SOCIAL CHANGE AND SHIFTING PARADIGMS:
THE CHOICE OF HEALER AMONG BLACK SOUTH AFRICANS
IN PSYCHOLOGICAL COUNSELLING

A thesis submitted in partial fulfillment of
the requirements for the degree of

MASTER OF ARTS

of

RHODES UNIVERSITY

by

ALEXANDRA BLYTHE JOHNSON

January 2000
ABSTRACT

Social change in South Africa brings to light the multiplicity of world-views operating in our society, which individuals encountering a variety of social contexts are faced with. This raises questions about the choices black South Africans face in response to influences from Western and traditional African culture. This issue was approached through examining help-seeking choices made between different health care sectors that stem from different world-views. This would indicate whether individuals are drawing on a variety of belief systems. The sources of their beliefs are put into context by looking at the communities of practice that influence their local knowledge. Help-seeking is also influenced by the identities the individual may ascribe to, which are derived from the multiple positions held by them in different social contexts.

In this research the use of health-care sectors by four black women attending psychotherapy is examined. Their use of these sectors reflects a potential multiplicity of world-views. Semi-structured interviews were conducted, focusing on participants' prior experience of different help options, and their current perceptions of traditional African healing and psychology. The texts were analysed using a qualitative hermeneutic method, the reading guide. Data was looked at through three main themes, the individual's relationship to the health care sectors, their knowledge of different world views, and the identities they adopted which may be influential in their choice of a healer.

It was found that in two participants there was some movement away from traditional beliefs, with one rejecting the
traditional healers who did not help her, once she has discovered therapy, and another identifying herself completely with Western medicine. In contrast, one participant illustrated a rediscovery of traditional healing, whilst still attending psychotherapy. This suggests that shifts in knowledge are not necessarily away from traditional beliefs.

It was also found that the two participants who had experienced a broader variety of social contexts and identified with multiple belief systems, tended to use a variety of Western and traditional healing sources and selected the healing option they felt was most appropriate to a particular problem. It is argued therefore that having a variety of knowledge and beliefs places individuals in a more powerful position to determine their choice of action than those with a limited range of knowledge.
CONTENTS

Chapter 1: Introduction............................page 7

Chapter 2: Literature Review.......................page 10

Chapter 3: Methodology.............................page 33

Chapter 4: Results..................................page 39

Chapter 5: Discussion..............................page 68

Chapter 6: Conclusion..............................page 87

Appendix............................................page 92

References..........................................page 95
ACKNOWLEDGEMENTS

I wish to thank the Centre for Science Development for their bursary contribution and state that this work is independent of their opinions.

I also wish to thank Cynthia and Thorold for their perpetual support, and Ed, Athina, Tami and John for their help and interest. And of course, prasads to Oegglipoegli.
We swim in a sea of competing intelligibilities, where discursive currents from dislocated periods of history...are forever surging one against the other, and the mingling of disparate pasts is forever generating new and appealing (or appalling) possibilities. Thus, regardless of the dominant cultural realities, and their related practices, there are always groups whose realities are scorned, suffering that goes unheeded, and visions of positive change that are muffled by the secure and the sanctimonious. (Gergen, 1994, p.57).
CHAPTER 1

INTRODUCTION

In one of the black residential areas in Port Elizabeth there is a Xhosa man whom people in the black community refer to as "the Magical Doctor". Here he runs a practice which is frequented by local black residents. To an outsider it may be surprising that this man is completing a PhD in clinical psychology, and is running a psychotherapy practice.

Whilst this is not an entirely new phenomenon in South Africa, it does raise questions about people's choice of a healer. The term "Magical Doctor" is reminiscent of the 'magical' healing that is associated with the African traditional healers, the amaqgirha and witchdoctors, the amaxhwele. Yet, this "Magical Doctor" is practising something which has its origins in Western academia, far from the world of African traditional healing, and which in South Africa has been a preoccupation of predominantly white middle class people. What has led black South Africans to seek out this form of healing, and what are their relationships to the traditional African healing practices and beliefs?

These questions take on particular significance at this time in South Africa. We are in a dynamic period of political change, the pot has been stirred, and many habits and perceptions are being shifted by rapid social change. We are at that moment of disturbance, the very crucial, fluid moment when there is an openness to possibility, and things can slide in any direction. When looking at a phenomenon such as I have described, questions emerge relating to a changing situation. For example, black people may be familiar with the traditional African beliefs that formed a strong part of previous generations, and simultaneously are encountering contexts where a modern Westernised world-view is the norm. How do they react to these bodies of knowledge from different cultural world-views? Is it a case of choosing between different
belief systems, or are they finding a way of simultaneously participating in multiple world-views? Their responses may also depend on the strength of their involvement with different communities whose practices stem from different belief systems. This would affect not only what knowledge is familiar to them, but also would influence the identities that the individual may ascribe to. The question of shifting identity would thus also be relevant to understanding the choices an individual makes between different forms of healing, in a situation of social change.

In this research I have listened to the stories of four women who are in therapy with the "Magical Doctor" from Port Elizabeth, and asked how they chose (or happened) to go for psychotherapy. This involved looking at how they related to other forms of healing, possibly from quite different world views. Kleinman's (1980) model of the health care system is a useful guide to examine the range of possibilities available to someone seeking help. I have paid particular attention to the perceptions the participants have of traditional healing, in comparison to more Western forms of healing, as an indication of the effect of social change on beliefs and choices. I also examined the different social contexts or communities of practice that may have influenced their perception. This accounts for their experiences of acculturation and the meeting of different kinds of knowledge. Finally I looked at the different identities that these women affiliate themselves with, as an indication of the effect that different knowledge and social influences have had on them. I have taken particular interest in the multiplicity of identities they may experience, and whether they experience these as being in conflict or have found ways of harmonising them. This would indicate how individuals are adapting in a situation of rapid social change.

In the spirit of social constructionism, I am proposing that beliefs which inform choices stem from a social, interpersonal level, and therefore, reflections from the individual are expressive of social processes. People's thoughts, words and actions thus mirror the larger trends in thought that surround
them, which become patterns formed from and constituting this fluid entity, the social world. Individual beliefs and actions thus form a picture of the different realities that exist within our society, and the tensions between these realities, some of which assert themselves as more legitimate than others. Realities competing for legitimation thus require the individual to contend with the power dynamics created by such tension. This may be part of what the individual faces in encountering different world-views.

My position as researcher and writer of this thesis follows the hermeneutic and social constructionist approach, which acknowledges the researcher's influence as co-constructor of a reality that emerges both in the interview, and then as interpreter of the resulting text. I acknowledge that I cannot be an objective viewer; I have no separate window beyond my own cultural perspective through which to view the 'findings'. I would argue that all research ultimately is such a subjective co-construction of reality.
A common feature of humanity is that we experience suffering in various forms, and that our societies have evolved methods of understanding and providing organised help for suffering. Suffering can be described in different ways, such as physical, emotional, mental, spiritual or social. The distinctions between these different categories vary, yet anthropologists find that in all human societies, one of the most important features is the system of beliefs and practices that relate to dealing with different forms of suffering and promoting health and healing (Helman, 1990). These systems have certain common characteristics. For example, we develop some standard which is considered an optimal state of health or non-suffering, which is aimed for with healing. There are also methods (categories or narrative structures) by which to identify specific afflictions to health. There is the role of the healer, who enters into a healing relationship with those who are in need of help. And there are the methods of therapy or 'cure' which are believed will amend the suffering (Kleinman, 1995).

A startling variance between cultures is found in the remarkable deviation in different cultures' classification and response to different forms of suffering, their beliefs about the origins of illness and suffering, and the very diverse forms that treatment takes. For example, the experience of 'mental disturbance' (a Western term, but a generalisable phenomenon), is understood in cultures throughout the world as stemming from completely different sources (Torrey, 1986). American psychotherapy focuses primarily on experiential causes, such as childhood traumas, but also ascribes psychological disturbance to biological causes such as brain
chemical imbalances; Chinese psychotherapy aims to correct imbalances in yin and yang, the male and female principles, in the brain, through acupuncture; metaphysical causes are widely believed in throughout the non-Western world, such as spirit possession, offence to an ancestor or a deity, or neglect of a ritual. Solutions to these problems must be consistent with the belief system ascribed to. For someone who felt that they were depressed because of an imbalance in their brain chemical composition, being told to slaughter a goat to appease their deceased grandmother would sound senseless and would not provide them with confidence of a cure.

In trying to understand how culture may account for these differences, we need to explore the relationship between the individual and culture.

**Culture and the social construction of the individual**

Geertz (1975) articulates an approach to culture that centres upon the vital role played by culture in creating us as functional, intelligent beings. As humans, unlike other animals, we no longer have strong instinctual drives that direct our behaviour. Rather, we are born into a social world that is filled with meaning. Socially created and learned signs and symbols guide our actions and understandings way beyond the capacity of our now muted genetic instincts. This collection of meaningful symbols, such as language, forms the instructions or rules that guide us on how to behave, what actions have what meaning, and give us concepts with which to think about the world. We are not, from this perspective, human individuals who have culture as an additional decoration to our beings. We are formed by the social world we come into, and constructed by our culture.

From this we can begin to understand the striking differences that may occur between people from different cultures and how the world-view of our culture may be so highly influential in our
understanding of reality, which is expressed somewhat unconsciously in our everyday thinking. To share meanings and understandings is to identify with a particular community and have a sense of belonging within it. Arthur Kleinman (1980), has been an instrumental thinker in looking at how health care systems, which arise as socially organised responses to illness, are born out of a culture's world-view, and embody the cultural beliefs and realities about causation and treatment of illness, assumptions about the roles and relationships between patients and healers, as well as the actual process of what constitutes healing and social settings and institutions related to treatment. It is from this body of cultural knowledge that the individual's beliefs are derived.

Language plays a powerful part in creating this shared reality. Harland (1987) describes Sasseur's observation that language forms a system of referents that coheres together independently from the world of objects. The meaning of a word depends on its relationship to the whole system of words which defines its boundaries. In understanding how separate the language system is from an objective, neutral world, we can see how differently the world can be perceived from within different cultural and language systems. Language functions as a permanent set of lenses through which we see the world and which forms our collective understandings.

Barthes (1972) was interested in the way collective thought affects the individual mind, but also sweeps through the whole society in a larger momentum above the level of the individual. Ideologies and mythologies within a society are embedded in word meanings, which do not simply reflect the world but are loaded with associations and connotations which are socially constructed. Barthes explored this by looking at the way that words used in advertising relate to other images and associations, which create particular perceptions (Barthes, 1972). Thus "...language is constantly and secretly slipping into our minds a whole universe of assumption that will never come to judgment." (Harland, 1987, p18).
This is an echo of how Durkheim, earlier in the century, saw that individuals are a secondary product that emerges out of the more powerful entity, society (Harland, 1987). He explored the nature in which group habits arise in a collective way, not through a combination of individual preferences or choices that happen to coincide, but rather by a process in which individuals seem to follow the collective. Harland describes this eloquently: Something is not the popular choice "because everyone likes it, but because everyone else likes it." (Harland, 1987, p. 21). Following the same perspective, social constructionism, according to Gergen (1994) is concerned with the meaning that results through relationship; intelligibility results from patterns of relationship, which become social processes and, over time, take on the form of tradition or practices or belief systems.

The following brief descriptions illustrate the differences, communicated through language concepts, between traditional African and Western world-views relating to perspectives in healing.

**Western and African world-views**

In Western culture, the individual is generally seen as unique and independent from society, having an internal locus of control and an influence over the environment (Sue, 1981). Draguns (1989) argues that the mental health model adopts the approach that internal personal factors provide explanations of behaviour. Distress is reduced to the level of the individual, rather than being seen as a problem on the level of underlying social or political dimensions (Littlewood, 1992). In many psychotherapies, the healing process consists of individuals talking, in a one-to-one encounter with a therapist, and gaining insight into the reasons for their feelings and behaviour. The mental health system also largely adopts a medicalised approach to problems and healing. 'Pathology' and 'symptoms' are very often used to describe problems that clients are presenting (Littlewood, 1992).
The world-views of traditional African cultures are very different to this. South African black cultures share many similarities with one another (Donald & Hlongwane 1989). I will draw an example from the Xhosa culture. According to this world view, man and nature are in a continual relationship, in a state of cosmic balance (Schweitzer, 1977). Illness or misfortune results from an upset in this balance and signs of disturbance are immediate and unmistakable. Causes are always seen as emanating from an outside agent, either the ancestral shades or a witch, never by chance. The diviner, who is in communication with the ancestral shades, and is able to interpret the causes of misfortune, prescribes an appropriate activity that will remedy the problem. This is often a ritual in which a cross-section of the social network of a dominant group (relatives, friends, neighbours) is included. Thus, the healing process is not focused on the individual in isolation but involves maintaining social connections within the community while allowing for a symbolic healing process (Hirst, 1990; Schweitzer, 1977).

Looking at the contrast between these world-views which inform perspectives in healing, we can see how different belief systems are formed through discourses that are specific to that cultural reality. It is through the use of such discourses and their continued correspondence with and affirmation from the social reality, that individual identification with this reality would be maintained.

Kleinman (1980) speaks of 'symbolic reality' which is the bridging reality that links social, cultural reality with internal, psychological reality, using meaning derived in the social world to understand and make sense of inner experiences, thus forming an individual identity that accords with the cultural reality. The discourses of healing would thus form the individual's conceptions of illness and cure and would inform them about choices of healing.
The multicultural reality

The descriptions of Western and African world-views illustrate just how fundamentally different world views and experiences of reality can be, and hence how incompatible healing methods from another culture might be for someone within a single cultural reality. It is rare, however, that people live in exclusive cultural enclaves. Almost all societies have more than one culture within them (Helman, 1990). This means that there are different world-views potentially available to individuals. Thus, through proximity and availability of divergent healing methods, it is possible for people to be aware of different healing methods and to choose to seek help from a variety of clinical realities. South Africa epitomises such a society, with a mixture of people from different cultures, who, despite many lingering divisions, are very much intermingled. We have, in particular, various healing traditions of black South Africans, which stand in stark contrast to the formal medical health system which has its roots in the Western world. In addition there are other sources of help which may be appealed to, such as faith healers and new age, esoteric healing. In seeking satisfactory solutions, would people turn to forms of healing that arise from divergent conceptual frameworks or world views? The answer is that people do tend to use a variety of healing methods.

In research done in Durban on the health seeking behaviours of urban blacks, Pillay (1996) identified four broad areas of help-seeking that were appealed to, namely, self-help, religious prayer, African traditional healing and medical. Obviously these different sources of help stem from very diverse bases of belief. Other research by Schlebusch and Ruggieri (1996), also in Natal, has shown that the majority of people who were attending a hospital for medical treatment, also used faith healers and most believed in the ancestors and traditional healing. These participants were of varying levels of education, but the majority had not completed secondary school.
What can we say about the fact that people are consulting healers from such different sources and belief systems? One approach is to look at Kleinman's understanding of the relationship of help-seekers to the different sectors of health care. Another is to consider how acculturation is affecting people's beliefs and identity, and consequently their choice of healing.

Kleinman (1980) is concerned with looking at the interrelationship between different healing practitioners within a society. He is critical of ethnologists and anthropologists who focus only on the exotic traditional healing of a culture, and fail to look at the use by patients of other types of healers and how patients decide which to consult. Kleinman is concerned with the pluralistic nature of the health care system. He is also conscious of how in developing societies there is movement from old ways of doing things to new ones, and often there is a mixture of modern and traditional beliefs and practices, with varying degrees of resonance and dissonance. He has described three sectors of health care which are useful.

**Sectors of health care**

Kleinman (1980) describes the popular or lay sector, the folk sector, and the professional sector. In a context of medical pluralism, all three sectors may be appealed to at different times for help. Help-seekers may work their way through these sectors, approaching them successively if they do not achieve satisfaction. Sometimes the different approaches appeal to some of their beliefs more strongly than others, and therefore they would tend to approach only one of the sectors. Or they may consult different sectors simultaneously for help with the same problem (Kleinman, 1980). Helman (1990) and Swartz (1998) have also explored these categories in their work.

The popular or lay sector is where help is most easily accessible, as it includes self-treatment and help from family or friends,
which could be in the form of advice, or home remedies. It would also include help or healing from a church, a cult or a group. Treatment appeals to lay beliefs about causality and cure, as well as what a healthy lifestyle consists of, be it what food to eat, or which charms to wear to ward off misfortune (Helman, 1990). The popular sector is the one that is usually approached first and is the most widely used. In the United States and Taiwan, 70 to 90 percent of health problems are treated in the popular sector (Kleinman, 1980). This is where lay people's values and beliefs about health and illness are formed, and is the basis from which people make their decisions to consult the other sectors, and from which they evaluate treatment (Kleinman, 1980). The popular sector usually contains a variety of disparate approaches to healing, not necessarily compatible with one another (Swartz, 1998).

The folk sector is particularly extensive in non-Western societies, and consists of individuals who have specialised in a particular kind of healing, either sacred or secular, or a combination of the two, for example the diviners and herbalists in African traditional healing. Types of folk healing world-wide are many and various, including faith healers, shamans, bone-setters, acupuncturists and clairvoyants. Skills are often acquired by apprenticeship or through having healing power, either as a gift or through inheritance. In contrast to the professional sector, the folk healers usually share the values and belief system of the people amongst whom they originate (Helman, 1990).

According to Kleinman's model, the professional sector is the 'official' component of the health care system, and in most societies this is considered to be Western scientific medicine. By professional and official is meant specialised knowledge, which is difficult to acquire, and is used only by those who have mastered it. There is control over this body of specialists, a monitoring of their ability and protection of their interests (Helman, 1990). Western medicine has achieved dominance in the health care field, through legal support, and thus tends to have higher status and income than other health sectors. It also has power regarding
administering of drugs and diagnosing or categorising people's illnesses in a way that can have considerable impact, legally and otherwise (Helman, 1990). Kleinman does speak of indigenous medical systems such as Ayurvedic medicine in India, which might be considered part of the folk sector but which is professionalised in a similar way to Western medicine (Kleinman, 1980).

In the context of black urban South Africans, the available health sectors stem from different cultural influences. The lay health sector stems largely from the family, friends and neighbours. This is the sector that is first appealed to for help, so it is this sector which would direct the thinking and hence the choices made about where to go for further help. Often where the older generation holds traditional beliefs, these may be a strong influence which would inform the individual's world view. Increasingly, however, in an urban context there may be a Western influence in thought within the family (Uzoka, 1980). Often there is dissonance between the generations, with older beliefs being scorned by the contemporary youngsters (Swartz, 1998).

The folk sector forms a significant part of healing amongst black South Africans. This is the domain of the traditional healers: the herbalists (inyanga) and the diviners (isangoma or iqgirha). This is also the domain of the faith healers, of the African independent churches, such as the Zionists. Here there is the Western influence of Christianity, combined also with traditional influence. For example traditional beliefs about possession are intermingled with the Christian-based beliefs about exorcism (Swartz, 1998), and often the 'shades' or ancestors (a conception from traditional beliefs) are used to intercede on a person's behalf, with God (Bate, 1995).

Western medicine is very much used by many black South Africans. In terms of 'mental health' professionals in South Africa, there is a greater abundance of primary health care workers, social workers and psychiatric nurses, with clinical psychologists being
comparatively few in number and psychiatrists being even scarcer (Swartz, 1998).

**Explanatory models and paradigms**

In Kleinman's exploration of how people make choices of healers in a situation where they need help, he articulates how people hold explanatory models (E.M's) which "offer explanations of sickness and treatment to guide choices among available therapies and therapists and to cast personal and social meaning on the experience of sickness" (Kleinman, 1980, p.105). He describes also how "vagueness, multiplicity of meanings, frequent changes and lack of sharp boundaries between ideas and experiences are characteristic of lay E.M's." (Kleinman, 1980, p.107). E.M.s are not always easily articulated by lay people, nor necessarily fully conscious. People may work their way through various help-options until they receive treatment that satisfies them (Boonzaier, 1985), or use different options concurrently in the hope of achieving healing (Pillay, 1996; Rappaport & Rappaport, 1981). Leslie Swartz gives the example of how he used a range of different healing options to treat an allergy he was experiencing. The treatment ranged from biomedicine to anthroposophical medicine and homeopathy. He reflects that he had complete faith in none of these on their own, and simply hoped that by using them all simultaneously, something might work (Swartz, 1998).

In considering the individual as a health seeker, Kleinman's model gives an idea of what an individual may do when faced with a pluralistic health care system. First there would be the step of deciding that they have a problem that requires help or healing. This would be determined to a large extent by their belief system. Illness and optimal health are relative concepts, differently determined in different cultures and influenced by factors such as affluence or economic status. For example, someone who is struggling to feed his or her family is unlikely to go to a psychotherapist to have a disturbing dream analysed, because this
would not be an affordable priority. However, if this person were from a cultural background where dreams are considered very significant, they may well make the financial sacrifice of seeking an advisor to interpret a meaningful dream.

Cultural variation will also determine whether something is interpreted, or even manifests, as a physical or non-physical problem. For example, regarding 'depression' as understood in the West, in different cultures it may be somatisized to different degrees (Marsella, Sartorius, Jablensky and Fenton, 1985). In my research, the concern is with problems that would be taken to a psychotherapist, and thus in Western terms would be described as 'mental' or 'emotional' problems. The same problems may manifest or be interpreted very differently in other cultures.

In identifying the problem that needs assistance, the individual may be guided to a source of help through explanatory models. However, as Kleinman illustrates, this is often a haphazard process. Frequently it is the most accessible source of help that is approached. Availability of different types of healers, transport, appointments and sick leave may all have an influence on who is turned to, as well as the affordability of the treatment (Pillay, 1996). Western medicine can be prohibitively expensive, although the reverse may also be true. For example, in Crossroads, Cape Town, Boonzaier (1985) reports, fees at the local clinic were only fifty cents while the traditional healers charged up to R100.

Assessment of whether the problem has been helped by the treatment, would relate to the conceptual frame of reference that the individual is using. However, it is possible that people may not reassess E.M's that are not validated by supportive experiences. Health seekers may keep returning to a form of healing for a long time regardless of whether they are being helped or not (Kleinman, 1980). This could depend on how open they are to alternative explanatory models, as well as the availability of alternatives. Or they may turn to another form of help, possibly from a totally different sector of health care.
Jahoda (1961) conducted a study in Ghana of five traditional healers and their clients. Their case loads were analysed to establish what problems clients were consulting healers for. In terms of diagnosis, often a supernatural cause would accompany a physiological diagnosis of a condition, as though explanatory models from two different world views were sitting comfortably along side one another, but erratically and idiosyncratically, rather than systematically. To consider further what influences the individual to hold different explanations or to move across the boundaries of different paradigms in the choice of healer in a multicultural society, we need to look at how cultures impact on one another and the effect this has on beliefs.

**Local Knowledge**

We have looked at Geertz's conception of how culture creates our landscapes of knowledge and reality. From this comes the concept of 'local knowledge' which Gilbert (1995) describes as knowledge which is the tacit product of acting and sharing meanings with members of one's community, which forms a body of accepted wisdom about everyday reality. Local knowledge is fluid and adaptable and changes as social relations and cultural practices change. Thus, as Thompson (1996) describes, it is differentiated from traditional knowledge, where the term 'traditional' refers to a static conception of culture in the past. This meaning of 'traditional' creates an illusory concept of tradition, which overlooks the transitional nature of social reality, and asserts an artificial rupture between the past 'traditional' social system and the present. 'Traditional' is presented as some kind of baseline against which the present is measured. The concept of local knowledge fits with Thompson's alternative notion of 'tradition' as the background assumptions in a culture about how to conduct one's activities, which, through routine practice, collectively forms a world view or understanding of reality. In this research the word tradition is used to describe the contemporary practices that do not stem from Western influence, which are perceived to be African in origin, a definition derived from Coplan (Spiegel, 1989).
Local knowledge is sensitive to social change, and being fluid and dynamic, it will change for those members of a community who are encountering other forms of knowledge and being influenced to think and perceive the world differently. Such 'external' knowledge which is impacting on the local knowledge has been termed 'exogenous' knowledge, for example formal knowledge based on Western thinking would be exogenous to a non-Western community. A meeting of different knowledge forms may not be consciously intended, as happens when different cultures are co-existing. At other times there is a deliberate attempt to introduce a new knowledge form into a community's local knowledge as part of social transformation.

Related to the health care system in South African, there is both a co-existence of different cultural forms of healing, and also the intention to make Western medical services available to all people. At times this has led to encounters with communities who are unacquainted with, or do not necessarily support, Western perceptions of the world. Gilbert (1997) describes the possible outcomes of such an encounter between what he refers to as the "focal community" and the "change agent" or carrier of exogenous knowledge. One possibility is that the focal community rejects the exogenous knowledge and refuses to partake in activity related to the new knowledge. The second possibility is that the focal community rejects their own local knowledge and practices and adopts those of the change agent. Local knowledge would be lost, without providing any gains to the exogenous knowledge, other than new practitioners. The third possibility is that new practices or knowledge incorporate both forms of knowledge, and thus new local knowledge is formed. This gives recognition to the validity of both bodies of knowledge, rather than domination of one over the other.

Domination is most likely to occur when the strengths of a community's local knowledge are not acknowledged or the tacit assumptions in exogenous knowledge not made explicit. In South Africa there are numerous examples of this, for instance, an article by Gillis, Koch and Joyi (1989) entitled "Improving
compliance in Xhosa psychiatric patients. The concern here is with Xhosa patients in Cape Town who did not consistently take their psychiatric medication, and how this problem could be improved. Obviously from the perspective of medical psychiatry this is a potentially serious problem, but it is interesting to see that the perspective taken here is very much aimed at winning the patient over to the views of Western medicine. An example of this perspective is contained in the following view expressed in the article.

The next step in coming closer to conventional medicine is the acceptance of both systems concurrently and, with increasing acculturation, this is followed by the rejection of traditional explanations and treatment. It is common experience, however, that a retreat to the beliefs of the forebears may occur during stressful periods. (Gillis et al, 1989).

This idea of acculturation is defined by Lamensdorf and Linden (1995, p.1231) as

cultural change that is initiated by the meeting of two or more autonomous cultural systems. The key elements of the construct are contact or interaction between cultures which is continuous and firsthand, change in the cultural or psychological phenomena among the people in contact, and a process of change which is dynamic.

Inherent in this definition is the idea of change occurring for both communities encountering one another, not just one. However, the perspective on acculturation portrayed in the above article extract suggests that change is necessary only for the 'traditional' community, and acculturation is achieved in rejecting traditional beliefs and practices and adopting those of Western culture. There is no consideration of the local knowledge that is being lost in the rejection of traditional explanations, nor a real
questioning of why traditional beliefs are returned to during stressful periods. This shows an unreflective desire to assert Western domination.

**Acculturation in South Africa**

In South Africa the influence of acculturation has been very much from the dominant group (European) to the indigenous group. On the group level, acculturation changes include changes in social structure, economic base and political organisation. On the individual level – that which concerns us here – the changes affect identity, values and beliefs (Berry, Poortinga, Segall & Dasen, 1992).

Gilbert (1997) explains that according to Lave's concept of a "community of practice" individuals interact, working towards a common goal and generating common understandings and forms of knowledge. In a society, individual acculturation varies with some cultural and psychological aspects being affected more than others. This is because different members of a community participate to different degrees in activities within the community of practice and similarly would respond to and participate in acculturative influences to different degrees (Gilbert, 1997 and Berry et al., 1992). Individuals may also participate in a number of different communities of practice. This would account for the variety in local knowledge that can be seen in communities experiencing rapid social change. Positive own-group attitudes and negative out-group attitudes would lead to resistance to acculturation whereas the reverse would encourage it (Berry et al., 1992).

In South Africa there are a variety of sources that have facilitated acculturation, and which would have different effects on individuals (Donald & Hlongwane, 1989). Change in language and following of mass media has a strong influence on perceptions (Berry et al., 1992). Christianity has largely infiltrated black cultures, in many instances discouraging the practice of
traditional beliefs and customs. Modernisation and social mobility have become desirable, encouraged by the appeal of materialism portrayed by mass media. School education is modelled on Western norms and values which encourage individual achievement, which contrasts with the more community and group based values of African culture (Donald & Holongwane, 1989). Urbanisation and migrant labour has affected the kinship system as well as the structure of the African family (Donald & Hlongwane, 1989). Although the move to nuclear families is not an inescapable accompaniment of industrialisation, it is often a result of urban living, and would remove children and parents from the immediate influence of the older generation and their more traditional belief systems.

A study was conducted in Ghana to assess whether social change was influencing beliefs among school teachers about mental disorders and treatment preferences (Lamensdorf & Linden, 1995). Amongst those who had experienced a greater degree of social change there were higher levels of belief in internal causes of depression and dependent personality disorder, and the participants had more desire for participation in the healing process. All participants believed in multiple causal factors regarding mental illness, such as biological, social and spiritual. Subjects generally gave a low rating to the belief in supernatural causes of illness. This could be due to a number of factors. It is possible that this reflects the acculturation of the sample, who are all educated in Westernised institutions. This could be enhanced by another factor, the manner in which the research was conducted being conducive to giving 'educated' responses. Further, it is possible that attributing causes to spiritual forces could happen indirectly, for example as the cause lying behind the more apparent physical cause.

**Detraditionalisation and identity**

Tradition plays a role in the formation of both individual and collective identity. The beliefs and behaviour patterns normalised
and legitimated by tradition, form the symbolic materials that create the basis for identity. It is an assumption of the modern world that development brings about the gradual decline of tradition; a process of detraditionalisation. A different perspective on this brings to light the fact that traditions do not simply disappear, but rather that they become more open to question. Thompson (1996) argues that as a means of providing a world view, and a sense of group belonging, tradition may still play a significant part. However with detraditionalisation, the legitimising and normalising aspects of tradition lose their strength. This allows a more active process of self-formation, as individuals no longer have identities provided unquestioningly by their cultural roles (Thompson, 1996).

Parker (1992) argues that discourses are central in constructing different types of self or identity. Discourses themselves always arise in particular social contexts and through social processes, and thus represent certain concerns or worldviews, as expressed in the following:

We take discourse to mean frameworks of meaning that are realised in language but produced by institutional and ideological structures and relations. (Berman, Kottler, Levett and Parker, 1997, p.8)

Discourses provide the meanings which comprise a belief system. An individual subscribing to this belief system will develop a sense of self, or identity, in relation to these beliefs. Through the use of discourse this identity is reinforced.

Through different social contexts the individual is positioned in different roles. The self, as Harre (1979) puts it, is the sense of holding multiple positions in a society of beliefs and ideologies. These social, public positions serve as the concept an individual uses for his or her private sense of self. Hall (1990) describes how one's identity is always in production. In the
context of social change, the discourses that have formed the individual's beliefs and identity may become more visible when other discourses are encountered. This could lead to challenges or contradictions between different discourses and the identities that accompany them (Berman, Kottler, Levett and Parker, 1997). For example, the media has an impact on people in presenting images to them that do not relate to their daily lives, of 'non-local knowledge', to use Thompson's (1996) term. This enables the individual to adopt a more flexible approach to self-formation as they are to "draw increasingly on symbolic materials transmitted through the media to inform and refashion the project of the self" (Thompson, 1996, p.97). Gergen (1996) describes research which illustrates how easily we slip between different perceptions of ourselves, dependent on our contexts and social surroundings. Similarly Mead expounds that the self, being formed in various different social contexts, will contain aspects that reflect different social relations, appropriate to some situations and not to others: "There are all sorts of different selves answering to all sorts of different social reactions" (Mead, cited in Larrain, 1994, p. 147).

For some the contradictions between different discourses may be confusing. Van der Walt (1997) conducted research exploring black university students' perceptions of their own cultural identity in a changing South Africa. The majority of black students expressed confusion: "I do not know whether to follow the norms of Western culture or to fall into the tracks of my forefathers' culture", and, "Should I become a Westerner and abandon my culture or remain an African and not keep up with the times? I need an idea of who I am!" (Van der Walt, 1997, p. 104). The conflict is clearly between Western and African cultural identity. Another example shows the conflict manifesting in terms of religion: "I don't know whether to pray to God or seek help from my ancestors. In times of real crisis I revert to my ancestors" (ibid, p. 104) For others there did not seem to be such confusion between different world-views: "I am using both African and Western culture so that my life should be
well balanced" (ibid, p.104). This shows adoption of identity from both world-views, synthesised to the advantage of the individual.

Conflicts of self-perception may manifest in choice of healer: Africans who are becoming Westernised, are often ashamed to admit to their use of traditional healers, and although they continue to consult them, they may do so secretly (Rappaport & Rappaport, 1981). One of the amaprofethi (prophets) of the Zionist church described how people coming for private healing sessions who belonged to one of the mainstream churches, would often come at night to avoid being seen by other members of their congregation (Bate, 1995). This illustrates people's sensitivity to the identities that may be ascribed to them, and their self-evaluation in terms of what they perceive as the 'dominant' or authoritative world-view.

Parker (1992) and others would argue that discourses are always intended to support and reproduce belief systems which in turn may maintain particular power relations. The origin of a particular identity, expressed through discourse, can thus be located with an institution or ideology that holds a set of beliefs. In the above examples, the contradictory belief systems are those of traditional African culture and Western culture. The former is identified as belonging to the forefathers, figures who are traditionally respected, whereas the latter is associated with being modern and conforming to current 'norms'. Understandably these individuals feel pulled in two directions by discourses which both have a dominant and assertive effect in directing beliefs and ways of being.

Shotter (1989) uses the term 'social accountability' to describe the need individuals feel to use discourses that are appropriate to the publicly consented reality or ideology of their social context. This limits individuals to speaking in certain established ways that conform to shared meanings as well as to experience themselves in ways delineated by the positions they adopt within these
discourses. Thus, in looking at the discourses an individual uses, the context, institution or ideology that the individual is accountable to (often unconsciously) can be identified.

In a situation of social change where the individual is positioned by conflicting discourses, there may be confusion about which realities or 'authorities' they feel accountable to. Two examples from van der Walt's (1997) research illustrate the conflict in perceived accountability: "If I worship the ancestors, people will always refer to me as uncivilized and primitive" (ibid, p.112) and, in the case of such worship, "what would happen to me if the priest should hear or learn about it. I have to lead a double standard life: ancestor on the one hand and church on the other" (ibid, p.113). Here there is a conscious recognition of the 'authorities' that the individual feels accountable to. The one is the institution of ancestor worship, which both individuals appear to want to practice. On the other hand, this conflicts with the ideology of Christian religion, which in some social contexts frowns upon ancestral worship. The second speaker locates the authority that he or she feels accountable to in the personage of the priest, who would stand in judgement. The first speaker feels the conflicting authority in the form of those who would judge traditional practices as primitive, perhaps in a Westernised social context. In a similar way health seekers may anticipate judgement of their choice of a healer, from the perspective of others located in different social contexts.

Alternatively, individuals may find a way of harmonising discourses that speak from different positions of authority. In Van der Walt's study, some students found a comfortable way of accommodating Christian and ancestral beliefs: for example, "Our contact with God is through the ancestors to whom we pray", and, "Jesus Christ is the Head of everything – also our ancestors...He is not an ordinary ancestor but a divine one" (ibid, p.114).

A key to understanding the choice a person makes between multiple healing paradigms, is in seeing that individuals may have a range
of possible identities available to them, which would dictate which help-options they would consider most suitable. Different help-options might satisfy different identity positions that they hold and thus be appealed to at different times.

An example of how on a larger social level, multiple discourses are available that appeal to different world views, and give rise to multiple explanations and choices of healer occurred in the Eastern Cape (MacLennan, 1999). At a church school in Umtata, there was an incident where more than a hundred girls were convulsing, foaming at the mouth and screaming. This condition had begun the previous week, with children "fainting, falling about and crying...Others were just stiff, others were shivering as if they were cold" (MacLennan, 1999). Action that was taken immediately, stemmed from the religious paradigm, and then from the medical world. An Anglican priest, the school chaplain, performed an exorcism ritual using prayer, holy water, oil and incense and laying on of hands. The priest performed individual exorcisms after trying a mass exorcism, which did not work because, he claimed, the evil spirit "was moving from one girl to another". He felt that the ceremony had been successful despite the spirits saying that they would not go. Afterwards, some of the girls were taken to a general hospital where some were sedated and one was kept in the psychiatric section. Comment in the newspaper report (MacLennan, 1999) mentioned two explanations, one from an African cultural perspective, where this phenomenon is known as Amafufunyana, a kind of madness, and the other, a psychological speculation, based on research findings, that this event may be linked to stressful situations of rapid social change from traditional to Westernised and competitive urban culture.

This scenario is interesting in that it illustrates four different belief systems employed in response to this event. There is the priest who believes in the protection, through Christ, from the possession by an evil spirit. There is Western medicine, which responds on the level of brain chemicals, sedating the girls to calm them. There is the African traditional understanding which
diagnoses a condition of madness, induced through witchcraft. There is the psychological account which attends to the mental and emotional coping ability of children in a socially stressful situation. It is striking how easily these very different discourses were situated beside one another and led to divergent treatment responses. This scenario illustrates the different communities of practice that are co-existing in a multicultural society. Perhaps this serves as a mirror for what may happen on an individual level for someone who is able to employ divergent explanatory models. Perhaps, too, it enhances the possibility of people perceiving that multiple realities can coexist, thus increasing the tolerance for a range of potential approaches to healing in our multi-faceted South African culture.

**Choice of psychotherapy by black South Africans**

The participants in this research have chosen to go to psychotherapy, which is historically a Western form of healing and has in the past been practised in South Africa mainly by white people. These individuals are therefore stepping beyond traditional African culture in this choice. This implies a number of possible relationships to different healing options. The participants may have undergone some degree of shift away from traditional beliefs, in order to adopt the explanatory model and world-view on which psychotherapy is based. This could be the result of encountering exogenous knowledge which may have led to a shift in their personal beliefs, or they may have grown up in a context where, due to acculturation, they never believed in traditional African forms of healing. Alternatively participants may be subscribing simultaneously to beliefs from different world-views, which would allow them to hold different explanatory models in different contexts.

Examining the participants' relationship to the health care sectors, based on Kleinman's (1980) model, and the various kinds of healers they have consulted, provides a useful view of their
choices and knowledge related to the field of health care. Local knowledge, communicated through discourse and activity, would provide the beliefs and meanings the individual would use in their explanatory models to identify and make sense of a problem they are experiencing, and which would direct them to particular sources of help. Shared meaning connects the individual to a particular community, which would be reflected in their discourse. In this research the discourses that the participants used are examined as an indicator of which communities of practice or social contexts they are affiliating themselves with, and the sense of identity they have, influenced by these contexts. Not only is identity created in relationship with the meanings and discourses employed in particular communities, but maintaining a chosen identity also perpetuates particular beliefs and perceptions and thus is a significant consideration in the question of their choice of healer.

It would be expected that in a society of change where individuals are experiencing varieties of social contexts, they would face situations where beliefs and identities may be in conflict. Gilbert's (1997) work provides a useful guide to the potential outcome of the meeting of local and exogenous knowledge, particularly in considering the meeting of traditional African healing and Western medicine, where there is a vast difference in world-views and cultural practices. Individuals may find themselves positioned within multiple roles with a range of conflicting beliefs and identities available to them. Their choice of affiliation may be influenced by different sources of social accountability or authority as described by Shotter (1989). The strength of different enculturating influences may determine which sources of authority have the most persuasive impact.

The participants’ relationship to possible healing choices would be informative about their reactions to situations of social change. Their choice of identification would reflect where they are choosing to place themselves in a context where multiple roles and choices of action reflect different belief systems. The process of exploring these questions is presented in the next section.
CHAPTER 3

METHODOLOGY

This study was of an exploratory nature. The concern was with experiences and meaning, and a qualitative, hermeneutic study based on semi-structured interviews was most appropriate.

THE RESEARCH PROCESS

SAMPLING

Contact was made with a black psychologist, Mr M, in Port Elizabeth who had predominantly black clients. He agreed to ask four of his clients whether I could interview them, and he set up interview times. He selected which of his clients to ask. As this research was not intended to produce generalisable results, but rather to examine particular cases, the sample did not need to represent any particular criteria. It was thus left quite open as to which clients he selected. The participants were of an interesting variety in terms of beliefs and backgrounds, and they were all women. They were aged between forty-five and fifty-three years. Three of them had received tertiary education, and one had completed the first year of high school. They have been given the pseudonyms Nokuphila, Grace, Nomakhasi and Khuleka.

DATA COLLECTION

Each participant was interviewed once for about an hour. Khuleka, however, spoke quite extensively, so I decided to interview her a second time. She agreed to this. Two of the participants, Nokuphila and Grace, I interviewed in the house where Mr M conducts his therapy. Khuleka I interviewed in the psychiatric hospital where
she was spending a fortnight. Nomakhasi I interviewed in the house where she lives with the other trainees. I also interviewed the psychologist, Mr M, to gain some knowledge of his own perspective on psychology and traditional healing, and the kind of therapy he conducted.

The interviews were semi-structured, recommended by Kvale (1996) as useful for gathering specific information, while also exploring issues that emerged with the different participants. A transcript of the interview questions can be found in the appendix. Interviews were conducted in English, which, for three of the participants, was not a hindrance. Nokuphila, who had less formal education, at times struggled to express herself and to answer some of the more abstract questions. The interviews were about an hour long, and were recorded on audio cassette with the participants' permission. The data was transcribed from tape into text.

**DATA ANALYSIS**

The method of analysis was chosen because of the narrative nature of the text and the social constructionist approach to meaning creation. The hermeneutic approach, outlined by Packer and Addison (1989) and Kvale (1996) offers a method and philosophy for examining a text through a circular movement, between the parts and the whole. This approach stems from Heidegger's observation that our understanding is always circular: The whole is understood through its constituent parts, and any part can only be fully understood with a prior understanding of the whole (Packer & Addison, 1989). Heidegger based this on the premise that any form of investigation begins with preconceptions. Research operates from within paradigms, which are created out of particular cultural perspectives. We thus already have an agenda in our approach to research, and opinions about what we are investigating. Hermeneutics acknowledges this; in fact as Packer and Addison (1989) highlight, the interpreter should come with a well prepared forestructure – knowledge about the research domain – which is made
explicit. This acts as a conceptual framework which takes us forward into examining the text, and then through the process of circling between the parts and the whole of the text, we are able to gain perspective on our own forestructure, so that it remains fluid, and we remain receptive to that which we are investigating. Thus, hermeneutics makes no pretensions to being dispassionate and neutral. Instead it aims to acknowledge the cultural perspective in which an investigation is rooted (Packer & Addison, 1989).

The hermeneutic approach also takes cognisance of the fact that the text generated in an interview is something that is produced in a context of interaction. It is thus not simply a reflection of the individual's inner world, but is a product of an interaction between two people (Kvale, 1996). We need to critically reflect on this interaction context: What meanings, realities and discourses were allowed, co-constructed or silenced? Furthermore, interpretation is something that happens in the space between the interpreter and the text. The meaning thus produced is partly created by the reality of the interpreter.

Research, in this light, appears to be a shared process of meaning production, and this, if acknowledged, can give strength to the understandings produced. The advantage of this shared process is that it allows for multiple perspectives to come to light, so illuminating limited view points.

**The Reading Guide technique**

The Reading Guide is a technique in hermeneutic inquiry (Brown, Tappan, Gilligan, Miller and Argyris, 1989) which aims to provide a practical method for initialising the movement of the hermeneutic circle. In dealing with narrative texts, they have come to understand that the way in which the participant defines or interprets the situation, and what she or he focuses on as relevant to the problem - is related to what
actions she or he describes and the thoughts and feelings that follow from or accompany this description. (Brown et al, 1989, p.145).

This approach is sensitive to context, power relationships between people, and personal and cultural history. It identifies and then listens to the different voices of the "narrative self" in the text, voices which each "has its own psychological 'logic', its own psychic legitimacy and organization" (Brown et al, 1989, p.148).

The procedure in the Reading Guide technique is to reread the text from the perspective of these different voices within the text. The initial reading attends to the story, the context, the events. Subsequent readings adopt different interpretive lenses which will reveal the different meanings ascribable to different voices within the text.

**The procedure**

In the analysis of the transcribed texts, the interviews were read and reread. The initial readings identified the experiences and perceptions of the participants: their past knowledge and experiences of psychology and traditional healing; the process by which the participants came to therapy; their current perceptions of psychology and how it can help, and current and comparative experiences or perspectives of traditional healing. From this, and through the literature, three interrelated areas of interest emerged that comprised the conceptual framework.

1. The participants' help-seeking behaviour in the light of Kleinman's description of the health care sectors highlighted the beliefs and world-views which were familiar to them. Their perceptions and behaviour illustrated whether they employed singular or multiple explanatory models in conceptualising their problems, for example in separating different kinds of problems as needing help from different types of healers. This indicated
their relationship to multiple approaches to healing, which illustrated their reaction to different belief systems in a context of social change.

2. Considering the local knowledge and social contexts or communities of practice that the participant has encountered, including their childhood exposure to traditional healing and knowledge of psychology, would help to illuminate their relationship to a variety of world-views. This would illustrate the effects of acculturation, for example their degree of familiarity with traditional beliefs. With the experience of changing social contexts the individual may experience shifts in their local knowledge pertaining to healing. Exploring this would reveal how they have responded to social change.

3. Participants may affiliate themselves with various identities. Examining their discourse as a reflection of their identities would reveal where they most strongly position themselves in relationship to different social contexts and bodies of knowledge. This would aid an understanding of their choice of healer. It would also indicate whether participants have adopted different identities in relation to different social contexts. These identities may stem from significantly divergent world-views, in which case the conflict or harmony between them would indicate the participant's response to a situation of social change. Also of interest is the source of social accountability or authority that has the strongest influence on the participant's identity, as this would also indicate their relationship to the variety of available beliefs.

In the next step the texts were read from each of these perspectives, using them as lenses through which to view the data. These three areas overlap, for example, the belief system or community of practice that influenced the individual also situated them in a particular identity. These multiple readings thus viewed similar information from different but congruent angles. The texts were sorted into sections of information which represented the
different areas of interest, and contained the accounts of the four participants' experiences. This is presented in the Results section. The data was analysed and discussed in the light of the questions posed in this research and the responding conceptual frameworks provided by the literature.

By considering the relationship between the three areas of interest, the findings could be considered as a whole. This revealed the overlaps between the three areas. The hermeneutic circle emerged as a depiction of the different scenarios the four participants represent in their response to choices in a multicultural society.
CHAPTER 4

RESULTS

This chapter begins with Part One, the results from the interviews conducted with Mr M, the psychotherapist to whom the participants went for therapy. This is followed by Part Two, the results from the four participants.

Mr M's approach to therapy is of interest, because it reveals his perspectives which obviously influenced the therapeutic interaction he had with his clients and thus had an effect on their perceptions of therapy. The opinions he expressed should be treated as coming from his perspective, rather than as facts.

I have presented the results for each participant separately. I began by mentioning the problems that they came to therapy with. I looked at their present use of the health care system, which gives an idea of their experience of different bodies of knowledge and their choice of explanatory models. The latter I also dealt with separately. The process of therapy reveals the participants' journey through the health care system in dealing with a specific problem.

Next I dealt with the second area of interest, the participants' background knowledge and experience. This explains where the participants' current beliefs and perceptions originated. Following this I looked at whether their beliefs have shifted between different belief systems.

In the third area of interest, I described the different identities that emerged through the participants' discourse about their relationship to different social contexts and different health care sectors. I looked at what authority figures or institutions may
have guided these identities, and I considered whether the participants experienced conflict between identities or found harmony.

Part 1: Mr M

What brought his clients to therapy?

As a psychotherapist Mr M initially accessed clients through referral. His reputation grew and many of his clients have since been recommended to him by friends. Most of his clients were struggling with emotional suffering or adjustment into marriage.

Mr M felt that his clients believed there is something he knew that they did not, which could help them to resolve difficulties. Mr M felt that this belief was based on the Western doctor-patient healing model, which clients learned from the medical world. In almost all cases he felt it was difficult for his clients not to see him as a doctor. However this perception was slowly eroded because he did not give them answers. This ultimately "grabs them" and caused them to come back to therapy.

What approach did he take to psychology and therapy?

He took what he perceived to be a phenomenological approach, looking beyond the concrete or the shared cultural sense, to find the personal, symbolic meaning that the client held, of, for example, an ancestor. He gave examples of helping clients to elicit a personal interpretation of their dreams rather than a cultural one. In this way he saw therapy as having an educational effect; clients learned the language of psychology, and began to move between the concrete and the symbolic.
When necessary he addressed cultural beliefs or issues, for example, the traditional meaning of the 'home', if this arose. Occasionally, if appropriate, he talked about the ancestors to help clients realise he does echo their experiences.

**The effect of therapy on client's perceptions of traditional healing of psychology.**

He said that some clients may be disappointed with therapy and return to traditional healing. Others stay, or return once again to therapy. Ultimately, he felt, 'therapy' is a human institution, a process of healing of the soul, and not strictly a Western or traditional thing.

His encouragement of a move to more symbolic understandings did not change his clients' perceptions of, for example, the ancestors. Rather, traditional and psychological understandings coexisted, living side by side. For some people this was comfortable, for others there was a struggle to integrate that which can only be symbolically integrated, not concretely. However, he felt all of his clients had the experience of integrating Christianity with a traditionally lived experience, so it was a question for these people, whether they were comfortable with this plurality or not. He comments that "I suppose they are...but the question has not been absolutely resolved".

**Part 2 The Participants**

**NOKUPHILA**

Nokuphila had been educated up to the first year of high school, standard six, and was fifty two years old. She worked as a cutter in a textile factory. She struggled with speaking English and did
not always understand what I was asking her. She had been in therapy for one year. The pseudonym Nokuphila means she who has found something that made her come alive, which characterised this participant's discovery of psychology.

1.1 Problem brought to therapy

Nokuphila's problem manifested as an inhibition related to sexual intercourse. She expressed her problem as "I'm not feeling to sleeping with my man, my husband. I haven't got feelings since I was born".

1.2 Current use of health care system

Nokuphila made use of two different sectors of health care, the traditional healers in the folk sector, and Western medical doctors, the professional sector.

She continued to consult the Western medical system regarding her problem, even though the doctors were not helping her. However, she became disillusioned with traditional healers. They told her that the solution to her problem was for her to become a traditional healer. She refused to follow this advice because she felt that they had not acted true to the traditional healing practice of being able to say why she had come to them. Hence she did not trust them because they failed to conform to their own traditional rules.

Thus, despite the lack of an explanation for her problem, she quite adamantly judged each sector on its own terms, in her expectation of the treatment it offered.

1.3 Process of coming to therapy

It was by chance, rather than choice, that Nokuphila came to psychotherapy. She had been to numerous traditional healers,
seeking help. She had also consulted Western medical doctors. They had given her medicine, but none of them was able to help her. It was a doctor from a hospital who referred her to the psychologist. She went to therapy expecting that it would be another Western medical examination.

1.4 Exploratory Models

Nokuphila did not seem to have one clear explanatory model for her problem. Rather, she was seeking an explanation from an outside source. Thus she expected to be examined and given medicine from the Western doctors, and simultaneously, would accept any form of remedy from the traditional healers, if they could tell her why she had come to them. She would even follow the prescription that she herself become a iqgirha, if she could trust them. Trustworthiness was an important concern for her, indicating her belief that expert knowledge is a necessary requirement for a healer to have.

She did, however, believe that something was "wrong" with her, and it was important for her to have an explanation of "what is wrong". She said "I'm just wanting someone to helping me".

In rejecting traditional healers, Nokuphila made a distinction between this problem she was experiencing, and problems she would classify as physical, such as having a headache, which she said she would still consult a traditional healer for, and expect to be helped.

2.1 Background knowledge relevant to health care sectors

Nokuphila obviously drew on a significant local knowledge of traditional healers because, although as a child she did not go to the traditional healer herself, her family would sometimes go and as an adult she visited many of them to try to get help for her problem. She also applied very firmly to them the traditional understanding that they should know what her problem was without
being told. On the other hand, Nokuphila also consulted medical doctors, and had the expectation that they would examine her physically and treat her with medicine.

2.2 Shift in knowledge after going to therapy

Nokuphila had very little high school education and no prior knowledge of psychology or therapists. She fitted Mr M into her expectation of a medical doctor, thinking that "he was going to check me and give me medicine". She was puzzled when he broke the expected behaviour pattern and just talked to her. However, she continued to return to him, saying that even after the first session, she felt that he could help her.

There was a significant shift in Nokuphila's local knowledge: She had discovered a form of healing that she did not know existed before, but which she felt was helping her, saying,

Doctor's talking those things I know...and he's asking me about things long ago and I know everything about them...In my body I'm feeling all right when I'm coming here.

This indicated that she had found an explanation for her problem, which is what she was searching for in her quest for healing. Therapy gave her an understanding that it was experiences in her past that caused her to have this problem. She said that she was "happy because I know what's going on with me". This indicated the importance to her of finding an explanation.

Nokuphila expressed her relationship to the newness of the psychotherapeutic approach by asking me for reassurance that talking, without medicine, could help with her problem. She said she still sometimes wondered why Mr M did not give her medicine to help her.
Nokuphila's gain in knowledge of an alternative form of healing gave her a position from which to reject the traditional healers. However, she still expressed a persistent belief in their healing power by saying that if they had proved their trustworthiness by telling her why she had come to them, she would have followed whatever treatment they recommended. It was congruent with her knowledge of the rules by which traditional healing operates that she rejected them as untrustworthy, thus her rejection was based on a belief in the system itself, rather than a complete moving away from these beliefs.

3.1 Identities expressed

Identity with knowledge of psychology

Nokuphila's response to the traditional healers positions her as someone who once consulted them and now has lost faith, and is able to reject them as being unhelpful for her problem. She sounded mistrustful, and at times angry; for example, when she described her response to the amaqgirha’s inability to diagnose her problem. She reflected her feeling regarding the

Why don’t you tell me, not me tell you...then I understand and then I trust.

Her encounter with psychology has enabled her to move towards a new kind of discourse, where she can be critical of the traditional healers and can acknowledge the power of the healing that she has discovered in psychotherapy. When she spoke about her experiences of therapy she sounded happy and confident: "When I'm coming here I'm not worried". She said that in the future she would go to a psychologist.

She was not, however, dogmatic in her rejection of traditional healers. She said she thinks the amaqgirha help the people she knows who still go to them.
3.2 Influential authority

In discovering her new trust in the psychologist, Nokuphila relinquished her trust in the amaqgirha, and placed authority in the psychologist: "Doctor tell(s) me everything". Her hesitancy towards this external authority, probably because of its newness to her, was expressed in her asking agitatedly whether I agreed that "just talking" could help her. She seemed to have placed me in a similar position of authority.

3.3 Co-existence of identities

Nokuphila's search for an explanation of her problem was answered by psychotherapy and for this reason perhaps she expressed no conflict in giving up her trust in the amaqgirha and turning to a completely different source of meaning that positioned her with a different discourse, that of someone whose problem stemmed from her past experiences.

This easy rejection of the traditional healers could be because of the limited faith she had previously had in them. She says she did not really trust them before she sought help for her problem. The fact that she thinks they can still help her with minor ailments, such as headaches, shows that she did not exclude them from all spheres of her life. She mentioned that they still help her friends and family and thus still identified with them in some respects, but was more comfortable with the new identity she had adopted.

Nomakhasi

Nomakhasi was a teacher by profession and was training to become a traditional healer or iqgirha. She was staying at the house where she was training and she referred to her iqgirha teacher as her
'"Mother". She was forty five years old, and had started therapy about two years previously. The pseudonym Nomakhasi means she who is cautious about what she says, which characterises the way this participant spoke about her life as a trainee in the world of the amaqgirha.

1.1 Problem brought to therapy

Nomakhasi described herself as having a "social problem":

> It's because I was frustrated and I was always locking me up and I mean trying obviously to be alone.

She needed to express her feelings about this problem so that she could face it.

1.2 Current use of health care systems

Because she was training within the traditional healing profession, Nomakhasi had close, inside knowledge of what this form of healing involved and how it operated. She was quite clandestine about this information, saying that she had "secrets" which brought her to the world of traditional healing. She was living with her sangoma teacher and practising this form of healing.

In her case, it is interesting that although she was strongly aligned with traditional healing, she was not exclusively committed to this sector of health care. Instead she had knowledge of the variety of potential sources of help within the health care sectors.

1.3 Process of coming to therapy

Nomakhasi was not actively seeking help for her problem. She met Mr M by chance at a funeral and after talking to her, he said he would
like to see her, so she went to him. At this time she did not know about traditional healing so would not have considered it an option.

1.4 Explanatory Models

Nomakhasi felt strongly that different problems require different healers. In this way she could be seen as dividing the body and mind into separate areas that are quite distinct. For example, she argued that learning disabilities, emotional stress and insomnia all need a psychologist. A speech therapist would deal with speech problems. There are other things that can only be dealt with by a traditional healer.

In this division she tended to create a dichotomy between traditional healing and psychology or other Western specialist healing. She spoke of the need for people to learn to "differentiate between the two" systems, but she did not divide the problems taken to traditional healers into separate categories. She created the impression of help options being traditional healing versus the range of Western healing specific to different problems. She said she was not allowed to mention what problems she treats people for as an igqirha, apart from the physical problems of hypertension and diabetes. However, in wishing to educate people about alternatives, she was implying that traditional healing has limitations, and that there are areas of healing that it does not help. She spoke of people needing to know which "part" of their problem can be helped by which healer.

In terms of her beliefs about psychological healing, she felt that if she had not gone for therapy, she would by now be "psychologically wrong". The helpfulness of therapy, for her, lay in its allowing her to express herself and express emotions, and in the fact that no decisions were imposed on her.
2.1 Background knowledge relevant to health care sectors

Nomakhasi grew up with little knowledge about traditional healing because her family would not take her with when they went to consult healers. It was thus part of her family's local knowledge, although not her own personal knowledge or belief system. As an adult she studied to become a teacher, joining the workplace in the Western system of education. Perhaps her belief in the variety of Western healing forms is partly owing to the fact that she came to believe in traditional healing only later in life. At the time that she started therapy, traditional healing was still unfamiliar to her.

Nomakhasi's access to psychology through Western education is revealed in her professed knowledge of its theoretical but not its practical side, prior to therapy. "I did not know it to be helpful".

2.2 Shift in knowledge after going to therapy

Nomakhasi underwent a radical shift in her beliefs. Therapy seemed to have encouraged her belief in psychology as a necessary form of healing. However, the biggest shift for her was in the direction of traditional healing. She did not believe in traditional healing until she had finished a teachers' training course, at which time "there (were) things happening" which she could not speak to me about, which changed her beliefs, to the point that she came to train as a traditional healer.

Nomakhasi said she did not have any particular expectations of therapy. It was something new for her, but she did not express any surprise at the way it operated. She did, however, describe herself as having an understanding of how psychology works. She had adopted it into her belief system and believed that there are problems, such as stress, that definitely require psychological help rather
than another form. If she felt it relevant, she advised other people to seek psychological counselling.

3.1 Identities voiced

Identity as training iqgirha

Nomakhasi's identity as a training iqgirha was a relatively new one, as she had begun believing in traditional healing only after she had started therapy two years previously. She positioned herself strongly in this identity. For example, she said, "In our cases, we are not familiar with this, different types of therapy". By "our cases" she was referring to people who follow traditional beliefs and practices, and in her statement "we are not familiar" she was affiliating herself with this group, even though she herself was familiar with therapy. She was thus identifying herself with the cultural group that are not Westernised in their beliefs and practices. Her cultural placement was also expressed by the fact that she feels a white psychologist would not understand her regarding cultural issues. The strength of this identity was reinforced by her living in the home of her iqgirha teacher, wearing the beads of an initiate and holding exclusive knowledge. She said

"Things come to me...These are my secrets...that can be taken away from me by my ancestors if I tell those things, what happened."

Identity within the Western world-view

Nomakhasi also expressed an identity of someone who knew about psychology and Western healing. When speaking to the traditional world about therapy, her discourse reflected the perspective of
someone who knew how helpful this healing is. As she had "the understanding" she could advise her clients that they needed to go to a psychologist instead of a traditional healer, when relevant. Being able to help people to understand both worlds of healing emerged as a fairly strong role for her, from which she could act as an educator, informing others about available healing options. She was interested in the possibility of workshops at school to educate parents and pupils about psychology.

3.2 Coexistence of identities

Nomakhasi's identities spoke to each other from different worlds. There was the discourse of the educated woman who came from a non-traditional outlook, who could now speak with a voice of authority within the iqgirha world, to educate about Western healing. The voice of the iqgirha trainee, however, was deliberately reserved when speaking to me, possibly positioned as a representative of the Western world. She did not want to share her "secrets" about her experiences as trainee, and she had a defensive and protective attitude about her knowledge and events within the sangoma world. On the other hand, she actively tried to inform people about Western healing, referring them to psychologists when necessary. Nomakhasi experienced no conflict in living her role as a school teacher and being publicly perceived as an iqgirha trainee. People at the school also knew that she was seeing a psychologist. She wore her iqgirha beads to school and knew that the parents and children accepted her role. She felt no judgement. Thus, her identities were not undercover, nor restricted to separate exposure.

Nomakhasi acknowledged her position of experience in these two worlds and described herself as "very much lucky" because "I know how to use them, to which side I could go". While she had a strong identity as a traditional healer, she was also able to see the limitations of this side when it came to dealing with, for example,
emotional problems, and she knew she could play a role in "teaching the others" about alternative options. She said she did not feel any conflict between the two systems, and she did not find it strange, to be using both. She was happy in knowing what to take to each side: "This part can be helped by a sangoma". Therapy, on the other hand, had helped her to explain and express herself, and to describe her feelings.

3.3 Influential authority

There were strong authority figures governing Nomakhasi's identity as a traditional healer. One was the ancestors, who could take her powers away from her if she revealed her secrets. This accounts, perhaps, for her silence when speaking about her experiences as a trainee. The other authority was the figure of her "Mother", the teacher in whose house she was living, and whose rules she had to abide by as a trainee. This was expressed in her concern about time during the interview. She had obligations that she had to attend to. She also had to obtain permission for certain things: "There are rules and regulations".

By contrast, she asserted an independence when it came to her choice of activities beyond her obligations as a trainee. She said that there were no rules forbidding her to go to a doctor or a psychologist. This independence may reflect her position as holder of knowledge about Western healing, and she would thus be entitled to pursue it.

GRACE

Grace, fifty two years old, had trained as a nurse and was working in a hospital. Her children were studying at university. She had begun therapy three months previously. A Western pseudonym
associated with Christianity was most appropriate for her: I named her Grace because of her repeatedly expressed faith in God.

1.1 Problem brought to therapy

Grace described herself as having "personal problems", with an unhappy marriage that was breaking up, and problems at work. She described the feeling of a "heavy load" and that she was very much disturbed. I felt that life problems have really destroyed me, I have got nowhere to go.

She was under great emotional stress that seemed to be heading towards depression.

1.2 Current use of the health care system

Grace's primary sector for consultation was the Western medical, professional sector. Working as a nurse within this sector, she believed in its ability to diagnose and treat illnesses. At the same time this made her very sceptical about traditional healing and its claims to cure, and she would never have consulted this sector. However, her strong Christian faith would have allowed for the possibility of consulting faith healers or attending church prayer gatherings, and she considered prayer an important source of help.

1.3 Process of coming to therapy

In seeking help for her problem, Grace considered and then rejected help from within the lay sector, in the form of speaking to friends or her church leader about her problems. She expressed concern that people use others' suffering as a subject for gossip. Her
alternative help source, which could be described as also coming from the lay sector, was prayer, which she said she frequently used to solve problems. She felt that this led her directly to seek help from the professional sector: God showed her that she needed to speak to someone about her problem, and that "this somebody should be the psychologist".

Grace initially approached her doctor with her problem, but this was with the hope that he would refer her to a psychologist or a psychiatrist. However, he once made a joke about her problem, which upset her; consequently she chose to find a psychologist from the telephone directory.

1.4 Explanatory models adopted

Grace followed the biological explanations of Western medicine for physical problems and rejected traditional healing, whose treatment of physical illness, she argued, sometimes resulted in problems becoming severe by the time the patients went to hospital. She described how a doctor would treat the "underlying cause" of illness; for example, the germ that destroys your lungs in cases of tuberculosis (T.B.), by examining "the signs and symptoms" and then giving appropriate treatment. In reference to traditional healing she said, "I'm someone who doesn't believe in that". This was a direct result of her experiences in the hospital, witnessing patients who were not cured by traditional healing, who then suffered with advanced cases of T.B. or gangrene. Her perspective was uncompromising in this regard: In the case of someone insisting on help from the traditional healer, she said, "He won't see that the traditional healer can't help you".

She thus witnessed Western medicine as the final cure. Her voyage into therapy began in this system, although her explanatory model expanded beyond the medical, to include emotional stress and the value of talking. Grace also believed that God guided her and had a deliberate influence in leading her to therapy.
2.1 Background knowledge relevant to health care sectors

Grace's strongest sources of local knowledge were her faith in Western medicine, which she encountered in her job as a nurse, and her church community and the Christian beliefs that she grew up with, under the influence of her father, who was strict and a "highly religious person". These both stood as reinforcements in her opposition to beliefs in traditional healing.

Grace's first encounters with psychology took place in a psychiatric ward in the hospital setting where she observed patients going for therapy. She was told that the psychologist tries to find the cause of the mental problem, not through direct questions but through assessing the patient's history and problems. Grace thus initially associated psychology with medical practices that use diagnoses of symptoms to determine the causes of problems.

2.2 Shift in knowledge after going to therapy

Grace's knowledge of psychology that she gained in the medical context is accompanied by another belief she has that psychology is helpful in talking through emotional problems. The dissonance between the medical world and the healers of emotional distress was perhaps brought home to her when her doctor made a joke about her problem. This motivated her to find a therapist.

Grace was surprised by therapy in that she did not expect consultations to be for as long as an hour, nor that talking would occupy as much time as it did.

She described therapy as going deeper than she had experienced in talking before. She also expressed a new understanding in her explanatory model of emotional distress: She realised that keeping quiet about problems, for example marital problems, is what has caused "damage to my health".
If somebody could advise me when I have the problems as I am growing up, to go to the therapist, maybe I wouldn't be feeling angry.

Her idea of damage was also expressed in the idea that one could become "mad" or "completely destroyed" if psychological help was not given. She equated psychological help with her beliefs about medical help in her view that psychology "helps you permanently".

3.1 Identities voiced

Two strong identities emerged with Grace. One was her self-professed identity as a "modern" woman. The other was her identity as a Christian.

Identity as a modern woman

Grace affiliated herself with the Western scientific world view. This identity was expressed through her role as a nurse and her knowledge of medical diagnoses and cures.

We as educated people, we are among the people who knows how to solve problems the right way and really permanently.

For Grace, the distinction between this world view and the traditional, and her choice of identity therein, was quite final and irreversible: "Fortunately for me it happened that I must come to the modern way of living". She directly attributed this outcome to education:

If I was just an ordinary person without an education, I would be going there (to traditional healers).

Grace's association of psychology with the medical world could explain her choice of therapy as suiting her identity in this
world. She said she would not mind seeing a white psychologist, because she believes they are all trained in the same way.

**Identity in relationship to traditional culture**

Grace's discourse revealed that she related to the traditional African world as an outsider, although also with some ambivalence because she did not want to distance herself too much from her people:

I won't say that I feel different (to people of her culture). They are my people. But they can't tell me to go back to the olden way of living.

She showed in part a desire not to condemn the people who hold onto traditional beliefs: "I don't want to say they are uneducated. They are not enlightened". Later she used the term "uneducated" to describe them. In other words, for her, traditional beliefs are not inherent; they can be transcended through education.

She felt that traditional healing is doomed to fail:

I see that even if people start there (at the traditional healers) but they end up this way, on this side (Western medicine).

This statement also reveals her placement of her identity on the side of Western medicine. Her separateness is again revealed:

I am talking as an individual, but you must know that out there most of the people are still believing in it (traditional practices).
Grace's desired relationship to traditional beliefs for her culture as a whole is one of remembrance of heritage, rather than active use:

I wouldn't say we must practice it, but just to keep it, to know our roots, our people used to live this way.

This shows some degree of identification with tradition, yet Grace did not wish for an active identity in this direction.

**Identity as a Christian**

Her identity as a Christian and its roots in her upbringing also played a role in her distance from traditional healing practices. With a father who was "highly religious" and did not encourage this interest, she had limited exposure to traditional healing practices. She quite frequently and without prompting referred to her relationship with God, to prayer helping her, and to how God guides her. This came up particularly when she was speaking about therapy, needing to speak to someone whom she could trust with confidentiality.

**3.2 Coexistence of identities**

Grace spoke of people who were not helped by the traditional healer having to then come "to our side" meaning the hospital. For her, the sides were separate and mutually exclusive, and she did not consider the possibility of inhabiting both. She saw no usefulness in traditional healing, rejecting the idea of washing in herbs as a cure. She described it as the "olden way", with all the distance which that implies. Her identity as a "modern" woman was supported by medical science, which she had seen countless evidence for as a nurse. Her identity in this duality was quite clear and unmoving. In this respect it seemed not to fluctuate according to circumstances.
Regarding her religious identity, this did not seem to be incongruous with her modern identity. It was compatible with the rejection of traditional beliefs, and with a Westernized outlook. She did not express any clash in this with her scientific outlook.

3.3 Influential authority

For Grace, her traditional culture never had authority or hold over her: "They can't tell me to go back to the olden way of living". Rather it was the world of science that has the answers, and that solves problems "permanently". This was her authority which she was answerable to, the authority of scientific investigation. God was also her authority, He was the one who always guided and watched over her and hence had an effect on her destiny by leading her in certain directions, for example to therapy.

KHULEKA

Khuleka, fifty three years old, was articulate and went into great detail at times. Because of this I interviewed her twice. She had a university education and was putting her children through university. She was working as a librarian. Khuleka means easy to talk to and very relaxed, which describes the way this participant interacted in the interview.

1.1 Problem brought to therapy

Khuleka described herself as having crises - mental breakdowns - that were interfering with her job. She mentioned having "attacks" and at these times she was using symbols, such as making triangles with her hands while she was talking.
I was really depressed and under a stressful situation...I couldn't understand, so when I am talking to you, I will have to use certain signs, and I'm very fast with my hands, ne, and people won't understand. That's how I'm not all right.

She felt that her problem stemmed from the childhood trauma of being forced to write with her right hand at school, despite being left handed. She described how this creates confusion for her now, a feeling of disorientation, because she always has to think which hand or foot to use when she is about to do something.

1.2 Current use of the health care system

Khuleka was familiar with the different sectors of health care, the traditional healers, Western medicine, and lay or self-help. Of these, she made the most active use of the lay sector. She favoured self-healing for simple illnesses, and gained guidance and inspiration from her ancestors through dreams, which directed her in her own 'traditional' rituals and prayer. She seemed to prefer acting independently, to seeking outside help. Even her practice of Christianity was quite independent: She did not need to go to church to pray, and when she did, she still had most of her Sunday free for herself.

Khuleka was fairly critical of traditional healers, although she did at times consult one when her dreams were not clear. She said she admired him because he was a Christian, disciplined and hygienic. He told her that she should become a traditional healer, but she said to herself, "Sorry, that's not my life" and that put her off consulting the traditional healers.
1.3 Process of coming to therapy

Khuleka’s path to therapy actually began with the medical profession because when she had the first emotional crisis she was sent to hospital where she encountered a psychiatrist. This resulted in her rejection of the medical side of the mental-help profession, psychiatry, because she did not like the "pumping of drugs". This experience, however, was not an active choice.

The second time she had a crisis, she was able to follow her own ideas. She seemed very clear about her choices. First she asked her colleagues to take her to a priest who would pray for her, and then she wanted to be taken to Mr M.

This reveals her very deliberate use of different health care systems; she wanted help from both. She was not simply trying one to see if it would work and then moving on to another.

Inspiration to see the psychologist came from her peers, who thought that she was a suitable candidate. She says, however, that she went to therapy "on my own will".

1.4 Explatory models

Khuleka employed a range of explanatory models that stem from quite different world views. She usually knew exactly where to take different problems. For example for health problems, such as a cold or flu, she felt it unnecessary to go to a doctor and would rather treat herself. Whilst not rejecting the medical explanation for these illnesses, she felt their treatment was limited or unnecessary.

At other times, when she had dreams which she interpreted to be messages from her ancestors, she entered the explanatory world of traditional beliefs and followed the instructions her ancestors were sending her. When she had dreams that were unclear to her, she
turned to the advice of the traditional healer, acknowledging that he has access to the world of knowledge of which the ancestors are a part.

Regarding psychotherapy, Khuleka held the explanatory model that it was past traumas that caused current emotional distress. She felt that if things were hidden they would surface later, hence the need for honesty in therapy, and a focus on the painful parts, crying if necessary. She also felt that the therapist would be able to interpret her body language and tone of voice. This implies that some degree of analysis by the psychologist would be expected.

2.1 Background knowledge relevant to health care sectors

Growing up in rural Transkei, Khuleka, of all the participants, had the strongest knowledge of traditional healing. Her aunt was a traditional healer and her grandfather was a herbalist. When she was a child her father would sometimes bring a healer to the family home to perform cleansing rituals. Her mother was "very religious" and did not believe in these practices, but would not have gone against her husband's wishes. Khuleka recalled a time when she travelled with her mother to a spring which people believed produced holy water with healing properties.

She was also the participant who seemed to have the clearest sense of what therapy was about, prior to her experience of it. This was through studying psychology as an undergraduate at university, and her experiences of informal counselling as a nurse. She anticipated that it would require investigating into her childhood traumas. She had also written something that gave her colleagues, who had experienced therapy, the idea that Mr M would be able to help her.

2.2 Shift in knowledge after experiencing therapy

Therapy was not different from what Khuleka had anticipated:
That's what I expected, that he must dig, you know, so that all the old wounds can be opened.

Khuleka did initially associate psychology with the medical profession, because she described how when she first began therapy she was uncomfortable with the association of going to a doctor and therefore being sick, something which she was not used to and disliked doing. However, an initial deeper understanding of psychology is revealed by the fact that she could not separate it from her cultural self, and thus would not have considered seeing a white psychologist "because they don't know my culture". She also had not expected advice.

3.1 Identities voiced

Of all the participants, Khuleka was the most articulate and reflective about her identities and their relative importance in comparison with one another. She chose her strong left hand as representative of religion, her strongest identity, and her weaker right hand as representative of her identity within traditional culture, while education, which includes her work as a librarian, fell in the middle. She drew this analysis "to make myself comfortable", implying a discomfort in the multiple roles she was experiencing. She also expressed that "you have to choose as a human being which one is fit for you", even though she also advocated mixing them.

Identity within church and education

Khuleka favoured a position of independence and privacy. She strongly identified herself as someone who enjoys literature and learning, and the personal privacy of her religion: "Nobody can teach me". Her religion spanned a number of activities, such as reading religious books, going to church, and praying. From this position she favoured the cleanliness and simplicity of faith healing, where water and salt were used, above the 'unhygienic"
practices of traditional healing. She had not herself been to a faith healer, although she had consulted a traditional healer.

**Identity within traditional culture**

Khuleka felt that her personal relationship to traditional culture was the weakest of her identities, but in the interview text it came across as a significant and strong part of her identity. She expressed her confidence in dream interpretation, which she frequently related to messages from the world of the ancestors, and she followed instructions from her dreams without hesitation. The admiration she received from the traditional healer regarding her dreaming may also have acted as a source of confidence or sense of power, for example in his telling her that she brought good fortune to his practice.

This side of her linked with her "strongest" side, namely her religion, because she also prayed to her ancestors. She may, however, have separated the activity of praying in a Christian context, from visiting the graves and praying to her ancestors.

**Identity in relationship to traditional healers**

Khuleka had a negative attitude in general towards traditional healers, although she did not exclude them completely from her identity. They fitted in regarding her personal relationship with traditional culture: she visited the healer she respected when she needed help interpreting her dreams. Outside of this, she compared traditional healers negatively to psychologists, at times without seeing the parallels within psychology. For example, she was critical of the traditional healers seeking out clients who had money, without considering how private practice psychology is almost exclusively aimed at those people who have sufficient incomes to pay cash or afford medical aid. She also criticised their help as being too short term so that the client has to keep
returning. She did not consider that psychology requires long term sessions to be effective.

She was most favourably disposed towards traditional healers who shared her other beliefs, namely those who were Christian, those who advocated educating the community, and those who turned to Western medicine when necessary.

Khuleka adamantly refused to take on the role of a traditional healer, even when it was expressed to her that she was very good in her dreaming. She said, "That's not my life". There was too much role confusion for her.

Her resistance was quite resolute considering how connected she felt to her ancestors. This could reflect the strength of her identity with the other Western social contexts, which clashed heavily with becoming a traditional healer. In addition it reveals a strong sense of her personal power and ability to communicate with the ancestors. She was not afraid of appealing to them for guidance in seeking another direction, whereas someone who felt less confident may have been more intimidated by a calling from the ancestors.

She was also afraid of the initiation process involved in becoming a traditional healer. However, she revealed her closeness to the traditional world through her need to appeal to the ancestors to show her another direction. Her rejection of the traditional calling was thus dealt with from within the traditional world. She appealed to the religious identities that her ancestors had had before they died, as a means for them to understand her position. The ancestors were very real for her; she was able to identify them when she dreamed of them.

3.2 Coexistence of identities
Khuleka expressed her feeling that religion, education and tradition are interrelated, but that a choice had to be made between them. She had made an overt choice in the favour of Christianity and education, and these seemed to occupy most of her time. These two identities are very compatible, and this is perhaps why she saw them as stronger: they supported one another. However she had not left the world of tradition behind her. When she found herself being invited to become a traditional healer, she took it seriously enough to consider how it would clash with the other areas of her life. She also took messages from her dreams very seriously, for example in going to visit the ancestral graves, and in following the direction from an ancestor in her dream to cook for her son at the time of his initiation, which she had not intended to do.

Rather than choosing, she seemed to integrate the different aspects of her life, adopting different identities when she deemed it appropriate. That she valued her privacy and independence can be seen in her ability to create her own synthesis of different identities.

3.3 Influential authority

A strong source of identity for Khuleka was her mother, who was "very religious and an educationist". Her mother rejected traditional healing practices, and favoured faith healing, religion and education. Khuleka saw her mother as the stronger of her parents and said that "I'm following my mother's steps". She felt called particularly to her religious identity by her mother: "You belong to the church and water" were her mother's words from beyond the grave. This was a powerful call for her. It came not only from her mother, but from her mother as deceased, thus positioned as an ancestral spirit.

Khuleka was also sensitive to the judgements of those who shared her religion and workplace identities. She feared their reaction to
her if she were to appear in the role of a traditional healer trainee.

**Conclusion to results**

None of these participants had experienced any resistance to therapy, and they felt that they had benefited significantly from the experience. All of them except Nokuphila were familiar with the concept of therapy and knew about psychology. Nokuphila was an interesting exception, knowing nothing at all and learning purely from her own experience in therapy. All of the participants, except Nomakhasi were to some degree sceptical of traditional healing, although only Grace had not actually consulted a traditional healer.

All of the participants had knowledge that stemmed from multiple world views and had consulted different sectors of the health care system, though to different degrees. All of the participants affiliated themselves with identities that were congruent with their perceptions and experiences as expressed in their voyages through the health care system and that had their roots in the social contexts that were familiar to them. There are, however, interesting differences in the experiences of the participants and their relationships to various belief systems, which indicate a variety of possible situations in a society undergoing social change. These will be explored in the discussion.
Social change implies a movement. In South Africa there has been much visible shifting in terms of racial integration, for example in education and the work place. This research is concerned with the less visible shifts, the more subtle results of different cultures sharing spaces. In these spaces, knowledge and beliefs that come from very different world-views must face the existence of one another. This could result in an interchange, and the multiplicity of beliefs, or in the domination of one world-view and the silencing of another. The choice of which healer one consults taps into these subtle effects of social change where beliefs and influences may not be consciously articulated.

Looking at the individual's choice of healer and explanatory models provides useful insights into the effects of different knowledge systems that may come into play for a black person choosing psychotherapy. Thus the issues of acculturation and shifts in local knowledge can be considered as processes which affect the choice of healer. Looking at social change also requires one to take cognisance of the individual situated in certain relationships, held in place in society by various roles. An experience of different cultures and world-views, and the institutions they create, may affect these roles. Individuals may find themselves with a wider choice of roles, or greater conflict between roles that are influenced by different sources. Hence looking at the identities that the individual assumes sheds light on the impact of social change.
This research found individuals who have all been affected by multiple world-views and belief systems, and in some cases have experienced marked shifts in knowledge or perception. Their various beliefs and practices have affected the sense of identity that they portrayed in a manner that substantiates Geertz' (1975) articulations of the social and cultural construction of the individual.

I shall now discuss the findings in light of the conceptual framework through which the data was analysed, namely the choice of healer in the light of participants' relationships with the health care sectors, their knowledge gained from significant communities of practice, and the identities they adopt in response to their surroundings.

1.1 Health Care Sectors

As discussed in the literature review, the sectors of the health care system for black South Africans stem from different cultural origins. The lay sector, where help is sought from family and friends, is potentially strongly influenced by traditional beliefs, especially where these were followed by the older generation. However the impact of Western beliefs and practices in the home may also have a significant influence. The folk sector also consists of both traditional healing practices, and faith healing within the Churches. The professional sector consists of Western medicine. It must be kept in mind that the divisions into these sectors are artificial. It is not implied, for example, that because Western medicine enjoys professional status it is therefore superior in terms of effectiveness to traditional healing or to self-help within the family. This is presented as a model which Kleinman (1980) employed to examine help-seeking behaviour.

In this research Kleinman's model provides a useful map with which to examine the participants' relationships with different bodies of knowledge that they have engaged with in their search for helpful
healing. It guides the examination of the extent to which individuals are using multiple forms of healing that would require them to hold different beliefs or explanatory models simultaneously. We can also see whether individuals move successively through different healing options in the search for help, as Boonzaier (1981) found. If they are using different healers simultaneously, are they approaching each one with different types of problems, coherent with their explanatory beliefs, or are they trying different sectors for the same problem? These questions shed light on how individuals in a multicultural context are dealing with the different options available to them and the different forms of knowledge and belief that they can appeal to. This brings us to the question of acculturation and shifts in knowledge, which will be dealt with after looking at the health care sectors.

All of the participants used more than one sector of the health care system, although not necessarily in seeking help for the problem that took them to therapy. This is where their explanatory models become relevant, in determining whether they sought specific help for specific problems, or consulted multiple healers for the same problem. This will be discussed shortly.

The varieties of beliefs that the participants may have held, collectively stem from the full range of the health care system. For example, their beliefs derived from the traditional African world view and Western medicine (Khuleka and Nomakhasi), medical science and Christian prayer (Grace), and Christian prayer and prayers to the ancestors (Khuleka). They thus simultaneously held quite different forms of belief. For example as a contrast to the beliefs of medical science, which have a material basis as explanation for all illness, is the belief in the ancestors, which gives authority to the wisdom of the deceased forefathers.
1.2 Explanatory Models

Explanatory models, according to Kleinman (1980) reflect the beliefs to which the individual subscribes in trying to understand an illness or problem. Looking at whether the participants turned to different health care sectors for different problems indicates whether they differentiated their problems according to separate explanatory models for different types of problems, or consulted different health care sectors for the same problems. This could show whether they held different world-views quite separately, or whether in seeking help they did not discriminate between different belief or knowledge bases.

Khuleka and Nomakhasi both separated their problems according to different explanatory models, and sought help from separate sources. Nomakhasi made very clear distinctions between sources that should be turned to for help. She felt that a traditional healer would not understand the problems that she had taken to therapy. She says, "Emotional stress, that thing don't need a sangoma". She thus implicitly acknowledges the very different world views that lie behind these two forms of healing, and the fact that she could inhabit both of these worlds but knew that they may not accept one another's legitimacy. Her explanatory models were also quite detailed within the Western world view. She believed that some things need to be dealt with by people who have specialised in those problems; for example, speech therapy for speech problems, and psychologists for emotional stress.

Khuleka also inhabited quite distinct worlds of explanation; for example, she moved between her traditional beliefs in the ancestors, who have their own causal powers, and seeking the origins of her psychological problems in childhood experiences. Both of these women held separate beliefs about the causes and cures for different types of problems and restricted their search
for help to the domains from which these beliefs originate. For them these world-views coexisted as separate but equally valid.

Grace differed from Nomakhasi and Khuleka in that she followed one main source of explanatory models for healing, namely the Western medical model. Her work as a nurse centred around the physical, and she tended to respond to questions about healing from the perspective of physical healing. When I asked her about the possibility of traditional healers helping with 'non-physical' problems, she responded with an example of a psychiatric case in the hospital, with which the traditional healers were unable to help successfully. She thus read the non-physical in terms of the medical, material approach. For all physical problems she would seek help from within the Western medical world. However, she realised this source was limited when it came to finding help for emotional problems. At this point she turned to alternative sources, such as prayer and talking to members of her Christian community, and finally therapy. This showed that although she had a predominant explanatory model she would seek alternative approaches for some problems, such as her religion, and the belief that talking could help her release her emotional burdens. She did not, however, seem to view these as deviating from her 'modern' belief system.

Nokuphila was the participant who initially had the least fixed explanatory model regarding her problem, and in trying to find help, she consulted different sectors of the health care system without being preoccupied by the difference in world-views that she was engaging with. She did however have certain expectations of each sector, thus viewing them within their separate world-views. However, once she had discovered therapy, she did seem more inclined to separate her approach to different sectors according to the nature of the problem. She rejected the traditional healers as not being helpful for her psychological problem, but said she still consulted them for physical complaints such as headaches. She came to believe in taking emotional problems to the psychologist, and would have advised friends to do likewise.
1.3 Simultaneous or separate use of health care sectors

In the case of Nokuphila, without a clear explanatory model she was not led to a particular health care sector in seeking help for a problem. Nokuphila fitted Kleinman's description of someone whose "vagueness and lack of sharp boundaries between ideas and experiences" (Kleinman, 1980, p.105) was revealed by the fact that she was prepared to accept quite different forms of healing, from the different healers: Medicine, from the medical doctors, or any remedy from the traditional healer, as long as they prove their trustworthiness. She also had been to many traditional healers and Western doctors, which supports Kleinman's observations that people may continue to use a form of healing regardless of success in treatment. In Nokuphila's case this could be because of a lack of knowledge about alternatives, rather than a lack of openness. Once she discovered psychology, she gained knowledge that allowed a more discriminatory choice of healer.

In contrast to this less structured simultaneous approach to health seeking, the other participants were far more guided by their explanatory models to a source of help. In the cases of Khuleka and Grace, they deliberately approached another help source before their intended arrival at therapy.

Khuleka planned her successive visit to two sources of help, the priest and the therapist. This is reminiscent of Swartz's (1998) description of employing multiple healing to cover a range of beliefs. Khuleka fulfilled her religious beliefs in prayer before embarking on the lesser known form of healing, psychotherapy. She knew, however, that therapy was the source that would enable her to deal with her past, which she believed was the cause of her problems, and thus was the healing method she was aiming at. Similarly, Grace also had the perspective that therapy, as healing through talking, was what she needed. She too first approached a different source of help, her doctor, with the expectation that this would lead her to therapy. Nomakhasi was the one participant
who was not actively seeking help from any source when she was offered the invitation to go for therapy.

2.1 Local knowledge and communities of practice

Gilbert (1997) refers to Lave's concept of the communities of practice which provide social contexts in which the individual acts. Through this interaction the individual comes to a shared understanding of reality, or local knowledge. In the context of social change processes of acculturation are affecting the kinds of communities and activities that individuals are involved with. Looking at the interactive contact participants had with different activities bodies of knowledge adds to an understanding of why they held particular explanatory models, where these arose, and how their choices were affected by their past and present circumstances.

Grace was an example of someone who had been strongly influenced by a particular community of practice, namely the hospital setting. Through her involvement with this type of healing, she formed perceptions of causality of illness and belief in the Western medicine to an extent that she could not accept a symbolic healing such as washing with herbs and water. Her scepticism about traditional healing was further enhanced by her interaction in the hospital with patients who suffered from advanced illnesses because the traditional healer was not able to cure them. This reinforced her perception of Western medicine as superior. A further motivation against traditional African beliefs was Christianity. Her family, as a community of practice she participated in, strongly influenced her in her childhood, particularly her father who did not favour traditional healers. As an adult she was actively involved in her church community, and prided herself in being "a modern woman and a Christian". These two communities of practice left little room for adopting the meanings of traditional healing.
Like Grace, Nomakhasi was closely involved with a particular community of practice which she had encountered only as an adult, namely the community of traditional healers. Living and studying as an initiate, she was surrounded by this world view and this came across strongly. Her life prior to this, and outside of this community, for example as a teacher, was reflected in her knowledge and beliefs of Western healing and her concern with educating people about these. Thus her knowledge and beliefs reflected more than one community of practice.

Khuleka, more so than the other participants, had experienced a variety of knowledge sources and engaged with a number of communities of practice. Her childhood experiences and adult encounters had given her a knowledge of traditional healers, and although she was sceptical of some of them, she still admired their way of working. She maintained her connection to this body of knowledge by occasionally visiting a particular healer. She was also the only participant who grew up in a rural area, in the Transkei. This may explain the strong connection she had to the traditional beliefs and practices of communicating with her ancestors and carrying out traditional rituals when needed. Urbanisation is a significant factor in acculturation (Donald and Hlongwane, 1989) and may account for the other three participants having more limited experiences of traditional practices and healing in their upbringing. Khuleka was still connected to a community of practice regarding relationships with the ancestors; she used to visit her relatives in the Transkei who always took her to the graves of the ancestors. Another world-view which had its origins in her childhood and which she maintained through a community of practice was her Christian religion. Her mother was very religious and, Khuleka says, felt more drawn to faith healing than to traditional healing even though she had not practised this. She had also had sufficient contact with Western healing to know what this was about and to decide when she needed to use it. Thus her contact with a variety of bodies of knowledge and communities of practice that she was currently involved with provided a means
for her to be able to choose between different explanatory models and different sources of help when facing a problem.

Nokuphila did not express a participation in one clear community of practice that would account for explanatory models of healing. She was part of a community of people who consulted traditional healers – she mentioned friends and relatives who had been helped by them – yet she was ambivalent about these healers even prior to consulting them, and had no childhood experience of them. She consulted the medical doctors but had limited knowledge of this sector, not knowing what a psychologist is. She did mention her faith as a Christian, which may have been a more significant influence than emerged from the research interview. Her limited school education and financial limitations may have accounted for the fact that she had less knowledge available to her about Western healing resources such as therapy, in comparison to the other participants.

Geertz’ (1975) description of cultural knowledge having a fundamentally formative effect on the individual can be seen in the example of Khuleka’s childhood influences pertaining to traditional beliefs, and both her and Grace’s strong enculturation into the Christian religion. With all of the participants, it can be seen that the knowledge that informed their choices and actions around healing stemmed directly from the communities of practice that they were involved in. With Grace we see an example of somebody who had been affected by the acculturation process to the extent that she had substantially distanced herself from traditional cultural practices which were never a part of her belief system.

2.2 Shifts in knowledge

The fluidity that characterises shifts in knowledge can be seen in two of the participants who underwent significant shifts regarding knowledge pertaining to health care practices. As Gilbert (1997) describes, knowledge shifts occur when external, or exogenous,
knowledge is encountered by the individual in a context of activity in which the knowledge must be accepted or rejected.

For Nomakhasi the exogenous knowledge came in the form of traditional healing, which, although it is rooted in her own culture, was not something familiar that she believed in. Her calling to become an iggirha was obviously a powerful invitation to consider this body of knowledge. Unlike Nokuphila and Khuleka who rejected the same invitation, Nomakhasi accepted it and adopted this new form of knowledge. She conformed to Gilbert's (1997) description of someone who incorporates both this new knowledge and her previous knowledge. She still believed in and participated in therapy as a form of healing, whilst undergoing initiation into the world of the iggirha. This shows that neither form of knowledge had been invalidated or become dominant for her. This kind of shift in knowledge has interesting implications for a situation of social change in South Africa. It provides a challenge to perceptions about acculturation. Nomakhasi began as someone located in the worlds of formal education and psychotherapy and subsequently entered the world of traditional healing. From being a non-believer in "such things" as traditional healing, she returned to traditional cultural knowledge with which she had not previously been familiar. She subverted the scenario of moving away from traditional beliefs towards more 'modern' Western beliefs, as usually happens. This shows that there are no rules or absolute directions of movement in knowledge shifts. At any point any aspect of our social and cultural surroundings can have an impact that produces change.

Nokuphila is the other participant who underwent a significant shift in knowledge, in encountering psychotherapy. Her rejection of the traditional healers and her acceptance of this new form of knowledge followed Gilbert's (1997) description of the rejection of traditional local knowledge and the adoption of exogenous knowledge. Her rejection of the traditional healer's response to her problem was complete. She was seeking an explanation which she found in therapy, and she seemed to have no need to bring a
traditional explanation into synthesis with the meanings explored in therapy.

Regarding their experiences of therapy, none of the other participants experienced as profound an encounter of something new as Nokuphila did. Grace did not shift in her local knowledge by rejection or adoption of any other form of knowledge. However, based on her description of her experiences in therapy, she seemed to have undergone a process which was new and quite transformative for her. Thus I would suggest that her knowledge of this form of healing was significantly enhanced, but had not altered any other body of knowledge she held. Similarly Nomakhasi and Khuleka experienced therapy as something new but they did not express any intense perceptual shifts.

3.1 Identity and the health care system

We have looked at the effect that different forms of knowledge gained in different communities of practice have had on the individual's beliefs and actions, illustrated by their choice of healer. These different social contexts will also have an effect on the participants' self perceptions. Discourses carry meaning within particular communities of practice, and position individuals in particular roles (Parker, 1992 and Harre, 1979). By looking at the ways in which the participants described their relationships to various social contexts and healing sectors, we can see evidence of the identities that they subscribed to, expressed through their language, and hence the close links between identity, social contexts and sources of knowledge. This reveals where acculturation has had an effect, and where multiple identities are being subscribed to, perhaps stemming from both traditional and Western beliefs and practices.

Grace exemplified someone who created a strong identity for herself within a particular social context, the world of medicine and science. She affiliated herself with this "modern" way, and adopted
the discourses of the medical world in terms of treatment of illness. It is understandable that, considering the knowledge source that she was subscribing to, Grace was positioned as one who saw traditional healing to be a failure. She was the participant who had, in her self-perceptions, moved the furthest away from traditional beliefs, which she described as the "olden way". She also was the one participant who said she would as readily go to a white psychologist as to a black one, showing that she did not feel that she had issues requiring a cultural understanding which a white person would not have. She thus showed the greatest degree of acculturation.

In contrast, Nokuphila did not actively represent a particular community of practice or bodies of knowledge that stemmed from past experiences. This may indicate the limited variety in her experience or knowledge, but I feel it is more likely that she did not have the mastery of English or the confidence to voice her own world-views beyond the content of the interview questions. For example, it was only outside of the official space of the interview, after recording had stopped, that she mentioned her faith in Jesus as having helped her to find healing. However, the discourse that did emerge strongly in the context of the interview was that which represented her discovery of the healing power of psychotherapy. It seemed that the discovery of therapy had brought Nokuphila to a new form of knowledge, through a new discourse, and from this, possibly, a new identity from which she had the support and strength to reject the traditional healers. Nokuphila fitted the description by Mr M of someone who is turning away from traditional cultural beliefs through learning the "language of psychology".

Nomakhasi is interesting because when she was speaking as an igqirha trainee she was obviously using a relatively new discourse which she had adopted within the context of her training. Living and practising with her igqirha teacher and fellow initiates, she was being socialised into this particular identity with its discourse. This is apparent in her strong identification with the
'traditional' community, and in her reaction to me as an outsider whose questions were a potential threat to the safety of her 'secret' information from the ancestors. The fact that a large part of her life had been lived outside of this world of traditional healing was evident in her easy adoption of discourses in which she positioned herself as 'knower' regarding psychology and other Western forms of healing. This illustrates the marked distinction between different discourses, which Berman et al (1997) discuss in respect of encounters between different discourses.

Consistent with her participation in different communities of practice, Khuleka seemed to move fluidly between different identities. For example, when speaking about her experiences of dreams and the ancestors, she slipped easily into a discourse that reflected this reality and implied that she shared the meanings of this community of practice. Just as easily she adopted a critical stance towards traditional healing, and then also expressed her curiosity about the methods of this healing. She also expressed herself with a "psychologised" discourse, in relation to her experiences in therapy. This reflected her range of knowledge and her adaptable use of the health care system, and coheres with Mead's (cited in Larrain, 1994) description of the multiple selves responding to different social contexts.

3.2 Conflict or synthesis of identities

The question arises, in the context of diverse social contexts, and multiple realities, if different identities are being subscribed to, do people experience conflict or confusion in holding identities that may clash with one another? According to Berman et al (1997), identities become particularly visible when alternative discourses are encountered. This is apparent in the cases of Nomakhasi and Khuleka who both adopted identities from varying world-views.
Nomakhasi at times spoke very clearly from an identity within the traditional community, and then at other times spoke distinctly as someone who had knowledge of psychology. Unlike the examples from Van der Walt (1997) and Rappaport and Rappaport (1981) of people who felt ashamed of participating within different belief systems, she was very comfortable with holding different identity positions. She did this with confidence, having established acceptance of her alternative identities within all of her social contexts. She used the situation to her advantage by positioning herself as an authority, acting as informer in both worlds. Within each identity she was an expert on "the other side". This shielded her from disapproval and hence role conflict.

Khuleka was very comfortable in speaking about her different identities, and had dealt with the incongruities by making clear divisions and categories, even ordering the importance of her different sides. This was perhaps a means of controlling the pull that each identity had on her. For example, she expressed a certain amount of resistance and fear regarding the calling from the ancestors to become a healer. Her reasons for her scepticism of traditional healers were emotive; they are unhygienic and opportunistic in their money-making, which contrasts with the purity of faith healing, using water and salt. Perhaps she asserted religion and education as her strongest identities in order to create a clear rejection of this calling. She also revealed that in practice she could not simultaneously inhabit both the traditional and the Westernised social worlds. As with the examples from Van der Walt (1997) she would have felt shame in others' judgement of her if she went to work dressed as an iqgirha. She felt that the world of the traditional healer is not necessary to her worship of the ancestors.

Nokuphila is an example of Thompson's (1996) perspective on detrationalisation as a loosening of the normalising power of traditions, rather than their disappearance. She did not completely discard traditional healing - she would still consult these healers for physical problems - but she significantly
questioned her beliefs about it. Traditional healing lost its power to legitimise certain processes, such as the recommended cure for her - to become a healer - and in this she gained the opportunity to identify with a different understanding of herself, through therapy.

Grace's easy synthesis of the two identities she inhabited - the nurse who follows science and medicine, and the Christian who follows a faith in God - illustrates the easy trans-navigation of roles which Gergen (1996) speaks of. Although the beliefs of these identities are quite different, they both co-exist in the modern Western world, and it is this latter which perhaps is the overriding sense of identity that Grace carried.

3.3 Social accountability

In the results section I considered the authorities that guided participants into following particular identities. These would be the ideologies or belief systems, embodied in institutions, practices, or even particular individuals, which Shotter (1989) describes as creating a feeling of accountability within the social context. These are the sources that allow for certain discourses and identities to be appropriate and others not. For example, within the hospital setting, it would have been inappropriate for Grace to expound the virtues of traditional healing in curing T.B., to doctors who would not support this belief. Their negative response to her would have affected the sense of identity she had as a "modern" woman. Thus, she would probably not have considered using this kind of discourse.

Other cases may not be so clear. As Van der Walt (1997) illustrates, some people feel torn between different authorities, in being accountable to different sources of approval. This came out particularly in conflicts between adherence to traditional beliefs, and in following Western practices, such as Christianity. Khuleka provides an example of the latter, where her work
colleagues functioned as an authority that deterred her from following traditional practices that would have identified her as very different from them, for example in dressing as an iggirha trainee.

Khuleka also illustrates the ability to follow multiple voices of authority in her participation in different social contexts. Her ancestors were a powerful influence in giving her directions through dreams, and the social accountability she felt in these situations was embodied in activities in her family context as much as in her sense of duty towards her ancestors. Khuleka also identified very closely with her mother, whose invisible presence acted as a strong authority for her, with an almost omnipresent sense: Khuleka experienced her as a vision one night, as if her mother was always aware of Khuleka's movements. Even the authority of the ancestors calling her to become a healer was powerful enough for her to ask for another direction, rather than dismissing this instruction as inconsequential to her.

Authorities may be expendable in a situation of social change. Nokuphila, who experienced a significant shift in local knowledge, lost her respect for the authority of the traditional healers and replaced it with an authority invested in the psychologist. This came out fairly strongly in her perception of him providing her with the answers, which helped her to understand her problem. Nomakhasi, on the other hand, did not lose a sense of accountability to the social contexts she has been involved with, when she entered a new realm of knowledge, traditional healing.

Nomakhasi illustrates another response to a multiplicitous social world. She had strong authority figures, both those related to her role as a trainee, and those related to her position in Western education. However, she asserted her freedom to move between them as she wished, and was respected within each for her knowledge of the other.
Overview The interactive hermeneutic circle

The hermeneutic circle that I have used to examine the data was made up of three main parts: The health care system, local knowledge and acculturation, and identity. These function together, supporting one another, yet act as different lenses for looking at the healing choices made by the participants. They each tell the story in a slightly different way, although all with similar outcomes.

There is a strong relationship between knowledge and beliefs from different world views, and choices within the health care system. Nomakhasi and Khuleka had experienced a variety of world views, particularly the contrasting worlds of traditional African beliefs and practices, and Western education. Both of them had a fairly extensive knowledge of what is available in different health care sectors, and thus could be quite selective about what they needed at any point, and in how they chose to define their problems. They also tended to locate specific problems within sectors they viewed as most appropriate according to their variety of explanatory models.

Nokuphila on the other hand had less variety of knowledge available through which to understand her problem, and was anxiously seeking an explanation. She had no knowledge of psychology and would never have chosen this option if she had not come across it through the medical system. Grace, on the other hand, was located strongly within the world-view of medical science and interpreted most problems from the perspective of this knowledge.

A connection is revealed between having a wider knowledge of different explanatory models, and having greater choice and possibly more control over the help-seeking process. Nokuphila was the passive receptor of a referral to a form of therapy that she
knew nothing about, whereas Khuleka had a very exact idea about wanting to first be prayed for by a priest and then going to the psychologist. Khuleka was thus in a more powerful position to determine her choices and actions.

This illustrates the link between knowledge and power. Power, through knowledge, began to operate for Nokuphila. Once she had the knowledge of an alternative form of healing that really helped her, she had a conceptual tool which allowed her to discriminate between different healers for different types of problems and to be able to reject the traditional healers with the confidence that she no longer needed them. Nomakhasi, through her knowledge of a healing form that can deal with emotions, was empowered by a tool to help her function in the traditional healing world which does not directly deal with emotional stress.

Identity is also formed by knowledge gained in different social contexts. This is illustrated with Grace, whose knowledge centred around Western medicine and whose identity was strongly positioned in this 'modern' approach to the world. Conversely, identity to some extent determines the choice of knowledge that is pursued. Nomakhasi chose to explore knowledge within the world of traditional healing, because she chose to pursue the identity of a healer, whereas Khuleka was intrigued by the knowledge that the traditional healers have, but would not follow a calling to pursue this because it clashed with her sense of identity in the other worlds she inhabited.

Identity is also linked to the use of the health care systems and different bodies of knowledge through social accountability, the authority that determines which frameworks of thought the individual feels compelled to follow. For example Khuleka feels compelled to follow her mother's footsteps, which means favouring the church and faith healing above traditional healing practices.
These different parts of the hermeneutic circle are interrelated and cohere in painting the scenario of different ways of functioning in a multicultural society.
CHAPTER 6

CONCLUSIONS

This research was concerned with the influence of social change in South Africa on the personal lives of individuals. I have used the choice of a healer as a vehicle through which to look at this issue. I have looked at black women who have chosen a form of healing that is Western in origin and in South Africa has been traditionally frequented by the white population. This captures the flavour of some of the cultural transitions that are occurring at this time.

Cultural multiplicity is becoming part of the reality of the new South Africa, with contact being made between beliefs and bodies of knowledge from different world-views. In situations where action must be taken, this requires a response from individuals that will reflect their relationship to available world-views. Rejection of beliefs or knowledge, either local in favour of exogenous knowledge, or vice versa, is one possibility. Alternatively there may be a synthesis or coexistence of culturally different forms of knowledge.

Examining the participants' relationship to the different health care sectors which stem from divergent world-views illustrated examples of all the above possibilities. Nokuphila rejected the belief in traditional healers, who were not helping her, in favour of new knowledge, that of psychotherapy. Nomakhasi returned, in a sense, to 'older' knowledge, that of traditional healing, which she only came to believe in subsequent to attending therapy. Both she and Khuleka came to a synthesis of knowledge from different world-views. For Nomakhasi, there was no experience of conflict in openly inhabiting these different worlds, whereas Khuleka tended to create more separation between her different social contexts.
Acculturation has thus had varied effects on individuals, and we cannot presume that there is a predictable progression towards Western knowledge and away from traditional influences. For example, with Nomakhasi we have seen that traditional healing is still a valid choice of new knowledge for someone who had no prior belief in this. Congruent with the ideas of social constructionism, the current communities of practice that individuals are involved with, strongly influence perceptions, through shared meaning.

This research also showed a close relationship between knowledge that participants were familiar with, and the explanatory models that they employed in finding a healer. Those participants who had a wider knowledge from different social contexts tended towards a more deliberate and more varied use of the health care sectors. They also tended to have separate explanatory models for different types of problems. For example, Khuleka understood and responded to emotional trauma quite differently to her response to dreams sent by an ancestor.

Identity is closely linked both to a community of practice and to knowledge, which provide the discourses through which identity is expressed. For example, Grace frequently reflected the discourse of the medical hospital setting where she worked, and was strongly aligned with the identity of a modern woman who had faith in medical science. Experience of a variety of social contexts was linked to a multiplicity of identities, different roles that could be adopted when appropriate. The potential for conflict between identities was expressed by Khuleka, who was sensitive to judgement about her affiliations with traditional healers by her work colleagues, who did not participate in this former community of practice. She illustrates the influence of social accountability, which encouraged her need to order the importance of her three main identities so as to affirm her preferred self-perception. It also influenced her continued connections to the world of the ancestors, which had been a strong part of her enculturated beliefs.
The outstanding conclusion that this research leads me towards is that there is power in being able to draw upon different forms of knowledge, from different world-views. This provides conceptual variety with which individuals can view a problem, create an explanatory model and find a solution. It also allows them to live between conventions and fixed realities. This provides the freedom to see beyond absolutes that may be potentially oppressive. In seeing that the rules change when they step into another world-view, a different light is cast upon the very idea of rules or authority. It also allows for a broader sense of self, open to fluctuation, rather than a single identity. This may relieve the pressure of being answerable to a fixed source of authority or accountability. Perhaps the encouragement of multiplicity, rather than the search for a source of 'correct' answers or ways of being, could allow individuals greater freedom from oppressive institutions in their various forms, as well as to cope better in a situation of social change and multiplicity of cultures.

**Critical reflection on the research process**

Considering the process of meaning-creation in an hermeneutic enquiry, it is essential to assess what has happened, what meanings have been allowed to emerge, and importantly, what meanings may have been silenced. Firstly, the situation of the interview, where the creation of the text happened, may have been more conducive to some meanings and discourses than to others. The participants may have, to varying degrees, perceived me as representative of certain bodies of knowledge or world-views. They may thus have more strongly presented those aspects of themselves which they felt resonated with those particular world-views.

Secondly, I chose to focus on a comparison of traditional healing with psychology. This brings a particular focus into the interview process which may have silenced other information or other world-views. For example, I did not specifically ask questions pertaining to religion, but this emerged as significant, being mentioned by
three of the participants. Nokuphila, the shyest of the participants, mentioned it only once. Perhaps, had I questioned her in more depth, it would have emerged as a significant consideration.

Thirdly, I chose a particular conceptual framework, focusing on the participants' use of the health care system, their relationship to knowledge grounded in communities of practice, and the identities they ascribed to. The latter emerged from my interactions with the text, and at times I felt limited by not having pursued this within the interviews themselves.

**Recommendations for further thought and action**

The question of response to a multicultural reality is not simply reserved for 'research participants' but is relevant for everyone to engage with, as we are all created and recreated within our social reality. Regarding Gergen's (1994) quote in the beginning of this work, we are being swept by the waters of competing realities, and we are all explorers, creators and receptors of the multiple possibilities that are generated. It is our responsibility to consider how we relate to different realities, and question whether we really are receptive to 'otherness'. If not, how are we imposing our perceptions, through fear, arrogance or ignorance, so that people's voices are drowned, visions remain unexplored and realities denied?

This research aims to support the idea that no culture is superior to another, no healing method is definitive. Hopefully this could erode some of the assumptions held by particular individuals or groups about correct or superior methods, and encourage, rather, an appreciation of difference. I also wish to encourage the awareness of the impact that a dominant form of culture has, such as that of Western culture in this country and much of the world. I suggest that we need to be at least aware of the processes that emerge with cultural exchanges.
In the work of psychotherapy, there is the opportunity of 're-storying' the past which involves conversations between narratives, the narratives that the client has about his or her past, and those that are co-constructed with the therapist (Parker, 1992). Here is a place where narratives call upon the different identities that the client holds, and where these identities may become malleable, and observable. The identities that are available to the individual will determine the kinds of effect and the kinds of stories that they can produce. In the South African context, this is a powerful tool for drawing meaning from different experiences, and allowing for the different identities that the individual experiences, to be exposed in a non-judgemental way.

An exciting domain for further research would be the processes that are gone through in therapy with clients who are dealing with divergent cultural identities.
APPENDIX

INTERVIEW QUESTIONS

Past and recent experience of traditional healing

1. When you were a child, did you and your family consult traditional healers?

2. For what problems?

3. What was the treatment? Was it helpful?

4. As an adult have you continued to consult traditional healers?
   If so...
   a. For what problems?
   b. Were they helpful?
   c. How did they help you?
   If not...
   d. When did you last consult a traditional healer?
   e. What are your reasons for no longer going to them? (When and why did you stop believing in them?)

5. Does your family consult traditional healers? Who specifically? (spouse, parents etc)
Knowledge of psychology before therapy and recent choice to go to therapy

6. When did you first learn about psychology? How?

7. What were your impressions of psychologists before you started therapy?

8. Whose idea was it that you go to therapy? Your own or referral?

9. In this case, of going to therapy, did you consider other forms of help? And traditional healing? What made you decide to go to therapy rather than (or in addition to) other forms of help?

Participant's expectations of therapy

Background knowledge of psychology

10. Was therapy what you expected it to be? (explore)

11. Did it seem unusual or different to what you had experienced before?

12. Did any of it feel familiar or similar to past experiences?

13. After your first session or two of therapy, did you think it could help you?

14. And after a longer time in therapy, did you think it could help you? (explore)

Perception of benefits of therapy

15. Did you feel that therapy actually helped you with your situation?

16. What do you think happened in therapy that helped you? (elaborate)

17. Did it help you in a different way to what you expected

18. Were you at all disappointed by it?
Comparison between two healing systems and current attitude towards traditional healing

19. Did you feel that the therapist understood your issues?

20. How do you feel a traditional healer would have understood the problem you took to therapy?

  *ie is his/her shared world view still relevant to this client?*

21. How do you think he/she would have helped you?

22. Do you think there are some problems (perhaps for some people) best dealt with by a traditional healer?

  a. If so, how?

  b. If not, why not?

23. Would you consult a traditional healer now? For what sort of problem?

24. Would you recommend that your family or friends consult a traditional healer? For what problems?

25. Would you recommend therapy to your family or friends?

26. Do you think they would go if you suggested it?

Conflict between two systems

Comment, if relevant that the participant is fortunate to have experienced different healing systems.

27. Do you feel that the methods of traditional healer and therapist can help with the same problem?

28. How could the ideas of the two go together, or are their ideas too different?


Pedersen, J. Draguns, W. Lonner, & J. Trimble (Eds.), Counselling across cultures, Honolulu: University of Hawaii Press.


