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Samples of Indigenous Healing: The path of good medicine

L. L. Levers*
Duquesne University, USA

In this article, I review five articles selected for this Special Issue of the *International Journal of Disability, Development and Education* on indigenous healing. I have considered the various traditions of indigenous healing, and I situate my analysis within the context of disability, development, and education. Such an analysis reflects the conundrum involving professional identity politics and the elusiveness of intentionality. In response to the five articles, I offer commentary on the social constructions of health, illness, healing, and disability, as these constructs vary across cultures. I suggest that the ability of professionals to inspire trust among clients is potentially a practitioner marker of efficacy across medical paradigms, and is a dynamic that is often misunderstood. I illuminate the healing process as a dynamic of reciprocity and engagement. Finally, I discuss and emphasise the need for developing collaborative programming and integrative service delivery models.

Keywords: *Healing and Disability; Indigenous Healing; Integrative service delivery*

Introduction

There are two literary quotations that I have come to view as my "essential quotes," and that I like to share, as early as possible, with Masters and doctoral students in our counsellor education programme, in an effort to incite the self-reflective process. I have placed the words on overhead transparencies in large bold block letters. I suppose that, given technological advances, I soon will need to transfer the quotes to PowerPoint. Both of these quotations resonate with my 32 years of clinical practice and academic work. The first is from Bernard Shaw's play, *The Doctor's Dilemma*. Ridgeon says, "We're not a profession: We're a conspiracy." Sir Patrick then responds, knowingly, "All professions are conspiracies against the laity." In the very

*Counselor Education and Supervision, Duquesne University, 600 Forbes Avenue, Pittsburgh, PA 15282, USA. Email: levers@duq.edu

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best of scenarios, professionals advocate for "doing no harm," and our clients and patients benefit. In less-than-the-best of scenarios, professional associations may operate a bit more like medieval craft guilds than advocates for clients or patients.

The second quote is from Mary Shelley's novel, *Frankenstein*: "I was the cause of a series of evil and incredible acts … yet my heart overflowed with the love of virtue." The situation began as a sympathetic one, in which Frankenstein was scientifically engineered in the laboratory; but he later rebelled against the scientist who created him. Unfortunately, when Frankenstein was appropriated for the cinematic screen, the resulting "monster film" lost much of the original social commentary of the book. But in Shelley's novel, the disconnection was apparent between the scientist's intentions and the outcomes of the scientist's actions; in spite of his best intentions, he created a monster.

I submit that both of these "essential quotes" speak volumes in the contemporary context of western medical, social, behavioural, disability, developmental, and educational services. I also believe that by making their meanings explicit, as I do when I project them on overhead transparencies, they have the potential to serve as prevention-based hedges against the hubris that is so inherent in much of the modernist focus on professional expertise. This is not to condemn the professional or the expertise—this is merely an admonition that favours the often-quoted adage *Physician [nurse, educator, counsellor, psychologist, social worker, and so forth], know thyself*.

A Sample of One

Given my socialisation as a modern practitioner, and, as hinted above, having some postmodern sensibilities regarding our professional complicity in "conspiracies against the laity," I was intrigued when I was asked to write a concluding article for this *International Journal of Disability, Development and Education* Special Issue on indigenous healing. I began to reflect upon the ways in which my own life has intersected with bodies of Indigenous knowledge. I was struck by the extent to which my experiences have influenced how I am situated as a western scientist/practitioner who considers Indigenous knowledge as vitally relevant to a variety of contemporary discourses. This informs the way in which I feel that I must analyse and respond to the five special articles.

My mother's family is Hispanic, and my father's family is Anglo-American. I recall how my "*abuela*" (Spanish for grandmother), Obdulia, would retrieve various herbs from her backyard whenever any of us were ill. Toward the end of my undergraduate years at university, I began to study *Kung Fu* and *Tai Chi Chuan* with a Shaolin Master from China, who also was a Master of acupuncture. Studying with him for nearly 15 years, I had the privilege of learning a great deal about Chinese traditional medicine.

After obtaining my Master's degree and during my doctorate, I worked at an inner-city community mental health centre. While there, and over the years, I have developed clinical expertise around my work with survivors of trauma. At the centre,

I learned a great deal from all the clients I served, and, as a part of my clinical knowledge base, I learned a great deal about African-American cultural belief systems and some of the "folk remedies" used by clients. It was such a revelation for me, then, during my first trip to Africa, when I serendipitously encountered an exhibit on the practices of *Sangoma* in the Republic of South Africa. I recognised some of the *Sangoma* behaviours and trance-like states of consciousness as being parallel to certain clinical features and the dissociation of my severely traumatised clients. I was intrigued and tried to understand as much as possible about African traditional healing. I particularly was fascinated by the proposition that what defined a person as a shaman in one culture served to define psychopathology in another culture. I also came to learn, in retrospect and within the African context of their origin, about many of my former clients' remedies.

I subsequently received U.S. federal funding to examine traditional healing practices and rehabilitation services in three southern African countries (Levers & Maki, 1994, 1995). It was then, in the early 1990s, that I first learned from the traditional doctors, even before reading about it in the professional journals, just how serious an impact HIV/AIDS would have on the southern African region. I have continued my traditional healing inquiry there and in other parts of Africa, and this has evolved into an interest in children affected by HIV/AIDS. Recently, as a Fulbright Scholar in Botswana, I was able to continue my investigation of cultural factors and contextual influences associated with the spread of HIV/AIDS. In conversation with a young doctor/resident there (by way of India and medical school in the United States), I could see that he was dumbfounded by my research with traditional healers. I could not resist telling him about meeting Dr Letsie, a Mosotho physician, who had been trained in the West, returned to Lesotho to practice biomedicine, and initiated cross-training projects with the traditional healers there. He instituted activities such as helping the healers to understand how HIV can be transmitted by blood, not a typical construct in their healing paradigm. He explained to them how this necessitated more hygienic handling of traditional instruments; teaching the healers, for example, how to sterilise razor blades between uses to prevent further HIV transmission. The young doctor/resident left the conversation seemingly more open to how this perspective might have advantages.

Over the past 8 years, I have been involved in a federally funded mental health project for children at one of the largest Native American Indian reservations in the United States. When I was invited by the Tribe to serve as the evaluator for the project, I gratefully accepted, but on two conditions. The first was that when I returned to the reservation for the first time in my new role, we would meet immediately with tribal elders so that they could tell me about the problems faced by their children and families. The second was a request to the tribal shamans for a cleansing ritual, so that I could begin with a culturally "clean slate." Both requests were met with the same respect with which they were made, opening doors for invitations to other ceremonial activities. Learning more about the importance of specific tribal practices enabled me to advocate for the inclusion of culturally relevant healing practices within the scope of the funded services.

One issue apparent to me, in the discourse about differing knowledge systems and competing medical paradigms, is how easily and quickly the discussion places us upon a slippery slope. These paradigmatic worldviews are complex matters, and the fullest discussion is generally beyond the scope of the typical journal article. I therefore proceed with caution. Certainly, western colonial structures have oppressed indigenous peoples around the globe, and with tragic consequences. The hegemony of Cartesian thinking in the Academy has been one part of the problematic at the root of the so-called culture wars, and this has had deleterious results. Western biomedicine has been deserving of recent castigation for its insensitivity to cultural practices, and it needs to reform. But I remain reluctant to throw the proverbial baby out with the bath water. I am eternally grateful to the technically proficient physicians who performed complicated open-heart surgery on my father; nearly 20 years later, he lives to join me in thanks. On the other hand, after every biomedical intervention failed, I finally was able to convince my frustrated mother to see a Chinese physician who also performs acupuncture; the effects of her Bells palsy only were mitigated through this particular treatment.

Perhaps one part of the efficacy of healing resides in the ability of the practitioner to be trusted by the patient or client for care. If "trustability" is a part of the medical mix, then it stands to reason that this might be a practitioner marker in every medical paradigm. Perhaps this is, in part, what Portman and Garrett mean by "Good Medicine." Although their article is about the Native American Indian medical paradigm, when I read the line "… walking the path of Good Medicine" I was flooded with memories of a particular authoritative African traditional healer who told me: "We talk to our medicine, and our medicine talks to us" (Levers & Maki, 1994, 1995). This healer helped me to understand the reciprocal sets of relationships among the healer and his or her medicine, called "*muti*" in many parts of the southern African region, and the person seeking healing. "*Muti*" might be made from a medicinal plant, from herbs. "*Muti*" might be an object. "*Muti*" might be embodied by drumming. "*Muti*" also might be a way of living or a way of relating to or connecting with others. In this case, "others" might mean those who are living or the ancestral shades. I read "walking the path of Good Medicine" as implying the same level of reciprocity and engagement. I believe that this represents a concept that is rooted in indigenous medicine or traditional healing paradigms found around the world, and one with which much of western biomedicine has lost touch.

A Sample of Five

The five articles selected for this *International Journal of Disability, Development and Education* Special Issue cover an array of indigenous healing practices, crossing geographical, religious, and cultural boundaries. Obviously, cultural differences account for varying details across systems of indigenous knowledge. At the surface, global paradigms of indigenous healing seem to have much more in common with one another than any one of them has in common with the biomedical paradigm. However, we need to be cautious about making sweeping assumptions, and as

Feierman (1985, p. 105) points out, "… [our] assumptions need to be examined carefully."

At the risk of precariously ascending that previously mentioned slippery slope, perhaps one major distinction between Indigenous and western models of healing is biomedicine's Cartesian roots. Descartes's dictum, "*Cogito, ergo sum*" ("I think, therefore I am") represents a significant epistemological shift in western thinking and offers the foundation for its philosophical duality. This dichotomy also offers the cultural metaphor for the separation of mind and body and of science and spirituality, splits that mark not only modernity, but the positivist worldview that is embedded in the biomedical perspective and its practices. However, it is important to understand this within its cultural context, in much the same way that the authors of the five articles and I advocate that indigenous healing systems be understood within their respective cultural contexts. Descartes' rationalist vision anticipated the period that we refer to as the Enlightenment, or the Age of Reason. Rather than to vilify Descartes, we need to understand that his philosophy was, in many ways, a reaction to the earlier Dark Ages, an era that included the Inquisition, persecutions, and other human atrocities.

Conversely, indigenous cosmological perspectives are based upon the interconnectedness of mind, body, and spirit; this is concomitant with a focus on balance and harmony. Indigenous healing processes are linked with wider social, cultural, epistemological, ontological, and cosmological considerations. The five articles in this *International Journal of Disability, Development and Education* Special Issue offer an opportunity for closer examination of these broader links with their selected indigenous models of healing. Three of the five articles have a psychiatric or psychotherapeutic focus in terms of their respective investigations of Mexican *curanderismo*, African traditional healers, and Pakistani Muslim healers. The remaining two articles focus on the general practices of Native American healing traditions and on indigenous healing practices among rural elderly African Americans.

Mexican Curanderismo

Zacharias presents the results of her ethnographic field research with three Mexican traditional healers and their patients. She explicates the treatment practices of the "*curanderos*" and the effectiveness of these practices as mechanisms for change. She offers "*curanderismo*" as one example of ethnopsychotherapy and illuminates its efficacy in treating mental illness. She makes a significant contribution to the literature regarding ethnopsychotherapy, with the exposition of her notion of bifocality of ritual interventions.

African Traditional Healers

Mzimkulu and Simbayi offer the results of their phenomenological examination of Xhosa-speaking African traditional healers' perspectives and practices in the management of psychosis. Their study is unique in that it involved traditional

healers treating psychiatric patients who were undergoing simultaneous traditional and western treatments. I also appreciated the explanations of certain highly descriptive Xhosa words. For example, the word for schizophrenia is "*amafufunyana*" and literally means "ants from the grave." When I recall some of the ways clients have described their schizophrenia-based symptoms to me, I resonate with "ants from the grave" as a descriptor.

Pakistani Muslim Healers

Farooqi reports the results of her study concerning Pakistani Muslim healing practices. The study focuses on the types of healing practices sought by psychiatric patients, as well as gender differences in the type of healing sought and in the number of visits. Given the nature of the research, the sample of 87 psychiatric patients is large and provides useful descriptive information.

Native American Indian Traditions

Portman and Garrett examine Native American healing traditions. While acknowledging tribal differences in systems of healing, their approach to the topic is inclusive, placing Native American healing traditions within a cultural–relational context. They emphasise the connection between the person seeking healing and the Indigenous Healer, as well as the relationship between cultural values and healing practices. They highlight the Native American perspective of wellness as harmony, and present information about specific traditional ceremonies. The authors point to the balance among human, ecological, and spiritual systems as "Good Medicine."

African-American Healing Practices

Harley identifies indigenous healing practices used by rural elderly African Americans. She offers a vital discussion of contemporary practices that can be traced back to Africa and that endured in the United States in spite of slavery and post-emancipation oppression. She connects indigenous healing practices, as they have survived and evolved in the United States, with a larger system of Indigenous knowledge, situating these practices within the context of the African Diaspora. Harley highlights the ongoing racial and ethnic health disparities that commonly occur in the African-American community, echoing a theme that reappears throughout the ethnomedical literature; many of the world's poorest people seek health care services from traditional healers.

Synthesis

The authors of the five articles identify many of the universal roots of traditional medicine. Some common themes across many, if not all, systems of indigenous

healing include the following tenets: (1) mind, body, and spirit are all interconnected; (2) healing is based on harmony and balance; (3) healing is a sacred process; (4) healing is a personal meaning-making process; (5) there is a connection between the person seeking healing and the healer; (6) healing involves multiple interactive processes; (7) wellness represents harmony; (8) illness represents a disruption of natural balance; (9) there is an active relationship between the physical and spirit world; and (10) the healer remains an important medical resource and cultural intermediary.

The authors echoed many of the critiques of the biomedical model, including an emphasis on the hegemony of western medicine, its negative colonial impact, and the cultural encapsulation of its practitioners. The authors also made connections between the respective Indigenous healing models and their larger social, political, and economic contexts. Many pundits of biomedicine who criticise Indigenous healing practices forget, or simply do not recognise, that traditional doctors are often the only health resources available to those who live in developing countries, or, indeed, who live in the poorest parts of developed countries.

Lacunae

The five articles in this Special Issue illuminate the enduring vitality of global Indigenous healing traditions. However, the absence of an article on Chinese acupuncture, or another Asian system of traditional medicine, reflects a lacuna in this volume. I am left wondering, perhaps somewhat cynically, if this gap might be a reflection of Chinese acupuncture as perhaps more acceptable to, and therefore more like, the western biomedical ethos, in terms of capital, than other types of indigenous healing. I refer to its presence as the one form of Indigenous healing that has been prominent enough to be recognised in some countries by insurers for reimbursement.

Another gap is the lack of a strong linkage between the Indigenous practices discussed in the articles and issues relating to disability, development, and education. Three of the articles deal with psychiatric disability, but, in general, there is little articulation of connections between healing and developmental and educational issues. This is enormously significant, because the healers are often the first caregivers consulted by parents about their children. Levers and Maki (1994) learned from the healers, for example, that when they were consulted about early childhood disabilities and associated developmental delays, in situations where cross-training endeavours had provided them with relevant information and where services existed, they preferred to make referrals to appropriate childcare experts. This also is important because the same Cartesian heritage that gives rise to the hegemonous attitudes often associated with western biomedicine also spawns similar attitudes among allied health, social service, behavioural, and educational professionals. In other words, much of what can be implied about indigenous and western perspectives in the health care arena stems from the same systems of knowledge as parallel perspectives in other professional arenas.

Healing and Disability

The ethnomedical literature emphasises health and illness as socially constructed concepts that are parts of larger medical paradigms; and some, for example, Csordas and Kleinman (1990), even suggest the need for investigating western biomedicine as a type of ethnomedicine. The literature amplifies the importance of understanding how various paradigms of health and illness are bound to culture, social construction, and worldview. Phillips and Verhasselt state that "… there is evidently neither a single, universally applicable health system nor an agreed view of health as a concept" (1994, p. 316). Feierman (1985, p. 73) offers a thoughtful discourse regarding the social and cultural determinants of health and illness, stating that the "… evolution of health cannot be separated from the broader story of social change."

Comaroff (1978, 1980, 1982) analyses the symbolic representations of medicine and healing in non-western cultures, while emphasising the absence of parallel analyses related to western culture. She addresses the relevance of how individuals experience and perceive illness in their cultures (Comaroff, 1978), and notes that affliction is a disruption in social and environmental processes (Comaroff, 1980). She describes healing as "… fundamentally concerned with the reconstitution of physical, social, and spiritual order … [and that] … it cannot be meaningfully examined if isolated from the wider sociocultural system" (Comaroff, 1980, p. 639). She explicates healing as a symbolic process that is universal (Comaroff, 1982).

The discourse is rich regarding social and cultural constructions of health and illness. However, there is little mention in the literature as to how the concept of disability (and its associated issues of development and education) plays into this discussion. Yet, an equitable argument can be made for a view of disability as a socially determined construct that varies greatly across cultures. As a result of the investigation of traditional healing and disability in three African countries, Levers and Maki (1994) introduced the concept of ethnorehabilitation, defining it in terms of how various cultures attribute different meanings to disability. Ethnorehabilitation is clearly intended as a way of understanding and conceptualising disability within various cultural contexts, and certainly not as a means to legitimate socialised stigma. It is precisely from a human rights perspective that the ethnorehabilitative perspective can be useful in adopting reasonable positions of advocacy from culturally advantageous viewpoints.

Related to the construct of ethnorehabilitation, Levers and Maki (1994, 1995) also urged the development of a more productive perspective on pluralism among service providers. In this and in subsequent research in Africa (Levers, 2006a, 2006b), I have observed much of the western-influenced psychosocial and rehabilitative service sector as being culturally encapsulated. Services often are not particularly connected with local culture, are much more reflective of western culture, and have tended to dismiss traditional healers and other important Indigenous cultural brokers. I have advocated for the delivery of western donor-supported psychosocial and rehabilitative services in developing countries from more of a perspective of

bioecological pluralism, rather than from one that is exclusively based on the biomedical model. Service delivery systems must be tolerant of an array of professionals—western trained and Indigenous—who provide interdisciplinary care to Indigenous populations. One salient example of the current need for such a pluralistic perspective is HIV/AIDS in Africa. I have argued elsewhere (Levers, 2006a, 2006b) for the need to include traditional healers at the decision-making table in order to see a really significant impact on HIV/AIDS.

The Need for an Integrative Sample

All of the authors for this Special Issue echo the need for developing collaborative programming and integrative service delivery. However, three decades have passed since the publication of earlier World Health Organization (1976, 1978) mandates for collaboration between the biomedical and indigenous healing systems. Very little successful collaboration has resulted, and, as Moodley (2005, p. 10) points out in his recent discussion of religion, magic, and healing, "… we lack a set of vocabularies, idioms, and phrases to explain the merging of these divergent practices in modern health care." Yet according to a more recent World Health Organization (2001) publication, we see that nearly two-thirds of the global population continue to rely upon the health care services of traditional doctors. The call for better integrative health-related modalities seems obvious, and the resistance to facilitate this primarily emanates from the biomedical sector.

Conclusion

I wish to revisit my "essential quotes." Just as I know that I must transfer them from the tired old technology of overhead transparencies to the newer/higher technology of PowerPoint, I also realise that their meanings have not lost potency—regardless of how the words get projected. Likewise, I know that biomedical professionals must transfer tired old thinking about the ideological superiority of one paradigm over all others to a fresh drawing board. Let us not continue to collude in any "conspiracy against the laity." And let us be canny pre-emptors of well-intentioned medical, psychosocial, or educational programming that, in reality, may result in "creating a monster."

Merely one person at one particular time on our planet, I am able to recount the ways in which multiple Indigenous healing paradigms have intersected dynamically with my life. I also am able to attest to the efficacy of biomedical care, when my Dad's cardiac condition necessitated the highest level of technological response, and to the efficacy of Chinese traditional medicine, when all biomedical interventions failed to relieve the symptoms of my Mum's Bells palsy.

Advances in modern medical technology are to be applauded, but many members of our global community do not have access to this level of health care. And whether we do or do not, our social and cultural contexts continue to be essential aspects of our health care needs, including those that affect our disability, developmental, and

educational spheres. And it is the nature of these very contexts that determines the best pathways of Good Medicine across our respective cultures.

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