldview are conceptualised	*Extract 6*: "And when they talk to the witchdoctors, the witchdoctor says, maybe your problem could be answered by being cut and then you'll be blessed, they will chase away everything but actually the cuts

Table 2 (*continued*)

Process	Conflict		
	Strategy	Explanation of strategy	Example of strategy
		negatively within another worldview	on the body, is an opening for diabolical attack (the devil) to that person'' (RH11)
	Undermining	Discourse which acts to discredit the powers, ability and motives of healers and their healing practices or portray them as abusive	*Extract 7*: ''Because he's a witchdoctor, ….so either through cuts or through sexual intercourse, or through making people either swallow tablets or human flesh are disguised'' (RH11 SZ)
Mutual incompatibility	Mutual incompatibility	Discourse in which the healer recognise that two spiritual worldviews co-exist, but indicates that allegiance to one will have a negative impact on the other	*Extract 8*: ''Or alternatively it could be due to someone like the Balokole (born again Christians) usually do …… they tend to burn cultural items……and then the spirits…… disturbed him because they want to be re-installed'' (TH01)

Half of the indigenous healers referred to parallel management, suggesting that a client could be treated by both indigenous and allopathic medicine. For example, one healer suggested that allopathic medicine can be used for symptom management whilst indigenous healing deals with the underlying spiritual causes.

The process of accommodation was also evident in the indigenous healers discourse. They used allopathic terms and practices, particularly those associated with infectious disease such as HIV/AIDs and malaria, in their discussions of madness. One also used psychological and psychiatric concepts and had established a 'Cultural Mental Health Clinic' in the city, using a standardised assessment procedure and pre-printed treatment protocols. Six of the healers also used positive parallels: for example, referring to the shrine as a 'clinic' and a consultation with the spirit world as an 'X-ray', a means of finding out something which is not visible by humans alone (Extract 10).

Extract 10

> [T]he X-ray gives me what to do…. that this is *lubale* [an astral spirit], this is fever, its witchcraft, its jealousy (IH10).

The relationship between religious healers and allopathic healers

The religious healers used specialisation when discussing their role in relation to allopathic medicine. They referred primarily to the expertise of the doctors, but held a broader concept of medical causes of 'madness', which included mental as well as physical health conditions (Extract 11).

Extract 11

> If I kind of thought there was a mental sickness there, I'd advise them to go to the psychiatric hospital, or to consult a doctor to have that diagnosed (RH09).

Only two, both Christians, evoked the concept of parallel management. One employed an ex-psychiatric nurse in his 'clinic' and combined allopathic and faith healing, the other advocated more holistic approaches to mental health problems incorporating both allopathic and spiritual components.

More of the religious healers used the process of accommodation and drew on a range of terminology and concepts from both physical and psychological medicine. For example, they used concepts of depression and stress as well as physiological processes in their spiritual explanations of the individual's condition (Extract 12).

Extract 12

> [T]hey (the demons) come and mount over someone, break the wires of that person, and that person can become insane (RH06).

They also discussed allopathic diagnostic and treatment methods as part of their practice to a greater extent than the indigenous healers, for example, asking clients about their medical history and blood test results. In addition they frequently referred to using counselling, an approach rooted in western psychological models of distress.

Seven of the religious healers used the strategy of conceptual hegemony in their discussions of bio-medicine, attributing the curative powers of

Table 3
Number of respondents in each healing group using the different strategies in their discussions about others service providers in the healing system (IH = indigenous healers; RH = religious healers; AM = allopathic medical practitioners)

Process	Tolerance					Conflict		
	Defining expertise		Accommodation			Negation		Mutual incompatibility
Strategy	Specialisation	Parallel management	Integration	Conceptual hegemony	Positive parallels	Undermining	Re-conceptualisation	Mutual Incompatibility
IH–RH	0	0	4	0	5	0	0	4
IH–AM	9	5	6	1	6	0	0	0
RH–IH	0	0	0	0	0	9	9	3
RH–AM	6	2	5	7	0	0	0	3
AM–RH & AM–IH	5	5	1	6	0	4	1	4

Religious healer ($N = 10$), indigenous healers ($N = 10$), allopathic medical practitioners ($N = 6$).

medication to God or other processes. The discourse of a Christian pastor, is typical of the way in which this was discussed during the interviews (Extract 4, Table 2).

The relationship between the allopathic healers and indigenous and religious healers

The predominant explanatory model of 'madness' provided by psychiatric staff is a stress-diathesis model consistent with standard western biosocial models of 'psychosis'. This is expressed in terms of a genetic predisposition to the disorder triggered by biological, psychological or social stressors. Throughout the interviews the respondents indicated that they had an understanding of their client's explanatory models of their experiences. This understanding included aspects of the indigenous and Christian spiritual worlds and reflected concepts of witchcraft, ancestral spirits, Satan and God. No reference was made to Islam.

The psychiatric staff's discourse about indigenous and religious healing was characterised by both tolerance and conflict. Many used the strategy of specialisation; however, they made a within-worldview distinction indicating that treatment for individuals with psychotic disorders is predominantly within the remit of the psychiatric staff, whilst those experiencing 'neurotic' disorders can be helped by spiritual healers (Extract 13).

Extract 13

> [I]f you get an illness like either hysteria or these neurotic illnesses… in the process of praying, they might be doing psychotherapy without knowing they are doing psychotherapy and the patient gets cured. But not with bipolar, because bipolar is a major psychotic illness which cannot go with that (ST08).

They also referred to parallel management, indicating that clients may see indigenous and/or religious healers whilst also engaging with the psychiatric services, suggesting, for example, that engaging in rituals or using herbal medicines might be helpful to the client.

These attitudes were not based on an acceptance of the alternative worldviews underlying these practices. Indeed, allopathic healers used the strategy of conceptual hegemony to conceptualise alternative healing systems in terms of the bio-psycho-social model. Whilst most of them agreed

that it was important to take account of alternative explanatory models, they consistently viewed these as psychological constructs that could be addressed by indigenous and religious healers. For example, psychosis needed to be treated primarily within the western medical healing system; however the psychological aspects of these disorders could be addressed by indigenous and religious healers. Furthermore, parallel management was seen as a means of engaging the client in medical treatment (Extract 14).

Extract 14

> So in our teaching, we actually encourage clients to see indigenous healers … because we want the family to establish a good relationship with us. We tell them ''you are doing your rituals, remember take the treatment'' (ST09).

The discourse of the psychiatric staff about spiritual healing systems was also characterised by conflict; undermining and mutual incompatibility commonly emerging. They portrayed indigenous healers as disingenuous, lacking the skills and abilities they purported to have and motivated by financial gain. For example, one member of staff suggested that indigenous healers secretly administer chlorpromazine to clients, whilst another suggested that successes claimed by indigenous healers are due to natural remission (Extract 15).

Extract 15

> Now for bipolar affective disorder…. the course is very clear ….. it is episodic, treated or untreated it will still resolve, except it will prolong the period. And so when they got him this man, he (indigenous healer) will keep them for some two or three weeks or a month and then the illness will clear by itself, actually he said he had treated it very well, yet we know it was the duration of the illness, you know (ST 09).

Some respondents stated that the indigenous healers physically abused and restrained their clients, whilst others suggested that psychiatric conditions could be made worse as a result of the healer's intervention.

In addition, the staff sometimes indicated that indigenous and spiritual worldviews are incompatible with the 'medical' model because they prevent clients engaging in allopathic treatment. Two referred to the importance of changing the beliefs of clients, their families and the wider community.

Relationship between the indigenous and the religious healers

The relationships between the indigenous and religious healers were characterised by conflict. The religious healers negated indigenous healing practices by using negative conceptual hegemony and undermined the skills and motives of the indigenous healers. Most conceptualised the indigenous spirit world in terms of the Christian dichotomy of evil (manifested through the Devil or demons) and good (manifested through God and Jesus). In doing so they reconstructed ancestral spirits as malevolent: for example, using the terms 'demonic' and *mizimu* (an indigenous spirit) interchangeably and dismissing the client's explanation of auditory hallucinations as ancestral spirits and attributing them instead to demons (Extract 16).

Extract 16

> But what's happening is an evil spirit mimics or imitates the spirit of the dead person. So you get a visitation and hear your grandmother talking to you or you feel someone touching you and it's the hand of your dead father or whatever, but in fact it's just an evil, a demon imitating or mimicking your ancestor… (RH09).

In addition the religious healers frequently referred to the practices of the indigenous healers as 'witchcraft'. It appears unlikely that they were using this term in the same way as the indigenous healers, instead using it to describe indigenous practices negatively. In addition they explained the indigenous beliefs and practices as psychological mechanisms used to evoke negative emotions (Extract 17).

Extract 17

> Most of this witchcraft stuff exploits fear in people, people are afraid of spiritual influences …. they've been to witchdoctors, they've been given things to eat, to drink, to put under their pillow, to put in the roof, or whatever, and the fear of what will happen if they don't obey what the witchdoctor tells them to do, and so people get trapped into this fear and it can really be a terrible problem, where people just can't think

straight anymore, they see demons around every corner, everything is attributed to cures and demons and people go crazy (RH09).

The religious healers also portrayed the indigenous healers as exploitative. For example, one referred to the 'witchdoctor' as creating fear in order to extract money from members of the community (Extract 18) whereas others suggested that indigenous healers commit rape or give clients disguised human flesh to eat in the name of treatment.

Extract 18

> They bring a lot of fear in our people. You will die, something will happen, so and so died, and now if you don't behave, not only do they take money, but they, many a time, even do things which they themselves as witchdoctors, do not know the consequences (RH11).

Three of the religious healers also used the strategy of mutual incompatibility to account for the development of 'madness', suggesting that it can result from the individual's struggle between their indigenous spirituality and Christianity.

By contrast, the indigenous healers spoke very little about other spiritual models of 'madness'. Those who did, referred to Christians, in particular born again Christians (*balokole*). This discourse was characterised by the strategy of mutual incompatibility, whereby an allegiance to a Christian spirit world had an impact on the indigenous spiritual world (Extract 19).

Extract 19

> For instance…… a family member decides to become born again (*balokole*) and you get your ancestral items and you carry them from the shrine and put them there and put them on fire. That if you got rid of them, it will make the ancestral spirits to come with vigour afterwards…….and they disturb him, they make him suffer from madness (IH05).

Accommodation was also evident in the indigenous healers' discourse about Christianity and Islam. Several indigenous healers equated the indigenous spirits with the *jinnh*, one adapted his practice to accommodate clients who were *balokole*, whilst two drew upon both Arabic and *kiganda* systems of healing. They also used stories from the Bible and the Koran to explain how spirits cause 'madness'. For example two of the indigenous healers referred to the story of the Madman of Kadara (Mark, Chapter 5) to explain how people become mad.

Discussion

Healers vary in their attitudes towards other parts of the healing context. The indigenous and religious healers were tolerant of allopathic medicine, although the religious healers were inclined to explain success in terms of a Christian or Islamic framework. In contrast, the allopathic healers made little reference to religious healers and were ambivalent towards the indigenous healers. The relationship between the religious and indigenous healers was one of conflict. The religious healers consistently negated the beliefs and methods of the indigenous healers, whilst the indigenous healers regarded indigenous spirituality and evangelical Christianity as incompatible.

The question arises: why do the indigenous, religious and allopathic healers develop different strategies in relation to the pluralistic healing context? To try to understand these differences the data are considered both through the socio-historical context of healing and spirituality in Uganda, and a social psychological framework, where the strategies adopted by the healers are understood in terms of them maintaining their power and self-esteem within the context of competing paradigms of healing.

A socio-historical perspective

Allopathic medicine is the universal paradigm for health and is equated with science and legitimacy. Its success in preventing and curing infectious diseases is hard to ignore and it is understandable that the indigenous and religious healers have sought to incorporate this model within their frame of reference. Mental health, however, has received little attention, and allopathic models of mental health are not commonly understood within the local community. Sufferers are more likely to consult indigenous or spiritual healers (Ensink & Robertson, 1999). Allopathic treatments for mental health problems in Uganda are limited to long-term prophylactic medication. This type of treatment is often not maintained by patients (Liberman et al., 2005), when it is, symptoms are likely to recur (British Psychological Society Division of Clinical Psychology, 2000).

The data from this research suggest that indigenous and allopathic healers have adapted to this context. In order for indigenous healers to retain the legitimacy of their healing system they appear to have relinquished aspects of 'physical health' that they perceive as appropriately belonging to allopathic medicine. In contrast, the limited influence and apparent ineffectiveness of allopathic medicine in mental health provide a rationale for spiritual explanations and interventions for 'madness'. Thus the indigenous healers are able to retain the treatment of madness as a significant part of their healing repertoire.

The mental health professionals, however, have the rhetorical power of science to maintain their allopathic model of madness even in the midst of unsuccessful treatment and patients preferring to see spiritual and religious healers. In order to make sense of the role of the indigenous and religious healers, they alternate between conceptualising the indigenous and spiritual healers within an allopathic framework and rejecting them as abusive or charlatans.

The history of formalised religion in Uganda may play a role in the current relationships in the healing system. The introduction of Islam and Christianity during the 18th century saw the beginnings of the demise of indigenous spirituality and medicine. Indigenous beliefs and practices, including managing misfortune, were viewed as 'primitive' and associated with ignorance. As a result these beliefs were held secretly, and many Ugandans learned to accommodate their own spirituality with Christianity or Islam. Since the 1980s there has been a massive growth of fundamentalist Christianity and independent churches in Africa which are more akin to the indigenous spiritual experience than more established religions (Haynes, 1996).

Today many of the population identify themselves as Protestant, Catholic or Muslim, whilst also holding indigenous beliefs and practicing indigenous rituals in response to misfortune. However, overtly indigenous beliefs and practices have been relegated to the level of ''culture'' and are viewed primarily as symbolic, having little power to challenge the religious establishment. As a result indigenous healers have been forced to adopt the position of mutual incompatibility in relation to religious healers, especially the fundamentalist Christians who see healing as a key part of their ministry. In contrast, religious healers, many of whom were drawn from the fundamental churches, continue to assert their claim of superiority and hostility to indigenous spirituality.

A social psychological perspective

Since the 1950s social psychologists have suggested that people continuously seek to maintain a positive self-concept. Self-Evaluation Maintenance (SEM) theory predicts that when someone is outperformed on a task that is relevant to their self-definition, their self-evaluation can be threatened or bolstered (Tesser & Martin, 1996). In response the person may distance themselves from the person who outperforms them, change the relevance of the task to their self-definition or change their performance relative to the other person. Baumeister (1994) suggests that the need to maintain a positive self-evaluation in comparison to others is universal 'even across cultural boundaries' (p. 72). Others, however, have challenged this view, suggesting that culture plays an integral role in this process (Heine, Lehman, Markus, & Kitayama, 1999). Whilst it is acknowledged that the SEM theory must therefore be applied with caution, it provides some useful insights into the complex relationships between the healers.

The apparent efficacy of allopathic medicine may constitute a threat to the self-definition of the indigenous and religious healers. The strategies of specialisation and parallel management may represent attempts to change the relevance of the healing task to their self-definition. By relinquishing the task of curing physical health problems and retaining responsibility for 'madness', they maintain a positive self-evaluation. Similarly, by attributing the efficacy of bio-medicine to a higher spiritual power, the religious healers minimise the performance of the allopathic healers and re-attribute efficacy to God and, by inference, themselves.

A similar strategy emerges amongst the allopathic healers. Psychiatry in Uganda retains the status of bio-medicine despite the lack of investment in services, the absence of data concerning efficacy and the high number of people consulting indigenous healers (Ensink & Robertson, 1999). By redefining the task of the indigenous healers within an allopathic framework the staff maintain the validity of their own framework. They achieve this by drawing on the distinction between 'neuroses', which they define as psychological and therefore treatable by indigenous healers, and 'psychoses', which are biologically determined and therefore

treatable only by allopathic medicine. This approach, however, perpetuates the Eurocentric view of psychopathology and denies the validity of the indigenous worldview.

By reconstructing indigenous explanations within a Christian or Islamic framework, the religious healers are similarly attempting to preserve their self-definition as professional healers while reducing the performance of the indigenous healers relative to themselves. In this way, the religious healers maintain a positive self-evaluation in the face of any positive outcomes achieved by the indigenous healers.

Constraints of the research

By using a qualitative, non-directive approach to exploring attitudes with and relationships between healing groups the authors felt that the healers would be more willing to engage with the research process and share their views. Such an approach, however, has limitations as well as benefits. In qualitative research the social context and the research process have an impact on the resultant data and analysis. Reflexivity, the ability of the researcher to recognise the ways in which their presence and a priori assumptions influence data collection and analysis, was a central part of the research process. The research team used strategies such as reflexive diaries, peer discussion with Ugandans and expatriates, and memo-writing to monitor, reappraise and make explicit factors influencing the interpretation of the data. For example, spontaneous discussion, particularly with Europeans, about indigenous beliefs is often difficult (Weiss, 1997) and can be viewed as indicative of ignorance. It is possible that the healers protected themselves from being labelled 'ignorant' by adopting spiritual, rather than indigenous theories and privileging those based on western medicine. The indigenous and Muslim healers may also have assumed the interviewer would not understand their worldview, and provided 'accounts' which they felt she would understand. Further research in which Baganda are the primary interviewers could examine these hypotheses. In addition the team developed a coding system from the data from indigenous/religious healers in order to counter the tendency to impose a Eurocentric model of psychiatric disorders and care. A possible consequence of adopting this approach was that themes intrinsic to the allopathic group were less likely to emerge. Future research might adopt a mirror-image approach, using a coding system based on data from allopaths to see what differences emerge. The in-directive approach adopted in this study allowed the relationships between the healers to emerge; however more concrete concepts may have emerged if a more directive approach had been used.

Finally the qualitative nature of this research limited the number of respondents who could be accessed. A consequence of this is that only a small number of Muslim healers were recruited for the study, and as a result there were insufficient data to explore the attitudes and relationships of Islamic healers as distinct from other religious healers. Future research might focus specifically on religious healers with a view to exploring and comparing the roles and attitudes of healers from different religions.

Policy implications

There appear to be opportunities for dialogue between the indigenous healers and allopathic doctors. Both these groups see a role for each other in the treatment of psychosis and have developed a relationship of tolerance. The relationship between the religious healers and the psychiatric staff is less clear-cut. Whilst the religious healers appear to have carved out a role for themselves and allopathic medicine in a similar way to the indigenous healers, their persistent use of conceptual hegemony suggests that they are less willing to accept the paradigm of western medicine. Whether this presents a problem to developing a dialogue is unclear.

Conclusions

Ugandans continue to access indigenous and religious treatment for experiences, which, within a western psychiatric system, would be characterised as psychotic. There is therefore a need for allopathic services to develop strategies that enable a more interactive dialogue with these other service providers. A first step is to gain an understanding of the relationship between the different service providers. The results of this research go some way to providing this understanding amongst the Baganda. Further research examining the relationships between different healing groups within different tribal groups and in other African countries would be useful if these findings are to be extrapolated.

References

Al-Issa, I. (2000). *Al-Junūn: Mental illness in the Islamic world*. Madison, CT: International Universities Press.

Baumeister, R. (1994). Self and identity: A social psychology perspective. In A. Tesser (Ed.), *Advanced social psychology* (pp. 51–98). Boston: McGraw-Hill.

Beckerleg, S. (1994). Medical pluralism and Islam in Swahili communities in Kenya. *Medical Anthropology Quarterly*, *8*(3), 299–313.

Bracken, P., & Thomas, P. (2001). Postpsychiatry: A new direction for mental health. *British Medical Journal*, *322*, 724–730.

British Psychological Society Division of Clinical Psychology. (2000). *Recent advances in understanding mental illness and psychotic experiences*. Leicester: British Psychological Society, Division of Clinical Psychology.

Edgerton, R. B. (1966). Conceptions of psychosis in four East African societies. *American Anthropologist*, *68*, 408–425.

Ensink, K., & Robertson, B. (1999). Patient and family experiences of psychiatric services and African indigenous healers. *Transcultural Psychiatry*, *36*(1), 23–43.

German, A. (1987). Mental health in Africa I. *British Journal of Psychiatry*, *151*, 435–439.

Good, C. M. (1987). *Ethnomedical systems in Africa: Patters of traditional medicine in rural and urban Kenya*. London: Guildford Press.

Hacking, I. (1995). *Re-writing the soul*. Princeton, NJ, USA: Princeton University Press.

Hacking, I. (1999). *The social construction of what?*. Cambridge, MA: Harvard University Press.

Haynes, J. (1996). *Religion and politics in Africa*. London: Zed Books.

Heine, S. J., Lehman, D. R., Markus, H. R., & Kitayama, S. (1999). Is there a universal need for positive self-regard. *Psychological Review*, *106*(4), 766–794.

Helman, C. G. (1994). *Culture, health and illness* (3rd ed). Oxford: Butterworth-Heinemann.

Hogle, H. (1990). *Summary of readings on traditional healers (THS) in Uganda*. Unpublished manuscript.

Horwitz, A. V. (2002). *Creating mental illness*. Chicago: University of Chicago.

Jacobsson, L., & Merdasa, F. (1991). Traditional perceptions and treatment of mental disorders in western Ethiopia before the 1974 revolution. *Acta Psychiatric Scandinavica*, *84*(5), 475–481.

Kirmayer, L. J., & Corin, E. (1998). Inside knowledge: Cultural constructions of insight in psychosis. In X. F. Amador, & A. S. David (Eds.), *Insight and psychosis* (pp. 193–220). London: Oxford University Press.

Liberman, J. A., Stroup, T. S., McEvoy, J. P., Swartz, M., Rosenheck, R. A., Perkins, D. O., et al. (2005). Effectiveness of antipsychotic drugs in patients with chronic schizophrenia. *New England Journal of Medicine*, *353*, 1209–1223.

Lund, C., & Swartz, L. (1998). Xhosa-speaking schizophrenic patients' experience of their condition: Psychosis and *amafufunyana*. *South African Journal of Psychology*, *28*(10), 62–70.

MacLachlan, M., Nyirenda, T., & Nyando, C. (1995). Attributions for admission to Zomba mental hospital: Implications for the development of mental health services in Malawi. *International Journal of Social Psychiatry*, *41*(2), 79–87.

Murray, C. J. L., & Lopez, A. D. (1996). *The global burden of disease*. Geneva: World Health Organization.

Mutambirwa, J. (1989). Health problems in rural communities. Zimbabwe. *Social Science & Medicine*, *29*(8), 927–932.

Obbo, C. (1996). Cultural fundamentalism and syncreticism in Buganda. *Africa*, *66*(2), 181–201.

Odejide, A. O., Oyewunmi, L. K., & Ohaeri, J. U. (1989). Psychiatry in Africa: An overview. *American Journal of Psychiatry*, *146*(6), 708–716.

Orley, J. H. (1970). *Culture and mental illness: A study from Uganda*. Nairobi: East African Publishing House.

Ovuga, E., Boardman, J., & Oluka, E. G. A. (1999). Traditional healers and metal illness in Uganda. *Psychiatric Bulletin*, *23*, 276–279.

Patel, V. (1993). Traditional medicine has much to offer [letter]. *British Medical Journal*, *307*, 387.

Patel, V. (1995). Explanatory models of mental illness in Sub-Saharan Africa. *Social Science & Medicine*, *40*(9), 1291–1298.

Romme, M., & Escher, S. (2000). *Making sense of voices*. London: Mind Publications.

Scull, A. T. (1979). *Museums of madness*. London: Allen Lane.

Sharp, L. A. (1994). Exorcists, psychiatrist, and the problems of possession in northwest Madagascar. *Social Science & Medicine*, *38*(4), 525–542.

Tesser, A., & Martin, L. (1996). The psychology of evaluation. In E. T. Higgins, & A. W. Kruglanski (Eds.), *Social psychology: Handbook of basic principles*. New York: The Guildford Press.

Teuton, J., Bentall, R., & Dowrick, C. (2007). Conceptualising psychosis in Uganda: The perspective of indigenous and religious healers. *Transcultural Psychiatry*, *44*(1), 79–114.

Van Duijl, M., Cardena, E., & de Jong, J. (2005). The validity of DSM-IV dissociative disorders categories in south-west Uganda. *Transcultural Psychiatry*, *42*(2), 219–241.

Weiss, M. (1997). Explanatory Model Interview Catalogue (EMIC): Framework for comparative study of illness. *Transcultural Psychiatry*, *34*(2), 235–263.

Whyte, S. R. (1991). Knowledge and power in Nyole divination. In P. M. Peek (Ed.), *African divination in systems: Ways of knowing (African systems of thought series)* (pp. 153–172). Indiana: Indiana University Press.

World Health Organisation (1996). *Investing in health research and development: Report of the ad hoc committee on health research relating to future intervention options*. Geneva: World Health Organisation.

World Health Organisation (2001). *World health report. Mental health: New understanding, new hope*. Geneva: World Health Organisation.