The Marginalization of African Indigenous Healing Traditions within Western Medicine: Reconciling Ideological Tensions & Contradictions along the Epistemological Terrain

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In examining the production of knowledge in the health systems in Western and non-Western societies, this paper argues that scientific knowledge in Western medicine serves to foster and sustain the marginalization of ‘African indigenous’ health knowledges. Using conceptualisations of illness, symptom presentation and help-seeking among African peoples of the diaspora, the paper argues that the epistemological terrain upon which both indigenous and Western health professionals traverse is not level, resulting in a hierarchy of knowledge, as well as superficial dichotomies between the indigenous and Western health approaches that obscure opportunities for alliances at the epistemological crossroads. The paper concludes with a discussion on opportunities for forging alliances between both health systems.

The notion that physical and mental illness are conceptualised and experienced similarly throughout the world is one of the many erroneous assumptions made about culturally diverse peoples around the world by some health practitioners working within Western medicine and psychiatry. Every society embraces particular ‘cultural theories’ or ideologies that set the parameters within which normal, abnormal and deviant behaviour is defined. These cultural theories on illness, treatment/healing and health often stem from diverse observations, understandings and interpretations of specific symptoms, the behaviour of persons affected by illness and how symptoms are uniquely experienced and explained in specific cultures.

Scholars who are becoming increasingly concerned with the failure to acknowledge the histories, cultures, and knowledges of marginalized peoples in academic texts and theories consider the ‘indigenous knowledge project’ useful for investigating and interrogating why and how certain knowledges get validated in the academy. As scientific development and research and development
activities gained in importance, Western society constructed a hierarchy of knowledge whereby diverse, but equally valid forms of knowledge were ranked unequally based on their perceived value. Dei (2000a; 2000b) argues that indigenous knowledge seeks to examine the process of knowledge production by questioning and challenging how imperial ideologies about legitimate and non-legitimate knowledge serve to marginalize and silence subordinate knowledges. Consequently, non-Western knowledge systems that are evaluated based on a Western epistemological frame of reference are ultimately devalued and delegitimized (Dei 2000a; Dei 2000b). The inherent power inequities between indigenous and Euro-Western knowledges are illustrated in the production, reproduction and dissemination of health discourse, and in the institutional structures that support professional practices that reflect the dominant health discourse. Karumanchery’s (2006) assertion that “the oppressor has mapped out social space in ways that normalize, idolize and reify his image, knowledge and experience... “ (p. 175) seems apropos here when we consider that it is Western scientific traditions, epistemologies and practices that often dominate within the social structures of Western and non-Western societies, resulting not only in the normalization and privileging of these traditions, epistemologies and practices, but also the pathologizing of non-Western ideologies and practices.

The term ‘indigenous’ describes specific groups of people who are grouped under the criteria of ancestral territory, collective cultural configurations, historical location in relation to the expansion of Europe, and knowledge that emanates from long-term residence in a specific place. Since the 1980s, ‘indigenous’ has been used alongside the term ‘knowledge’ to signify a social science, philosophical, and ideological perspective that acknowledges the significant role that knowledge plays in the power relations that emerged from the expansion of Europe (Dei 2000 b; Purcell 1998). Moreover, unlike scientific discourse, indigenous knowledges make no claims to a universal truth. Roberts (1998) conceptualized indigenous knowledge as knowledge “accumulated by a group of people, not necessarily indigenous, who by centuries of unbroken residence develop an in-depth understanding of their particular place in their particular world” (p. 59).

This paper uses the term ‘indigenous’ to characterize what is often referred to as ethno-medicine or ‘folk’ medicine practiced by peoples in Western and non-Western societies and which is thought to differ in significant ways from Western medicine or biomedicine. For example, Parks (2007) observes that the ‘folk psychology’ that characterizes the beliefs and healing practices of African American families and communities and that is passed down through generations encompasses a wide range of beliefs, including personal agency, human
understanding, capacity for inner healing, self-image, personal security and moral lessons. Unlike the Euro-Western conceptualisation of illness, which is perceived to have originated in a genetic, biological or some other internal source, indigenous or folk conceptions of illness are more likely to consider how factors external to the individual (e.g. punishment by an angry spirit, witch or ghost) contribute to illness. Illness in many of these societies is often perceived as ‘culture-bound’ because the explanations given for various illnesses are based on personal understandings of health and illness that reflect the symbolic structure of specific cultures and societies, as well as local histories, and environments. Conversely, scientific explanations for illness that are embraced by Western medicine are not tied to personal or symbolic structures. Rather, they are applied universally under particular methodological conditions that are often independent of the health practitioner’s beliefs or the socio-cultural realities of individuals (Clement, 1982).

Yen & Wilbraham (2003) contend that initiatives to nurture collaborations between indigenous healers and Western practitioners are often fraught with challenges because the moral space in which psychiatry is located is characterized by a discourse that construes indigenous healing as unprofessional and naive. Moreover, they argue that the professionalist discourse within which Western medicine and psychiatry are couched marginalizes and stigmatizes indigenous healing as ‘the other’. The authors observe that professionalist discourse is characterized by sharp boundaries between professionals and non-professionals and perceived rationality of professionalist discourse due to professionals’ membership in institutions that regulate medical knowledge and practice.

Following Yen & Wilbraham, this paper argues that the epistemological terrain upon which both indigenous and Western health professionals traverse is not level, resulting in a hierarchy of knowledge, as well as superficial dichotomies between the indigenous and Western health approaches that obscure opportunities for alliances at the epistemological crossroads. It examines the epistemological and professional tensions and contradictions between African indigenous healing methods and Western medicine in North America, the Caribbean and Africa and probes the challenges in reconciling the unique epistemological traditions that are inherent to both systems. In examining the superficial dichotomization between Western medicine and African indigenous healing methods, the article argues that opportunities for syncretism between both health systems need to continue to develop and evolve. In addition, the paper considers how the established power, hegemony and status of Western medicine peripheralizes the health traditions and practices of African peoples of
the diaspora by reproducing and sustaining hierarchies of knowledge that position indigenous health knowledges (and in particular African health knowledge) on the lowest rung.

It is important at this juncture to acknowledge how whiteness, the power and privilege that come from that racialized status and the hegemonic character of Euro-Western thought come to be enmeshed within the process and practices of modern-day institutions, such as health. Whiteness as a culturally normative space is manifested in all aspects of health services, from the epistemological framework that informs health beliefs to the ways in which individuals are assessed, diagnosed and treated within health services. It can be argued that the cultural normativity of whiteness accords white privilege and Euro-Western thought a kind of invisibility that allows for its operationalization within a hidden and unmarked space, resulting in its re-production and re-affirmation within discourse, social structures and institutional practices. Whiteness, then, extends beyond mere skin colour to the discursive spaces and practices that sustain the privilege, power and dominance of Euro-Western thought within a variety of social institutions, including health. This ‘cultural embeddedness of whiteness’ within various discursive spaces and practices means that the dominance of Euro-Western thought remains unconscious, standard, normal, common-sense, universal and consequently, the yardstick by which the belief systems and practices of non-European groups are judged. The ‘common-sense’ knowledge in every society includes those ideologies, beliefs, and traditions that constitute the moral fabric of that society and that are presented and perceived as natural, obvious and normal. In Euro-Western and non-Euro-Western societies, this ‘common-sense’ knowledge is often considered to be those ideologies, traditions, practices that emanate from a Euro-Western frame of reference predicated on European cultural traditions, ideologies, and values. Interrogating the hegemonic and imperial character of Euro-Western thought within medical knowledge is important if we are to understand the health disadvantages experienced by racialized groups. Assessments, diagnoses and treatment within health services are shaped, for the most part, by Euro-Western health belief systems that are often at odds with the health beliefs of culturally and racially diverse groups. Conceptualizations of illness and health are rooted in the ‘common-sense’ knowledge of the society in which they operate because the actions, beliefs and motives that provide the basis for understanding ail illness are conceptualized in unique ways depending on the society.

When the health system presents Euro-Western health approaches as standard and universal, the consequence is the denunciation, devaluation and marginalization of the cultural belief systems and traditions that shape the health ideologies of culturally and
racial diversity. Consequently, racially and culturally diverse groups are often less satisfied with the quality of care they receive or hesitant to access health services, which may result in under-diagnoses of illness, lack of appropriate health care and poor health outcomes (Ali, McDermott & Gravel, 2004; American College of Physicians, 2004; Deitch et al., 2003; Halli & Anchan, 2005; Hyman, 2003; McKenzie & Bhui, 2007; Woods et al., 2005; Wu & Schimmele, 2005).

Conceptualizations of Illness, Healing & Treatment among African Peoples of the Diaspora

Clement (1982) states that:

In a sense, folk representations are affect-laden ‘descriptions’ of the environment provided by the group through artefacts (e.g., ceremonial objects, tools), through routinized discourse (e.g., folktales, myths, novels), through ritualised, routinized and dramatized events (e.g., curing ceremonies, games, plays), through terminology systems (e.g., classifications of emotions), and through the statements and actions of authorities, specialists, and other culturally-defined spokespersons. (p. 193)

Conceptualisations of illness, disease, symptom presentation and treatment/healing that are shaped by various social, cultural, ethnic, economic and political variables within individual societies are interpreted, assessed, diagnosed and treated in unique ways in different cultures. The majority of mental illness in non-Western cultures and societies is explained in intrapersonal (i.e. emotional) rather than naturalistic (i.e. physical) terms: (a) possession of the patient’s body by a ghost, spirit, or deity; (b) punishment for breaking a taboo; and (c) witchcraft (Foster & Anderson, 1978).

Various healing systems around the world are predicated on knowledge systems that are often at odds with rationalist and positivist ideologies upon which Western medicine is based. For example, Durie (2004) observes that Maori perspectives on health in Aotearoa, New Zealand embrace holistic conceptualizations that perceive good health as a combination of mental (hinengaro), physical (tinana), family/social (whānau), and spiritual (wairua) dimensions. Maori researchers have challenged existing measures that are grounded in Western scientific models by developing the Maori Mental Health Outcome Framework (MMHO) to measure mental health outcomes for Maori. Hopton (2006) contends that understandings of health and illness in Chinese culture relate to physical functions and pathological changes and are rooted in three main concepts: 1) the concept of Ying and Yang, which describes how things function in relation to each other; 2) five phases which
describe the development of illness due to an excess or a depletion of earth, metal, water, wood or fire, and 3) the concept of Qi, which understands optimal health as culminating from a balanced body in which Qi flows in harmony with the environment.

The traditional African worldview is premised on the interrelationship between the living and the nonliving, natural and supernatural elements and the material and the immaterial. The emphasis on spiritual phenomena is also another important aspect of this worldview, particularly the belief that deceased individuals transform into invisible ancestral spirits and involve themselves in all aspects of life, including assisting individuals in obtaining good fortune, assisting with interpersonal relationships, and promoting good health and preventing illness (Bojuwoye, 2005). African health systems across the globe are considerably pluralistic, focusing both on biological approaches that are concerned with disease and illness originating in the body, as well as culture-bound illnesses that are understood within the context of specific cultural histories and traditions. Within African health systems, identification, assessment and classification of diseases and treatments are all shaped by the makeup of the physical environment, the level of exposure and access to Western medicine, levels of literacy, social class, the beliefs that people hold about diseases and cures that are inherited from past generations and a cultural continuity that has survived within each generation (Bojuwoye 2005; Marshall 2005). Feierman (1979) discusses some of the common conceptualisations of illness in many non-Western societies:

Some cases of sickness are attributed to sorcery, others to the actions of spirits, still others to the malfunctioning of organs in a purely physiological sense. Each of these indigenously defined causes can also result in disturbances other than sickness. Sorcery might result in loss of business. Spirit possession can lead to law breaking and police arrest. The cures are equally diverse, including exorcism, propitiation, hospital visits, penicillin injections, ritual purification, magical counterattack, the administration of herbal medicines and others. (p. 278).

Aarons (1999) notes that medical pluralism is a significant feature of Caribbean societies. The healthcare system as a whole is characterized by a plurality of beliefs and practices, despite the fact that the regulations governing medicine in the Caribbean only acknowledge Western, scientific biomedicine. The rising cost of Western medicine, the concentration of health professionals in this sector in urban and coastal areas, the shortage of health professionals, poverty and personal and
spiritual beliefs have resulted in increased utilization of alternative or complementary health care.

African American folk medicine exemplifies the cross-fertilization of the health beliefs and practices of Africans, Europeans and American Indians during slavery in the rural south when slaves relied on a variety of folk healing methods to resolve physical, emotional and spiritual difficulties, as well as the uncertainties of life and death. The terms conjure, hoodoo and rootwork all describe the elaborate healing system in the African American community that includes calling on ancestral spirits, magic, herbalism, and witchcraft. These healing methods are an amalgamation of classical European medicine of an earlier day, European folklore, African cultural traditions and ideologies from modern-day scientific medicine, tenets of fundamentalist Christianity, elements of vodun or the voodoo religions of the West Indies, Native American healing traditions and magic. Today, African folk or indigenous practices remain an important feature of health care delivery for African Americans residing in the rural south and in some southern and northern cities.

A study conducted by the Centre for Addiction and Mental Health (1999) in Toronto found that some African Caribbean peoples are suspicious about the effectiveness of Western approaches for treating mental illness, such as psychiatry, therapy, and counselling. There is, however, a greater tendency to embrace the idea that mental health problems can be more successfully resolved through more informal routes, such as spirituality, religion, church, social networks and self-help strategies. According to this study, common beliefs about mental illness in the Caribbean community in Toronto include the following: (a) mental illness is caused by a spell or evil spirits; (b) mental illness is a punishment for wrongful deeds committed by an individual; (c) the person affected is crazy, dangerous, or weak in character; (d) the person affected is pretending to have mental illness; and (e) mental illness is hereditary. Beliefs about coping and treatment in this community include the following: (a) the belief that psychiatry, counselling and therapy will not cure mental illness; (b) the fear that admitting to having a mental illness and seeking treatment will subject individuals to institutionalization within mental health agencies, as well as long-term medication; (c) preference for resolving mental illness through the church, spirituality and religion and repentance; and (d) a belief that mental illness can be cured with the use of home-made herbal remedies and assistance from spiritual healers.

Several authors (Carrington, 2006; Schnittker, 2003; Schnittker, Freese & Powell, 2000) describe conceptualizations of mental illness among Black women specifically. Carrington found that the ways in which African American women present symptoms of depression are
often culturally determined, resulting in their failure to seek treatment for a number of reasons, including beliefs that depression is indicative of a weak mind, poor health, a troubled spirit, and lack of self-love. She also pointed out that these women are often reluctant to seek treatment because of a lack of trust in healthcare providers, denial that they have depression, lack of knowledge about the causes of depression and stigma associated with mental illness in this community. Schnittker (2003) found that African American women are sceptical about embracing the biomedical model as the cause of depression and reluctant to use psychiatric medications, believing that these medications were experimental or mind altering. They were, however, more likely to rely on their spiritual connection to God and maintaining a positive ideology as means of transforming feelings of depression. Schnittker, Freese and Powell (2000) also argue that negative attitudes that many African American women hold about mental health services are due to the fact that many do not believe that mental illness is caused by genetics or poor family upbringing, both of which are seen as stigmatizing.

Contrary to the hypothesis set out by Stone and Finlay (2008) that African-Caribbean participants would perceive the diagnostic label of schizophrenia as more stigmatizing than White Europeans, the authors found that White Europeans were more likely to label vignettes presented to them as mental illness, to perceive the diagnosis of schizophrenia as stigmatizing and to recommend professional treatment. In general, the authors found that the beliefs and perceptions of White Europeans reflected a western psychiatric model of mental illness, while African Caribbean participants conceptualize mental illness using alternative labels and evaluations of how mental illness should be resolved.

Understanding the unique conceptualizations that various cultural groups hold about illness is important because, as Carter (2002) notes in his discussion on African Americans, professionals who lack knowledge of distinct cultural characteristics, religious beliefs, values, and practices may misdiagnose individuals when they present with symptoms that don’t reflect the diagnostic categories outlined in the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV).

Recent studies (King et al., 2005; Musgrave, Allen & Allen, 2002; Taylor et al., 2000; Waldron, 2003; 2005; Watlington & Murphy 2006) suggest that the influence of religious beliefs and practices, as well as the reliance on religious social networks for fellowship may replace or delay the need to seek treatment among African Americans. For example, King and colleagues found that religion plays a central role in the lives of African Americans and that many African American families believe that religion, personal responsibility and agency and accessing health
services are all important for maintaining good health. In other words, they don’t believe that human agency and reliance on health professionals are violations of faith in God. These families also have dynamic perspectives on the extent to which religion and human agency play a role in health outcomes, including attributing some health outcomes fully to divine agency or attributing health outcomes to a combination of divine and human agency which works through medicine, health behaviour or religious behaviour modification. Musgrave and colleagues found that African American and Hispanic women tend to embrace Christian principles of spirituality, which was associated with positive health outcomes, including increased rates of mammography, the ability to cope with poverty and HIV and an improved perception of their own health status.

Religion, belief in a higher power and spirituality are used to explain mental illness in Caribbean, African American and African communities and are important sources of strength for these individuals, playing a significant role in offsetting the stresses and anxieties that may lead to depression and other health problems, particularly in the face of racism and other forms of discrimination and oppression. Early studies (Bair, 1981; Boyd-Franklin, 1991; Brown & Gary, 1994; Handel, Black-Lopez & Moergan, 1989; Heath, 2006; Paris, 1995; Princeton Religion Research Centre, 1987; Schreiber, Noerager & Wilson, 1998) indicate that the common belief that one’s problems will be resolved by believing in a transcendent divine and almighty entity and establishing a relationship with a higher power is an important feature of the cultural philosophies of African peoples around the world.

Heath (2006) suggests that spirituality plays a significant role in the recovery of mental health concerns among Black women who must cope with gender, race and class inequalities and that a womanist approach may be effective for addressing how spirituality may help relieve the mental health problems experienced by these women. This approach is grounded in African traditions that include oral tradition, music, dance and calling on deceased ancestors to resolve personal and community struggles. Schnittker, Freese & Powell (2000) observe that racial differences in etiological beliefs play a significant role in the tendency for African Americans to perceive professional mental health treatment in more negative ways than whites. Other studies (Bojuwoye 2005; Waldron, 2002a/b; 2003) demonstrate that help-seeking among individuals in Africa and the Caribbean is informed by Western medicine and African indigenous methods and is determined by education, social class, religious background and residence in urban or rural locations. They identify three main categories of individuals in Africa and the Caribbean who seek treatment for mental illness. First, the ‘traditional’ type includes those individuals who use religious
faith/African indigenous healing exclusively. Second, the ‘mixed’ type is characterized by a hybrid of religious faith healing and Western practices and includes individuals who use Western-oriented methods like psychiatry, counselling and therapy as a complement to religious faith/African indigenous healing. Finally, the ‘Western-oriented’ type includes individuals who use Western-oriented methods exclusively.

The fact that these studies provide strong evidence for the preservation and revitalization of African styles of worship, forms of ritual, systems of belief, and fundamental perspectives independent of and also in partnership with Western medicine speaks to how important it is to bridge alliances between Western medicine and African indigenous health systems. Moreover, given that the help-seeking patterns of African peoples around the globe can be characterized as a kind of “hybrid” of African indigenous and Western approaches, it is important that health professionals working in both sectors acknowledge and integrate into their practice healing and treatment approaches that combine both approaches.

Is Syncretism Possible? Reconciling Tensions & Contradictions at the Epistemological Crossroads

Despite the increasing propensity to embrace spiritual, indigenous and traditional approaches in Western society, initiatives to forge authentic alliances between Western medicine and indigenous health practices remain problematic because, as Yen and Wilbraham (2003) argue, the professionalist discourse in health is characterized by sharp boundaries between licensed Western medical professionals whose knowledge and practices are regulated by licensing and regulatory bodies and unlicensed indigenous healers who practice outside that system. Moreover, many indigenous health professionals have little interest in practicing within a highly bureaucratized institution such as the general hospital.

It is important to address some of the ways in which indigenous healing methods and Western medicine can benefit from one another, resulting in a more balanced two-way exchange between these two epistemological frameworks and health approaches. Many professionals working within indigenous health system are increasingly interested in looking at how indigenous healing methods can benefit from Western approaches to health. For example, Chen (2001) argues that combining Western and Chinese values into the Chinese health care system is not only beneficial to patients, but also crucial if nursing research is to be advanced in ways that will benefit the global community. There are many examples of the growing interest in traditional Chinese medicine in many Western countries, including the development of a science-based data bank that was developed in the United States and made
available from the National Institutes of Health Center for Complementary Medicine and the acknowledgement by the World Health Organization that acupuncture or moxibustion can resolve many health problems.

Chen’s observation (2001) that “the Chinese played a major role in the development of science in Europe.... Medicine in China produced great physicians before Hippocrates” (p. 272) not only suggests that Chinese health beliefs and practices informed and were informed by Western medicine, but also that socially constructed hierarchies of race, culture and the knowledges and practices that are associated with particular racial and cultural groups have resulted in the privileging of Chinese culture and, by extension, Chinese Traditional Medicine in the Western medical literature and practice over African, Aboriginal and other indigenous approaches. The fact that African indigenous health approaches, in particular, were persecuted for their perceived problematic ideological content and continues to be rejected as legitimate health knowledge within Western medical discourse must be understood within the context of colonial historical processes in the Caribbean, the United States, and Africa, where it was forced ‘underground’ by European imperial processes that sought to maintain the dominance, status and power of Western thought.

Similar to Chen, Iwama (2003) argues that health professionals that fail to validate and incorporate into their practice Western ontologies and epistemologies will find it difficult to evolve and develop. Iwama discusses Japanese occupational therapy specifically, which continues to validate biomedicine and a skills-oriented practice, while maintaining its identity and status within the Japanese health care system. The challenge, according to Iwama, is to adapt Western theory and knowledge that has emerged in the past 20 years into occupational therapy practice that reflects the present-day realities of Japanese peoples, particularly since the theories and models that underpin occupational therapy reflect Euro-Western traditions and experiences.

It can be argued that the insular nature of indigenous health knowledges in general, particularly their reliance on oral tradition, have contributed to perceptions of indigenous health as exotic, mysterious, primitive, unscientific and, ultimately, a threat to the social order. Non-biomedical health professionals (including chiropodists, herbalists, acupuncturists, homeopaths, naturopaths, or practitioners of traditional indigenous medicine) are not recognized by law in the Caribbean and, consequently, no regulatory bodies exist to monitor their practice or to safeguard the health of individuals seeking assistance. Interestingly, African indigenous health knowledge was part of the mainstream of medical ideology during the colonial era in the Caribbean. Although it is
now tolerated, it is no longer recognized as an orthodox form of medicine by the mainstream medical establishment (Aarons, 1999).

African indigenous health knowledge remains marginal to this day because its adherents remain powerless in the context of a Western scientific domain in which political power is key to legitimacy. Moreover, it has yet to transcend local or national boundaries that would enable it to penetrate into the international arena in any legitimate or credible way. Although African indigenous health knowledge is a product of the cross-fertilization of various cultural traditions, including European medicine, Western practitioners have, for the most part, failed to acknowledge the historical links between African and European health practices, resulting in a superficial dichotomy between the two ideologies that is more a social construction than any real or authentic separation or discontinuity between the two modes of knowledge. Toldson and Toldson (1999; 2001) provide suggestions for integrating African traditions and values into psychological and psychiatric health care and clinical group therapy with African Americans, including providing treatment in patients’ homes and allowing them to have contact with family. The authors recommend clinical approaches based on Black expressive psychology, such as integrating African symbolic elements that reflect positive African values, such as interdependence, collectivism, cohesiveness, as well as activities that relay emotional challenges, such as dance/drilling steps, music and dramatic storytelling.

Studies by Teuton, Bentall and Dowrick (2007) and Teuton, Dowrick and Bentall (2007) examine approaches for resolving mental health problems in Uganda. According to these authors, in Uganda and many other African countries, Western medicine and indigenous and spiritual approaches exist side by side within the healthcare system. Religious healers are significantly influenced by Western medicine, relying on Western psychiatric terminology to characterize mental health problems, such as ‘schizophrenia’, ‘depression’ and ‘psychosis’. Although spiritual and physical models were used to explain ‘madness’, indigenous healers more fully elaborated on spiritual models, suggesting that spirituality played a more significant role in understanding and resolving mental health problems. Religious healers, on the other hand, were more likely to use western psychological models to explain distress whilst simultaneously attributing mental health problems to social ills, such as economic problems, personal problems and societal conflict.

Teuton, Dowrick and Bentall (2007) also examined the relationships between religious healers, indigenous healers and allopathic healers in order to propose opportunities for fostering increased dialogue and improved relationships between indigenous healers, religious healers and allopathic doctors. The study found that
while indigenous and religious healers were tolerant of allopathic medicine, religious healers attributed its success to spiritual divination. Allopathic doctors were unlikely to acknowledge religious healers and were ambivalent towards indigenous healers. Finally, religious healers held little regard for indigenous beliefs and methods, while indigenous healers perceived indigenous spirituality and evangelical Christianity as incompatible. In their quest to retain the legitimacy of their healing system, indigenous healers have decreased their role in healing physical health, perceiving this to be the domain of allopathic medicine. They have, however, maintained their dominant role in treating ‘madness’ due to the ineffectiveness of allopathic medicine in this area, their perception that spiritual explanations and interventions are more effective in resolving ‘madness’, and patients’ preference for receiving treatment by spiritual and religious healers.

Liddell, Barrett and Bydawell (2005) argue that while biomedical understandings of illness dominate in Sub-Saharan Africa, particularly with respect to HIV/AIDS causation, which has been accommodated into indigenous conceptualizations of STD causation, the tendency for Western approaches to HIV/AIDS prevention to locate blame for the disease to individual actions challenge the core values and beliefs of individuals. The authors contend that a culturally grounded and responsive approach to HIV/AIDS prevention in these communities requires a flexible approach that integrates both Western and indigenous understandings. While Western practitioners have yet to develop an effective blend of traditional and biomedical approaches to prevention, traditional healers have been more accommodating, incorporating cultural beliefs about illness representation and acceptable sexual behaviour in Africa.

Torrey’s statement (1986) from 23 years ago that: “[p]sychotherapists are the secular priests of post-industrial societies” (p. 27) is relevant today because it points to spirituality as one foundation upon which psychotherapy is still based. While I do not believe that Torrey is asking us to take his statement literally, he does suggest that spirituality continues to have a significant influence on psychotherapeutic techniques. Sollod (2005) supports this statement when he argues that psychotherapy has long tapped into spiritual healing techniques and teachings, despite its failure to acknowledge this influence. Moreover, mental health issues that are now considered to be the domain of psychotherapy have long been addressed by spiritual healing traditions and teachings, which have a tradition of embracing holistic conceptions of health that are premised on the inseparability of the mind, body and soul and of mental and physical illness. Sollod (2005) identifies seven factors that illustrate the influence that spirituality has had on a variety of healing methods, including psychotherapy. First,
both the spiritual healer and the psychotherapist may undergo a change
in her or his state of consciousness that is dissimilar from waking
consciousness. Second, spiritual healing and psychotherapy share
similarities with respect to methods for perceiving and conceptualising
the client. In addition, both approaches use intuition to understand the
client. Next, both approaches are premised on the notion of the
inseparability between the processes of the healer/therapist and the
client. Related to this is the idea that the process of healing the client
often culminates in the healer’s/therapist’s resolution of her or his own
personal issues. Sixth, both approaches require that the healer/therapist
and the client use visualization techniques. Seven, spiritual healing and
psychotherapy both understand that restoring health requires the
forging of a relationship with the spiritual realm. Finally, prayer and
meditation are perceived as important aspects of healing and therapy.

Causal explanations for health did not differ in any substantial
way throughout European history and have ranged over a number of
categories to include chemical, natural, and supernatural phenomena,
among others. For example, mental illness was not perceived to be
distinct from other medical illnesses in Graeco-Roman medicine.
Moreover, explanations given for both mental and physical illnesses
were not dissimilar. For example, evil spirits, witchcraft and other
demonological theories were used to explain both psychiatric and
medical illness during the Renaissance period (Fabrega 1982).

Greater and more significant opportunities for alliances between
African indigenous health approaches and Western medicine can be
fostered and nurtured if superficial dichotomies between the two health
approaches were eliminated. For example, Vaughan (1994) argues that
characterizations of African indigenous health systems as concerned
merely with social relations and culture-bound illnesses negate its
interest in the pathology of the body, a concern it shares with Western
medicine. Where these two approaches diverge, however, is with respect
to how they conceptualise the connection between the social and the
corporal. While, African indigenous health systems focus on how the
body acts as a vehicle through which social conflicts and tensions are
expressed and how problematic social conditions must be resolved if
illness is to be cured, Western medicine focuses on individual pathology,
perceiving the body and illness as de-contextualized from the social and
cultural experiences of the patient. Vaughan also suggests that the use of
the term ‘healing’ in discussions on African indigenous conceptualisations of health contributes to the creation of false
dichotomies between African indigenous health systems and Western
medicine. She argues that while ‘healing’ is often used to characterize the
activities of African healers, the term ‘curing’ is applied to professionals
working within medicine, implying the superiority of the latter in terms of its effectiveness in treating illness.

An example of the historical links between African indigenous health systems and Western medicine is illustrated in the activities of Western-trained missionary doctors and nurses in colonial Africa. These professionals perceived their activities in terms of healing and, similar to African healing, were concerned with the symbolism of the body and of disease, their connection to various social ills in African societies and a Christian healing ethic concerned with saving souls.

The criticism that has been levelled against indigenous health knowledges by Western medicine and psychiatry has much to do with a long-held perception of indigenous healers as having failed to modernize their practice in keeping with an ever-changing society. Despite the tensions that arise at the interface of two seemingly distinct epistemologies around health, the historical links between indigenous and Western knowledges, in general, are evident. Dei (1999) argues that Euro-Western scientific discourse has a long history of co-opting the knowledges of marginalized groups and re-framing them in ways that obscure any connection between these knowledges and Euro-Western thought and science. Dei identifies three main ways in which the disciplines of science make use of marginalized knowledges and traditions. First, he argues that the discipline of anthropology was constructed around the history of subjugated groups. Second, he states that the traditional health practices of marginalized and indigenous peoples have been re-fashioned as ‘herbal remedies’, offering what is perceived as a more ‘civilized’ version of these remedies for mass consumption. Finally, despite the lack of acknowledgement, indigenous conceptualisations of the world have significantly influenced Euro-Western science and technology. The ‘hybridity of knowledge’ that characterizes indigenous and Euro-Western health traditions illustrates how these two seemingly different types of knowledge systems continue to influence one another.

Oftentimes, indigenous approaches to health are only granted credibility when they are evaluated using scientific measures and perceived as having some commonality with medicine, thereby maintaining the dominance and status of scientific medical discourse. Consequently, a segregated health system is reinforced and the indigenous health sector of care remains pluralistic, quasi-legal or illegal, unregulated, and unlicensed. It is important to point out, however, that over the past several years, Western medicine, psychiatry and other therapeutic approaches have been increasingly influenced by Eastern and other non-Western philosophies and religions, resulting in a broader range of therapeutic approaches to health and mental health, including ‘complementary medicine’, ‘homeopathy’, ‘holistic medicine’ and
‘behavioural medicine’. Today, a considerable number of Americans are using complementary or holistic medicine for physical and mental health concerns, a phenomenon that illustrates the changing ideologies about illness and health in the West, particularly the increasing propensity to embrace holistic conceptions of health and treatment that acknowledge the interrelationship between mind, body and soul (Poulin & West 2005). Moreover, it is important to point out that these changing conceptions of health are occurring within the context of the increasing propensity to embrace ideas about ‘para-normal’, ‘new-age’, and ‘astrology’ within Euro-Western thought (Dei 1999). In light of the decreasing stigma associated with indigenous and spiritual healing approaches, opportunities for integrating spiritual healing approaches within psychotherapy and other Western-based healing traditions are rife with possibilities.

**Collaborative Models Combining Indigenous & Western Health Knowledges**

There are various examples of successful collaborative models that attempt to bridge the gap between indigenous and Western health knowledges and that demonstrate the generational evolution and fluidity of help-seeking among culturally diverse peoples whose access to health services can be characterized as a ‘hybridity of knowledges and practices’ informed by varying degrees of indigenous healing or Western medicine, or both. For example, the First Nations and Aboriginal Counselling Degree Program at Brandon University in Manitoba, which was created in collaboration with Aboriginal peoples, combines Aboriginal and Western knowledge and skills to initiate an indigenous healing movement that acknowledges the interaction of physical, social, psychological and spiritual elements in counselling. The strength of the program is in its acknowledgement of how counselling practice can revitalize indigenous holistic world views whilst being open to multiple ways of knowing, as well as its critical questioning of the limitations and strengths of Western counselling theories within Aboriginal cultural contexts. Aboriginal Services at the Centre for Addiction and Mental Health, which is supported by Health Canada’s First Nations and Inuit Health Branch and the Oshki-Pimache-O-Win Education and Training Institute, combines therapy with cultural and spiritual teaching. It collaborates with Aboriginal and non-Aboriginal agencies across Northern Ontario to build local capacity to address mental health and addiction issues, including training by a Provincial Aboriginal Training Consultant. The Aboriginal Health Branch of the Manitoba Government works in partnership with multi-sector stakeholders to develop counselling/therapy services that combine Aboriginal spiritual healing practices and Western health care. Similarly, The First Nations Health
Plan is a collaborative project between the provincial government and the First Nations Leadership Council that outlines steps to improve the health status of First Nations in British Columbia. *The First Nations Health Plan: Supporting the Health and Wellness of First Nations in British Columbia* will involve partnerships between First Nations and regional health authorities to improve access to primary health care services in Aboriginal health and healing centers.

Across Boundaries, a mental health centre that provides a range of support and services to racialized people in the Greater Toronto Area with severe mental health problems/serious mental illness, utilizes a holistic approach that validates the interdependence of spiritual, emotional, mental, physical, social, economic, cultural, linguistic and broader environmental aspects of life. The centre values a community development approach that combines social and recreational activities, support groups, alternative and complementary therapies, art therapy, creative expressions, community kitchen, individual support from psychiatrists and general practitioners and community outreach. Similarly, TAIBU Community Health Centre in Scarborough, Ontario values a holistic approach to the health issues experienced by racialized groups. The Centre addresses the physical, mental, social and spiritual aspects of individuals and relies on a multidisciplinary model that includes clinical services (physicians, nurses), dental services, complementary health care professionals and community health programs.

In an era of increasing globalization, transnational migration, cultural diversity and blurred cultural divisions, it is crucial that the health system take a more prominent role in forging links between African indigenous health and Western medicine in ways that do not compromise either faction. It is crucial that the health care system create more opportunities for oppositional and subordinated knowledges and Western medicine to co-exist by re-defining the discourses, structures, processes and practices through which these knowledges are produced, validated and disseminated. Thus far, medical syncretism has merely meant the appropriation of indigenous health remedies, knowledge, and methods by Western medicine, which denies indigenous health approaches legitimate status in the healthcare system. If true syncretism is to be achieved, professionals working within both health traditions must begin to critically reconcile their differences with respect to the epistemologies upon which health beliefs and practices are premised, as well as the practices that are informed by these epistemologies. Only then will professional working within both traditions be able to transcend those differences, embrace those instances where they do share common ground and begin to develop meaningful partnerships that allow them to strategize on how to better enhance and strengthen
each other’s practice and improve health outcomes for racially and culturally diverse groups.

REFERENCES


Multiple Readings of Our World. (pp. 70-88). Toronto: University of Toronto Press.


Feierman, S. (1979) Change in African therapeutic systems, Social Science & Medicine, 13(B), 277-284.


differences in beliefs about the causes and appropriate treatment of mental illness, *Social Forces*, 78 (3), 1101–1130.


