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# Traditional Healers Action Research Project

*Final Report prepared by The Tavistock Institute of Human  
Relations*

*for The King's Fund*

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*“Tell me and I’ll forget;  
show me and I may  
remember; involve me  
and I’ll understand”*



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# 1. Introduction

This report is an account of a project that was set up to explore the potential for improving the understanding of community mental health care between 'mainstream' NHS health practitioners and practitioners from African healing 'traditions'. This was to be achieved by engaging practitioners from those different healing traditions and service users in an action research project that would foster intercultural dialogue. A key aim was to promote an increased understanding of different explanatory models of mental health and well-being, in order to create new ways forward for improved patient centred care, particularly for members of African and Caribbean communities in East London who were experiencing mental health problems.

## 1.1. Background to the original proposal:

There were a number of starting points for this project, but one of the main ones was the concern at the over-representation in mental health services of people from African and Caribbean communities. There was also the hope that support from healing and spiritual traditions of African and Caribbean origins and a better understanding of the support that these could provide, by mainstream services, might help to address this issue (Department of Health, 2002)<sup>1</sup>.

We deliberately started from a loose definition of what healing traditions would be included in this project. The World Health Organization (WHO) defines 'traditional' medicine 'as including diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and /or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness.' (WHO,2002)<sup>2</sup>. The WHO has been for some years promoting the value of mainstream (biomedical) health services working with 'informal' mental health services such as 'traditional' healers, families, self-help groups and volunteer workers.' as part of a strategy of supporting the development of community based mental health care services, and ensuring care is integrated into the wider context of life.

In East London, we were aware that there were a number of different spiritual and religious traditions operating which drew broadly from an African and Caribbean origin, many of which had some kind of 'healing' practices or ministries. Some of these drew from African 'traditional' healing practices, as defined by the WHO, above, while others were aligned to mainstream religious groupings, such as Christianity, or Islam, but which incorporated some specifically 'African' elements, linked to the wider cultures and religions of the countries from which they derived. We were also aware, from previous (unpublished) research undertaken by members of the research team, that such

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<sup>1</sup> Department of Health (2005) *Delivering race equality in mental health care: An action plan for reform inside and outside services* and the Government's response to the Independent inquiry into the death of David Bennett

<sup>2</sup> World Health Organization (2002) WHO *Traditional Medicine Strategy 2002-2005* World Health Organization Geneva

practices often provided a valuable resources, and source of support, for people experiencing life difficulties, and mental health problems.

A number of policy documents<sup>3</sup> have advocated the valuing of the diverse cultural needs of mental health service users and for assessments that lead to the establishment of care plans to include religious, cultural and spiritual beliefs. However, in practice there is little information available for mental health professionals concerning spiritual and religious practices of a specifically African or Caribbean origin. Many conventional health practitioners are either unaware of the community support networks linked to spiritual or religious practices, or view them with considerable suspicion, particularly when they have little knowledge or understanding of them. The psychiatrist, Dr Andrew Powell, speaking on a DVD created by Croydon Mind on spirituality and mental health<sup>4</sup>, suggests that only one third of psychiatrists and psychologists hold spiritual beliefs, substantially fewer than the population at large, which, he suggests, can lead to difficulties in them appreciating the significance of the spiritual dimension in the 'patient/service user's world'. This may contribute to patients slipping out of main stream care, becoming seriously at risk or in danger of being exploited by healers with a limited understanding of their health problems or the support available within conventional health care systems.

## 1.2. Aims of the research

It was in the light of the above concerns the research project set out to address the following questions:

- What is the current role of traditional and faith-based healing practices originating from Africa in the care and support of patients with mental health problems?
- What elements of these practices would it be useful for mental health care practitioners working with African and African-Caribbean communities to be aware of to improve the care and support of their patients and to minimise risk?
- What guidance on biomedical knowledge would complement and assist the work of African traditional practitioners and faith based healers?
- What is the potential for dialogue to maximise the support of patients?

It is useful to note, at this point, that it was not the intention of this research project to ask whether any of the various healing traditions that we were exploring 'worked' more effectively than another, in the sense of improving the clinical symptoms. Indeed, the whole question of how mental health is conceived, what symptoms might mean, and

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<sup>3</sup> See section 2.3.1 for details of recent policy documents relating to the importance of valuing racial and cultural diversity in mental health services

<sup>4</sup> "Hard to Believe" DVD produced by Croydon Mind

what constitutes 'healing' or recovery within different healing traditions was at the heart of the exploration that we proposed to undertake.

We were also aware that it would be difficult to address the questions posed through a conventional research approach. This was partly because we were working in an area in which the previous evidence base was very limited, which meant that the approach adopted needed to be both exploratory, and to be adapted to knowledge as it emerged.

At more profound level, the methodology had to be appropriate to an area in which the very cultural assumptions, from which a more conventional research approach might start, would be challenged. The fact that the different healing systems are based on fundamentally different assumptions about the nature of reality and the body, and from different understandings and approaches to maintaining and restoring health can mean difficulties in communication and mutual comprehension.

These embedded cultural assumptions, we believed, could not be encompassed or addressed through questionnaires, surveys and a written report alone but would need to be challenged through a participative learning process. We also believed that focusing on 'cultural difference' alone is not the correct basis for dialogue and action. Our understanding of the processes of acculturation, the formation of local cultures, the complexity of transnational networks and global influences that intersect in what we might describe as the 'East London Mental Health System' was one that appreciates and builds on the positive mutual learning that is on-going in the area. We needed to find a methodology that worked with this process, rather than imposing an artificially rational structure on top of it.

### 1.3. Research approach

The methodology we chose was drawn from a combination of three different traditions: anthropological research, action research and intercultural dialogue. We also recognised that, in practice, the work would require a healthy dose of pragmatism, drawing on whatever sources of knowledge and information that were available that might help to elucidate the issues explored and answer the research questions posed. In this respect, the approach could be summarised most succinctly by Levi Strauss's notion of 'Bricolage', which he described in his famous text 'The Savage Mind'<sup>5</sup> as being adept at working with whatever is at hand, compared to the engineer who works with a defined set of tools conceived and procured for the purpose of the project. We saw ourselves as working with whatever resources were to hand, including any cultural differences, ideological and possibly moral clashes that emerged within the project, which would then become tools to do the job rather than limitations.

#### *Anthropological methods*

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<sup>5</sup> Claude Lévi-Strauss, *La Pensée sauvage* (Paris, 1962). English translation as *The Savage Mind* (Chicago, 1966). ISBN 0-226-47484-4.



At the heart of the 'research' element of the action research project was an anthropological approach to the collection and interpretation of data. This included the use of anthropological methods to the collection of data – often through identifying and following up a range of informal contacts and discussions, and through observation, including participant observation of healing activities. There is a long tradition within anthropological research of exploring the cultural dimension of spiritual and health related practices and the role that these play within the wider functioning of a community or particular cultural group. (There are further discussions of insights that could be drawn from the field of medical anthropology to this piece of research in chapter 2).

Anthropological perspectives pay close attention to discourses relating to health and how practitioners and patients understand themselves and each other through those discourses. It also explores the way in which these different discourses relate to dimensions of hierarchy and power within the population within which they take place. This was especially important in a piece of action research in which we were aware, from the start, that there would be considerable inequality between biomedical models of mental health and the African models and healing practices. Left unchallenged these power relations are likely to hinder the flow of participatory action research. From the outset our intention was to question any assumption that there may be one 'system of beliefs' that took precedence over another within the research framework. Rather, we started from the assumption that both biomedical models and the broad range of African healing that we were exploring were equally 'traditions' that could be questioned and delved into in terms of their history, structure and value base, and how they manifested in day to day practice.

### *Action research*

An action research framework was important for a project in which we were inviting those directly involved in different healing practices to explore with us the meaning and role of these practices and how they affected the lives of patients. At its heart, action research is about exploring the social environment as a dynamic field which interacts with human consciousness. Since these dynamic fields are fundamentally about understanding 'actions' then, as Lewin famously observed "If you want to truly understand something, try to change it."<sup>6</sup> Action research could therefore reasonably be viewed as 'practical science' with a distinctive iterative cycle of problem identification, diagnosis, intervention, evaluation and problem re-statement (Checkland, 1991)<sup>7</sup>. The emphasis is on sharing, agreeing, cooperating and making the research process as open and equal as possible.

At the heart of the action research method in the present project was the establishment of an Action Learning Set (ALS) that would bring together practitioners from different healing approaches, researchers/consultants and service users. Central to the Action

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<sup>6</sup> Lewin, K. (1946) *Action research and minority problems*. J Soc. Issues 2(4): 34-46

<sup>7</sup> Checkland, P. "From framework through experience to learning: the essential nature of action research," in *Information Systems Research: Contemporary Approaches and Emergent Traditions*, H-E. Nissen, H.K. Klein, R.A. Hirschheim (eds.), North-Holland, Amsterdam, 1991, pp. 397-403.

Learning Set was an attempt to create, and potentially disseminate, an 'intercultural dialogue' which would help to shape the remaining stages of the research.

### *Intercultural Dialogue*

The idea of Intercultural dialogue potentially provides the bridge between anthropology and action research, through the use of techniques that facilitate the communication of cultural difference between different groups in order to discover the commonalities from which groups begin to form new cultures - in this project around patient centred care. It is different to more conventional approaches to work with groups with potentially conflicting views of the world such as mediation approaches which have been criticised for assuming that the underlying values of win-win are universal. But there are many ways of dealing with conflict based on values that go beyond individual rights (Walker, 2005)<sup>8</sup>. The underlying principle explored in this work is that the capacity for the different practitioners to work together for the therapeutic benefit of the service users might be realised through explaining what we believe to be different about ourselves to 'others' and actively listening to the difference of others. Participants can then become more aware of the shared culture they have and build on that in their working practices.

Our use of the term dialogue refers to a particular kind of conversation in which the goal is not limited to expressing your perception or position, but rather focuses on clarifying the sources and meanings of the various points being expressed; not just what you want or believe, but why these particular things are important to you. The intention that organises the activity and experience is one of deep understanding; it is not an individual's position that is explored, but there they are coming from, the meaning it has, and its relationship with beliefs, values, goals, expectations and loyalties. As these are things that we may not know immediately about ourselves, the conversation requires active listening, or listening coupled with a particular kind of open inquiry, aimed at making sure we understand and have been understood. The stance in dialogue is that of exploration and discovery not of right and wrong- understanding how the perspective of the other person coheres and relates to his/her actions (and making one's own understood) as distinct from winning or losing a point.

## 1.4. Processes of data collection, analysis and feedback

The project work was designed to take place in six stages:

- preliminary scoping activities
- establishment of the action learning group
- exploring narratives
- running the action learning group (5 meetings)

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<sup>8</sup> Walker, P.O. (2005) 'Decolonizing Conflict Resolution' *American Indian Quarterly* (28) 527-549

- analysis of data
- Reporting and dissemination.

In practice, these stages were much less clear cut than was initially intended - in part because of a number of delays that took place which meant that discussions with the Health Trust, and with health professionals could not take place until after we had been awarded ethical clearance for the research – which was shortly before the action learning group began to meet. (The next chapter gives more information about the delays and the implication of this for the project and learning derived from the project).

It is therefore simpler to describe the research activities in terms of three broad clusters of activity:

- Research: scoping, exploring narratives through interviewing, observation and reviewing documentation
- Action learning sets and intercultural dialogue
- Dissemination of learning through website, podcasts, dissemination event and research report.

### 1.4.1. Research

The first stage of the project was seen as a ‘scoping phase’ and focused on accumulating knowledge about different healers that were working in the community and establishing links with the broader network of organisations and community based organisations working in the field. Initial exploratory discussions were also held with the Trust, and we were able to attend a number of meetings, including meetings of the cultural consultation club which was also exploring issues of cultural diversity within mental health services in East London. A key aim of this phase was to establish key contacts and identify people that might be interested in taking part in the Action Learning Group. It was also during this phase that we prepared our submission for ethical clearance – individual interviews with Trust staff or with service users could not take place until after this had been awarded.

Because of various delays, ethical clearance was not awarded until April 2008, at which point we were keen to get the action learning sets under way before the summer holidays started. We therefore decided to continue with the same kind of ‘scoping’ interviews and discussions alongside the action learning activities – with contacts and connections informed in part by discussions with members of the action learning group and by our growing contacts with healers and churches working in the area. Interviews at this stage became a bit more formal – in many cases we recorded and transcribed the discussion, and used a more formal interview topic guide. In the earlier stages, because discussions had been more exploratory, they were more informal, often quite partial in the kind of information that was recorded, although often very useful in

generating information about the kind of healing activities that were taking place in the community, and which were being used by service users.

We also at this stage sought to set up a number of focus groups – with healers, with health professionals and with service users. The aim at this point was to gather stories – narratives – and accounts that would supplement the learning derived from the action learning group. The two activities proved very complementary – for example, during the period that the action learning group was meeting (May to July 2008) a trail of contacts finally led us to the opportunity to interview a healer in the Ifa tradition who was visiting the country from Africa. Because this healer held a position of authority within his community, he was able to speak about aspects of healing within his tradition that healers within the action learning group had felt reticent to divulge. Hearing that someone with considerable authority had been speaking about their tradition, members of the action learning group felt more comfortable in speaking about aspects of their tradition, themselves.

Overall, the number of discussions and interviews that took place alongside the action learning activities included discussions or interviews with

- 30 'service users' (including 3 focus groups)
- 18 'healers' (including 1 focus group)
- 16 'health professionals'
- 10 representatives from African centred community services, service user organisations and other organisations involved in issues
- 4 policy makers work in the area of mental health and race

In addition, we attended a number of events – including 6 faith or traditional healing events, a meeting for health professionals and service users organized by a local church, and a number of events associated with the 'bicentenary of the ending of the slave trade', including one which explored the role of churches in the slave trade, and ending of the slave trade. We also attended a number of meetings with service user organizations and with community organizations working with African and Caribbean communities.

In addition to interviews and discussions, we also began to accumulate a considerable amount of relevant literature during this phase. A systematic review of the literature was never intended as part of this project, and would, in any case, have been somewhat difficult for reasons explained in the next chapter. In brief, the topic of use of traditional healers by mental health service users from African and Caribbean communities was closely intertwined with a number of other areas – such as the whole area of spirituality and mental health, trans cultural approaches to mental health, the position within the mental health service of people of African and Caribbean origin – each with their own,

quite considerable, literature. To fully explore, and give justice to any of these areas was beyond the scope of this project, which had as its focus the question of dialogue, rather than a definitive account of the subject itself. However, a list of useful resources was compiled, which is available in appendix A

It was also during the initial period that an advisory group for the project was established. This included a number of experts in the field of different healing traditions, in the area of mental health and race, and involved in relevant community or service user organizations. This group met three times during the course of the project, and also commented on and advised during the preparation of the website, dissemination activities and final report. We are particularly grateful for the contribution of this group to the research. A full list of members is available in appendix B.

### 1.4.2. Establishment of Action Learning Set

A detailed account of the establishment and running of the action learning set is presented in chapter 5 of this report. In brief, however, the process began with an invitation to a one day event, sent out through the various networks and contacts that we had established during the scoping phase of the research. Invitations were also sent out through the Trust, with the assistance of the Assistant Director of Race equality.

We had a very positive response to this invitation, both from health professionals and healers, working in various traditions. We also had a number of responses from people working in community organisations and from health professionals not working for the Trust, and from a small number of service users and carers. 12 of these were invited to the all day workshop, out of which an action learning set of 8 was formed. The group met five times over a three month period and formed the basis of the 'intercultural dialogue' part of the work. All discussions were taped and transcribed. The main learning from the action learning set is presented in chapter 5 although some of the material also appears in chapters 3 and 4.

### 1.4.3. Reporting and Dissemination

Sharing the results of the initial research and action learning sets with different audiences is a crucial part of the overall design of this project. Our initial plan was to produce a video – recording both the action learning process, and some examples of different types of healing. However, this proved to be inappropriate – members of the action learning group felt that videoing proceedings would get in the way of open discussion, and it was difficult to predict when 'healing' events would be taking place, and to be ready to record these.

Instead, we decided to produce a website with 6 podcasts recording the voices of some of those involved in the project together with information from the project, and a list of resources for those wishing to find out more about the issues discussed. A post card advertising the website was distributed widely amongst relevant organisations.

The website was launched at a large public event, primarily designed for service users from East London. The event was part of a series of events called 'stereohype' organised by Mellow, a community organisation funded by the Trust. As well as launching the website, and playing brief excerpts from some of the podcasts, the event had a panel discussion with a number of experts involved in the issues, and one of the researchers. There were also a number of artistic inputs into the event – music, poetry and a short one man play exploring related issues.

Following this, a number of smaller meetings were held with various groups of health professionals and within the community, discussing the findings of the research and promoting information about the website. One formal conference presentation was also made at the OPUS conference in late 2008 – many of those attending this international conference were working in the field of mental health.

## 2. The project in context

### 2.1. Introduction

This chapter is about the way in which the project evolved, and something about the wider context within which it took place – two issues which turned out to be closely related. As was noted earlier, in the section on research approach, the ‘bricolage’ approach meant that all sources of learning were to be drawn on, including the processes within the research itself, in so far as these highlighted issues related to the questions addressed – particularly ways in which conventional and African based healing traditions interrelated.

As has already been indicated, the time scale, and way in which the project unfolded, was very different to the one anticipated, and some of the reasons for this were in themselves related to difficulties surrounding the exploration of this subject area. For a short period our work with the East London Mental Health Trust was suspended and, partly because of this, we sought to engage with a wider range of ‘actors’ involved in the fields of mental health provision, traditional healing and social and cultural issues relating to African and Caribbean communities living in London. This highlighted for us close inter-relationship between the area that we were seeking to explore, and a number of other overlapping areas of research, policy and service development, which potentially impacted on issues related to the interface between mainstream and African traditional approaches to mental health and healing. There was little space in the project to give these related areas the attention that they deserved, but they did emerge time and again during the course of the project, and so we felt it was useful, in this part of the report, to briefly refer to these and some of the work that is taking place, in London, the UK and elsewhere in the world.

### 2.2. Joint work between Tavistock Institute and East London NHS Foundation Trust

This was always intended to be a project that had to be conducted in partnership, since it involved bringing together representatives from some very diverse groups to create a dialogue. The key component was a joint working arrangement between the Tavistock Institute, as a research Institute with experience in the fields of anthropology and action research, and East London NHS Foundation Trust, as an NHS organisation involved in delivering clinical care to people with mental health problems, operating in an area in which there were large African and Caribbean populations. The project also required making contact with representatives of alternative healing traditions which were accessed by people of an African or Caribbean cultural background, and with users of mental health services who might be using a range of different support mechanisms, including these alternative healing traditions.

The initial conception of the project arose out of a dialogue between, an anthropologist working as a researcher at the Tavistock Institute and an occupational therapist working

at East London Mental Health Trust. Both had an interest in the role of the churches, and traditional healers in East London. There was also wider interest within the Institute, both in the issue of inter cultural dialogue and in the integration of alternative approaches to health and illness within the NHS. The King's Fund announced their intention to fund research into complementary and traditional health systems, as part of their 'Health in Partnership' initiative, provided the opportunity to bring these different areas of interest together in a project exploring the interface between traditional healing systems and the mental health services in East London. Work on a proposal for this funding stream took place early 2006, bringing together the four people mentioned in the paragraph above. A psychiatrist from East London Mental health Trust also gave endorsement to the project. From the community, a mental health advocate was invited to become involved as a member of the team, with the task of enabling contact to be made with churches and traditional healers.

There were however, a number of changes in personnel between the proposal being submitted and its acceptance, and the start of work in February 2007. A change of staff within the Tavistock Institute meant that another anthropologist with similar interests had to be appointed, and the occupational therapist at the Mental Health Trust changed his position, leaving less time to work on the project.

There were also some difficulties around the contracting process, which highlighted different understandings about the nature of the research and what this should, or should not, involve. Relations between the two organisations broke down for a while, and we started discussion to establish a connection with an alternative clinical site.

The discussions also brought to the surface a number of issues which were to become important themes in the later research. Although the community mental health advocate was still working with the team, the team had to take the criticism that it was 'another white research project looking at black issues' seriously. It became quickly apparent to us that issues around race, and particularly white, western attempts to suppress or exploit traditional African healing traditions, was going to be an important theme throughout the project. The balance of race and gender in the project was addressed partly through the recruitment of a black, male, consultant to help facilitate the action learning group, and partly through the establishment of an advisory group for the project which had strong representation from the African, and Afro Caribbean communities.

### 2.2.1. Re-establishing links with East London NHS Foundation Trust

Although disrupted for a while, discussions with East London Mental Health Trust were resumed towards the end of 2007, when contact was made with the Head of Equality and Diversity at the Trust, who was very keen to become involved in the project, and to facilitate our contacts with individual health professionals within the Trust. There were a number of other interesting projects taking place at the Trust around this time, including plans for the 'Heartsounds tour', a visit by a small group of professionals and patients to



Uganda, to hold discussions with mental health professionals, service users and traditional healers involved in mental health services in that country. Having re-established our links with a clinical partner, we were now able to restart the process of preparing the Ethical Clearance (LREC) application, which involved partial rewriting due to changes in the project as we gained a growing understanding of the issues with which we were working. Our application was submitted in December 2007, and accepted, following some revisions, in March 2008.

Work had to proceed quickly to establish the action learning set, in order to allow time for six meetings of the learning group before summer holidays began. The late start had two implications for the ALS – first, we decided to shorten the time period between meetings from three weeks to two. Second, because we had at this stage carried out more exploratory work and individual interviews with community and faith groups than within the Trust itself, in the end, representatives of these groups were better represented than mental health professionals in the group membership.

The background work that we had undertaken was also helpful at this stage, not least because we had established a number of new links with people involved in relevant fields that could inform our work, and help to recruit participants in the ALS. Several of these key individuals were now involved in our advisory group and provided useful feedback on project developments.

### 2.3. Exploring the wider context

During the gap between starting our work with the Trust, in early 2007 and obtaining ethical clearance in March 2008, a number of links with churches and traditional healers within the community were established. Through looking outside of East London for possible clinical settings within which we could work, we became aware of the number of initiatives that were taking place that had a close bearing on the issues that we were seeking to explore. These included some national initiatives taking place on issues related to race, culture and mental health services, including a number of initiatives seeking to develop a more cross-cultural approach to provision of psychiatric services, and services that had a uniquely African orientation. Our attention was also drawn to a number of initiatives taking place around issues of spirituality and mental health, as well as wider initiatives designed to promote greater regulation in the area of non-conventional medical practices.

While we cannot claim to be authoritative in any of these areas (each has its own extensive literature, professional organisations and interest groups, journals and conferences), a brief overview of these areas does give a useful context to, and greater depth, to the findings of our research project, as reported in the remaining chapters of this report.

### 2.3.1. Racism, health inequalities and mental health

As has already been noted, an early driver in the project had been the growing awareness within main stream mental health practice policy that Black service users, and particularly people of African Caribbean origin, were both over-represented within mental health services, often having both a negative experience of these services and poorer outcomes. Men, in particular, often enter the service via police intervention, and being compulsorily detained under sections of the Mental Health act. A number of reports highlighted and explored this issue, and particularly the difficulty in addressing this within existing services.

'Provision for patients from minority ethnic communities often remains basic, insensitive, and piecemeal leading to patients feeling alienated and isolated. It is dispiriting that the serious issues of inappropriate care and treatment of patients from black and minority ethnic communities, which were raised in previous biennial reports, continue to cause concern and to be noted in the reports of commission visits' From the 7<sup>th</sup> annual report of the mental health act commission (1997)

One of the most thorough explorations of this issue was undertaken by the Sainsbury Centre and published in their 'Breaking the Circles of Fear' report of 2002<sup>9</sup>. This put forward the hypothesis that three interconnecting areas of 'fear' were combining to cause this over-representation of Black<sup>10</sup> people, particularly within secure mental health provision: fear of mental illness, racism (fear of 'the other') and fear of mental health services. This, the report argues, leads to a 'pernicious circle of fear, a circle that impacts negatively on the engagement of black people with services and vice versa'.

Mainstream mental health services, a number of reports had shown, were often experienced by the Black community as inhumane, unhelpful and inappropriate, with Black service users often not treated with respect and their voices not heard. Because of this, there is a tendency to only use these services at a time of crisis, rather than as a source of support at earlier stages of mental illness. Services were not perceived to be accessible, welcoming, relevant or well integrated with the community.

There was also evidence of 'institutional racism' within mental health services in which stereotypical views, racism and cultural ignorance was perpetuated throughout services. These issues were particularly highlighted by the independent enquiry into the death of David Bennett<sup>11</sup>, an African-Caribbean man, who had died while being restrained in a secure unit. The report highlighted the need for training in cultural awareness and sensitivity for staff working in mental health services, for written policies on dealing with racist abuse, for care plans to have a mandatory requirement to include details of each

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<sup>9</sup> Sainsbury centre (2002) Breaking the circles of fear, a review of relationship between mental health services and African and Caribbean communities

<sup>10</sup> In this report the term 'Black' refers to people of African descent and origin, people who may commonly be referred to as African or African Caribbean.

<sup>11</sup> Norfolk, Suffolk and Cambridge strategic health authority (2003) Independent inquiry into the death of David Bennet, Department of Health

patient's ethnic origin and cultural needs and for the workforce in mental health services to become more ethnically diverse.

Three sections of the Sainsbury report are particularly pertinent to our study.

'Professional cultures and staff attitudes were cited as a factor that hinders change. These were viewed as fixed, stereotypical and discriminatory. There was a perception that staff were not able to incorporate other belief systems and explanatory models into their understanding of mental health in black communities. The challenge is to achieve a balance between drawing on western models for care and incorporating healing strategies that are embedded in other belief systems. (Barnes and Bowl, 2001, quoted in Sainsbury report, *ibid* p31).

'There was a perception that black people do not have adequate knowledge about services, how they are structured, how they operate and how to access them. Such lack of knowledge therefore also meant that they did not always know how to negotiate access to services. Professionals on the other hand lacked knowledge and understanding of cultural traditions. More importantly, they lacked an appreciation of cultural traditions and the impact of racism on the lives of service users'. pp33

'Support from families, the church, cultural groups, religions or spiritual practices etc. was generally perceived positively. It has been recognized that religion plays a supportive role through the psychological and social support derived from the membership of faith communities. Yet, it has been found that spirituality or religion is not taken into account in psychiatric history taking. (Ngegwa & Kilshaw 2002). However, the support that is offered in church should not be accepted as always unproblematic. For example, some religious standpoints may obscure underlying mental health problems, by categorising some behaviour as demonic possession. Their concerns could be addressed through education and partnership within mental health promotion programme'. pp39

The Sainsbury report called for a 'wide ranging programme' to break the circles of fear, through ensuring that Black service users were treated with respect and their voices heard, and to deliver better early intervention, and for greater support and funding to services led by the Black community. A key element of this was the call for Gateway organisations to be commissioned to develop bridge building programmes to support the reintegration of Black service users. Of particular relevance to the present study it called for action to:

'Increase understanding and effective communication on both sides including creating a culture which allows people to discuss race and mental health issues'.

In 2003, the Government published the consultation document: Delivering Race Equality: A framework for Action<sup>12</sup>. This was, in part, a response to the earlier report 'Inside Outside'<sup>13</sup> which set out to explore the significant disparities in mental health care access, experience and outcomes between BME people and the white British population, part of the Government's response to the publication of the mental health national service framework in 1999 and the recognition that more needed to be done to address the failure of services to adequately meet the needs of black and minority ethnic services users and the lack of confidence by those communities in mental health services. The 'Inside Outside' report concluded that:

"There does not appear to be a single area of mental health care in this country in which black and minority ethnic groups fare as well as, or better than, the majority white community. Both in terms of service experience and the outcome of service interventions, they fare much worse than people from the ethnic majority."<sup>14</sup>

The report called for a national approach aimed at reducing and eliminating ethnic inequalities in health services experience, and criticised the sometimes simplistic views and approaches that have been adopted within existing services.

A number of government led programmes were set up to address the issues raised in these, and other reports. Delivering Race Equality<sup>15</sup> was a five year plan set up by the government in 2005 for ensuring that 'every person receives the same standard of care from mental health services'. This programme was supported by the Care Services Improvement Partnership (CSIP), and focused around three strands – developing more appropriate and more responsive services, improved community engagement, and better information for staff and service users, including improved ministering of ethnicity within services. The last of these aims was supported by 'Positive steps online'<sup>16</sup>, an online resource which provides guidance and information about good practice for delivering Race Equality in mental health care. The programme also led to the establishment of race equality leads in a number of regions, the appointment of community workers and focused implementation sites in which partnerships have been developed between statutory services and third sector organisations.

A number of other initiatives were also developed which sought to address the issue of racism in all health services, and in all types of mental health provision. One of these was the much wider government strategy which seeks to address health inequalities across all types of statutory provision, one strand of which was the adoption of robust equal opportunities policies in all services. Within London, the Greater London Authority

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<sup>12</sup> Department of Health (2003) Delivering Race Equality: A Framework for Action

<sup>13</sup> National Institute for Mental Health in England (2003) 'Inside outside': Improving mental health services for Black and Minority Ethnic communities in England.

<sup>14</sup> National Institute for Mental Health in England (2003)

<sup>15</sup> Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response

to the Independent inquiry into the death of David Bennett (Department of Health)

<sup>16</sup> Department of Health (2007) Positive Steps: supporting Race Equality

adopted both health inequalities and equality and diversity strategies, and our contact with members of the teams involved in these proved very useful, both during the early exploratory and during the dissemination phases of the research.

### 2.3.2. Insights from anthropological studies

As the reports quoted above indicated, difficulties around the integration of people from African and Caribbean communities effectively into mental health services had thrown a spotlight on the issue of cultural sensitivity, and also highlighted the lack of knowledge, by many of those working in mainstream services, about the culture from which service users were drawn. In the present study, we were particularly concerned with the knowledge and understanding by mental health professionals of African traditional and faith based healing systems, and it soon became clear that this was often very limited.

In part this was because of a lack of written information available for health professionals on this subject, although it was also soon apparent that there was an extensive anthropological literature available on different African spiritual traditions, and their role in healing. This literature is not particularly accessible to non-academics: it is often published in academic books and journals, or framed within theoretical debates which may have little interest to those with general, rather than scholarly field. Most studies also focused on these healing traditions within their original cultural context, and it was unclear how relevant this was to the practice of these traditions in the UK. There is also sensitivity around some anthropological literature because of its historical association with colonialism, and a tendency in older literature to study 'Other' cultures – as something different and exotic. This appears to have left a legacy in terms of a reluctance to broadly publish research outside of the field of academic anthropology. As the focus of the present study was on encouraging a cultural dialogue rather than a detailed exposition of traditional healing systems themselves, we did not seek to delve in detail into the anthropological literature on African healing systems unless this was particularly drawn to our attention by those involved in the study. Nevertheless, it is worth saying a few words about the anthropological study of health and healing, and what insights it may bring to the present study.

The anthropological study of health and healing systems is generally referred to as medical anthropology, a discipline 'about how people in different cultures and social groups explain the causes of ill health, the types of treatment they believe in and to whom they turn if they do get ill'<sup>17</sup>. The notion of culture is central to the study of anthropology – a notion which has been subject to many different definitions. For the present purposes, it is useful to see culture as operating on a number of different levels, from the most visible aspects, such as rituals, ways of dressing or cooking and eating habits, to more subtle levels of language and values, and the underlying assumptions and rules, which form the 'taken for granted' part of the cultural world, operating largely out of conscious awareness. It is largely the more subtle aspects of culture with which

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<sup>17</sup> Helman, C G (2007) *Culture, Health and Illness*, Fifth Edition, Hodder Arnold, London

the present research project was concerned, sometimes referred to as the 'ideational' aspect, a view of culture as 'systems of shared ideas, systems of concepts, rules and meanings that underlie and are expressed in the ways that human beings live'. (Kessing and Stathern 1997)<sup>18</sup>. The concept of 'culture' is imperative to all anthropological work, referring to acquired (non-'natural') human behaviours and ideas, that are located in particular contexts (Eriksen 1995 Geertz 1973)<sup>19,20</sup>. Avoiding ethnocentrism is a central research method within anthropology, which means refraining from prejudice and stereotypical cultural assumptions: 'culture' must be understood in its own terms, not through external impositions (Eriksen 1995). Anthropologists are ultimately concerned with understanding how people interpret and act in the world by forwarding the 'everyday', 'lived experiences' of communities and individuals themselves *in context* (Geertz 1973).

Medical anthropology has long held an interest in how mental ill health is defined within different cultures, and how spirituality and religious practices intersect with notions of health and ill health. It has, for example, been recognised for many years that some aspects of behaviour which, in western culture, might be interpreted as signs of highly abnormal, or indeed, psychotic behaviour, are, within other cultures, part of normal behaviour and understandings of the world. Examples of beliefs which might be seen as 'normal' in some cultures, but signs of insanity in another include a belief in witches, the hearing of voices (e.g. of ancestors, spirits, or of god), glossolalia (or speaking in unknown tongues), shamanic trances, and self-neglect, as in the case of a sadhu or holy man who subjects himself to rigorous fasting and who walks around naked, smeared with ashes, with hair, beards and nails uncut. For example, Lewis suggests that where the reality of possession by spirits or witchcraft constitutes an integral part of the total system of religious ideas and assumptions, a disbelief in such things would be seen as a striking abnormality, a bizarre and eccentric rejection of normal values<sup>21</sup>.

However, there is also a recognised distinction between behaviour of this kind which represents an accepted, or relatively controlled, form of abnormal behaviour, and that behaviour which is recognised by the wider culture as being beyond the boundary of what might be considered culturally acceptable, and is seen as a symptom of either 'mad' or 'bad' behaviour. For example, in one study of four quite divergent East African tribes<sup>22</sup>, it was found that there was a considerable agreement about what behaviours suggested a diagnosis of madness. These included violent conduct, wandering around naked, talking nonsense, and 'sleeping and hiding in the bush'. The author noted that this view of 'madness' was not very different to western definitions of psychosis, in so far as it was abnormal, not controlled by social norms, and had no discernible cause or purpose. However, once a general diagnosis of mental ill-health has been made, anthropological studies also show us that more specific diagnostic categories, as well

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<sup>18</sup> Kessing R M and Strathern A (1997) *Cultural Anthropology: a contemporary perspective*, Wadsworth Publishing Company

<sup>19</sup> Erikson T H: (1995) *Small Places Large Issues, an introduction to social and cultural anthropology*. Pluto Press, London

<sup>20</sup> Geertz, C. (1973) 'Thick Description: Toward an Interpretive Theory of Culture.' In: *The Interpretation of Cultures* New York Basic Books

<sup>21</sup> Lewis I M (1971) *Ecstatic Religions*, pp 178-205, London, Penguin.

<sup>22</sup> Edgerton, R.B. (1977) *Conceptions of psychosis in four East African societies*. In: *Culture, Disease and Healing: Studies in Medical Anthropology* (Landy, D. Ed.). London: Macmillan, pp. 358-67.

as prognoses made, treatments used, vary considerably from one culture to another, even within the western world.

Another relevant insight from medical anthropology concerns the way in which illness manifests itself in different cultures, and how personal distress is communicated to other people. This 'language of distress' can be quite culturally specific: this includes how people behave; how they describe their symptoms and the kind of emotions they express when they are ill. It has been noted that hallucinations and delusions draw heavily on the symbols and imagery of the patient's wider culture: patients from cultures with a strong orientation to the spirit world are more likely to report spirit possession, while possession by 'Martians' or 'extra-terrestrials' is a particularly western phenomenon. In one study, 40% of patients with severe psychoses who were born in the Caribbean or Africa, described their illness in terms of religious experience, compared to only 20% of white patients born in the UK (Littlewood & Lipsedge<sup>23</sup>). Similarly, the somatisation of mental distress will also tend to focus on different parts of the body in different cultures: an Iranian or Punjabi might refer to 'heart distress', in France the focus of attention might be on the liver, while in the UK, the focus is often on the bowels. In other words, individuals literally 'embody' the values of the culture of which they are a part.

There are also many insights which can be drawn from cross cultural analysis of ways in which healing is conceived in different cultures, and what steps are taken in order to achieve healing. In some cultures, for example, the health of the spirit may be of greater importance than the health of the body – physical death is less of a cause of a distress than the idea that one's soul or spirit has been destroyed or consigned to a hellish fate. Western healing systems are distinct from many more traditional cultures in its separation of physical, and mental, healing, from a wider vision of cultural and spiritual wellbeing. For example, one feature of western healing systems that has been noted by a number of anthropologists is its extensive focus on the individual, to the exclusion of the family, and wider group of which they are a part.

This contrasts to many non-western cultures within which mental illness is considered to be more of a social event, and one which intimately involves the patient's family, friends and community, and in which both mental and physical ill health are interpreted as indicating conflicts or tensions in the social fabric (Helman et al)<sup>24</sup>. The concept of 'cultural healing' (Klienman, 1980)<sup>25</sup> has been used to describe healing activities designed to restore such social conflicts and 'reassert threatened values and arbitrate social tensions'. Thus, unlike the private consultation between western doctor and patient, healing will often take the form of a public ritual which may serve to strengthening ties within and between groups, and help to reintegrate the ill individual back into his or her social context. As has been observed (Wexler 2006)<sup>26</sup>, this contrasts with western approaches to treatment which may often serve to alienate the

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<sup>23</sup> Lipsedge M and Littlewood R: *Aliens and Alienists* (2006) ethnic minorities and psychiatry. Taylor and Francis e-library

<sup>24</sup> Helman, C G ( 2007) *Culture, Health and Illness*, Fifth Edition, Hodder Arnold London

<sup>25</sup> Kleinman A (1980) *Patients and healers in the context of culture : an exploration of the borderland between anthropology, medicine, and psychiatry*: University of California Press

<sup>26</sup> Wexler, B. (2006) *Brain and culture*. MIT Press

sick person even further from society, and may also establish a very negative, rather than hopeful, prognosis for the future.

One final set of insights from anthropological studies which is useful to draw on in the present study is the research that has been undertaken on mental illness amongst migrants – people who have moved from one cultural environment to another. A number of studies have indicated higher rates of mental illness amongst migrant groups, but the reasons for this remain disputed. Many stressful factors impact on the wellbeing of migrants: multiple deprivation, language difficulties, loss of status, the clash between old and new cultural values, and exposure to prejudice and possible physical attack from citizens of their adopted country. However, the extent to which these affect the health of individuals is also mediated by cultural factors. Being part of a strong family or social group, having a strong positive motivation for moving, maintaining ties to their previous culture, and having good financial and educational resources, or a coherent religious or cultural world view, can all help to protect against the harmful effects of migration. On the other hand, rigid gender divisions and social isolation of women, strong religious taboos and restrictions, hostility to the host society, intergenerational conflict and extreme pressure on children to succeed financially and academically, can all increase the risk of ill health<sup>27</sup>.

Migrant groups may also adopt a number of different strategies in order to maintain their sense of identity and reduce feelings of ‘cultural bereavement’. They might seek to create a micro cultural world, within the home, or by establishing clubs and associations with others from the same culture – faith groups may be a very important part of this. Many retain strong links with their original culture, through visits, letters, email, or access to local media, but some may also exaggerate their original culture, retaining intact features of their original culture which may now no longer exist ‘back home’. A somewhat different strategy is the strong rejection of the original culture, as the individual seeks to forge a ‘new life’ through conscious efforts at assimilation to the new culture. This may be accompanied by ‘cultural amnesia’ – refusing to speak their native language, changing their name, converting to another religion or intermarrying with the local population.

It became apparent in the present study, that retaining, or re-establishing lost links, with traditional or faith based healing practices originating from Africa or the Caribbean was for some people an important element in addressing a strong sense of cultural dislocation and distress, possibly also a way of overcoming this ‘cultural amnesia’ and an accompanying sense of loss of something important. However, access to traditional practices was sometimes not easy once the informal connections had been lost. Where they were available, they were functioning within a very different social and economic context to the one in which they functioned within Africa. In some cases this added to the risks attached to such practices (they are not subject to the same social controls in the UK). They also may be subject to considerable criticism and rejection by those members of their community that were seeking to put traditional beliefs and practices

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<sup>27</sup> Helman, C G ( 2007) Culture, Health and Illness, Fifth Edition, Hodder Arnold London



behind them, as they assimilated into life in the UK. Seeking help from this source could therefore become something of a minefield.

### 2.3.3. Integrating the notion of culture into mental health practice

Insights from medical anthropology are beginning to have an influence on mainstream psychiatric practice, not least because they often raise questions about the extent to which psychiatry, as it has evolved within the developed world, has incorporated some fundamental assumptions that might not have universal application. There is a growing body of research and debate concerning the 'Eurocentric' nature of modern psychiatric practice, and how this might affect those seeking help from services from a very different cultural orientation.

#### *Cross cultural psychiatric practice*

There are now a number of initiatives that seek to promote greater dialogue between psychiatrists from across the world, in order to gain a greater understanding about what 'cross cultural' psychiatric practice might entail. One of the main drivers behind this is the World Alliance of Cultural Psychiatry (WACP) the main purpose of which is 'to promote the exchange of scientific knowledge, research initiatives and clinical experiences in the field of cultural psychiatry worldwide'<sup>28</sup>. The organization brings together psychiatrists, mental health workers, and social and behavioural scientists, for the purpose of 'working together to increase the availability and effectiveness of clinical services for diverse peoples and populations throughout the world'.

In the UK, the Royal College of Psychiatrists set up a transcultural special interest group which is affiliated to the WACP, which issues regular bulletins<sup>29</sup> exploring various issues related to the question of cultural sensitivity in psychiatric practice. This group has played a pivotal role in developing the curriculum for psychiatrists, policies for asylum seeking and refugee care, inside/outside policy and contributing to the national Delivering Race Equality policy.

The Royal College of Psychiatrists (RCP) also set up an ethnic issues project group which published a report in 2001<sup>30</sup> that called for all psychiatrists to be trained to be culturally sensitive in their interactions with people and culturally competent in their therapies. This group has also called for a systematic review of the structures of the RCP to determine whether or not there was evidence of institutional racism.

#### *African centred mental health services*

A somewhat different approach to developing culturally appropriate mental health services has emerged from a movement by health service professionals and service

<sup>28</sup> From WACP website 2008: <http://www.waculturalpsy.org/>

<sup>29</sup> <http://www.rcpsych.ac.uk/workinpsychiatry/specialinterestgroups/transculturalpsychiatry.aspx>

<sup>30</sup> Royal College of Psychiatrists (2001) Report of the Ethnic Issues Project Group: <http://www.rcpsych.ac.uk/files/pdfversion/cr92.pdf>

users who are themselves, of African origin and who are seeking to reclaim, or reassert, key values from their original culture. This is part of a larger movement to recover the culture, and history, of Africa from the colonial domination that it experienced throughout the last two centuries and to address the racist attitudes endemic in western society. African centric thinking has incorporated both academic work that has sought to document the many philosophical and spiritual traditions originating from the African subcontinent, as well popular cultural developments in terms of communal traditions, music, food and dance.

In the mental health field, there have been a number of efforts to establish African centred services, including African or black history groups, community services and one of the most ambitious in the UK, the Pattigift centre set up in Birmingham in 2003<sup>31</sup>. This was:

“a 12 bedded residential and ten place non-residential mental health service specifically for people of African and Caribbean descent who are experiencing there first or second episode of mental illness, as an alternative to hospital. Its aim was to provide an African centred model of care that is highly therapeutic, holistic, and founded on psychological models that incorporates the effects of enslavement and colonisation as well as being psycho social, and assertive”.

“Therapy will have an African Centred approach and by this we mean viewing the world, the person and their behaviour from an African understanding. It is not restricted to a particular African ethnic group, but based on a cultural unity that permeates all African cultural groups”.

The features of an African centred perspective address matters relating to -

- Self-Definition. Viewing ourselves from our perspective not the definition of others
- Spirit. The essence of all things and which reflects the interconnectedness of all matter.
- Nature. The processes in nature provide instruction on human functions
- Community and Self-Knowledge. Self-knowledge is the basis of all knowledge community provides the process.

Unfortunately, this centre like many other African centred facilities suffered from lack of funding, and had to close. A review of seven of projects with a similar ethos was undertaken by the Mental Health foundation in 2003 in its ‘Black Spaces’ report<sup>32</sup>. Most

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<sup>31</sup> From Pattigift centre report on pilot period. For more information see <http://www.pattigifttherapy.org>

<sup>32</sup> The Mental Health Foundation (2003) Black Spaces Project

of these have strong community involvement, whether in the form of user involvement in the management of the project or its activities, in the role of volunteers, and in terms of outreach activities with the wider community. Active involvement of family and the wider community, rather than focusing attention on the person with mental health problems alone, is often seen as an important dimension of more African centred approach to supporting people with mental health problems. Activities often focus as much on cultural activities – dance, sewing, sport – as on more conventional approaches to care through counselling and ensuring appropriate medication.

Creating a sense of identity is an important part of many of these projects. A report on the 'Black Spaces' project, for example, an early report from the 'forward' project<sup>33</sup>, a community based project for African and Caribbean service users quotes staff as saying that the project:

- 'feels' Black because it:
- acknowledges and involves the family which is the foundation of all Black communities, but which has not been sufficiently acknowledged by mainstream services.
- recognises that issues underlying people's brush with psychiatry stem from social and psychological reasons so counselling and psychotherapy are often a relevant intervention.
- recognises and acknowledges the effects of racism both internally for the individual and externally.
- incorporates cultural themes and values, such as music, art and belief systems into the services that are delivered.

### 2.3.4. Mental health and spirituality

Closely linked with the idea of different cultural conceptions of mental health is the idea that, in many parts of the world, mental wellbeing, mental health and spirituality is closely interlinked. This contrasts with the western view that makes a clear distinction between spirituality, mental and physical health. Within a cultural framework in which no clear distinction is made between the physical, social and spiritual realms of life, mental health disturbances are often identified as manifestations of spiritual disturbance, whether this is seen in terms of falling out of a sound relationship with God, spirit beings and ancestors, or a failure of integration within an individual's inner being. Research indicating that a healthy religious or spiritual life can have benefits for both physical and mental health has also led to a growing interest by mental health practitioners in how

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<sup>33</sup> This quote is from p24 of The Mental Health Foundation Black Spaces Project | Action on the ground' report. See main report (ibid) for full account of the Black Spaces Project

this can be used to support the mental health of service users. A survey in 1998 by the Mental Health Foundation<sup>34</sup> revealed that over fifty per cent of service users hold religious or spiritual beliefs, which they see as important in helping them cope with mental illness, and highlighted the need expressed by many patients for encouragement in discussing such concerns with their psychiatrists.

This has led to a number of guidelines and reports being made available, both for service users, their families and carers, and for health professionals, encouraging these to become more familiar with the different spiritual and religious traditions to which their clients might be turning for support.

The Royal College of Psychiatrists has had a special interest group on spirituality since 1999, which was founded:

“to provide a forum for psychiatrists to explore the influence of the major religions, which shape the cultural values and aspirations of psychiatrist and patient alike. The spiritual aspirations of persons not identifying with any one particular faith are held to be of no less importance, as well as the viewpoint of those who hold that spirituality is independent of religion. The meetings are designed to enable colleagues to investigate and share without fear of censure the relevance of spirituality to clinical practice. The Special Interest Group aims to contribute a framework of ideas of general interest to the College, stimulating discussion and promoting an integrative approach to mental health care. For patients, there is the need to help the service user feel supported in being able to bring spiritual concerns to the fore”.<sup>35</sup>

This group defines spirituality as: 'the essentially human, personal and interpersonal dimension, which integrates and transcends the cultural, religious, psychological, social and emotional aspects of the person' or more specifically 'concerned with soul or spirit (the term 'spiritual' is now included in DSM IV under the heading of 'other conditions that may be a focus of clinical attention')'. The Special Interest Group has a correspondingly varied and wide-ranging agenda, including consideration of protective factors that spiritually sustain the patient in crisis and otherwise contribute to mental health.

The group supports the exploration of such fundamental questions as the purpose and meaning of life, which are so important for mental health, as well as the problem of good and evil and a wide range of specific experiences invested with spiritual meaning including birth, death and near-death, mystical and trance states and varieties of religious experience. Both pathological and normal human experiences are considered in order to understand better the overlap and difference between the two'.

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<sup>34</sup> Faulkner A (1998) Knowing our own minds: Users views of alternative and complementary therapies Treatments in mental health

<sup>35</sup> Taken from: <http://www.rcpsych.ac.uk/workinpsychiatry/specialinterestgroups/spirituality.aspx>

The Royal College of Psychiatrists produced a leaflet on spirituality and mental health<sup>36</sup> which outlines the relevance of spirituality to mental health and mental healthcare, and explains some of the benefits. A similar booklet has been produced by the Mental Health Foundation, "Making space for spirituality: how to support service users"<sup>37</sup>. In 2005, a local branch of MIND also produced a DVD called 'Hard to Believe' on a similar subject<sup>38</sup>.

### 2.3.5. Non-conventional practices in mental health services

A resurgence in interest in spirituality has coincided with, and sometimes been linked to, a growing interest in the role of complementary and alternative therapies for patients with mental health problems. This is linked with a growing interest in complementary and alternative medicine (CAM) across the health service, and has been expressed within a number of initiatives set up to explore the potential for integrating CAMs with mainstream health provision. Foundations for this work were established by the Prince of Wales's Working Party on Integrated Health<sup>39</sup> and then by the House of Lords Scientific Committee on complementary and alternative medicine<sup>40</sup> which led to a growth in interest in the regulation, training and enhancement of the research base for CAM activities.

However, 'traditional' rather than westernised complementary and alternative therapies were largely overlooked by these discussions. The House of Lords scientific committee report identified one group of healing systems (Group one, often described as the 'big five', includes acupuncture, herbalism, osteopathy, chiropractic and, homeopathy) that was closest, in terms of professional structures and evidence base, to statutory regulation. Another group of healing systems (Group two) were seen as being supportive, rather than claiming to diagnose or treat patients, and so less in need of regulation. 'Long established and traditional systems of healthcare' that were seen as claiming to '*offer diagnostic information as well as treatment and which are indifferent to the scientific principles of conventional medicine*' were included in group three, and currently seen as being a long way from either voluntary or statutory regulation. However, although this group included number of traditional systems such as Ayurvedic medicine, Traditional Chinese Medicine, naturopathy and Unani Tibb, no mention is made of traditional African healing systems, and no written or verbal submissions were sought or received by representatives from these traditions.

Considerable work has taken place since this report was published to move the Group 1 and to a lesser extent, Group 2, therapies towards either a statutory or voluntary framework for regulation, however work has been much more limited in relation to group three therapies, not least because of the diversity represented by these practices. Yet

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<sup>36</sup> <http://www.rcpsych.ac.uk/expertadvice/treatmentwellbeing/spirituality.aspx>

Mental Health Foundation (2007) Making Space for Spirituality How to support service users, [http://www.mentalhealth.org.uk/content/assets/PDF/publications/making\\_space.pdf](http://www.mentalhealth.org.uk/content/assets/PDF/publications/making_space.pdf)

<sup>38</sup> <http://www.mindincroydon.org.uk/hard-to-believe.asp>

<sup>39</sup> The Foundation for Integrated Health (1997) 'Integrated health, a way forward for the next five years, a discussion document'.

<sup>40</sup> House of Lords Select committee on science and technology, Complementary and Alternative Medicine, session 1999-2000, 6<sup>th</sup> report, HL paper 123.

the issue of how best to regulate, and reduce the risk attached to traditional medicines, particularly protecting patients from unscrupulous practitioners, remains an issue of concern. This was a key issues explored in the WHO policy on traditional healing systems<sup>41</sup> .

## 2.4. Conclusions

As noted at the start of this chapter, the process of implementing this project has been as vital a source of learning about the subject matter as the actual research activities undertaken. Lessons arising from this have provided a number of themes which have emerged over and over again throughout the research

### 2.4.1. The importance of race and cultural history

In undertaking work on the boundary between mainstream health services and healing systems in an African and afro Caribbean tradition, issues of race, and the inequality of relationship between England and its former African 'colonies' is never far from the surface. Secrecy surrounding the traditions that we were seeking to gather information about surfaced regularly during the life of the project. While this was partly due to the secret nature of the healing traditions themselves (which are rarely shared with non-initiates – see chapter four), it also relates to a history of suppression and living 'in the shadows' particularly during the years of slavery. There are many accounts of the attempts made to actively suppress traditional healing practices in Africa during the colonial years, including the passing of laws to control 'witchcraft' and the sale of traditional herbal medicines. Notwithstanding, it is important to recognise that today, in Africa, 80% of people approach traditional healers before seeking conventional medical care.<sup>42</sup>

The rawness of the race dimension came to the fore a number of times during the course of this project, surfacing in suspicion on the motives of the researchers when they sought interviews with healers and in the concern expressed, early on, that a project being undertaken by a predominantly white team would not effectively study an essentially 'black' issue.

Later it was to emerge strongly in the advisory group and the action learning group, both of which had members with a strong interest in ensuring that the African heritage and history is represented in modern western society, and the power of this in providing a strong cultural identity, and positive wellbeing, by people of African origin, living in the west.

### 2.4.2. The breadth of the subject area

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<sup>41</sup> World Health Organisation 2002:WHO traditional medicine strategy 2002-2005 (WHO/EDM/TRM/2002.1)

<sup>42</sup> World Health Organisation (2000) promoting the role of traditional medicine in health systems: a strategy for the African region 2001-2010. Harare WHO (document reference AFR/RC50/Doc.9/R)

The issue of how the NHS and mental health services can work effectively with traditional and faith based healing systems impinges on a large number of other areas. In this respect, it is somewhat more complicated than the better charted area of integration between (western) complementary and alternative healing systems and the NHS. The users of traditional healing systems are non-white, often speaking either little English or English as a second language, with a number of cultural obstacles to accessing health services, and particularly, mental health services.

This means that issues of health inequalities and of equality and diversity policies and practices have an important role to play in the debate, which can be closely intertwined with issues of racial and religious prejudice. Similarly issue of culturally sensitive, culturally aware psychiatry and psychiatric practice (or more specifically, the question of African centred psychiatric practice) may be central to the understanding of the role that different conceptions of health and illness, represented in these traditions, can play in improving mental health services for people from an African or Caribbean background. More broadly, the question of spirituality in mental health services – and the dangers of mistaking genuine expressions of spiritual experience or religious belief with psychiatric disturbance, cannot be overlooked. The role of spiritual or religious practices in supporting the wellbeing of individuals suffering from mental health problems, and when this shades into risk - of failure to receive appropriate treatment or receiving treatments that are dangerous – brings the topic into the area of regulation and protection for patients from unscrupulous or dangerous practitioners.

Because of the breadth of the different areas what potentially impinge on the issue of how the NHS can work effectively with traditional and faith based healing systems, the potential contributors to work in this area are also broad, and in some cases, have had little connection with one another. The advisory group provided a valuable opportunity for some of these to meet, and hear about one another's work for the first time.

### 2.4.3. The time factor

Work in this area is slow – and in our experience, cannot be rushed or fitted easily into a pre-planned schedule. In many cases, our connections came through word of mouth and fortuitous meetings. A great deal of time was spent pursuing links that led nowhere, or attending meetings and events which turned out to be different to the kind of event advertised. It took time for word to get around that our intentions were honourable and we were to be trusted.

It took time to penetrate and understand, not only the world of the faith and traditional healers, but also the equally, in its way, esoteric world of the NHS. Both have their key gate keepers who allow, or prevent access. Both have their own structures of power and authority, often far from explicit, which have to be navigated. Communication is often difficult – with the churches and traditional healers, because word of mouth and person to person contact is usually more effective than electronic communication – telephone or e-mail. In the NHS, communication is hampered by the level of pressure,

and amount of electronic communication, that professionals and managers have to deal with on a day to day basis.

A great deal of the time, in this project, has been spent in waiting – for responses to requests for meetings for replies to calls and e-mails, for promised contact details or documents to be forwarded. On the other hand, when promised meetings and contact came through, this often required an instant response – a traditional healer was in the country this week only, a useful meeting was taking place tomorrow. The team had to be willing to instantly rearrange planned schedules, and the most valuable meetings often took place either in the evening or at weekends.

#### 2.4.4. Working on the boundary of formal and informal systems

The last of these points, the fact that many of the 'healing' events that we sought to visit took place outside of office hours, highlights another important dimension of the dialogue between conventional health services and traditional healing systems – the fact that the former take place within a highly structured and formalised organisation, while the latter are part of what might be described as 'civil society' - not formally organised or regulated by an external structure, but closely embedded within community and family life. The rules and regulations surrounding civil society are very different from those operating in formal organisations – implicit understandings; rules of politeness and convention, with issues of trust, friendship and interest are often the key to whether continuing contact is maintained. Informal structures of power and authority are crucial in terms of accessing different parts of the community, and in terms of what information is shared, or withheld.

#### 2.4.5. The global dimension

Another important dimension emerging in this project was fact that the networks we were exploring often spread much wider than the UK itself. Many of our informants had lived in several countries – and were able to provide valuable insights into differences in terms of mental health service provision, access and attitudes to traditional healing systems, between different countries. Several of our informants were difficult to access because they were moving out of the country for several months at a time, or were only visiting the UK for a short period. We were informed (see chapter three) that service users sometimes returned, or were sent by their family back to Africa, in order to access traditional healers, and we were told by one of our informants that 'true' traditional healing could not take place in a UK context. In working with the trust we were also invited to contribute to a project that was being planned, drawing on a close partnership that had been established between the Trust itself and a hospital, and service user group, in Uganda. Part of this involved the organisation of a visit – the 'Heart Sounds Tour' – by three health professionals, three service users and one community representative, to Uganda, visiting both conventional health services and traditional healers during the visit.



## 3. Mental health services in East London

### 3.1. Introduction

This section provides information about mental health services in London – the setting for the project. The project took place jointly with East London NHS Foundation Trust, partly because of the high population of people of African and Caribbean heritage living in east London, and partly because it was a Trust that had already taken on a number of initiatives seeking to address some of the issues highlighted in the reports and policy documents outlined in the previous chapter. Although connections between the Tavistock Institute and the Trust were beset with difficulties in the early stage of the project, the relationship settled down into a creative and productive one as the work progressed, culminating in the establishment of the action learning group, and the successful development and launch of a website through which learning from the project could be shared with a wider audience.

This section of the report starts with a description of the Trust and the context within which it works. It goes on to outline some of the many initiatives that were taking place seeking to ensure that its services were sensitive to the needs of its service users, and accommodated the views of all staff, including managers and health care professionals working at the Trust, as well as staff involved in some of the community based services partly funded by the Trust, and some of the people using these services.

This includes discussions that took place during the establishment of the partnership relationship and in the process of setting up the action learning group, as well as in more formal interviews, which took place either as group interviews (1 with staff and 3 with service users), or one-to-one.

One important point needs to be made about these interviews – the fact that the demarcation line between staff members, community service workers and service users was not a hard and fast one. Several of the staff members we interviewed had themselves been service users at some point in their lives – often the reason for them taking up a professional career in mental health, or working for a community organisation. Several of the organisations we visited had a strong self-help, and active service user involvement ethos. Some of the views about the use of mental health services have been drawn from staff members, based on their own experience as service users, as well as their observations about the experience of people using current services.

### 3.2. East London mental health trust and issues of cultural diversity

As has already been noted, East London NHS Foundation Trust was unusual in a number of respects. The areas served by the Trust are amongst the most culturally diverse and deprived areas in England, and its service user population, and to some

extent its staff group, reflect this diversity. The Trust was formed in 2000 through the merger of mental health services from the three community trusts in Tower Hamlets, Newham, The City & Hackney, and was awarded Foundation Trust status on 1 November 2007. It was also awarded University status at this time, and has a history of taking an active interest in research, including research in the field of mental health services and cultural diversity. At the time of the research, it was providing mental health services for a population of 710,000 in East London, and forensic services to 1.5 million across the whole of North East London. It employed over 1,800 staff, across more than 50 different sites.

In 2000 the Trust became part of the Delivering Race Equality Clinical Trailblazer Network, with its 'Alternative Pathways' project which reflected its commitment to addressing the over representation of BME communities within mental health services. This project sought to improve understanding of how Black African and Caribbean communities access services, the barriers they experience and how these could be overcome. The first part of this project involved mapping the local population and how this population was represented in mental health services. Tables from the report on this first stage show the proportion of Black service users detained under the Mental Health Act (1983) was up to three times the proportion of the same groups in the wider population.

**Table 1: Represented ethnic groups in East London August 2006<sup>43</sup>**

<b>CITY &amp; HACKNEY AUGUST 2006</b>		
<b>ETHNICITY</b>	Detentions %	Local Population%
Black or Black British Caribbean	29.9	10.3
Black or Black British African	24.6	12.0
White British	18.9	44.1
<b>NEWHAM AUGUST 2006</b>		
<b>ETHNICITY</b>	Detentions %	Local Population %
Black or Black British Caribbean	17	7.4
Black or Black British African	20	13.1
White British 18 33.4		
<b>TOWER HAMLETS AUGUST 2006</b>		
<b>ETHNICITY</b>	Detentions %	Local Population %
Black or Black British Caribbean	16	2.7
Any Other Black Background	11	0.5
White British	17	42.9

<sup>43</sup> Source: East London NHS Foundation Trust – Mental Health Act 1983 Data, reported in 'Alternative pathways' report on the first stage of the work

These figures also show the relatively high proportion of Black or Black British African people living in the Borough compared to other parts of the UK<sup>44</sup>, although similar to other parts of London, such as Lewisham, Southwark and Lambeth<sup>45, 46</sup>.

### 3.2.1. Equality and diversity initiatives at the trust

The diversity of the population served by the Trust was reflected in its having both a robust equality and diversity policy and a number of initiatives that support the development of culturally inclusive services. This included a policy of working closely with the voluntary sector.<sup>47</sup> During 2007, a new head of equality and diversity was appointed, and took an important role in facilitating the present project. In addition to this lead position, three local equality and diversity leads were also appointed to work in each of the local authority areas covered by the Trust.

#### *Transcultural services*

A number of senior staff at East London mental health trust have taken a considerable interest in transcultural issues. For example, Professor Kam Bui, has written a number of books on transcultural psychiatry<sup>48, 49</sup> and was for some years the Chair of the Transcultural Psychiatry Special Interest Group at the Royal College of Psychiatry. We were also given information about a number of psychiatrists and psychologists, as well as ward staff and members of allied professional groups who took a particular interest in these issues and this was supported through a number of initiatives such as the 'Cultural Consultation Club'. This met monthly and was described in Trust briefings as a 'useful and effective way of helping clinicians develop their practice and improve their understanding of how cultural issues influence the expression, presentation and management of mental distress and .....fills a gap in ongoing CPD activities around this subject'.

Another interesting development which took place during the time we were developing the healers project was the funding of a 'Heartsounds tour' to Uganda, by a small group of Trust staff and service users, who visited mental health services, service user groups and traditional healers living and working in and around Butabika hospital in Uganda.

Some of the Trust's services are closely linked to other services provided in the borough, such as the Afro-families project, a project designed to support:

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<sup>44</sup> Overall, across England and Wales, 1.1 per cent of people are Black Caribbean, 0.9 per cent is Black African and a further 0.2 per cent is from Other Black groups.

<sup>45</sup> In Southwark, Newham, Lambeth and Hackney, ten percent describe themselves as Black African, while ten per cent of people in Lewisham, Lambeth, Hackney describe themselves as Black Caribbean, and a further two per cent of people describe themselves as 'Other Black'

<sup>46</sup> Figures taken from DH (2003) 'Positive steps – supporting race equality in mental health services. Accessed via <http://www.actiondre.org.uk/positivesteps/bme.html>

<sup>47</sup> From East London NHS Foundation Trust website

<sup>48</sup> Kam Bhui and Dinesh Bhugra (2000) Cross-Cultural Psychiatry: a Practical Guide Butterworth-Heinemann,

<sup>49</sup> Kam Bhui Racism and Mental Health

‘African families whose needs were being poorly met by mental health services inasmuch as the families would be very reluctant to engage with services that they felt would be rather judgemental, rather stigmatising... we developed a kind of new model of practice, working together one black worker and one white worker, in a way which was respectful of parents and their capacities and their efforts to do their best for their children rather than critical and judgemental of them, and implying that they were doing something wrong’. (From an interview with a psychologist working at the Trust).

### *Attending to the spiritual needs of service users*

Another important aspect of the work of the Trust was the role it took in supporting service user’s spiritual and religious needs. Work in this area is centred at the Trust’s Department of Spiritual, Religious and Cultural Care. A leaflet for this service emphasised the importance of recognising the spiritual and religious element of patient care: ‘The Service recognizes that ‘spiritual, religious and cultural needs often overlap and influence our mental wellbeing’ ...’we believe that it is important to celebrate our differences and respect our unique traditions’.

This department provided training for staff, together with one-to-one visits to wards, groups on wards, acts of worship, connection of service users to faith leaders, linking service users to their faith communities, celebration of festivals, provision of texts and monthly liaison meetings with staff. Training included one day events run in each locality which were designed ‘to equip staff and members of faith communities to holistically support those suffering from mental distress’ and a one year course providing a certificate in spiritual, religious and cultural care. .

The Director of the department spoke of the need for assessments of patients to incorporate a spiritual assessment in order to be truly holistic. He mentioned that psychologists would sometimes approach him if they were reluctant to pathologise behaviour which they felt might be cultural rather than pathological – for example, hearing voices. He mentioned a particular case brought to him by the psychologist of a patient who felt himself to be closely associated with a particular animal. With the Director’s assistance they were able to understand the explanatory model – this was strongly connected to the tribal connection.

Many of the staff we talked to had attended at least one day training with the department, in one case, specifically focusing on religions of an African origin.

### *Community based services*

In addition to its own, internal services, the Trust also commissions services from, or works closely with, a number of local community based organisations which cater specifically for the needs of service users from the African and Caribbean community, with mental health problems.

One of these was MELLOW, a service set up by the Trust seven years previously to find ways to address the over-representation of African and Caribbean patients in the mental health services. The project works with this issue in a number of different ways, including awareness raising with staff, project work in a number of areas, research into the causes of over-representation and the exploration of new treatment models and self-help strategies for service users. One of the activities was a series of 'stereo-hype events' designed to promote positive aspects of wellbeing amongst African and Caribbean service users, using drama, music and poetry and group discussions. The launching of a website to promote learning from the present project took place at a Stereo-hype event in November 2008. There were also a number of services run by local voluntary organisations, such as the Somali Mental Health projects run by Tower Hamlets MIND.

Service users from East London were also able to access a number of other services catering specifically for African and Caribbean peoples such as Kush Housing Association, specialising in the provision of accommodation for people of Black and ethnic origin. This organisation also provided a number of associated services to support people with mental health problems, including counselling and an employment project. Other accommodation-based projects mentioned to us were the Omega Community Living Trust, which works with volunteers to provide support and advocacy for people with mental health issues from the BME community, and the Ujima housing trust which provided similar services. Another source of support for some was the Siri holistic counselling services, based in Islington but with a London wide brief, which provides counselling and support within an African centred framework, including a strong interesting community and spiritual aspects of care.

Another important resource for some users is the *Catch-a-fiya survivor led forum* (supported by the Afiya Trust -Afiya means 'wellbeing'), which, with 250 members is the largest BME survivor group in the country. We were also told about the Antenna Outreach service which provides a provisional service for African and Caribbean young people suffering from the effects of mental illness, based in Haringey.

Each of these services was relevant to the present project because staff working in them provided an important source of information about the local community and the needs of mental health service users. Several of these services also helped us in involving service users in discussions about their use of traditional and faith-based healers.

### 3.3. Staff views

Staff working within the Trust itself, and within some of these community-based organisations mentioned above, were an important source of information about how well local mental health services addressed the needs of the African and Caribbean service users, and what attitudes were held, either within the Trust or by service users, concerning African-oriented traditional and faith-based healers. It would be a mistake, however, to claim that the views that we gathered were necessarily representative of

the staff group as a whole. Interviews and focus groups were held on the basis of an invitation, sent out through wards and existing networks, and may well have attracted primarily staff who already had an interest in traditional or faith-based healing, or a wish to find out more about these.

However, the interviews did bring to light a wide range of experience of and attitudes towards the healing practices that we were exploring. In several cases interviewees, or members of their family, came from Africa, and either had healers in their family, or had experience of healers themselves. Several had a strong commitment to a particular faith or religion which was seen as an important source of support and healing, as in the case of a staff nurse who described how she personally used both modern and traditional healing through prayer and hands on healing. In other cases the interest in healers and healing came either from their own experience of mental health problems, and having had some benefit from 'non-traditional' sources of support. One member of staff, for example, mentioned his interest in the crossover between mental health issues and spiritual crises, which arose from his own earlier experience – more recently he had become interested in Shamanism, visited a traditional healer in Botswana, and had become involved in a spiritual crisis network.

Some of these experiences of alternative sources of healing and healers were positive ones. One health professional, whose wife came from Africa, told us of a conference he had attended in Harare at which there were many faith-based healers who were working closely with mainstream services to come up with inventive ways of offering psychological approaches which borrow from more community ways of understanding and healing. A psychologist from Mozambique had spoken of the use of community rituals involving totems to help children recover from war time trauma, which had been very moving and powerful. Another manager, with a personal interest in herbal medicine mentioned a colleague of his who regularly consulted a traditional healer based in Ghana by telephone, receiving the herbal remedies prescribed, by post.

Others however, were more circumspect about the role of traditional healers in their country of origin. One community mental health nurse who had previously worked in mental health services in Nigeria talked about the strong belief amongst many in this country that mental illness was not an illness, but due to ju ju, or the devil, and who sought help from traditional healers, their ancestors or the church. They would receive special herbal drinks, have people pray for them, sometimes being looked after by the traditional healer or in the church's compound. However, in many cases they would be kept in isolation, locked up, often with wounds from being tied up, given poor food and poor physical hygiene. Some would die from their wounds, or from the herbs they were given. He observed that people would often stay longer in healers or church compounds than they would in hospital. People would often only turn to conventional medical services when the problem got out of hand, or when the resources of the family and community were exhausted, by which stage the physical health of the person was poor. He had also attended church-based healing of children believed to be possessed, which, he felt had been somewhat stage managed (nurse interview).

### 3.3.1. The need for culturally sensitive services

The majority of those we interviewed spoke of their awareness of the over-representation of people of African and Caribbean background within mental health services, and the challenges of providing services that were fully accessible and culturally sensitive to their needs. Several spoke of the need for more services that would pick up mental health problems at an early stage and to address the considerable distrust amongst these communities of mainstream mental health services.

‘there is an enormous distrust of what the western medical system has to offer, particularly in the domain of psychiatry....members of the congregation would come up to me and speak of brushes with mental health services, all of them seemed to be rather unfortunate, rather unsatisfactory, where they felt like that they had been poorly understood, felt like they had been given medication that doesn’t work, and they questioned whether the medication was appropriate for them. (Staff member P interview)

Although it was recognised that there were a number of initiatives taking place to address these difficulties, concerns were expressed by several staff members that we interviewed, that the notion of ‘cultural sensitivity’ had not yet ‘filtered down’ to all staff, nor radically transformed services in a way which would enable these to be fully sensitive to the needs of service users. In spite of all the talk about cultural diversity, a small number of our informants felt that services remained predominantly ‘eurocentric’, and that this meant that many of the very real needs of people from the African or Caribbean communities were not met. This view was put forward particularly by workers in some of the community-based services that we approached, whose specific aim was to provide a more culturally appropriate service.

One of the more critical informants commented on his belief that many services which claimed to be culturally sensitive were still in fact based on the European model and understanding of psychiatric disorder and were, in his eyes, still “European services dressed up in ‘rice and peas’”. Within this Eurocentric model it is impossible to divorce perceptions of healing practices as ultimately primitive and irrational. He talked about his own heritage which stemmed from both West Yorkshire and the Caribbean, and that in order to truly understand himself he had had to undergo a process of ‘unlearning’. This was a deeply personal and individual experience and he questioned whether any process or degree in ‘cultural competence’ could help him understand and define further his understanding and experience. This also raised the question of how one judges the success or merits of cultural competence or a culturally sensitive approach. There are no measures within the NHS to assess the value of what is delivered. There is a sense that where services present themselves to be culturally sensitive they are accepted as doing so and don’t come under due scrutiny or questioning.

Another informant expressed the view that it remained hard for service users, or indeed staff, who were not from the main stream ‘western’ culture, to have their voices heard.

An example of this was given of the Cultural Consultation Club failing to give real space where service users could express their views – for example, they were invited to take part in a discussion on staff development, but not to talk about their own experience of service delivery.

Another concern was the danger of stereotyping different communities, rather than recognising the considerable differences within them – for example, between first and second generation immigrants, or taking into account differences of age, class, gender and/or education, all of which could impact on care pathways to receiving mental health support. It was also important to recognise the different experiences and perspectives of the two different communities – African and Caribbean, as well as differences between different national identities within these two groups.

In some cases, it was suggested that language was a major barrier to providing a sensitive service. Interpreters are available and in some cases service users were able to communicate with staff members who were familiar with their language. However, interpretation was not available on a daily basis on the ward and this could lead to major difficulties in communicating about needs or talking about their concerns. Beyond the need for someone who spoke the same language, however, was the need to talk to someone who understood their culture, and with this, often, an understanding of spiritual and healing practices with which they were familiar.

### 3.3.2. Contact with traditional and faith-based healing.

When asked about the extent to which service users were turning to traditional or faith-based healers, the staff we interviewed generally gave one of two messages: either that they believed not many service users were accessing support from this source, or that they believed that service users would be unwilling to talk about accessing support from this source, so it was difficult to make any assessment of numbers.

The view that few service users were accessing support from traditional healers was expressed clearly by a community mental health nurse, who talked of only one patient from a case load of 26 who had mentioned accessing a traditional healer, and one who had turned to church for support. This was in marked contrast to his previous experience working in a similar role in Africa, where the majority of patients would have turned to traditional healers, or churches, for support, prior to accessing more formal mental health services. However, another manager of a mental health team was unaware of any clients using traditional healers, although he was aware of African and West Indian service users of Muslim faith, for whom religion, prayer and the support of their fellow believers were very important.

In contrast to this, the director of a small community organisation, when asked about the use of “traditional” healers commented that it was highly likely that some of those who had used her services were using these, but she was unaware of any practicing within the area.



One reason why the use of traditional or faith-based healers might be masked was given by another nurse who explained that the stigma attached to mental illness in the African and Asian communities meant that many families tried to contain the problem at home, seeking help from a priest or sometimes sending the patient away – back to their home country. They are not seen out in the community and their symptoms may be hidden. When the nurse is called in to do an assessment they would often try to deny the problem – saying it was just the stress of life. Having services coming in would often be seen as a sign of stigma – they don't want the neighbours to know. This idea that the use of traditional healers is being hidden being linked to the social stigma surrounding mental health problems was confirmed by another manager, who also felt that some parents might also fear having children taken away from them.

A worker from a community housing project explained that there was enormous anxiety about the idea of giving value to mental health practices from Africa or the Caribbean. He explained that there was a tendency to view these practices as something that had been 'left behind' in the journey to what was presented to be a more 'civilised' way of life. This concept of travel along a "civilising" trajectory, rendered all that preceded it as potentially less civilised, less founded and less legitimate. Within this discourse, ideas about 'returning' to previous practices or traditions were understood to be primitive and regressive. Understanding these dynamics and impulses were crucial to the deliverability of the research project. They helped to explain the individual and community's reluctance to come forward and their desire for such practices to remain hidden.

Negative media reporting of traditional practices were another factor (several of our informants mentioned media coverage of the Victoria Climbe and 'Adam' cases in which witchcraft was blamed for the death of young children) as well as the negative portrayal of these practices in popular films such as James Bond films.

This informant felt that mental health service staff, from an African and Caribbean background, might also be unwilling to talk about their use of these practices. He questioned what the impact might be, for example, if our report indicated that a high proportion of the African and Caribbean community used traditional healing practices, in terms of the prospects of these people obtaining employment in the NHS. He said that there was a very common experience whereby members of staff would be talking in tongues at the weekend and having out of body experiences through their religiosity and then return to work on Monday where they would perform a role which involved sectioning people for displaying similar behaviour. It may be very difficult for Psychological staff to talk about these issues as there are likely to be tensions in how they resolve these dual perspectives and approaches.

### *Support from religious and spiritual sources*

In practice, we heard very few specific accounts from staff members about service users who were turning to traditional healing practices, to either good or negative effect.

However, there were a number of accounts of service users who were turning to either churches or Mosques for help and support, usually with beneficial consequences.

One service manager explained that over his long career he had seen and felt that religion, and support from appropriate religious leaders, could play an important role in helping people who were in considerable despair about their lives. However, he also felt that there was not sufficient awareness of the role faith can play in chronic illness. A community mental health nurse told us that he was aware of a number of patients with strong spiritual beliefs: one had sought help from spiritual healers at this church and another had recently gone on Haj pilgrimage as a way of trying to heal his mental health problem. He thought that priests could sometimes be very helpful – telling patients to take their medicine so that there is more space to talk over their problems – they have the authority to do this, and the patient will often be more cooperative when supported by a priest.

Several of our informants indicated the importance of acknowledging the role that spirituality and religious belief could play in mental health – either in breakdown or recovery.

‘Sometimes, talking to a spiritual healer or pastor will be very like counseling - they are talking to someone that they feel really understands them – they are not giving orders, but are seen as having real authority, treated with respect.

The NHS can seem very strange to them in terms of their own culture, they might feel – you just don’t know me. They can be very confused about what is going on – they have been taken to a strange place, locked in. A spiritualist, or healer might talk the same language, have more time to talk, meet them half way, they have a feeling that they really heard. It is very useful to be able to use interpreters who can talk to them in their own language. It is also really helpful to be able to have access to a bible, a Koran’. (From interview with nurse AM)

It was very useful to be able to use interpreters who can talk to them in their own language. It was also really helpful to be able to have access to a bible, a Koran.

Several staff commented on the importance of the support received from religious or church groups, ministers, or Imams. However, one member of staff commented that he had tried to involve an Imam as part of building a network of community support for one of his service users, but had failed. He commented that the fact that most Imams were not on salaried posts, unlike Christian ministers and Jewish rabbis, may have been a factor. Another staff member commented that Imams charged individuals for providing them with help and advice.

### 3.3.3. 'Pathologising' spiritual or cultural behaviour

The idea that spiritual or culturally specific behaviours could be pathologised – in other words, seen as evidence of mental ill health, was strongly expressed by a small number of staff we interviewed.

'The difficulty was that on the one hand there was enormous anxiety about 'what if white people found about 'me'/ 'the community' using these practices – what would they think. How would it be used against us. Following this thinking there is a practical survival imperative which means that you would be 'taking your life in your hands if you tell someone you're hearing voices and that you understand this to be part of your world view which includes the presence of a spiritual dimension. Likewise anyone who admits to going to visit a traditional healer is likely to have these experiences and the associated belief systems pathologised' (from interview with staff member CD)

The similarities between a spiritual crisis and mental health breakdown were discussed, and the importance of staff being able to make an appropriate response to one or the other. The following account from one mental health 'survivor' now working as a counsellor illustrates some of these themes.

'He had been subject to an arson attack which had left him following with high levels of anger and paranoia and feeling 'out of control'. He was passed from one doctor to another, and much of the help he received felt inappropriate. At one point he was hearing the voice of his father (who had died), which he experienced as a privilege and gift as opposed to a problem. However, when he expressed to mental health staff that he had been speaking to his father this was understood by some staff as a part of his symptoms and illness as opposed to the intrinsic part of the healing he experienced it as.

At his 'darkest place, he was helped by one of the nurses, from Zimbabwe, who had his own connection to his ancestors and ancestor spirits, and this had been fundamental to his recovery. He felt strongly that his connection with ancestry and spirits was key to his recovery and mental wellbeing. He expressed that they enabled him to access his own internal resources – something he felt traditional psychiatry actively discouraged, instead of developing dependencies on external resources. He felt that the sense of a shared cultural perspective between his CPN and him had enabled this'. (interview with member of ALS).

## 3.4. The service user perspective

Our information about service user views comes from a number of different sources. This includes three group interviews (involving in all, 20 people) held with service users in community resources that provide services for people with mental health problems from African and Caribbean communities. In addition, we held a number of less formal discussions with service users contacted mainly through community organisations, or during the course of the scoping phase, when visiting various church-based

organisations and informal gatherings. Three of the staff members and healers that we interviewed had also been service users and talked of their experience of seeking to incorporate alternative sources of help alongside receipt of conventional treatment.

Because most of the interviews we undertook with service users took place inside African centred community services, this may well have been reflected in the strong views expressed about the inadequacies of NHS services, and the need for more cultural sensitivity.

Few people we interviewed claimed, themselves, to have turned to traditional healers for support – this may reflect the particular group of service users that we talked to, but also it may reflect a reluctance to talk about this with outsiders, or with other members of their own community who might disapprove of this. However, it was not feasible in this project to undertake any kind of ‘representative’ survey of service users to identify overall numbers of people turning to this kind of support. Apart from the fact that this was not the aim of the present study, the information that we did identify suggests that such a survey, in the present climate of reluctance to talk about such things, would be unlikely to generate meaningful results.

### 3.4.1. General views about mental health services

Although the primary purpose of our interviews with service users was to gather information about knowledge, or use, of traditional healers, in practice our discussions were often dominated by a prevailing frustration with mental health services. Many of these views had little immediate relationship to the fact that they were African or Caribbean. A great deal of anger was expressed about the dependence on medication for the treatment of their emotional distress, and the lack of other types of care, strongly expressed. Strong views were also expressed about the frequency with which the diagnosis of schizophrenia was used, with the negative connotation resulting from this, including the fact that it ‘labelled’ a person for life. The diagnosis itself was felt to be profoundly disempowering and unhelpful in terms of providing opportunities for recovery or healing.

There was also a prevailing sense expressed that mental health was about management of their symptoms and their behaviour, rather than a genuine attempt to treat the illness, or its causes.

Also expressed was a sense that there was little consultation with, or choices available for service users. Although the benefits of the medication they had been given was appreciated by some, the heavy reliance on medication meant that some felt that they had little choice over the treatment they received. If they refused to take their medication, then the threat of being sectioned hung over them.

Few other alternatives were offered. Treatment was, in effect, done to them: diagnosis and prescriptions were handed out to them, by those in authority within the service.

There was frustration that little information was provided about the kind of medication they were receiving, why it was being given, what was in it, and what were the side effects.

### 3.4.2. Call for culturally sensitive services

Beyond this general frustration there was also a wider sense, often hard to express, that services and staff, in the mental health system were particularly insensitive to the needs of people from the African and Caribbean communities. This frustration often focused around the issue of food – special, Indian or Halal food was available to some patients, but African or Caribbean food was not available. Staff were often felt to be insensitive, or uncaring, with service users needs, and their wider concerns were felt to be ignored, particularly as there was no one they could turn to talk about these. One service user gave an example of a very caring member of staff, but this was given as the exception to the rule – the only person she had come across who had shown such care in many years of receiving in-patient care.

One specific complaint was that the pastoral or spiritual care that they were able to receive in hospital was not the kind they would usually access. The chaplain was not from the churches they would normally attend, and one person described how he was not allowed out (he had been sectioned) to attend his own church, even though he had requested that he be accompanied by staff members.

It was in this context that people felt that they had to hide their particular beliefs, because of the fear that these would be misinterpreted. An example was given of service users who had had their cultural or religious practices – of talking with God, (plus other examples) interpreted and put down on their case notes as evidence of their continuing ill health.

There was a strong call for more dedicated, culturally sensitive community based services where people could receive support from staff and other users from the same community. In this setting, they felt that they would be better understood, and their needs more effectively met. More centrally, the view was expressed that such a centre would be ‘theirs’ and that they would have more say in how it was run and the kind of service that they would receive.

Being part of a dedicated service was felt to provide the opportunity to regain a sense of identity and overcome the stigma of being labelled as having a ‘mental health problem’. It helped put them in touch with positive images from their own culture and history.

The view was also expressed that it was in such services that they might be able to receive information and advice on alternative healing resources – whether these were the western options (usually described as alternative and/or complementary therapies) or healers working in an African-oriented tradition. This would help them to know about ‘safe’ alternative treatments that they could turn to for help in their recovery.

### 3.4.3. Access to African centred healing

The ability to access traditional healers or churches with a healing ministry can be seen within this wider context of the desire to access services that were culturally, and spiritually, sensitive to their needs.

Few of those we talked to claimed to have looked for, or received, help from traditional African healers. Several expressed little interest in these forms of healing – these were not relevant to their needs, and some held the view that these had little credibility, using terms such as ‘mumbo jumbo’ to describe them. It is in the context of the rejection of traditional beliefs that some people felt that even if they had chosen to consult a healer, they would not necessarily tell others in their community about this, and would also not tell their mainstream health providers. Healers too, as will be noted below, asked their clients not to tell others about the treatment that they had been receiving.

Others, however, describe the situation ‘back home’ with some nostalgia – how people with problems such as theirs would be able to go to a ‘bush doctor’, probably staying with them in their compound for some weeks, where they would be looked after and receive care. Their families would come and visit them, and most tellingly, they were not, in this situation, just a number or a case file, but a person, within a community, with a problem that was being attended to.

There was also talk of the herbal remedies that they might be able to access in African or in the Caribbean, and the fact that there would be ‘elders’ with amazing knowledge of these herbs and their healing powers. Sadness was expressed at the loss of this knowledge in the diaspora, and also some anger that ‘westerners’ were taking the knowledge of these African herbs, packaging this and selling it back to them at a profit.

There were also a few examples given of having had a negative experience of a ‘traditional healer’ in London. One person described how they had consulted a traditional healer (before he had been treated in hospital for his illness).

‘He had had 10 consultations with this healer, and been given potions to take, and to bathe in. However, he then believed that the healer had placed a curse on him; he was unable to tell what was in the potions he received, and was unable to tell whether the treatment he received was good or evil. The healer had also sworn him to secrecy, and told him not to tell others about the treatment that he was receiving’ (from ALS meeting 2 note).

Another wrote of her experience of visiting traditional healers in Ghana:

‘My experience of traditional healers in Ghana has not been the most positive in terms of the treatment. At the shrine I visit here patients are beaten if they refuse to take the herbs. The herbs are very strong sedatives and people find them very unpleasant to take (like anti-psychotics). It is routine for patients to be chained outdoors. Healers are reluctant to admit that their treatment has limitations

because this is their livelihood, and it is important to maintain your reputation as powerful and effective. Costs are high for relatives - often a couple of hundred dollars or more. That too is part of the system - if something is expensive it is of more value.

'This said, of course the hospitals too are sites for abuse, with high doses of medication, sometimes given as punishment rather than treatment, overcrowding, sometimes the nurses beat the patients etc. Given the choice I think I would rather be at the healers - just to be part of a small community living in the bush, than in some dirty overcrowded institution, so long as I was not beaten of course' (note from a student).

Several people did talk about the support that they received from their churches, including support while they were in hospital, when members of the congregation or their pastors had come to visit them and pray with them. Others said that their faith was their own business, so it was not something that they would necessarily talk to others about.

However, some also expressed the fear that they were stigmatised within their church because of their mental health problems, and that they had to be careful to hide their problems from the wider congregation, or they would be rejected or thrown out of the church.

### 3.5. Reflections and conclusions

#### 3.5.1. Implications for dialogue

We found that there were a number of staff at the Trust who, because of a personal interest or personal experience, had a strong interest in the role of traditional and faith-based healing and the possible role this had for the support of their patients.

However, because there were a number of parallel initiatives taking place at the Trust at the time of our work and the general demands of work (particularly shift working), they found it difficult to find the time to engage in the action learning group in order to have a direct dialogue with representatives of different healing traditions.

It was unclear how far this interest was shared with the wider staff group however, and how much interest there was more widely in the Trust for gaining more knowledge and insight into these practices, or the role they played in the life of service users. Because there was a prevailing view that relatively few service users were accessing these systems, although of interest, the priority given to finding out more about these practices was relatively low, at least as far as African-based healing traditions are concerned.

It is also unclear how far an interest in traditional and faith-based healing systems is leading to a real questioning of the way in which main stream services are provided, or

whether this is seen as something that can be 'added on' to mainstream provision to make this more acceptable.

The overwhelming call from the service users that we interviewed was for culturally sensitive mental health services. However, what exactly this meant was not easy to describe and articulate. Did it mean the overall way in which services were provided, the way language is used and understood, or the availability of signs and symbols that express a cultural identity, that enables a person to feel 'at home' and comfortable. It is, perhaps, in this context that the value attached to information about, and access to, traditional healers, by some service users, can be best appreciated.

What is clear from the comments made by service users is that the mental health services that they had received, grounded in a very western set of assumptions and values, was often experienced as profoundly alienating, disempowering and often distressing. It was seen to be generally uncaring and unsympathetic to their real needs, and offered little by way of hope or encouragement to engage in healing.

Although some had received some support, and comfort, from faith or traditional healing practices, unfortunately, these were also sometimes experienced as another source of distress. Like mainstream medicine, these could be disempowering – instructions and potions 'handed down' with little information the reasons for their use, what they contained, or the possible side effects. Churches could be rejecting of people with mental health problems as well as supportive.

It is in this context that service users were very keen to have access to good information and advice about traditional and faith-based healers that could be trusted, and who might be able to give them sensitive care. This, they felt, could only be received within a dedicated culturally sensitive service, such as the ones they were currently accessing (where they were interviewed). Such services, they felt, should not be an 'add on' but firmly supported and funded by the NHS as a central part of the care provided to service users.



## 4. The healers

### 4.1. Sources of data

This section addressed the question: what is the current role of traditional and faith-based healing practices originating from Africa in the care and support of patients with mental health problems? It reports on information that was collected in interviews and discussions with traditional and faith based healers, during the scoping phase, and alongside the action learning group meetings. This has included fourteen interviews with healers, a focus group with four participating healers and six sessions of the action learning group where four healers regularly participated.

We cannot claim that these healing practitioners are representative of the many different healing practices that are being used by mental health service users in east London, or a definitive account of these healing practices. There are many reasons why this is the case, the primary one being the major difficulty we experienced in identifying and contacting healers in different traditions who were willing to take part in this research. The reasons why we had these difficulties provided an important source of data for this project, and also has important implications for others who seek to establish a dialogue between health service professionals and practitioners in these healing traditions.

First, there are few 'formal' organisations or structures that represent these healing practices. In most cases, contact can only be established with practitioners through informal networks of contact and word of mouth. There are healers who advertise their services in newspapers, shops and radio, but on the whole, these are not recognised by those with authority within the traditional healing networks as being genuine practitioners of healing. Establishing contact with healers through informal networks required establishing contacts within these networks, with people who were willing to pass on information about when, and where, healers were practicing, and how these could be contacted. These contacts took a great deal of time to establish and often a number of informal meetings took place before an agreement was reached about becoming involved in the research.

The time required to establish these contacts also related to the issue of trust: that they believed we had a genuine interest in these systems of healing, and were not going to 'exploit' or misrepresent them in any way. Within the action learning group, 'trust was raised as an important issue and key to reasons why African approaches to health remained 'out of sight' and 'under the bed'. The individual's present expressed on-going fears about the misunderstanding and misrepresentation of African approaches to healing' (ALS meeting 1 note) This relates in part to the historical experience of attempts over at least 200 years to suppress, outlaw or ridicule these traditions by westerners, or designate them as 'primitive': worthy of study but not taken seriously, which has led to a strong legacy of mistrust. A healer participating in the action learning

set described the legacy of colonialism and the history of suppressing African healing practices:

‘People were taken away against our will from Africa...We were told you have to follow you, we have to live like you and then we were suppressed. That’s when certain things went undercover’ (Healer A, from ALS meeting 3).

Another important dimension in engaging healers in the research was the question of remuneration. Healers were operating as independent practitioners; therefore time away from their practice meant a loss of income. Several asked for payment for their involvement in the research: we provided this for participants in the action learning set, but did not set aside a budget to pay for those who were to be interviewed as part of the research. There was also a major concern expressed by one healer, that researchers such as ourselves were potentially benefiting from learning that had taken many years, and cost a great deal of money, to acquire. Like often before in the history of Africa, this could be seen as another version of western cultural imperialism, exploiting the resources of another culture and giving little back in return.

Another reason for secrecy is the fact that some might be described as part of an esoteric spiritual traditions, in which there is a body of teaching and practice which is only shared with those who have achieved a level of readiness, or in some cases, been properly initiated, into their use. Many of those we met did not feel authorised, or able, to share information with ‘outsiders’ about these practices or the beliefs that lay behind them. This also has relevance to the power attributed to these practices which are recognized as being capable of being used for both positive (healing) and negative (harmful) purposes. There were however others who were happy about, and held a commitment to, sharing information about their work with a wider world, and had the authority within their community to do so. One healer, a Babalawo from the Ifa tradition, describes the lengthy intense training process that is required to become an Ifa healer and gain the required authority:

‘If you want to become a Babalawo...you will stay with him, you will be part of his home, you will live his life, you will study everything about him...We have people who do this for as much as twenty five years before they will be given the freedom to be their own (Chief P interview p26).

## 4.2. Terminology and language

A question that was frequently asked throughout the project was what we meant by traditional or African centred healing systems, and which practices were, or were not, to be included in the project. From the start, we deliberately left the definition open: in part because we wanted to start from what people themselves (particularly those who were using mental health services) would understand by these terms.

The lack of prior definition had both an advantage and a disadvantage: it enabled us to make contact with healers operating within a wider range of different traditions, yet it was clear that within the different traditions with which we made contact there was a great deal of variation, both in the underlying beliefs, and in the way in which healing was understood and practiced. In this respect, the term 'traditional healing' can be seen to have much in common with the widely used term 'complementary and alternative medicine' (CAM): a term which similarly encompasses healing practices with widely different histories, traditions, theories and practices.

The issue of terminology and language used to describe different aspects of traditions and healing was an important one, as the terms used often have strong connotations which differ within and between cultures. In some cases, key terms can simply not be adequately translated into English without a significant loss of meaning. One example of this from the interviews was the term 'ajicon' which is badly translated into the English term 'witch'. Similarly, the words 'ritual', 'animal sacrifice', 'exorcism' and 'offering' have become imbued with negative meaning, and these words have become associated with danger and harm within European languages.

The use of language to stigmatise or denigrate traditional healing practice has also been widely prevalent in western culture, as in the case of designating it as 'mumbo jumbo', in cartoon depictions of 'witch doctors', or the negative connotations attached to the term 'voodoo' or 'voodun'. Because many of these traditions are primarily oral traditions, there is little written work to which Westerners interested in these traditions can refer to. This further adds to the widespread unfamiliarity with concepts and terminology used. In the world of mental health in particular, many practices are perceived as 'dangerous' or 'harmful' rather than promoting wellbeing. For example, one healer from the Ifa tradition felt that:

'most people see the whole thing as very frivolous or far-fetched or superstitious....even if you are at pains to go through all the processes to provide an analytical explanation...the moment you mention a Babalawo you are just mentioning evil' (Chief P interview p32).

The use of negative language coupled with prejudice and misunderstanding of traditional healing practices, contributes to the reluctance felt by many healers in openly discussing practices. According to another practitioner, healers from the Ifa tradition do not have a 'proselytising tendency' or actively seek to explain their practices to others, partly due to apprehensions around misrepresentation: they would 'rather have people approach them who want to make contact' (Healer B interview p32).

### 4.3. Diversity of healing traditions

It was clear from our informants that a wide variety of different healing traditions were being accessed, in some cases, accessed for either mental health problems or stressful life circumstances which could potentially lead to mental health problems. This report cannot claim to provide a definitive or authoritative guide to the many African centred

healing traditions that are operating in London. However, in the context of the present project, and in setting the scene for the establishment of a 'cultural dialogue' between mainstream and traditional healing systems, it is important to provide a report of the traditions that were described to us by the healers we interviewed, together with an account of some of the similarities and differences between them.

We found that the term 'traditional healers' was quite widely used to refer to healing traditions that were rooted in African religious or spiritual practices. Many of those we interviewed were broadly based on the Ifa tradition, which is primarily associated with Yoruba culture and medicine. As described by K. Abimbola<sup>50</sup> in *Medicine and Culture: Transcultural Needs in Modern Societies* (2007), Yoruba culture and medicine centres upon three-way relationships among: 'i) natural beings (plants, animals and humans) and other natural beings, ii) natural beings and spiritual beings, and iii) spiritual beings and other spiritual beings' (Abimbola 2007: 6).

Within Yoruba culture, the cosmos is viewed as a plane of existence in which there are various sub-planes. A particularly important sub-plane is populated by good beings called the 'Orissa' (meaning divinities), who are benevolent but sometimes punish humans who corrupt society (Ibid: p7). Another sub-plane of importance is populated by negative beings, the Ajogun (or Anti-gods), who are 'irredeemably malevolent' and 'wage war against both humans and the Orissa' (Ibid: p7).

Whilst Western-based biomedical practices focus on removing symptoms of illness, Yoruba medicine is also concerned with identifying the causes of illness (including spiritual causes) and maintaining a holistic balance between the body (Ara) and the soul complex (Emi, Ori and Ese) (Ibid: 8), and also restoring spiritual balance in the patient. Therefore within Yoruba culture, there is different understanding of the individual and wellbeing compared to Western biomedical approaches, as spiritual wellbeing is connected to the health of the body. Ifa healing by priests or priestesses (frequently referred to as Babalawuo), is an important part of Yoruba culture and medicine (Ibid: 9).

This Ifa tradition has been developed within the Diaspora into a range of healing systems emerging within the countries Africans have moved to, usually under the conditions of slavery. These are sometimes referred to as syncretic traditions, and include Santara (Cuban), Voudun (Haiti), Condoble (Brazil) Popoania (Jamaica) and Rastafarian church (Caribbean). Some of these have remained very much at the fringes of mainstream society, while others, such as the Condoble in Brazil, have been to some extent integrated into mainstream healing practices.

It is also important to recognise that there are variations not only between African and Caribbean healing traditions, but also *within* particular traditions. Similarly, within the action-learning sets and advisory group meetings, a number of healers stressed the distinction between 'faith-based' and 'practice-based' traditions: some healing traditions

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<sup>50</sup>Abimbola, K. 2007. *Medicine and Culture: Transcultural Needs in Modern Societies*: Clinical Risk 1 May 2007 vol.13 no. 3 112-117

are heavily embedded and defined by practice, whereas others are more extensively incorporated into religious theologies. However, it should be emphasised that the distinction between 'faith-based' and 'practice-based' healing does not neatly follow religious divisions: both are present in all 'religions' including the Ifa, Islam and Christianity.

The majority of data gathered within this project consisted of healing practices related to the Ifa tradition and also Christianity. This was not the original intention of the project, particularly as Islamic-based healing practices are also very prevalent within African and Caribbean communities in East London. However, due to the widespread 'hidden' nature of practices, the inability to undertake formal sampling and the flexible methodology of the project that focused on 'working with the resources at hand, under the conditions that develop' (see section 2), the majority of data and contacts that emerged were from Ifa and Christian background. This project has never aimed to give a complete representation of traditional healing practices in east London: rather it aims to foster intercultural dialogue and increased understanding between biomedical practitioners and traditional healers, from the contacts and data available.

The below case studies provide examples of the diversity of healing practices present within East London's African and Caribbean communities.

#### 4.3.1. Case study: Diversity *between* healing traditions

*Ifa-based and Church-based healing traditions.*

In recognising the diversity of healing traditions operating within an African world view, it is also important to recognize that there are sometimes strongly held views about differences between them, perhaps most marked is the difference between those that are rooted in African spiritual traditions, and those which are broadly based within a Christian tradition. There were those, working within Christian tradition of healing, who viewed Ifa-based healing practices as being the work of evil or devilish forces, and there were also those within the traditional healing world, who blamed the Christian church for the comprehensive destruction of traditional culture in many parts of Africa.

A number of church-based healers expressed strong apprehension about practices originating from the Ifa tradition, and one Pastor felt this prevented dialogue between healers:

'I would not like to be in the same room as someone who was practising the Ifa Religion...as I would not put myself near their demons' (Pastor D interview P3).

In some cases, the Ifa-based tradition was referred to as a 'pagan religion' that encouraged and created 'demonic' and 'evil' spirits: some church-based healers felt that Ifa healing practices were harmful and were a *cause* of illness to patients (Pastor D interview P3).

In contrast, an Ifa-based healer felt that Christian Churches has greatly contributed to discrediting the Ifa Religion and promoting stereotypes. He describes how historically the churches sought to erase traditional African practices, and perpetrated the negative assumption that 'African culture was not associated with intelligence and systems learning in the same way as other cultures' (Healer P interview P). He describes how over time, the assumptions promoted under European colonialism that African traditional healing was 'primitive' and 'uncivilised', were transferred to the African and Caribbean communities themselves, so that 'a number of African's themselves are not comfortable with this cultural heritage' (Ibid).

However, there were also a number of church-based and Ifa healers interviewed who recognised the commonality between these two sets of traditions, and were keen to work collaboratively together. For example, although one healer interviewed personally disagreed with certain healing practices in African Christian traditions, she worked with patients from all belief systems in her daily work. In her own practice coordinating the African Caribbean Energy Healers Group, she would ask each client about their own religion, and incorporate prayers or mantras that were relevant to the particular individual (Healer S interview P2). The central element to this healing approach was to provide space and time for each client to facilitate their own healing, that was relevant to their own religious and cultural background.

Even though there appeared to be strongly held views on the differences between practices originating from African spiritual traditions and Christianity, *in practice* it was reported that many people used a combination of approaches. There are often contradictions between the formal explanations of traditional healing, and what actually occurs in day-to-day practice. For example, a church-based healer may not explicitly refer to giving 'offerings' (associated with Ifa-based traditions) yet this may occur in practice (ALS meeting notes). Similarly as described by one Ifa-based healer, patients 'who call themselves Christians or Muslims, will always go back to their traditional practices, but they will never say they go back to their traditional practices' (Healer B interview P19) . This relates to issues of secrecy surrounding traditional healing, that is present even *between* differing healing traditions. It also raises questions around the perceived legitimacy of African and Caribbean healing practices within so-called 'mainstream' religions, such as Christianity and Islam.

#### 4.3.2. Case study: Diversity *within* healing traditions

##### *African Christian and church-based traditions*

There were a large number of black churches that practice healing, which can also be seen to be as operating from an African Christian or church based tradition. These include a number of Pentecostal and evangelical churches, and those sometimes called the 'white robe' churches, which have emerged entirely out of the African cultural milieu. From the interviews, there were significant differences in healing practices *between* differing church-based traditions, for example between the Aladura and Pentecostal churches.

One of the largest of church-based healing traditions within East London is the Aladura Church. Belief and faith is a central premise to healing within the Aladura church: as one healer (an Apostle) describes 'before any healing can take place, the individual needs to know and understand the word of the Lord. After teaching comes preaching and only then can healing take place' (Apostle A interview, P2 interview). Central to this premise is that healing does not result from individual apostles or Pastors, rather it is God that heals the person: 'we are not the healers, it is God that heals' (Pastor A interview, P2) Parsons within the church are endowed 'with gifts from God' (primarily ministers and elders) who act as 'vessels or channels through which healing takes places' (Apostle A interview, P2).

Another Pastor describes how 'Christ gave the commission for all persons in the world to go and hear the gospel- to heal the sick and raise the dead' (ALS meeting p2). Unlike biomedical practices, within the Aladura church the individual is perceived as dual in nature, part body and part spirit, and 'healing is to bring back the unity of both the body and the spirit' (Ibid). Healing is frequently a collective exercise and can incorporate confession, prayer, fasting and invocations. The laying of hands (channelling of the Holy Spirit), clairvoyance (the interpretation of dreams) and exorcism (the cleansing of demonic spirits) are all methods of healing practiced within the Aladura Church (Apostle A interview p3, Pastor A interview p4).

A number of healers from church-based traditions described how church-based healing helps connect vulnerable individuals with their community, which reduces isolation and provides structure in their daily lives:

'we will help to give some structure to their life, inviting them to attend church every week and to come along to other events' (Pastor D interview p2).

Similarly, listening to the problems of patients, and helping to build their self-confidence was a key aspect to the healing process in the Aladura church:

'I counselled with the guidance of the scriptures and showed her she was loved by God and if she was made in God's image how wonderful she must be. This helps her to build her self-confidence to know how loved that she is and how valuable that she is' (Pastor D interview p2).

However, from the interviews it was apparent that there were divergences between church-based healing practices. Even within one religion such as Christianity, there are differing theological interpretations on the value and legitimacy of certain healing practices. As described by one Pastor from the Aladura church:

'Even between Christians there will be disagreement. For example, Anglicans and Church of England do not believe in the presence of demons or devils- even though it is clearly written there in the scriptures' (Pastor D interview P3).

A number of healers described how the Church of England did not recognise exorcism, a method practiced by the Aladura church to cleanse individuals from negative and 'harmful' spirits' (meeting 1 note). Similarly in church-based traditions that actively practice traditional healing, there are differing methods and approaches. One Pastor from the Aladura church, differentiated between 'Pentecostal' and 'Spiritual' churches.

'In the Pentecostal church they expect everyone of their membership to speak in tongues. But in our church it is a different thing, healing is the inbuilt spiritual gift and there are certain people that are honoured by God' (Pastor A interview, p1).

Within the Pentecostal churches, there is the potential for all members of the congregation to develop healing capacities, yet in the Aladura church only select individuals are given 'a Gift from God' and able become healers.

### 4.3.3. Case study: Syncretic healing practices

#### *Combining biomedical approaches and African-based healing*

There were a number of 'healers' who were operating within a much more western framework of healing, but drawing on African traditional beliefs and practices as part of their work. Massage, hands on healing, stress management practices, counselling and sometimes the use of creativity (painting, dance, sculpture) were incorporated into their practice. Some of these had undergone the long training in one of the practices described above, others had had some contact with these practices, through working with a healer in this tradition, through reading, or spending time in Africa.

From those interviewed, this frequently involved a combination of Western-based approaches and those rooted in African healing traditions. The organisation SIRI Behavioural Health in East London, provides a range of services to individuals experiencing mental health difficulties, including counselling, cognitive behaviour therapy, information advice and guidance, and signposting to relevant traditional healers. They describe their approach as Afro-centric and holistic, that recognises the benefits biomedical approaches to mental health, yet also the importance of culture and community in helping vulnerable people. We were told by a project worker that SIRI focuses on linking individuals to faith-based or traditional healing networks, as many patients within East London feel isolated and alienated from their cultural roots (Project worker interview p3).

Another healer coordinated the African Caribbean Energy Group, used practices that cut-across a number of healing traditions, including the Ifa-tradition, church-based practices, more Western-based approaches (counselling and group therapy) and also using non-African practices such as Reiki. Though she used practices that drew from African traditional healing, she worked within a more Western-based biomedical framework. For example, she disagreed with using spiritual and religious reasoning as an explanation for illness, as this simplified the complex social and biological factors



that can cause mental health problems (Healer S interview p2).

A number of interviewees felt that Chinese and Indian health practices had greater legitimacy within mainstream health services because they had been 'de-spiritualised' and become disconnected from their cultural and religious roots:

'Many practices, like Acupuncture, are de-spiritualised to make it more palatable. So the actual historical and ancient elements of it are sometimes extracted for the masses' (ALS meeting 3 note).

These practices had been 'sanitised' and 'divorced from their belief system in order to gain currency' with biomedical practitioners (Healers focus group meeting note, P4).

A number of healers found this extremely problematic, as they felt that the religious and cultural elements of healing are integral to the practices: traditional healing is incorporated into belief-systems; therefore the practices cannot be separated from these cultural origins.

#### 4.4. Approaches to mental health and healing

Although the healing traditions and practices that we encountered were widely varied, there were also a number of themes and common characteristics that emerged across interviews, and across traditions. Many of those we talked to stressed the difference between their explanatory framework and understanding of health and illness, and the model generally used by mainstream health practitioners, working within the western 'rational, logical' mode.

Common themes between the practices described included the centrality of spirit to the vision of health and wellbeing, and the adoption of a holistic view, incorporating not only body, mind and spirit, but also the interdependence between the individual and community. This was closely linked to the idea that the wellbeing of the individual was closely tied in with the wellbeing of their community, which led to a strong emphasis being placed on history and culture, and respect for the role of 'elders' who had passed before them. The spirit world, which includes spirits of the elders, as well as a range of other spirit beings, is central many of the traditional healing systems, as is a strong link with nature. Work with natural objects, including herbs, is an important aspect of the work, as is ceremony and ritual, and the use of creativity (music, chanting) and the notion of 'sacrifice' or energy exchange that takes place as part of the healing process. Some also stressed the importance of faith, or belief, in the success of any treatment within their tradition. Similarly, training to become a healer in these traditions is usually lengthy (often life-long training), involving apprenticeship to a more experienced healer. Similarly, only those 'authorised' by the elders or seniors within a tradition are viewed as 'valid' healers.

### 4.4.1. Spirituality

Healers from multiple traditions repeatedly emphasised that Western biomedical approaches to health predominantly focused on the body, and did not sufficiently consider a person's spiritual wellbeing. This is related to different cultural conceptualisations of health and the individual, where spiritual health is just as important, and frequently connected to bodily wellbeing.

One healer from the Ifa tradition, described how:

'Purely physical and social explanations [of mental health] will not solve the problem'. In contrast, healers from this tradition 'adopt a holistic approach... because we have recognised that if it is more of a spiritual problem than a social or physical problem, you will also use spiritual means to handle it'. (Chief P interview p2).

Biomedical approaches concentrate on the body and ignore spiritual explanations that are imperative to the cultural background of some service users from African and Caribbean communities. This is not to imply that those healers interviewed wanted to ignore biomedical approaches, rather they wanted a more holistic approach to health and wellbeing, which used both Western-based medicine and also recognised culturally specific approaches to wellbeing (Chief P interview p5):

'Medicine can treat mental illness but often it will just be about managing or suppressing, or repressing the actual cause of illness. I'm not saying that medical perspectives are not valid, just that there are times when it is necessary for the spirit to be treated' (Pastor DP1 interview p1).

This relates to differing conceptualisations of the individual, where a person's spiritual wellbeing is interlinked with their bodily health. For example within the Ifa tradition, a person's spirit is located within the brain, therefore mental health difficulties have:

'touched your spiritual being, it has touched your occult essence whether you like it or not. And if you want to solve that problem of course it needs to be spiritual' (Healer P interview p5).

For those traditional healers interviewed, Western biomedical provided an 'incomplete' explanation of illness, and that service users also needed to contextualise illness within particular belief systems.

Across those African and Caribbean communities investigated, the presence of malevolent spirits that could cause ill-health was a common characteristic. Traditional healing practices, frequently focused on 'cleansing' or appeasing negative spirits to restore a person's spiritual wellbeing: 'that is not madness, that is the attack of spirit...and then we are going to prepare the appeasement for that spirit' (Chief P interview p35). Within the Ifa tradition, this includes giving offerings (either of food or

through animal sacrifice), invocations and the symbolic cleansing of malevolent spirits. Within church-based traditions this includes the 'laying of the hands', prayer, invocations and exorcism (where negative spirits are removed from a person by God): 'that is God's real job to take out the demonic spirit of the person – what we call exorcism' (Pastor A interview p4). Within these belief systems, unless the spiritual balance of an individual is restored, it is believed that the bodily illness may reoccur, due to the interdependence between the body and spirit.

#### 4.4.2. A holistic and interdependent world

Those African and Caribbean healing systems investigated were premised upon differing conceptualisations of the individual. Unlike in Western conceptualisations, the person is interconnected with the spirit world, and the body is only one aspect of a person. As explained by a Pastor from the Aladura church:

'We believe in a 'tripartite' understanding of individuals- that is the body, the soul and the spirit. Medicine will only serve the body and the soul- the body through its understanding of hormonal, cellular activity and the physical and the soul through an understanding of emotions. The spirit however is that which we believe is the essence of being' (Pastor D interview p1).

Similarly, the individual is intrinsically connected with their ancestors and spiritual elders: within the Ifa tradition, a person is not perceived as an 'independent' or 'separate' entity, but rather their consciousness is linked to spiritual beings: 'When I'm referring to myself I'm not one. I am not 'I'. My person- my ancestors- are present where I am...It's not just you and only, it's collective consciousness' (ALS meeting 1, p1). Within these traditions, the individual cannot be perceived as independent from the spirit world and also their cultural community.

#### 4.4.3. Connection with community

From the interviews with traditional healers, there is a strong emphasis on the role of the community, in particular connecting a vulnerable individual with a cultural network or church-based community. As explained by a Pastor from the Aladura church, within

'mental health cases- sometimes the patient just needs to be able to pour their hearts out to somebody and to see that somebody cares' (Pastor A interview, p3).

This helps to reduce feelings of isolation and alienation, through linking a person to a supportive community network and also connecting them with their cultural roots.

#### 4.4.4. The importance of history and culture

The importance of history and culture was a central consideration across healing traditions. Within African and Caribbean communities in East London, it appeared that

traditional healing practices were central to cultural heritage and identity. As one Ifa healer explained, by undertaking traditional healing this links an individual with their cultural roots in African or the Caribbean:

'It's a cultural thing: you cannot practice a culture away from the culture' (Healer B interview A: p15).

Similarly, the majority of Ifa healers still live in Africa and only visit Europe occasionally, therefore providing a direct link to a person's cultural heritage (Healer A interview p1). Differing cultural perspectives and belief systems compared to Western conceptualisations (such as on 'health', 'illness', the 'body', the classification of 'religion' and 'medicine', were a recurring theme within this project. A number of healers felt that Western biomedical approaches were insufficient and did not acknowledge the importance of culturally specific perspectives:

'The treatment being offered to them was not appropriate in the sense that it did not address the culture specific aspect of them' (Healer B, ALS2, P31).

However, it is apparent from this project that there is significant diversity in healing practices both *between* and *within* particular cultural traditions: African and Caribbean communities in East London are extremely diverse. Therefore it is important to recognise the highly specific cultural context surrounding each healing practice.

Involvement in healing practices appears to connect individuals with their specific cultural histories. The role of history, especially with relation to the legacy of colonialism, was an important factor in the development of healing practices. This contrasts to Western biomedical health practices, which for many healers did not sufficiently recognise its specific cultural origins: Western medicine does not sufficiently recognise that it stems from a specific European cultural context, and is linked to the history of Christianity and industrialisation in Europe:

'I think within western culture and ways of thinking we have disconnected ourselves from history' (note of ALS 2 p8).

Consequently, the history of European colonialism had a significant role in discussions with African and Caribbean traditional healers: in particular the way that healing practices were suppressed under colonialism, and cultures and African oral histories were 'eroded' (note of ALS meeting 2: p19).

#### 4.4.5. Working with nature

Another common characteristic among the healing traditions examined, was the importance of working with nature and the environment. In particular within the Ifa tradition, land played an important role in connecting individuals to their ancestors and to the spirit world. For a number of healers, nature and the land provide a channel to the ancestors and therefore are intimately connected to the person: nature is part of the

'collective consciousness' between individuals and the spirit world. As explained by one Ifa healer:

'I was listening to the land...and then they became my consciousness... you see the trees taking you to different dimensions, because you have an affinity with them...healing is to help ground people and to go through natural things, to bring out the collective conscious. My ancestors and the ancestors'. (Healer from ALS meeting 2 p3).

Additionally, on a practical level, a number of healing practices involved contact with nature, including animals and plants. This places constraints on healers when working within East London as they felt separated from nature. As detailed by another Ifa healer:

'One of the constraints in being an authentic practitioner here is the environment... when doing these things we need to really be in contact with mother nature... but that's not the case, we live in a city' (healer from ALS meeting 3: p15).

A number of Ifa healers detailed how 'authentic' practitioners did not tend to permanently live in London but rather visit from African or the Caribbean, as to practice effectively they need to have contact with nature and their cultural roots.

#### 4.4.6. Ceremony and Ritual

A number of healers emphasised the key role of ceremony and ritual within their practices. Ritual and symbolism was a central part of traditional healing processes: especially in terms of 'spiritual healing' and establishing links with benevolent spirits (such as ancestors and Orisa in the Ifa tradition or the Holy Spirit in African Christian traditions). Or alternatively when cleansing individuals of malevolent spirits (such as the Ajogun within Ifa or 'demonic' spirits in church-based traditions).

The use of ceremony and ritual is linked to providing 'holistic' healing to a patient, to restore their spiritual (not simply bodily) wellbeing. As described by one Ifa practitioner, healing cannot effectively take place without rituals:

'There is no way we can practice on our own in isolation without the rituals, we can do it but it will not be as efficacious as if you combined the two together. Sometimes give herbs, we give roots to people without necessarily doing the ritual but we know if want a holistic healing we must add the rituals' (Chief P interview p20).

Ritual within the Ifa tradition can take the form of incantations or chanting, the use of herbs and roots, and divination. In the article *Medicine and Culture* (2007), K.

Abimbola<sup>51</sup> describes the process of divination within Yoruba medicine: divination is one important means to diagnose a patient, by establishing a link among the client and the client's Orí (a person's divinity) and Ifa (the god of wisdom). The divination process involves invocations, the interpretation of a related poem, and subsequently (if the source of illness is spiritual), the prescription of herbs and roots, and animal sacrifice.<sup>52</sup> An Ifa healer interviewed also explained the use of 'dolls': these dolls are symbolic of the individual and can be manipulated by healers to restore spiritual wellbeing (and also to cause illness) (Chief P interview p10).

For healers from church-based traditions, the use of rituals has an equally important role in the healing process. For example, within the Aladura church this typically takes the form of ritual prayer, requests to God to 'cast' out 'demonic' spirits and occasionally the laying of hands (channelling of the Holy Spirit):

'Mostly it is prayer. Sometimes we will lay hands on a person, but mostly we will pray for them and will ask in the name of Jesus, on his authority for demons to be cast out' (Pastor D interview p1).

Exorcism is a particular ritual where God removes 'evil' spirits: this can take place for people or houses, with different ritual processes for each situation. Fasting and prayer can also play a key role in ritual healing processes in the Aladura church (Pastor A interview p5).

#### 4.4.7. Sacrifice and Exchange

In ritual healing (particularly in the Ifa-based traditions), animal sacrifice or 'offerings' are frequently made to appease malevolent spirits. Animal sacrifice is described by healers as a form of exchange: an animal is sacrificed in exchange for the wellbeing of an individual:

'If we don't want human beings to die then we must give something, it is either the rooster or the goat or sometimes a rat or a fish, those are the ones we are going to use replace human beings' (Chief P interview p18).

As described by Ambiola<sup>53</sup>, within Yoruba culture and medicine, sacrifice is compulsory within Ifa divination rituals: this is because 'sacrifice is believed to be the only effective means of warding off the Anti-gods' (2007: 10). In particular the anti-god of disease (Arun) who can only be dispelled through the appeasement of animal sacrifice. However, it should be emphasised that within Yoruba culture sacrifice is not merely for spiritual beings, 'sacrifice in Yoruba culture is also a social act'. When an individual is asked by a healer to offer a sacrifice to either a god or anti-god, they will invite friends

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<sup>51</sup> Abimbola, K (2007), *Medicine and culture: transcultural needs in modern Western societies: Clinical Risk* 1 May 2007 vol. 13 no. 3 112-117.

<sup>52</sup> Abimbola, K (2007), *ibid* p10

<sup>53</sup> Ambiola *ibid* p10

and neighbours to a feast (Ibid: 11). As with many religious traditions, ritual also has a social as well as spiritual function.

A number of healers felt that there were frequent misunderstandings around the practice and meaning of animal sacrifice. In particular, they felt that the sacrifice of animals is not perceived as a 'legitimate' religious practice in Western culture, even though this is central to many cultural traditions across African and the Caribbean:

'Because of the laws there is no ritual, no sacrifice that can be practised successfully here and that is the main problem because the key method of any Babalawo is the sacrifice' (Chief P interview p17).

They felt that sacrifice was key to misapprehensions and misinterpretations around African and Caribbean spiritual traditions.

Similarly a number of church-based healers expressed strong disagreement over animal sacrifice and offerings, describing them as 'pagan practices' (Pastor D ALS 3). However, it appeared that even though officially healers from African Christian traditions would challenge the use of sacrifice, in *practice* and informally, some do incorporate elements of Ifa-based practices into their healing.

#### 4.4.8. Creativity

The use of creativity, including poetry, sculpture, music and art was a common characteristic among those healing traditions investigated. Creativity was an important method to connect individuals with their culture, history and community:

'My system of healing is using creativity as a tool for healing- that is based on values, reclaiming, receiving, embracing African Traditions and culture... using the creativity to avoid having to speak, sometimes with trauma victims, using drawings or clay is good for people to express.....Creativity is a means and tool for expression...because being creative is also quite symbolic' (Healer AB, ALS 2 p7).

It was seen as a method of expression and had therapeutic benefits for vulnerable individuals. Similarly, creative practices were also crucial parts of spiritual healing: for example as explained by K. Ambiola, oral poetry was a key aspect in Ifa divination and the diagnosis of spiritual illness (Abimbola, 2007: 9).

#### 4.4.9. Faith and Belief

Faith and belief is central to the African and Caribbean healing traditions examined. Healing practices are frequently attached to culturally specific belief systems, such as that of the Ifa religion and the Aladura church. Similarly, those healers encountered often have different ontological and epistemological perspectives and world-views, such as on the nature of religion, the body, health, the individual and community.

For example, one Ifa-based healer described how within his religion every object is perceived as living and also as connected to the spirit world:

‘Our own definition of a living thing is different from the definition of living thing from the western perspective. Everything lives in our religion, even this house, this building, is a living thing, it has essence’ (Chief P interview p35).

Due this belief in the interdependence between nature, the body and the spirit, the importance of spiritual healing rather than only medical treatments (that only target the body and mind) becomes clearer. Similarly, within the church-based traditions belief plays a key role in healing practices: for example, within the Aladura church healing is linked to the central belief that certain individuals are endowed with a ‘gift from God’ to heal. These individuals are called ‘mediums’ or ‘prophets/ prophetesses’, some which are believed to have the gift of clairvoyance (hearing of voices) or by predicting the future through dreams:

‘Clairvoyance- that is somebody who just sits down and hears voices...there are some that are dreamers- they dream and things come true’ (Pastor A interview p2).

Belief is a key issue that can prevent dialogue between medical practitioners and traditional healers. Following the development of medical science in Western history and culture, over time, medicine and science have become separated from religion. Similarly within many European cultures, religion is viewed as predominantly a ‘private’ and personal activity, separate from the public sphere that incorporates public services (such as the health service). However, from the interviews with traditional healers from African and Caribbean communities, religion and belief is intimately connected with cultural perspectives on medicine and health. For these healers, the exclusion of religion and ‘the spiritual’ from Western medicine is highly problematic to their cultural world-views. Similarly, for a number of biomedical practitioners, religious beliefs and practices should not have a role within scientific medical practices. There are often conflicting cultural interpretations around the role of religion and science: for example, one Pastor from the Aladura church believes that hearing voices is ‘a gift from God’, yet for medical practitioners this is perceived as psychotic behaviour.

#### 4.4.10. Relationship to Western culture

A number of traditional healers made comparisons between their cultural perspectives and those of ‘Western’ culture. In particular, they felt there is a separation between the spirit, mind and body in European cultures: though religion and spirituality are important in Western perspectives, this is often suppressed and ‘hidden’ in the private sphere. The history of industrialisation was seen as causing a separation between the mind/ body, religion/ science and the private/ public:

‘We tend to overlook the spiritual developments as a result of things like industrialisation and the emphasis on science...we don’t tend to relate to the



mind-body connection...industrialisation tends to disconnect people from natural processes...there's no more emphasis on that psychic aspect of our beings' (Chief P interview, p7).

Those interviewed felt that issues of spirituality were often 'hidden' and suppressed within Western culture. This is not to imply that spiritual practices are not important, rather that spirituality is not openly acknowledged or discussed:

'There is no group on earth that did not have spiritual explanations for physical issues one time or another...In the Western world, people who do not believe in spirits, would secretly go and consult an astrologer instead of making it public' (Chief P interview p5).

There is the implication that the secrecy surrounding African spiritual traditions is also influenced by a culture of suppressing spirituality within European societies.

The legacy of colonialism in repressing and concealing African healing traditions was a key theme raised in the interviews. A number of healers described how under colonialism in African and Caribbean history, cultural heritage was eroded and practises such as traditional healing were de-legitimised:

'The aim of the colonial legacy is to take away your cultures' (Chief P interview p19).

The Ifa-tradition and healing practices were driven underground, and practiced in secret. The issue of legitimacy is a key question for many healers interviewed: they felt there is a lack of recognition of African-based cultures and traditions in Western society:

'No African in this country is qualified to circumcise male children...it's that kind of dynamics, it's a cultural setup and it's also power' (Chief P interview p15).

This also relates to conceptualisations and definitions of 'religion': many healers from the Ifa religion felt that their belief systems were not given the same legitimacy in Western culture as monotheistic religions such as Christianity, Judaism or Islam. Similarly they felt that perceived 'mainstream' religions such as Hinduism, Buddhism and Sikhism were given greater legitimacy than religions from African origin:

'Particularly the monotheistic religions, they are not as open to other spiritual expressions...it was discredited. People are still quite uncomfortable with it and people just assume its black magic and they have all these negative connotations... dialogue hasn't taken place, there's still a lot of misconceptions about it' (Healer, ALS 3 p5).

The healers implied there was a perceived hierarchy among religious traditions, and that the Ifa religion or church-based healing practices had been 'marginalised' and not viewed as an 'authentic' or 'authoritative' religious practice.

## 4.5. Risk and regulation

The question of risk in relation to traditional healing practices is highly sensitive, not least because assumptions that these practices are dangerous or harmful has often been invoked to discredit them, both in the past and also recently. However, a number of healers interviewed expressed concern about the potential risks to vulnerable people, who may turn to 'healers' who were not properly trained or may exploit them.

### 4.5.1. Risk to vulnerable people

There was concern that there are a number of 'unauthentic' healers working in East London, which target vulnerable people for financial gain or other forms of exploitation. A number of traditional healers interviewed expressed this concern, in particular about individuals that advertise in local newspapers: one healer interviewed felt that 'those that advertise in the back of the local newspaper normally have criminal intent'.

Similarly, those interviewed within the Ifa-based tradition felt that 'real' or 'authentic' healers tended to live abroad in Africa or the Caribbean, and only visited the UK for short-periods of time. They felt 'authentic' Ifa-practitioners need to be in contact with nature and also with their cultural roots:

'I find it hard to believe that there is a Babalawuo that is authentic and actually based here' (Healer ALS2: p15).

They felt that 'real practitioners' especially when treating patients with mental health difficulties are 'very, very rare' (Healer ALS2: p39). One healer interviewed was involved in producing a television documentary investigating exploitation by individuals claiming to be traditional healers: he posed undercover as a patient and found a number of individuals that sought financial gain, were not providing 'authentic' healing as prescribed in the belief systems, and were operating with the 'intentional deception' of vulnerable people (Healer P interview, p1).

Similarly there have been several high-profile cases of child-abuse, which have been linked to beliefs in spirit possession. In the case of Victoria Climbié, her aunt believed that Victoria was 'possessed by an evil spirit' and subsequently used this justification to inflict horrendous abuse on the child (Laming, Victoria Climbié Final Report 2003: p56). Victoria's abuser regularly visited a local church that was associated with an African Christian spiritual tradition: the pastor at this church also felt that Victoria was possessed by an 'evil' spirit, however he recommended that prayer was needed to spiritually 'heal' the child (Ibid).

From the final report of the Victoria Climbié Inquiry, it appears that Victoria's aunt and partner used the belief in spirit possession as a rationalisation to violently abuse the child. The death of Victoria Climbié in 2000, led to a high-profile public inquiry and also a significant range of reforms regarding Social Service child protection provision and inter-agency working. In particular, this led to *Every Child Matters: Change for Children*

2004 and a series of new policy and legislation on safeguarding children in the UK. The issue of faith-based abuse remains of critical concern, in particular abuse that is linked with beliefs in spirit possession. A number of preventative initiatives have been undertaken in this area, for example the City Parochial Foundation currently funds a *Safeguarding Children's Rights (2007-10)* initiative, which specifically supports work with London's African communities to strengthen and develop community-based preventive activities in this field.

Within this project it was important to consider the risks that exist in relation to African and Caribbean healing traditions. In particular the way 'culture' can sometimes be used to justify the abuse and mistreatment of vulnerable individuals, or as a means to exploit that in mental and emotional distress. The case of Victoria Climbié is a stark reminder of how cultural and religious reasoning from African spiritual traditions can be misused as a pretext for abuse. However it is equally important to acknowledge that the abuse of vulnerable people and children occurs across all cultural communities, ethnicities and religious traditions. The use of cultural justifications for violence and the mistreatment of others can occur across all societies (Freeman 2002<sup>54</sup>, Wilson<sup>55</sup>, Cowan & Dembour 2001).

#### 4.5.2. Regulation

Within those African and Caribbean communities interviewed, the risks associated with traditional healing practices were linked to the fact that there is no organising body or international structure. This is partly due to the 'hidden' nature of many practices and the history of suppressing traditional healing under colonialism. However, as explained by an academic advisor on African religions:

'Most African religions were organised differently, with no central organising authority and no grandiose overseer the practice – no equivalent head of the Church of England or the Vatican.'

This means that 'Ifa and other African traditions were fragmented in appearance and had many people doing things in very different ways'. Though a central organising structure is not necessarily a solution to preventing exploitation (for example, there have been a number of high-profile child abuse cases in the Catholic Church<sup>56</sup>, this does mean that it is difficult for patients to determine whether a healer is an 'authentic' practitioner of the religion. A number of healers interviewed felt that risks were

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<sup>54</sup> Freeman, M. 2002. *The Role of the Social Sciences. Human Rights*. Cambridge: Polity Press.

<sup>55</sup> ; Wilson, R, Cowan, J, and Dembour, M. 2001. *Culture and Rights: Anthropological Perspectives*. Cambridge: Cambridge University Press,

<sup>56</sup> White, M. & Terry, K. 2008. *Child abuse in the Catholic Church*. *Criminal Justice and Behaviour*, 35(5): 658-678

heightened when these healing traditions have moved from the cultures from which they originated, to the very different situation of urban western culture.

From the interviews, it was apparent that healing practices themselves are strongly rooted within a particular context and culture. Many healers stressed how healing practices are learned through many years, frequently a life time of training and practice, and closely tied into wider structures of power and authority. Only certain people will be accepted for training, often after years of preparation. As described by one healer from the Ifa tradition, this is an extremely intensive and lengthy process and the trainee 'will stay with him, will be part of his home, will live his life and will do everything the way he is doing it' (Chief P interview p26).

Similarly a Pastor from the Aladura church describes how there is a careful system of monitoring and validating the authenticity of spirit mediums:

'We monitor them and see how accurate they are and then again by their behaviour and actions, both within and without the church...you can only find them and confirm them within the church so that they can be recognised for their gift within the church' (Pastor A interview p2).

Within these contexts, traditional healers were therefore highly visible within their own communities. Due to this visibility and training, the knowledge that certain practitioners are unscrupulous or dangerous is more widely shared and easier to determine. However within urbanised Western contexts, these informal structures of accountability and authority are fragmented. A number of healers expressed concern about 'unauthentic' practitioners advertising locally and over the internet: 'those that claim to learn remotely via internet and post are not scrupulous' (Chief P interview p27). Within western culture however, such constraints no longer operate as strongly, and alternative structures of regulation have not yet been established. Even within Africa, it was suggested, the erosion of traditional culture has left a vacuum within which unethical healing practices are able to flourish.

A number of healers expressed interest in creating an international training institute for Ifa traditional healers. This would make it easier to determine 'authentic' practitioners and ensure that healers are trained appropriately (Chief P interview p 28). However, some interviewees felt it would be difficult to agree competency criteria and ensure the trainers were themselves 'genuine' (EC focus group p5): particularly as Ifa is primarily an oral tradition, it has never had any central organising structure and that across the diasporas there is great diversity *within* the Ifa-tradition in terms of healing practices.

There also remains an interesting division between those traditions that require years of formal training and apprenticeship, and those where healing is bestowed on individuals as a spiritual or god given 'gift'. In such cases, although the endorsement of the church may be required before the person practices, there is no formal 'training' to which they are required to take before sharing their gift, in healing, with clients. It is interesting to

note that some of the healers we talked to had gained their skills through a combination of formal training, the discovery of innate 'gifts' and developing their own methods of combining the two.

### 4.5.3. Risk with mainstream health services

A number of healers interviewed perceived that there were also risks to vulnerable members of their community with mainstream services: in particular there was apprehension about the over-representation of black patients in the mental health service, and fears of detention and misdiagnosis. As described by one healer, patients 'believe that once they go see a psychiatrist, from there they are going to be detained, that's their perception' (Healer ALS2 meeting note p31).

Similarly concern was expressed around potential racism in mainstream services, a lack of understanding, and in medical practitioners quickly resorting to medication and sectioning without trying alternatives:

'There are cases where black people are not even mentally ill but they are sent to hospital...and once they start giving injections, it causes problems' (Pastor A interview, p7).

Those interviewed were particularly worried about misunderstandings of belief-systems: there was concern that individuals who openly discussed their spiritual beliefs were at risk from being diagnosed with mental health problems. In one example, an emerging prophetess from the Aladura church was diagnosed as mentally ill when she went into a trance:

'She is not mentally ill...they don't know what is happening to her: she was a prophetess. Sometimes when the spirit comes...it comes with a force her natural strength cannot withstand' (Pastor A interview p7).

### 4.5.4. Conflicting moral perspectives

Within this project, there were a few of examples of conflicting moral perspectives, both *between* and *within* African and Caribbean healing traditions, yet also in comparison to certain Eurocentric moral viewpoints.

For example, some traditional healers adopted a strict approach to parenting, and felt that 'children have no rights', placing greater emphasis on discipline and obedience (Pastor A interview p11).

Certain healers believed that 'Africans are staunchly heterosexual' and expressed homophobic viewpoints (Chief P interview p23). Additionally, within some church-based traditions there was the belief that mental health is caused by 'sin' and previous wrongdoing. As with all religious belief systems, there are frequently examples of conflicting moral perspectives.

## 4.6. Conclusions

There are a wide variety of healing practices which can be designated by the term 'traditional' or African centred healing, some of which have some key features in common, but with also some important differences between them.

The difficulty experienced within this project in gaining access to practitioners of traditional healing, and the unwillingness by some individuals interviewed, to talk about their work certainly suggested that these practices were widely regarded as 'hidden' from the wider culture, and closely protected. On the other hand, there were those who denied that they were hidden, but indicated that they were widely available 'if you knew where to look'. However, it was also clear from our discussions with service users, that although there were healing practitioners who advertised their services widely, there was generally a lack of information about who could be trusted, and who could be seen as an authentic practitioner of traditional healing.

The hidden nature of these practices, particularly where patients or clients were asked to keep their use of them secret, can potentially pose a particular difficulty for health professionals seeking to understand the world of service users, or the particular course that an individual's problems have taken.

# 5. The challenge of dialogue - Learning from the Action Learning set

## 5.1. introduction

A central aim of this project was to promote dialogue between healers drawing on very different sets of traditions. The concept of dialogue has a number of different constructions, meanings and purposes dependent on the context.

This chapter sets out to discuss what “Intercultural Dialogue” means in the context of the Healers’ Project. In the original brief of the project, the intercultural dialogue sessions (which were later referred to as an Action Learning Set (ALS)) sought to bring together two diverse healing systems, broadly representing “cultures” of healing practices, to engage in Dialogue so that they could increase understanding of each other’s activities and underlying belief systems.

The chapter begins with an exploration of the broader theoretical and philosophical issues concerning Dialogue, culture and profession. It then sets out the methodological considerations and steps taken in organising, facilitating and running the intercultural dialogue sessions/ALS. Finally, it sets out some of the key reflections on process, findings and systemic considerations of conducting the ALS in the context of the Healers’ Project.

### 5.1.1 What is Dialogue?

There is a significant body of literature on the development of theoretical and operational understandings of Dialogue in the social sciences, psychology, psychotherapy and utilised in the fieldwork of anthropology. Dialogue has come to mean largely the system of identifying, sharing through speech those ideas and exploring the emotional dynamics operating at the same time as the “information” sharing. It has been suggested by de Mare et al. (1991)<sup>57</sup> that “out of dialogue emerge, first, more primitive sub-cultural features and, second, the micro-cultural systems that are a specific feature of the (society’s) larger group.”

Our work with the ALS was based largely on the philosophical basis of dialogue as discussed within the Gestalt therapy theory in the last two decades, informed by the work of Martin Buber (1958)<sup>58</sup> earlier in the 20<sup>th</sup> century.

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<sup>57</sup> De Mare, P., Piper, R., Thompson, S. (1991). *Koinonia: From Hate through Dialogue to Culture in the Large Group*. London, Karnac

<sup>58</sup> Buber, M (1958) *I and Thou*. New York: Macmillan Publishing Co

Buber (ibid.) spoke about dialogue as a method for connection, for contact. His theory of relationship requires both separation and connection, that is, it requires “between-ness”. For true connection to emerge one has to be able to participate in the being of another; one cannot instrumentalise the other. The dialogue that Buber described is a transcendental process, when contacting is in the form of dialogue; the contacting process becomes itself an evolving, spiraling developmental process.

In other words, as the dialogical process unfolds, one must have faith in one’s emerging solutions if the dialogical process is going to resolve itself well. There is surrender in the forming moment, rather than an attempt to control what would happen next. In the human interaction the trust in one’s “emerging solutions” translates into trust in the “between”. Genuine dialogue that leads to contact with another person involves entering into dialogue without controlling the other half of the dialogue (based on Buber, 1958 and Jacobs, 1989<sup>59</sup>).

Hycner (1985)<sup>60</sup> believes that the greatest therapeutic achievement when working in the therapeutic dyad is the restoration of full dialogue. This notion can be extended to groups as well, and it can be said that this has been our aim in our work in the ALS.

In a discussion describing inter/multi-cultural dialogues, Wheeler (2005) says that dialogue in this context means a particular kind of conversation in which the goal is not limited to expressing your perceptions or position, but rather focuses on clarifying the sources and meanings of the various points being expressed: not just what you want or believe but also why that particular thing is important to you.

The intention that organises the activity and experience is not prevailing but deep understanding. In Gestalt theory terms, this means a shift in focus from the figure to the ground. Not your position itself, but where you are coming from, what the meaning of the figure is to you, in relation to your own ground of beliefs, values, goals, expectations and loyalties. There are things that are not always readily available to us as answers hence the conversation requires active listening coupled with open curiosity and a spirit of inquiry.

These threads for understanding dialogue are appropriated at the ALS sessions to ensure that meaning can be articulated, shared and thereby transform the relationships and relatedness between the individuals and their systems of practice.

### 5.1.2 Creating the space for Dialogue in the Healers’ Project

The overall research framework for the Healers Project attempted to gather information from a variety of sources and using a range of methodologies. The ALS facilitators met to agree the format for the sessions, their respective roles and methods of working in the sessions.

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<sup>59</sup> Jacobs, L. (1989), Dialogue in Gestalt Theory and Therapy, *The Gestalt Journal* vol.XII, No 1 pp 25-67.

<sup>60</sup> Hycner, R. (1985) Dialogical Gestalt Therapy: An Initial Proposal, *The Gestalt Journal* vol. 8 (1) pp 23-49.



### 5.1.3 Aims of the Action Learning Sets

The primary task of the Action Learning Sets was to bring together Healers from the African tradition and NHS mainstream practitioners to discuss, listen and reflect on their practice in terms of similarities and differences with each other. The sessions were structured to be responsive to emerging ideas and concerns from the participants, but also able to incorporate, test and consider issues arising from other sources within the project as a whole.

In this respect, the meeting between healers from the African tradition and the NHS mainstream practitioners is a meeting between two professional cultures. A few words need to be said, therefore, about culture and profession.

### 5.1.4 The cultural context of the Action Learning Set

As mentioned in chapter 2, Culture, as a term used to define a social entity with particular shared meanings and practices (rather than a term used for arts and education) is a relatively new term, deriving out of the emergence of Anthropology as a discipline in late 19<sup>th</sup> century Europe.

The notion of ‘a culture’ which developed through the European travelers of that time, implies a difference between one identified group and an Other, and in fact, has often been used quite closely if not interchangeably with the word ‘race’, a broad term which in those days was used to include not only shared practices and beliefs but more so the presumed basic characteristics and capacities of members of that group. Calling a ‘culture’, ‘ethnicity’ or ‘race’ had the effect of lending an air of scientific, biological legitimacy to the discourse of cultures, in a time where science was rapidly replacing religion as the source of authority and values (Wheeler, 2005)<sup>61 62</sup>.

Another aspect of our use of the term culture that Wheeler (ibid) points to is that culture in the Structuralist era, early to mid-20<sup>th</sup> century, is “all those relatively stable features of a social group that are learned, are variable from group to group, and are in some ways passed on from one generation to the next over time. Like anything in development, what is learnt earliest then tends to be the most organising for subsequent learning- and thus the most embedded, the most resistance to change later on...may also be out of awareness, and is often experienced not as something learnt but as just “the way the world is” (ibid, p. 47; Levi-Strauss, 1963<sup>63</sup>)

The ‘way the world is’ is our deepest experience of reality; the challenge then in the clash/meeting of cultures is a challenge to our core sets of assumptions to do with our

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<sup>61</sup> Wheeler, G.2005. Culture, Self and Field: A Gestalt Guide to the Age of Complexity. *Gestalt Review*, Volume 9, No 1.

<sup>62</sup> Wheeler, G. 2005, Culture, Self and Field, in Levine Bar-Yoseph, T. ed.. *The Bridge: Dialogues across Cultures*, Gestalt Institute Press.

<sup>63</sup> Levi-Strauss, C. 1963. *Structural Anthropology*. NY: Penguin.

basic attitudes to trust and mistrust, outside and inside, future and past, autonomy and dependence.

Later in the 20<sup>th</sup> century, in what is known as the post-structuralist era, there is an attempt to go beyond the imposition of the structure of a culture by an outside observer, to the more interactive perspectives of participant observers. The work of Geertz (1973<sup>64</sup>, 1988<sup>65</sup>) is relevant here. For Geertz, culture is to be understood as the shared system of communicated meanings. It is therefore a coherent set of signs and symbols that a certain group of people is able to transact successfully based on a set of shared assumptions (Vigotsky, 1978<sup>66</sup>).

Conflict, with this understanding of culture in mind will be understood, therefore, not only as a clash of interests or of differences, but a clash of meanings. Meanings here can be considered as close to values, through which we attribute importance and significance to particular actions or principles.

The intercultural dialogue in this way is therefore a challenge to our capacity to engage with another's perspective with a spirit of inquiry that allows us to see deep difference without trying to make it the same as our perspective or reject it.

## 5.2. Setting up the action learning sets

### 5.2.1 Securing ALS Membership

Fieldwork to identify potential participants from the available African Traditional Healers was led by one of the Tavistock researchers, while a parallel process was held within the East London Foundation NHS Trust to identify staff in appropriate disciplines and grades. The NHS Trust had invested in a programme that intended to take staff to Uganda to meet and work with Traditional healers, so we anticipated that this task would be relatively straightforward. In reality, it was far more complex than originally planned, especially within the Trust.

The research team held various meetings to engage with potential participants in the ALS. This was a lengthy process requiring briefing the potential participant, outlining the research, the methodology, the intended outcomes of the programme and the limitations of the research to change, wholesale, the experience of African and Caribbean mental health service users.

The Traditional African Healers were wary of the research process on a number of levels, some offering to engage in offline discussions about the issues and concerns of Traditional Healers, and others only wanting limited exposure, that is, happy to take part in the research process but did not want to be named/photographed, and additionally others being curious, but not wanting to identify themselves as traditional healers.

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<sup>64</sup> Geertz, C. 1973. *The Interpretation of Cultures*. NY: Basic Books

<sup>65</sup> Geertz, C. 1988. *Works and Lives: the Anthropologist as Author*. Palo Alto: Stanford University Press.

<sup>66</sup> Vigotsky, L. 1978. *Mind in Society*. Cambridge MA: Harvard University Press.

The Research team made the decision to identify potential participants along a number of dimensions:

- Carers
- Traditional Healers
- African Spiritual /Churches
- Community/Voluntary organisations serving Mental Health users
- Users of Services themselves
- NHS Trust employees
- Other NHS employees or statutory providers

An initial invitation was sent out to a wider network of contacts that had been established during the early stages of the project, and to the professional networks of the director of equality and diversity at the trust. This resulted in 32 responses from people interested in joining the ALS. A review of this list indicated that some respondents did not fit into the categories that we had decided to include in the ALS, and there was also an over-representation from some groups. A selection was therefore made which represented a more balanced group of participants, and these were invited to an initial 'information day'. In the event, 15 people turned up to this day, and from this 10 participants agreed to join the action learning sets, the first meeting of which was held two weeks later.

### **Action Learning Set applicants and final list attendees**

<b>Participant representation</b>	<b>Expressed interest</b>	<b>Attended 'open day'</b>	<b>Involved in ALS</b>
Health professionals	7	3	2
'traditional' and faith based healers	12	2	3
Community or voluntary organisations	7	3	1
Service users and carers	7	3	3
others	6	4	1

	32	15	10
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## 5.2.2 Practicalities

### 5.2.2.1 The timing of meetings

There were six Action Learning Set sessions (ALS), the first being a whole day event to set the scene and provide potential participants with an opportunity to hear from the Project sponsors, the principal research team and facilitators. There was space to work with each other and question, challenge and test the process and then formally agree to take part, or depart.

The first full ALS session took place two weeks later, with a further four sessions taking place at three week intervals between April and July.

Recognising the importance of food both as a cultural mechanism and a tool to facilitate bonding, the sessions were timed from 11am to 2pm. Allowing considerations of time commitments (school runs, church, private practice issues etc.), we also sought to ensure that staff time off would be easy to facilitate for those working in the NHS Trusts.

There was usually a longish lunch break, during which participants could have a more informal discussion – although these were also times at which important issues could also emerge. However, the combination of a longish lunch break combined with the fact that sessions often started late (because of participants turning up late), that meant that the overall time for formal dialogue was usually quite limited.

### 5.2.2.2 Location of meetings

The initial meeting was held at the headquarters of the Mental Health Trust, and it was hoped that this would also be available for subsequent meetings, although there was some concern that this might be off putting for some participants – a ‘neutral’ setting being more appropriate. However, the Trust premises was not available for many of the subsequent meetings, and fortunately, there was a community centre next door to the trust headquarters. Although not ideal in terms of comfort and appearance (a rather large, dark room) it was convenient in terms of access and allowed for self-catering for the group.

### 5.2.2.3 Recording the meetings

Because this was a research project, keeping some kind of record of the meetings was an important element. In the original plan, it was hoped that some kind of video for wider dissemination would come out of the project. However, the members of the ALS were not keen to have the sessions recorded. They did, however, agree to have a sound recording made of the sessions, for research purposes only. For wider dissemination, a

number of podcasts were made: some members of the ALS were interviewed separately for this purpose. A written note was also made of each session and sent back to participants so that they had a record of the meeting, and could also make any changes to the content, if they felt that this did not fully represent what they had said in the meeting.

#### 5.2.2.4 Reimbursement

Participants in the action learning group were offered travel expenses, for those not employed by the trust, there was also some reimbursement for their time. Providing reimbursement for time spent in the research task has proved to be an important issue in this project, because it represents recognition of the professional standing of the healers taking part. While the amounts being offered were not sufficient to actually replace any earnings that participants might have been able to make during the time spent taking part in the group, providing some kind of reimbursement in itself was seen to be important. The provision of lunch was also an important part of the overall 'exchange' between the research project and participants in the action learning set.

#### 5.2.3 The involvement of service users

Some of the ALS members felt a degree of discomfort around the idea of involving service users in the ALS directly. We worked with a carer who was a service user as well and one past service user but over time we realised that involving more directly the current service users was potentially too difficult because it would have introduced another layer of complexity around the professionals critically questioning and exploring whether their practices were effective and or the most appropriate in the presence of the people whom they are seeking to engage and secure confidence (or as can often be the case of mental health service and drug regimes, compliance).

### 5.3. The content of the Action Learning Set dialogue

There were six meetings in all. The first meeting, as already described, was an exploratory one – providing an opportunity for participants to understand the task, and nature, of the learning sets proposed and to decide whether or not to join. This was a one day workshop.

#### 5.3.1 What's under the bed?

In session one of the now formed action learning group, a key theme was 'what is under the bed' – in other words, what aspects of traditional healing are kept 'hidden' from view. The naming of this topic came from one of the advisory group members who attended the first part of the first day and described his experience of working as a conventional doctor in Africa, and knowing that many of his patients had totems or charms hidden under their hospital bed, out of sight of the hospital's doctors and nurses although it was quite clear that everyone knew about this hidden activity.

In practice, it was probably too early in the series of meetings to explore this topic in the depth that it required, as participants were not yet ready to begin to share the more 'hidden' aspects of their practice, trust wasn't yet established. Another key issue to emerge quite early on was that some participants did not feel that they had the authority to talk about their practices. It emerged that in relation to some traditional healing practices there was a very hierarchical tradition, with newer, less experienced practitioners not being authorised to act as spokespeople for the tradition.

The willingness to talk openly about some of the practices increased dramatically following a meeting that one of the research team had with a very senior Healer in the same tradition, who was willing to talk openly about many aspects of his work. When the outcome of discussion was shared this seemed to 'give permission' to others to talk about their own work in the same tradition.

### 5.3.2 Systems of Belief underpinning practice

Over the next few sessions participants slowly began to open up to the detail of their practice. The second meeting centred around a discussion of the systems of belief underpinning practice and it emerged that the differences within the healers are just as diverse as between the healers and conventional medicine healing. For example, Christian faith-based African healer had a very different view which seems to be in opposition sometimes to a nature-based view of the African healer who drew their resource from the earth and the stones. Some participants brought herbs and stones to show to each other as representations of the "tools of their trade" explaining the meaning and significance of their gathering and their use in the execution of their practices. In turn, the "Western" practitioners added some discussion about their methods of practice and the different theoretical traditions that affected their practice.

The potential of healing to work with medication was of more interest to the health professionals than to the healers, who appeared reluctant to acknowledge the potential useful role of medication, although health professionals were willing to accept the possibility that traditional healing was potentially useful. We never fathomed whether the member who was a carer, whether the person she cared for was actually taking medication or not.

### 5.3.3 How do I work?

The theme of third meeting was a discussion of the healing practices of each member of the group. This was an important meeting in that it revealed some potentially radical world views. The discussion was well contained, however, within an atmosphere of openness and non-judgement and led to an understanding of the poignant differences amongst the ALS members.

### 5.3.4 Case Studies

In the fourth meeting, each member of the group agreed to bring a case study of someone with whom they had been working. This signified yet another step in the participants' willingness to share their practice with others but they were very clear about their wish for strict confidentiality outside of the sessions and it was agreed that no information would be shared about the actual practices undertaken in each session.

### 5.3.5 Difficult topics and endings

In the fifth meeting, a number of more 'difficult' topics, which the group had not been able to tackle before, were addressed. This included the issue of sacrifice and exorcism. The theme of endings was also evident in these discussions as this was to be the last meeting of the ALS. The role and nature of the life force was discussed and how various practices that related to a belief in the presence of life in all objects (not just in human beings) and how these objects often were considered to have representatives or "entities" that held the life force of the object. In this discussion an object could have been a tree, a village, a family, a disease, a stone/totem etc. These entities are thought to have their own life force and "will" independent of the observer or other objects (which includes human beings).

A powerful discussion about the impact and strength of animism was discussed and one member drew a powerful analogy between the western Judeo-Christian concept of the sin offering, represented most potently in the symbolism of Jesus Christ as the sin offering for humanity, whose blood bought salvation and the practice of sacrifice as a legitimate/unnecessary part of the practices in some traditional healing practices.

This led to the issue of exorcism as a healing practice, explaining that the belief that an "entity" could enter someone and influence their behavior and health status would lead to a belief that exorcism could provide relief was a challenging concept. Particularly for Western practitioners where "hearing voices" is a sign of schizoid ideation and not the presence of actual entities "whispering" to their host.

This Action Learning Set took us to the point of being able to have a look at some of the issues that are "under the bed". Although the conversation was tense and charged, there was a willingness to understand and to think about possible implications for practice.

## 5.4. Key reflections and learning from the ALS

### 5.4.1 The representation of the membership

We have never claimed, in this project, to be able to represent all the different traditional healing practices, or even all the different professional approaches that make up NHS services for people with mental health problems. What we did hope to do was to bring together a small number of people who represented significantly different approaches to

mental health that might be characteristic of traditional, and more orthodox (mainstream) approaches, as well as service user views.

In practice, the very diversity of the fields we sought to explore made the limitations of a small group of this kind apparent, particularly as the loss of even one member from a particular meeting meant that a significant voice was absent from the discussions. In practice, only one mental health professional from the trust took part in more than one meeting, which meant that a significant link to the trust, that was hosting the meetings, was missing. The 'service user' voice was also quite limited – one person came to an initial meeting but did not continue. There were a number of possible dimensions that we might have wished to explore – for example, we had no representation from Muslim healing traditions, and the representation of African healing traditions were drawn mainly from one primary tradition (the Ifa tradition). The Christian faith tradition that was represented proved to be relatively eclectic and sympathetic to the older African traditional religions – this is not the case for all the Christian traditions.

However, there were rather more eclectic views represented in the meetings in so far as, although people were attending the ALS nominally in one role, or because of their experience in one healing traditions, in reality several had multiple roles. There were healers and representatives of community services who had also been service users at some point in their career. There was one participant who was attending primarily in her role as carer of a son with mental health problems, but who had also explored various healing traditions on her own behalf. Members revealed more of their multiple role holding as the ALS meetings progressed.

#### 5.4.2 Motivation for joining the group

Another factor which was potentially important in terms of the ability to create an open dialogue between participants was the different sets of motivations for joining the group.

For mainstream mental health practitioners, a key motivation lay in an interest in understanding the practices that some of their patients were turning to – in addition to any personal interest they had in learning more about different healing practices. They were interested in telling traditional healers about conventional medical practice and in particular, explaining areas where these appeared to have considerable overlap with traditional healing practices.

For those representing traditional healing approaches, there was an interest in representing, and ensuring that more was known about practices which are generally marginalised in western society. How far these participants wished to know more about conventional mental health services was often unclear. Potentially, hearing that conventional services shared values and principles with their own practices could be experienced as quite threatening to the integrity of their own approach, and the clear boundary that they perceived there to be between their own, and western, approaches to health and illness, and in some instances a wish for the boundary to remain intact and unexplored.



### 5.4.3 Building trust, enabling discussion

A key element of establishing effective dialogue is for group members to begin to have sufficient trust in other participants to feel 'safe' to share their views, as well as feeling sufficiently comfortable to be able to listen to what others have to say.

In reality, five sessions was a somewhat short period over which to build up a sufficient level of trust amongst such a diverse group of people, particularly given the potentially difficult content of some of the discussions, and some of the underlying tensions and value conflicts that underlay this diversity.

One key element in enabling participants to talk freely about their work, which we had not anticipated, was that some members of the group did not feel they had the authority to talk about their healing practices, given the hierarchical nature of their traditions. This could also be interpreted as a defense against sharing professional "secrets" with competitor professions, and with a mistrusted research process.

### 5.4.4 The issue of authority

Related to the issue of hierarchy was the relative vulnerability of some members of the group who were relatively junior in their particular healing practices, and therefore lacking in confidence in speaking 'authoritatively' about their practices. In reality, this led to some members of the group to refrain from sharing at all on matters of significance, preferring to keep their silence. This is perhaps a particular issue in healing practices which do not have a formal 'qualification' process – this depending on informal acceptance that someone has spent sufficient time in an apprenticeship with an experienced healer to be acknowledged by their 'teacher' and other members of the community that they have reached a level of competence to practice in their own right. In so far as healers are operating in a western country, relatively separate from the wider community using such practices, this can be a particular difficulty.

### 5.4.5 The validity of different healing practices

Again, a practitioner of western medicine is in a relatively advantaged position in so far as their practice is based on a considerable body of research 'evidence', as well as being authorised by their professional organisations. The perceived legitimacy of the western professional bodies due to their scientific bias and power relations gives a weight to their assertions to healing. The traditional healer, on the other hand, is drawing on long standing traditions of their particular faith, or cultural community, supported in some cases by the scriptures underpinning their religious practices. In some cases, this faith is a very strong one, which does not tolerate a questioning of its underpinning principles or beliefs, much like scientific "evidence-based" practice, but it lacks recognition and therefore legitimacy.

### 5.4.6 Challenge and competition

A key aspect that had to be - if not addressed directly then at least recognised by the facilitators - the fact that the healing systems being discussed were potentially in competition with one another, since they posed directly opposed interpretations of what 'health' and mental health means and represents. One member, for example, talked about the limited concept of "drugs" and introduced the idea that all food should be seen as drugs and that when an individual is taken out of context, dislocated from their traditional food source that this can create and exacerbate disease conditions, and vice versa.

#### 5.4.7 The potential for action

One feature of action learning sets is the opportunity that participants have to learn from the discussions and to take this learning into their day to day practice, and then bringing reflections on this application of learning back to the group for further discussion. This did not appear to take place in this ALS: although it is possible that some participants did take learning from the meetings back into their professional life, there was little discussion within the groups of this taking place, or what impact it had had.

There are various reasons why this might have been the case. Firstly, the meetings themselves took place rather closer together than was originally planned – this was because of the late start of the sessions (owing to the time it took to get ethical clearance) and the need to fit the meetings in before summer holidays began.

Secondly, it took somewhat longer than was originally anticipated to get to the point where participants were able to be open with one another about their practices – which meant that most of the time in sessions was spent in exploring areas of difference, or similarity.

However, perhaps a more fundamental difficulty was that members were not necessarily in a position to use any learning derived from the sessions in their day to day practice. The mental health professionals were working within the constraints of their particular departments or professional roles, and did not have the seniority to make major changes to the way that these were conducted. A more senior (and in the case of the traditional healers, authoritative) membership may have allowed participants to explore making changes to policy and practice within their profession or community. For example, it was asked what authority a participating psychiatrist would have to change practices and policies based on their own learning and to operate outside the remit set by the Royal College.

#### 5.4.8 The role of the facilitators

The facilitators' role in these groups was very important to the overall task, since it was their responsibility to ensure that a dialogue developed, and some of the values and assumptions that underpinned areas of difference, or potential conflict, were brought to the surface for examination by the group.

In a topic where identity politics is potentially highly significant, the identity, and appearance, of the facilitators were important. The two facilitators were a white Jewish Israeli/ British woman and a Black British man of African-Caribbean origins. The importance of identity was referred to on a number of occasions, brought up in relation to physical characteristics (such as the length or appearance of hair), language (the fact that English was not the first language of one of the facilitators) and body weight (the weight of the male facilitator and the fact that he cut his hair short was criticised as being evidence that he was not taking proper care of himself). Whether the colour of the male facilitator meant that he was more vulnerable to criticism by other (black) members of the group may also have been important – similar criticisms were not directed at the other facilitator, in fact, she was celebrated as being a healer because she had and revealed her long hair.

A key role for the facilitators was to try to push the discussion beyond talking in generalities about areas of difference (or similarities) and to bring this back to very specific and tangible examples of ways in which practice was similar or different. The use of case studies and specific examples helped in this respect.

Another task was to try to dig deeper into the areas of difference, in some cases opening up areas which were uncomfortable for the group to discuss. In some respects this proved difficult to achieve until quite late in the series of meetings, when sufficient trust had been built up to enable the group to explore potentially 'dangerous' issues such as different attitudes to witchcraft, racism or the history of colonialism and slavery that had led some of the healing traditions to be denigrated and pushed underground.

One difficulty that had to be faced was the possibility of really talking about difference, without in some ways eliminating this difference. Particularly given the constraints of time, it was possible that the time limits increased a pressure to "get results" and exacerbated a fear that this was another exercise designed to extract information from indigenous communities and that the real purpose of the research was not to promote inter-cultural dialogue, but to increase power and diminish legitimacy of the traditional healer community, reducing it to fetishism and superstition.

One area of difference that it proved relatively 'safe' to talk about was food – a topic discussed most lunch times. The catering was different for each session, with different culinary traditions represented. The African and Caribbean lunches proved a strong topic for discussion (and criticism of the food provided) than the conventional western sandwiches and crisp lunch provided at the last meeting of the group. This discussion of food was possible

The facilitators themselves experienced difficulty at times in holding on to the core task of the meetings, as discussions went in different directions exploring and avoiding a range of issues and it was a challenge to maintain an open and inquiring stance whilst not shutting off what could be seen at one point as being of irrelevance. For example, one member was talking at some length about all humans being trees, the importance of being upside down in the earth and how this affected our ability to function in

harmony with nature. The method of storytelling was a complex tool in the traditional healer's communication style, and required a particular nuanced listening capacity and fearlessness to speak openly about "not knowing" to facilitate these learning environments.

Another role of the facilitators was to manage expectations, about what the project and the action learning group, could achieve. There was a large gap between the many hopes that the idea of the project brought up – that this would lead to a greater acceptance of non-orthodox healing practices – and the reality of a time limited set of opportunities for dialogue. On the other hand, a key task for the facilitators to ensure that the best use was made of a somewhat limited opportunity – this was potentially a pressure that they had to deal with internally, particularly given the challenging nature of the task.

# 6. Conclusions and the need for further work

## 6.1. Introduction

This project started out with a set of research questions which in practice are quite difficult to answer these directly: the nature of the project tended to lead to a questioning of the very framework within which the questions were conceived.

In this, the final chapter, of the report, we take each of these questions in turn and discuss the findings from the project, both in relation to how the questions themselves might be framed, and what answers we found. We then draw these together into a number of recommendations for the future.

## 6.2. African traditional and faith-based healing practices in mental health services

Although apparently quite straightforward, this is perhaps one of the hardest questions to answer in terms of current levels of understanding about the healing practices described in this report, particularly if the reader is seeking a clear cut, quantified and 'evidence based' answer. The question itself has two elements – the first one relating to the prevalence of the use of these practices, and the second, the role that such practices might play in the care and support of patients.

### 6.2.1. How many service users are turning to traditional and faith based healing practices?

Our research cannot give any clear picture of the frequency with which mental health service users in east London are turning to tradition or faith based healing practices. What we can say, with confidence, is that knowledge by health care professionals about whether or how many service users are turning to such practices is very limited. In many cases, the response to our question concerning the number of their patients turning to these practices was that 'very few' of their patients were using traditional healers, with slightly more reporting service users turning to faith based or religious practices for help with mental health problems, turning to churches or to prayer, seeking help from a pastor or Imam, undertaking a Hajj pilgrimage.

However, any assessment by health professionals about the prevalence of such practices has to be treated with care: lack of knowledge of the use of these practices by their patients could be seen either evidence of lack of use, or of evidence that, if service users were using such practices, they were not telling their professional carers. Several service users told us in no uncertain terms that if they were using or practices, or indeed, holding beliefs related to these healing practices, they would be reluctant to tell

their health care professionals, for fear of this being seen as a symptom of their mental health problem, rather than as a resource for its treatment or for recovery.

A similar difficulty arises from our discussions with service users, which again, revealed relatively few 'narratives' of how these practices had been used, and what benefits they believed they had derived from these. The research process itself allowed relatively little time to build up a relationship of trust with service users in which such confidences might have been revealed. Many of the interviews took place in focus groups, and some of the practices are regarded with suspicion and sometimes with contempt, not only by the mainstream, white, western, culture, but also by many of African or Caribbean origin, who have adopted a western life style and belief system.

We also heard from those who had used traditional healers, and from the healers themselves, about a culture of secrecy that surrounds many of these practices: people told by their healers not to inform others of their meetings, or the practices that they were told to adopt, or healers who felt too low in the hierarchy of their particular practice to reveal the practices that this involved.

There is one further difficulty which surrounds any assessment of the prevalence of use of traditional and faith based healing practice, which is the fact that no clear boundary can be placed between the healing practices themselves, and the spiritual, or religious tradition within which they are embedded. In the west, we are familiar with a separation of medicine from religious practices, and a separation (to some extent) between mental and physical health problems. Religion and faith is seen as being, to a large extent, a private affair, medicine and healing is subject to public policy and public funding.

However, the healing practices to which this report refers come from cultures in which these divisions have not taken place. One way of describing this is that they are 'pre-modern', arising within a culture in which health, healing, spiritual, mental and physical wellbeing are intimately intertwined. If the practices themselves can not be isolated as separate elements to be studied, then the research question has to address, not just the prevalence of use of these practices, but the prevalence of the set of beliefs and wider religious and spiritual practices within which they are embedded.

A few attempts have been made to do this. The 'Count Us In' report does ask questions about the prevalence of various belief systems practiced by mental health patients – but not only are African traditional spiritual practices entirely absent from the list, but also the level of detail concerning allegiance to Christian or Islamic belief systems does not enable any assessment to be made of the likelihood of these involving healing practices. One other useful study (Gwenzi) surveyed the prevalence of different types of belief about mental health within African and Caribbean patients; this perhaps, provides the most useful model for further research in this area.

### 6.2.2. What role do these practices have in the care and support of people with mental health problems

The question of what role these practices might play in the care and support of people with mental health problems is complementary to the previous question. Potentially, even if very few people are turning to such practices for support (and finding this of benefit) then this role deserves to be acknowledged. Just because relatively few NHS patients have access to, for example, intensive psychotherapy, does not deny the benefit that such therapy might have for those who do have access to it.

The most immediate answer to this question arising from the present study is that access to practitioners of healing based within an African or Caribbean cultural framework can be immensely helpful for some people, particularly in terms of enabling them to make sense of their identity, while living in a western environment, far removed from their own cultural roots.

In some respects, it is this 'sense making' element that is at the heart of many of these practices, in so far as they offer a framework for understanding the relationship between the individual, their family, their wider community, their own spiritual being and a wider spiritual reality – whether conceived of as 'God' or the notion of a spiritual 'web of being' that permeates all forms of life. The core element of many of these spiritual practices is to heal a rift that has taken place, and restore a sense of harmony between these different elements. For one healer (operating within a more 'westernised' model) it was a restoring a sense of connectedness between the individual, and to nature, or the land. For many, operating within a traditional African framework, healing is a community based, collective act, which helps to restore broken links between the individual, his wider community including his or her ancestors and other spiritual beings that look after the community. For some operating within a Christian framework, the healing is about obtaining forgiveness for either an individual or collective sin which is seen to be at the core of the health problem, and returning to a state of 'grace' with God. Similar beliefs underlie some approaches use for treating mental health problems within an Islamic tradition.

Another core element in many of these practices is the focus, not on the illness itself, but on the individual to whom the illness is happening. This is not to say that the illness was not perceived as a real entity which needed to be addressed. Indeed, the notion of a mental health problem as a djinn, or evil spirit that had entered the individual could be said to be an even more profound 'objectification' of the illness than is present in biomedicine. However, the focus of healing, as well as being, in some cases, to drive out the evil spirit or sin which is seen to be inhabiting the individual, but also in enabling the individual to develop the capacity to resist future attacks or relapses into a similar state of vulnerability.

How far such approaches 'work' is a question that will be returned to in the next section. What can be reported here is the profound need, expressed by many of the service users interviewed, for an approach to healing which provided a sense of meaning to their experience, and which offered some hope that harmony could, at some time in the future, be restored. Also expressed was a desire for methods and tools through which to they could build up their inner capacity to cope with their difficulties, both the symptoms

of mental illness where these were marked, and the causes of distress that had left them vulnerable to ill health. Many of those we talked to had suffered severe and disabling crises in their lives – surviving war, becoming a refugee or asylum seeker, homelessness and extreme poverty, isolation and grief, and racial abuse. Recovering and returning to a ‘normal’ life after a mental health crisis and overcoming the stigma of diagnosis with a psychiatric illness, sometimes after having been sectioned and come into conflict with the law, often appeared to require inner strengths which were beyond their capacity. For many, their mental health problems had also led to a rift between themselves, their family, and their wider community and in many cases, their own church or mosque, as a result of their mental health problems.

Undergoing some kind of public, or even private, healing ritual could in some cases be an important part of acknowledging that problem was present, but was in the process of being addressed, within a cultural framework that was acceptable to their wider community, family or church. In many cases, it can also involve other members of the community directly in the resolution of the problem – becoming involved in collective prayer for the wellbeing of the individual, accompanying him or her in a healing ritual or pilgrimage. It is one way of ‘normalising’ what had previously been seen as an abnormal and frightening experience, or one which potentially threatened the harmony of the family or community.

Turning to practices such as prayers and rituals, or attending some community religious activity, could also be a way of managing distressing external and internal circumstances: a special prayer to say when overcome with depressing or suicidal thoughts could be one way of getting through an immediate crisis and returning to some kind of stability.

In other cases, the healing practice could form an alternative culture, and community, to the one within which they had previously belonged, which had perhaps rejected them or viewed them with suspicion because of their mental health problems. This is particularly true of a small, and cohesive religious groups or church, where the idiosyncrasies of the individual are overlooked so long as they continue to show their commitment to the congregation, the tenets and practices of the faith.

For others, exploring the spiritual and healing traditions of their ancestors might be a personal pilgrimage in response to their inability to fit comfortably within their more westernised families and community. Returning to their African ‘roots’ and rediscovering and starting to practice spiritual traditions of which their parents or grandparents were part was mentioned by several of those we interviewed (both service users and those who were now practicing healing) as an important part of their recovery from profound mental health problems. For a small number, reconnecting with the spiritual traditions of their ancestors helped them to make sense of disturbing experiences which had previously been seen as symptoms of their mental health problem. Heard voices and vivid dreams turned from psychotic symptoms to evidence of an ability to connect with ancestors and the history, or future, of their tribe. Lack of a strong sense of personal self



takes on a new meaning when faced with belief system which gives greater value to a larger, spiritual reality of God, a cosmic or universal Self.

What elements of these practices would it be useful for mental health care practitioners working with African and African-Caribbean communities to be aware of to improve the care and support of their patients and to minimise risk?

Like the previous question, there are two different ways of approaching an answer to this question. The first is to consider what health professionals want to know, or would consider useful themselves, in order to improve care and support for their service users. The second is what we the researchers, or others with more familiarity with these practices, believe that it would be useful, or indeed, necessary, for health professionals to know.

### 6.3. What mental health care practitioners need to know about these practices?

This study has collected considerable information about the level of interest on the part of mental health professionals in healing practices derived from African and Caribbean culture (although we cannot claim to have carried out a representative survey). What is apparent from this is that attitudes are very mixed – or even divided – on the issue. There are those who are very keen to find out more about the healing practices that their service users might be using, and the central problem for these is accessing information about these practices. There are also those who express very little interest in finding out more, even expressing distaste for doing so and a profound distrust in the practices. There are also those who fall between these two groups, having a casual interest in finding out more. But this interest competes with many other demands on their time and interest, particularly if their particular client group has more pressing concerns (as, for example, a group who were working with a Somali community in which close familial marriages and inherited health disorders was a key issue).

Having said this, it is fairly easy to identify three key questions that summarise the main areas of interest by any other than those who find the whole subject completely uninteresting, or distasteful.

- *What are the main healing practices drawn from African or Caribbean history and culture?*
- *Do these practices work (are they helpful)? and*
- *Are these practices harmful?*

### 6.3.1. What are the main healing practices drawn from African or Caribbean history and culture?

In chapter four we identified three broad clusters of practices: those which link to traditional African spiritual practices and beliefs, those which are broadly connected to Christian or Islamic, traditions, and those which constitute a blend of these, or a blend of these spiritual traditions with modern, western healing practices.

We cannot claim, in the present study, to present anything more than a very cursory account of a few representatives of these traditions, each of which is highly diverse, rich in a multitude of different sets of beliefs and practices. Africa is a huge continent, made up of 52 different countries, varying in size from tiny countries such as Malawi or Gambia, to massive territories, like Sudan, which covers an area greater than the whole of Western Europe. Within this national diversity are also huge variations in terms of culture, language, history and religion. Having said this, there are some major spiritual traditions which are practiced in some form or another across the African continent, as well as in many other parts of the world.

In terms of traditional African religions, probably the most pervasive is Yoruba based healing traditions, which can vary in interpretation from one country to another. However, there remain a number of fundamental similarities, with mental health problems being seen as closely linked to wider personal, family or community disturbances, possibly arising from possession by a malign spirit or the results of failing to honour ancestors in an appropriate way. Healing takes place in many different ways, and can involve the use of herbs, incantations, rituals (individual and group) and the sacrifice of animals and birds. Dance, chanting and particularly drumming may all form part of a healing ritual.

In terms of Christianity, Africa has both some of the oldest Christian churches such as the Coptic churches of Egypt, and some of the newest. It has all the major world denominations, many of them dating from the missionary activity of the 18<sup>th</sup> and 19<sup>th</sup> century, and it has a number of independent churches which have broken away from the main denominations and adopted their own hierarchies of pastors and bishops, their own liturgy and approach to worship. Healing services and healing practices are a central part of many of these, as they are of churches operating within a broadly Pentecostal tradition.

The ability to heal, like the abilities to speak in tongues or prophecy, is seen to be one of the God given 'gifts' that accompanies becoming 'Born again' or establishing a direct relationship with Christ, within the life of these churches. Healing services in which members of the congregation pray with those experiencing stressful life circumstances or ill health, often accompanied by the laying on of hands, and strong emotional experiences, are a regular part of church life. As was reported in chapter three and four, mental health problems are often interpreted as being related to sin, healing taking place as a result of praying for forgiveness or as a result of receiving healing through the laying on of hands.

For many communities of African origin, Islam is the main religion. Nearly a third of the world's Muslim population is in the African continent, where it is the majority religion in some countries, such as Nigeria (where 70% of the population, or 40 million people are Muslim). Unfortunately, in this study, we were unable to explore Islamic approaches to mental health and healing, but were given accounts of service users who had been receiving help and counselling from their Imams, or who had been recommended to adopt certain practices, such as going on a pilgrimage, in order to help with their mental health problems.

In addition to these broad traditions there are also a whole range of healing traditions which involve a blend, either of the above major spiritual traditions, or the combining of these with modern western practices. Some of the African initiated churches incorporate elements of traditional African healing practices, reframed within a Christian world view. Traditional healing practices may incorporate modern pharmacology alongside traditional herbal remedies. Healers practicing in the west may incorporate elements of traditional African spirituality, and some traditional practices, alongside modern stress management techniques, or complementary therapies such as Reiki or massage, or combined with the practice of music, dance, sculpture and painting.

Because of this diversity, it is dangerous to make any generalisations about these practices, although many of them incorporate what is sometimes described as a 'radical holism': seeing the wellbeing of the individual as being closely interconnected not only with his personal physical, mental and spiritual wellbeing, but also with the wellbeing of his or her family, community, with the wider environment and the natural world. This can be particularly important in terms of providing meaning, and a wider context in which symptoms of mental distress are interpreted.

### 6.3.2. Do these practices work?

This is a question that was frequently asked by those who heard about our research, either by people who were highly sceptical of taking anything more than a cursory interest in these practices, or by those who were keen to see an 'evidence base' established for these practices so that they could be better accepted by the medical establishment.

The answer to the question is closely linked to the earlier question of 'what is the role of these practices in the care and support of patients?' We provide numerous examples of ways in which these practices appear to have benefits for those taking part in them, both in terms of reducing, but perhaps more fundamentally, reframing symptoms of ill health, enhancing the individual's ability to cope with these, and returning to a more balanced sense of wellbeing and functioning within their world.

The study itself explores fundamental questions about the way in which mental health problems, their treatment and management is culturally constructed, both within a western, biomedical, framework or within a variety of different other cultural frameworks. If mental health problems are seen, as they are in several of the traditions we were

examining, as being symptoms of a spiritual, communal, or even, environmental, disturbance, then 'healing' is regarded as more than just the removal of immediate symptoms, and more centrally about restoring a sense of spiritual, cultural and community wellbeing. To quote from one book on shamanic practices: 'healing is not about preventing death, but preserving the spirit'.<sup>67</sup>

Given the diversity of these practices, it is unlikely that they will ever be susceptible to the kind of rigorous research to which western medical practices are generally subjected before evidence of their effectiveness is said to have been found. Some of the herbal remedies used in traditional African practices have been researched, and found to have pharmaceutical properties, which can be used more widely. However, the way that they are used in traditional practice rarely conforms to the western practice of carefully controlled dosage, divorced from any accompanying ritual. (Unless, of course, the very practice of visiting a doctor and receiving a prescription is seen as the equivalent of a shamanic ritual having similar healing properties in addition to the pharmaceutical benefits of the drug).

### 6.3.3. Are these practices harmful?

We received considerable evidence to suggest that mental health professionals either did believe, or were perceived to believe; that their patients becoming involved in traditional or faith based healing practices was either a symptom of ill health, or damaging to the wellbeing of their patients. The risk attached to these practices was widely discussed, by all the groups we talked to, including the practitioners of some of the traditional healing practices themselves.

In considering the potential harm that might arise as the result of using these healing practices, it is useful to draw on similar debates taking place in relation to complementary and alternative therapies. In this field, three different 'dangers' have been identified in relation to the risks attached to their use.

- Inherent dangers in the practices themselves
- Dangers arising because people are using them instead of safer and better mainstream medicine
- Dangers arising from the exploitation of vulnerable clients by 'quack' practitioners

#### *Inherent dangers in the practices themselves*

In the field of complementary therapies there has been considerable discussion of the inherent dangers, for example, of liver damage arising from use of some herbal remedies, needle injuries from acupuncture, back injuries and even strokes being caused by the manipulation of chiropractors and osteopaths. In practice, the risk of

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<sup>67</sup>Bird S R (2004) Sticks, Stones, Roots and Bones: Hoodoo, Mojo and Conjuring with Herbs Llewellyn Worldwide, St Paul MN

damage of this kind is relatively rare, and mainly results, as in mainstream medicine, as a result of poor practice and inadequate training. However, a further criticism of many complementary and alternative therapists is that they tend to see their practice as inherently good, if not effective, then at least benign, and thus paying inadequate attention to their possible dangers.

There were a number of areas in which the traditional and faith based healing practices described in this report might be seen, in themselves, as being harmful. For some, they may be seen to promote 'dangerous' ideas, which contribute to the mental ill health of the individual, whether in terms of encouraging the content of delusions (that they are 'possessed' by an evil spirit), or in terms of encouraging the idea that they are inherently 'sinful' or damaged.

Examples of these ideas being present in a delusional form were seen as evidence of this danger. However, anthropologists have noted that the content of delusions will always take on prevailing cultural images, whether these are of possession by spirits, or by aliens arriving by space craft, or electrical influences coming through the ether<sup>68</sup>. Other dangers were seen to be present in the practices themselves, and particularly the sensationalised stories of people, including children, being beaten, starved or poisoned in order to drive out evil spirits. There have also been sensationalised media accounts of human sacrifices or the use of human body parts in the practice of rituals in some traditions. Evidence of the prevalence of either of these sets of practices is still quite limited, but it is relevant to note that the beating of child 'witches' is connected not with 'pure' traditional spiritual practices, but one result of combining traditional with Christian beliefs. Nevertheless, there is concern that, in Africa at least, the treatment of people with mental health problems within traditional or church based 'compounds' is often accompanied with poor living conditions, lack of food, sometimes imprisonment or restriction of movement. It is unclear if similar dangers are present in this country.

One interesting aspect, at least of healing practices originating within African spiritual traditions, was that there is a ready recognition that the power of these practices could be used both for evil as well as for good. The cosmology itself has both good and evil spirits – those working towards the wellbeing of the community, and those seeking to undermine and disrupt this wellbeing. It is partly for this reason that considerable stress is laid on the training, qualities and experience of the practitioner, with a ready acceptance that there were practitioners with less experience, inadequate training, or selfish motives, who might use the practices for harm, to curse as well as to heal. In this respect, these traditions have more in common with medicine, in which the potential of powerful drugs and intrusive surgery is readily accepted as doing harm as well as good, which requires a strong emphasis on appropriate training and a strong ethical code, in which the first requirement is a promise to 'do no harm'.

The faith-based healing traditions, on the other hand, are generally regarded by those who practice them as being of their nature benign, with harm coming about mainly

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<sup>68</sup> Helman, C G ( 2007) Culture, Health and Illness, Fifth Edition, Hodder Arnold, London

through a perversion of these practices rather than being intrinsic to them. A different view might be taken by those outside these traditions, reflected in debates, for example, about whether sexual abuse, are perversions of the Christian faith or an inevitable (albeit extreme) result of some of its central tenets, such as the celibacy of priest. There may be health professionals holding agnostic and liberal views who would regard the notion of seeing mental health as a product of 'sin' as being intrinsically harmful, although as this position is not widely held within the church itself, and a blind eye may be turned to any harmful effects of their practices.

These two different positions towards the potential for harm within their own practices are likely to have rather different implications in terms of their attitude towards regulation, or the adoption of measures taken to minimise risk. Several of the traditional healers we talked to were quite willing to discuss the question of risk and need for regulation: there was much less discussion about this amongst the faith based healers that we talked to.

### *Dangers of delayed diagnosis and treatment*

The problem of people turning to traditional healers when mental health problems first emerged, and so delaying receipt of mainstream services has quite widely discussed, both in the present project, and more widely in the field of 'integrated health' (combining of mainstream and alternative therapies).

In the present project, the problem of delayed diagnosis and treatment is closely tied to the stigma of mental health within some African and Caribbean communities, and the attempts, particularly by members of the family of the person affected, to contain the problem, within the family, and within the community. The central issue, therefore may be less the practices themselves, but the failure by healing practitioners to recognise when the problems they are addressing are within, or outside, the remit of their practices. Better training for practitioners of traditional and faith based healing, which incorporates some western understanding of mental health conditions, together with improved referral pathways to which these have access, is perhaps the best solution to this particular risk.

### *Dangers of charlatans*

It was the last of these risks which was most often discussed by the traditional healers we talked to, with a ready recognition that there were people claiming to be trained in their traditions, who were exploiting patients for their own gain. Healers who advertised through newspapers and leaflets, claiming to 'cure anything and make you rich' were widely seen to be charlatans, and their presence, and practice, regretted.

One factor which enables charlatans to flourish in the UK, which would be harder, at least in the rural areas of Africa in which the traditions originate, is that the healing traditions have been divorced from their cultural and social context, and particularly, from the hierarchical structure through which they are regulated in their original form.

In most of the traditions explored in this study, the selection and training of healers is a long and arduous process. The individual will often be tested against a number of different selection criteria (do they come from a family of healers, do they display signs of healing gifts, do they have the right personal qualities) before being accepted for training, which may last 20-30 years. Once accepted, the healer will be part of a hierarchy, both in terms of the social structure within their family and tribe, and within the healing tradition itself, with their practice only being sanctioned when they are deemed ready. Referral to a healer will be by word of mouth, and be based on the reputation of the healer within their own community.

Operating within the anonymity of a modern western city, these informal regulatory structures no longer apply, and individuals with little training, with inappropriate motivations, can practice with little authorisation, or sanction, from their wider community. It is to address this problem that modern structures of formal regulation, involving 'registers' of validated practitioners, and regulatory organisations, with ethics committees and an oversight of training, able to impose sanctions on individuals who break to rules of their regulatory body, have been established. In the west, these structures were established through law for all medical practitioners during the 19<sup>th</sup> century, and increasingly applied to associated health professionals, including some complementary therapies (i.e. osteopaths and chiropractors) during the latter half of the 20<sup>th</sup> century. Work is still in progress to establish similar, either statutory or voluntary, regulatory structures for many other complementary therapies.

Such structures are not totally lacking for traditional and faith based healing. The international association of Ifa now has an ethics committee, and a register of those practitioners that it recognised as being authorised within its own hierarchy of practice. Unfortunately, few people yet know that they can appeal to such an authority if they feel they have been exploited or mistreated by practitioners within the Ifa tradition, and there remain many other traditions that do not have a similar practice.

Many churches now have some structure in place through which pastors found to be involved in illegal or immoral practices can be disciplined or removed. However, there remains a problem where the churches are small, and training for the priesthood quite limited. Many operate within a culture that makes it relatively easy individuals to make a claim that they have been called by God to a ministry, or to set up their own church.

So the controls against poor practice or against financial, emotional or sexual exploitation by practitioners of vulnerable clients remain weak in this field. For the health practitioners wishing to protect their service users from these risks, the only solution at present is likely to be careful attention to what service users themselves are saying about the practices they are using, combined with some understanding of these practices, such that good, or bad, practices can be identified. This will only happen once information about these practices are more widely disseminated and discussed, and when service users feel safe to talk about their use of this practice without risk of criticism, ridicule, or these being seen as a symptom of their problem.

## 6.4. The potential for dialogue to maximise support for patients

This project has demonstrated that there is a great deal of potential for developing an effective dialogue between healers working within traditional and faith based religious beliefs and practices, and mental health practitioners. However, it would be a mistake to overlook the potential difficulties in establishing such a dialogue.

### 6.4.1. Difficulties in establishing a dialogue

The first challenge in the present project was to establish contacts with potential participants in such a dialogue. This proved difficult; both in terms of the traditional and faith based healers, and mental health practitioners, although the difficulties were in each case rather different.

In relation to the traditional and faith based healers, as already indicated, many work in relative 'secrecy' both because of the nature of the tradition itself, and because of the prejudice, real and perceived, against these practices within modern western culture. Few formal organisations through which contact with local practitioners can be established, many are not based at one location, but visiting England from elsewhere in the world, information about their visits may be passed only by word of mouth. Until we had begun to penetrate some of the networks through which this information was circulated, and built up some trust with key individuals within these networks, we were unable to gain access to these healers.

Even then, communication was often difficult. Phone calls and e-mails remained unanswered, and sometimes only a visit to the place where we were informed that a person was performing their healing activities led to the chance for face to face contact. In many cases, visits of this kind produced no contact. However, we were gradually able to build up a network of information and informants that did lead to a number of useful interviews, as well as to the participation in the action learning group of four representatives of different healing traditions.

In relation to contacts with health professionals, the challenge was equally daunting, in part because of the formal obstacles that had to be overcome. Ethical approval had to be obtained before any interviews could be conducted with either health professionals, or service users contacted via the NHS. The process of obtaining ethical approval was, in some respect, as arcane and obscure to the uninitiated as were the processes of some of the traditional healing practices that we encountered. Penetrating the formal organisational structures of an NHS mental health services and making contact with individuals willing to participate in the research project, and action learning set, was as difficult in its way as penetrating the informal networks surrounding the traditional healers. In the case of the latter, phone calls and e-mails frequently led to no response. Key gate keepers, in our case, in the form of the head of equality and diversity services, were essential before any progress could be made.



In some respects, access to service users was relatively straightforward: a number of community based organisations were happy to help with this, although establishing a group discussion proved a little more difficult. The fragility of funding for these organisations also proved a difficulty as organisations and groups can come and go with some rapidity.

### 6.4.2. Willingness to engage in dialogue

We were very fortunate in the present project in having a small group of individuals, representing health service professionals, traditional and faith based healers, and service users, who were willing to commit themselves to five three hour long meetings, to explore a dialogue between them.

For the health professionals, committing to this period of time was set against a number of other demands on their time, not only from their main professional role, but other, similar, initiatives that were taking place in East London at the same time. It is possible that the response might have been better, had alternative ways of exploring similar issues not been taking place at the same time. However, the presence of a number of initiatives also highlights the fact that, in this Trust, at this time, the idea of finding out more about African and Caribbean culture and its relevance to service users was an 'idea whose time had come', partly because of the size of the African and Caribbean population in the area, the numbers of service users from these communities, and the raising of these issues at a national level by initiatives. This had raised an interest in exploring these issues in the minds of a number of people within the trust and therefore prepared the ground for an initiative of this kind.

For the traditional and faith based healers, too, there was a sense that 'the time had come' when there was a need for greater openness about their practices and dialogue with the mainstream culture. There was a great thirst amongst many that we talked to, for a mainstream culture giving a greater recognition to the riches present in African and Caribbean cultural heritages. The fact that the project took place during the year which saw a number of events marking the bicentennial of the ending of the slave trade, may have been one factor in this.

Many service users from the African and Caribbean communities were also very keen to see a great recognition of their culture, something which coincided with a number of wider initiatives to explore what a more 'African centred' mental health service might look like. Another 'driver' for some service users was a desire for greater recognition of the role of religion, and spirituality, could play in their recovery – again something which was being recognised at a national level by work being undertaken by organisations such as the Royal College of Psychiatrists, Mind, etc. (see Chapter Four).

### 6.4.3. The challenge of dialogue

As we saw in chapter five, the willingness of a group of individuals to engage in dialogue was only the start of a process which was itself very challenging. As already

noted, both mainstream and alternative visions of mental health have within them built in notions of what constitutes 'reality' and the willingness to see one's own 'reality' as being relative, or only one of many equally valid realities, remains a relatively rare capacity.

On both sides, there were times when people were unwilling to bypass their preconceived view of what is 'real' in order to really hear what others were saying – about their practices, their beliefs or their value positions.

## 6.5. Recommendations for the future

This project was inspired, in part, by the recent concerns at the high proportion of mental health in patients from African and Caribbean communities. Explorations of the reasons for this have given, as one contributing factor, the cultural gap between many in this group of service user and service providers.

The project took one aspect of this cultural gap – the lack of familiarity or understanding by many health care professionals with healing resources drawn from either traditional or faith based practices – that some service users might be accessing. We have concluded that a greater understanding of these practices would benefit service users, because it would enable them to talk more freely about the importance that these have for them, and would also indicate a greater cultural sensitivity within services to the needs of service users from these communities. We also conclude that a greater understanding amongst practitioners of traditional and faith based healing practices, as well as amongst the leaders of the religious groups within which these take place, and of western mental health services and what they can offer, would also benefit service users.

### 6.5.1. Promoting greater understanding of one another's healing practices

There are a number of different ways in which this sharing of knowledge and information about one another's practices can be achieved:

- More action learning groups of the kind established in this project could be set up. These would require some investment of resources for administration, facilitation, the cost of a room and catering (sharing food was an important part of the whole exercise) and to cover participants' expenses. It is important to remember that healers are usually self-employed practitioners and hours spent attending a meeting of this kind means a loss of earnings.
- Community based 'dialogues' hosted by community or faith based organisations, to which mental health professionals, faith leaders and service users are invited. We attended one very successful meeting of this kind run by an evangelical church in East London. Such an event could also be run jointly by a statutory agency and a community based organisation.

- Greater involvement from faith based healing groups in ‘chaplaincy’ activities: this might mean encouraging more visits from traditional or faith based healers to service users when they are in hospital, or inviting these to give talks to chaplaincy staff and other health professionals.
- Investment in developing more accessible account of these practices, and of service users’ experience of these practices, through various media, including written word, video or audio recording, photographs. The website that emerged out of this work has gone some way in providing this information ([www.africanhealingforwellbeing.org](http://www.africanhealingforwellbeing.org)). We launched it in a highly successful event in a venue in Hackney. The website is no longer active but can still be found through a link to the Tavistock Institute’s website. There is also an interesting podcast which summarises the work of the Action Learning Set and gives a flavour to the diversity of healing practices available.
- A simple set of guidelines on frequently encountered mental health problems, and how these would be treated by mainstream mental health services could be provided for African and Caribbean faith leaders and members of their churches, particularly for anyone involved in pastoral activities. Such guidelines would ideally be produced as a joint activity by someone working within mainstream mental health services, and within the churches for which they are designed.

### 6.5.2. Communication of positive messages about African cultural and history

This project was welcomed by East London NHS Foundation Trust in part because it communicated a positive message concerning African culture and history. It was, and remains (with the availability of the website) an important symbol that this cultural heritage is not being ignored, and does have a positive place to play within service provision.

Finding ways of communicating these positive messages is far from easy, particularly when it comes to discussion about religious beliefs and practices, or healing practices, rather than the more straightforward ‘symbols’ of food, or decorations. Many of the traditions that are described in this report are not represented by any organisation that can negotiate access for their healing practitioners, or for service users wishing to access these practitioners, within mainstream services. This means that they are largely ignored, even when more mainstream religious practices. The main Christian denominations, Islam, or Hinduism, are represented in some form.

### 6.5.3. Finding out more about the use of these practices

It would probably be useful to gain a better understanding of the prevalence of use of traditional healing by service users, and the role that these play in their life. Surveys of public and patient use of complementary and alternative therapies have had an important role in raising awareness of the frequency with which these are used, and the

fact that it is important for health professionals to be aware of this use. However, it is unlikely that similar surveys concerning the use of traditional healing practices would be very effective, for a number of reasons already outlined – in particular, the close relationship between these and wider spiritual and religious practices and beliefs, and the secrecy related to some of these practices. A survey of beliefs and how this affects attitudes towards mental health might be more helpful, but would have to be handled very sensitively, probably through in-depth qualitative interviews, rather than a written questionnaire. A good understanding of the variations of traditions and practices would be essential prerequisite for such research.

#### 6.5.4. Addressing the question of risk

If there is to be greater information shared about these practices, then the question of risk, and perceived risk, will need to be handled openly, since for many, this does appear to be an obstacle to a greater interest in, and understanding of the various practices and beliefs used. There is clearly already some interest by genuine practitioners of African traditional healing in the establishment of some kind of regulatory organisation. Given the diversity of practices involved, and the lack of existing formal organisations representing the full range of these, this is likely to take some years to establish, although it is worth noting that the international Ifa association already has an ethics committee to which people can refer practitioners whom they believe to be making false claims or practicing unethically.

In the shorter term, probably the most realistic approach to addressing the possible risk to vulnerable patients from those claiming to be authentic practitioners of traditional religions, but who are exploiting people for financial, or other, personal gain, is improved communication and understanding.

If negative messages are communicated to patients generally about these practices, then their use will continue to remain hidden from health professionals' view, and health professionals will have no ability to assess whether they are helping, or damaging, a service users' health and wellbeing. However, communication of some understanding of these practices, including an understanding of what kind of training and preparation an authentic practitioner should be able to demonstrate, will potentially enable service users to make more informed choices about what kind of healers they can turn to safely.

There are already guidelines for people with mental health problems wishing to use complementary and alternative therapies developed by organisations such as Rethink<sup>69</sup>, The Mental Health Foundation, and the Royal College of Psychiatrists<sup>70</sup>. These could be relatively easily adapted include the use of traditional and faith based healing.

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<sup>69</sup> <http://www.rethink.org/diagnosis-treatment/treatment-and-support/complementary-therapies>

<sup>70</sup> <http://www.rcpsych.ac.uk/expertadvice/treatmentwellbeing/complementarytherapy.aspx>

# Appendix A: literature and other resources

## Traditional and faith based healing practices

World Health Organization (WHO) Traditional Medicines, Growing Needs and potential: Perspectives on medicines NO 02, May 2002: WHO Geneva

Overview of use of traditional medicines world wide, and discussion of issues related to safety, regulation and access. <http://www.who.int/medicinedocs/en/d/Js2293e/#Js2293e>

Kola Abimbola (2006). Yorùbá Culture: A Philosophical Account. Iroko Academic Publishers: Birmingham. Good Introduction of beliefs and practices in the Orisa tradition.

Somé, Malidoma Patrice, (1999) The Healing wisdom of Africa: finding life purpose through nature, ritual, and community (London: Thorsons, c1998.)

Adama and Naomi Doumbia (2004) The Way of the Elders, West African Spirituality and Tradition. Llewellyn Worldwide St Paul MN. Explains the fundamental beliefs and traditional village life in West Africa.

African Christianity: Guide to history and development of different churches across the African continent. <http://www.bethel.edu/~letnie/AfricanChristianity/index.html>

Particularly useful section on AICs (African Initiated Churches)  
<http://www.bethel.edu/~letnie/AfricanChristianity/SSAICs.html>

Hoskins, Richard: 'African Independent Churches'; 'Aladura'; 'The Celestial Church of Christ'; 'The Brotherhood of the Cross and Star'; 'Ngunzism'; 'Kardecism'; 'Kimbanguism'; 'Zion Christian Church'; 'The Nazareth Baptist Church' in *The Encyclopaedia of New Religious Movements and Alternative Spiritualities* (Lion Publishing, 2002).

Sue Salas, Imam Asim Hafiz, Khadijah Ziadi and Dr Sushrut Jadhav (2004) Sensitising mental health professionals to Islam: Foundation of nursing studies dissemination series 2004, vol2. No 5. Gives an account of work on increasing mental health professionals understanding and knowledge of Islamic cultures.  
[http://www.fons.org/ns/Dissemination\\_series\\_reports/Diss%20series%20Vol%202%20No%205.pdf](http://www.fons.org/ns/Dissemination_series_reports/Diss%20series%20Vol%202%20No%205.pdf)

Achterberg J 2002: Imagery and healing, shamanism and modern medicine. Shambala, Boston and London.

Reviews recent medical research showing the power of mental imagery often used in traditional healing practices that can help patients both cope with pain and mobilize the healing capacities of their own bodies.

## Traditional healing and Western psychiatric practices

Roy Moodley and William West (editors) (2005) *Integrating Traditional Healing Practices Into Counseling and Psychotherapy: Multicultural Aspects of Counseling and Psychotherapy*, Sage Publications, Thousand Oaks California.

Highlights challenges and changes in the field of multicultural counseling and psychotherapy – and is also a useful guide to a number of traditional healing practices.

Gilbert, J. (2006) *Two worlds: Integration, synthesis or conflict: Psychological perspectives on cultural identity in Africa*. In *Africa on a Global Stage*. Tanya Lyons & GERALYN PYE (Eds). Africa World Press Inc: Eritrea.

<http://www.janegilbert.co.uk/published%20papers/Two%20Worlds.pdf>

Collin . Airhihenbuwa (1995) *Health and Culture: Beyond the Western Paradigm*, Sage Publications, Inc: Analyses of the effect that culture has in determining our perceptions - and expectations - of health care, challenging traditional, Westernized, medical models.

## Spirituality and Mental Health:

Rethink: Spirituality and mental illness factsheet. Discusses what spirituality is, when it can be good or harmful to your recovering and maintaining your well-being, and pointers on how to discuss or assess your spiritual needs with others.

<http://www.mentalhealthshop.org>

Mind: Guide to spiritual practices: A practical guide to things that people can do to explore and express their spirituality, whatever that may be. It also looks at spirituality in relation to mental wellbeing, and highlights the benefits, as well as the possible pitfalls, which it might bring. <http://www.mind.org.uk>

Royal College of Psychiatrists: Spirituality and Mental Health; Leaflet providing guidance for the general public, people with mental health problems and carers, outlining the relevance of spirituality to mental health and mental healthcare, and explains some of the benefits.

<http://www.rcpsych.ac.uk/mentalhealthinfo/treatments/spiritualityandmentalhealth.aspx>

Nigel Copsey (2001) *Forward in faith: an experiment in building bridges between faith communities and mental health services in the London borough of Newham*, Sainsbury Centre. [http://www.scmh.org.uk/pdfs/scmh\\_forward\\_in\\_faith.pdf](http://www.scmh.org.uk/pdfs/scmh_forward_in_faith.pdf)

Nigel Copsey 1997, Keeping faith: Provision of community mental health services within a multi faith context. Sainsbury Centre. Highlights how the taboo mental health staff have around discussion of spiritual beliefs alienates many Asian, African and Afro-Caribbean people.

[http://www.centreformentalhealth.org.uk/publications/keeping\\_faith.aspx?ID=150](http://www.centreformentalhealth.org.uk/publications/keeping_faith.aspx?ID=150)

Caring for the spirit: a strategy for chaplaincy and spiritual health care workforce <http://www.nhs-chaplaincy-collaboratives.com/resources/caringforthspirit0311.pdf>

Engaging hearts and minds...and the spirit, Peter Gilbert, Journal of Integrated Care, volume 15, issue 4, August 2007 Describes a conference set up by NIMHE and the national forum on spirituality and mental health to explore how belief systems can affect people's wellbeing and recovery from mental illness.

Coyte M E, Gilbert P (ed) , Swinton J (forward) (2007) Spirituality, values and mental health. . Jessica Kingsley, Publishers, London. Discusses how the stigma often associated with mental health problems, and the subject of spirituality can be overcome: useful for mental health practitioners, service users, and healers

**Videos:** Both available from the Mind website: <http://www.mind.org.uk/>

Hard to believe: a film about mental health and spirituality (DVD) : This film tells the story of three service users, looking at how their spirituality was regarded within the mental health services they used, and the role that spirituality played in recovery. Publisher: Mind in Croydon, 2005, ISBN: VID04

Evolving minds: an exploration of the alternatives to psychiatry and the links between psychosis and spirituality: This entertaining and empowering video offers giving clear and practical information on a diverse range of ways of coping with psychosis such as nutrition, drumming, Shamanism, Buddhism and psychotherapy. Publisher: Undercurrents, 2004. ISBN: VID02

## Complementary Therapies and Mental Health

Rethink Factsheet on complementary therapies: Information on a range of complementary therapies that might be helpful for people with mental health problems and guidance on choosing a complementary therapist. <http://www.mentalhealthshop.org/>

Royal College for Psychiatrists: Complementary and Alternative Medicines 1: Herbal remedies and supplements and Complementary and Alternative Medicines 2. Physical Treatments.

For people who want to know more about using complementary and alternative medicines (CAMs) for mental health problems and how to find practitioners.

<http://www.rcpsych.ac.uk/mentalhealthinfo/treatments/cam2.aspx>

## Mental health issues and African and Caribbean communities

Mind factsheet: The mental health of the African Caribbean community in Britain: Gives overview of mental health needs of the African-Caribbean community, aimed at students, mental health professionals, carers, users of mental health services and the wider public. <http://www.mind.org.uk>

Sainsbury Centre for Mental health 2003: Breaking the Circles of Fear: a review of the relationship between the mental health services and African and Caribbean communities, Published by the 2. <http://www.scmh.org.uk/>

Department of Health February 2007 Positive Steps: Supporting Race Equality in Mental Health Care, Provides examples of good practice in meeting key mental health issues and religious and cultural needs for different ethnic groups, using needs for South Asian, and African and Caribbean groups as examples.

<http://www.rcpsych.ac.uk/pdf/FINAL%20Positive%20Steps%20guideAW.pdf>

National Institute for Mental Health in England 2005: Count me in: Results of a national census of inpatients in mental health hospital and facilities in England and Wales, giving data on ethnicity, age, gender language and religion. <http://nimhe.org.uk>

Professor S. P. Sashidharan, North Birmingham Mental Health Trust (for the National Institute of Mental Health) 2003: Inside Out: Improving mental health services to black and minority ethnic communities in England.

[http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4084558](http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084558)

Black spaces project: The Mental Health Foundation, Volume 4, Issue 20: Documents the experience of seven Black organization so that Black and mainstream mental health services to benefit from their expertise. Part of their Strategies for Living Programme.

<http://www.mentalhealth.org.uk>

## Other articles and books of interest:

Bhui K, Stansfeld S, Hull S, et al. Ethnic variations in pathways to and use of specialist mental health services in the UK: systematic review. British Journal of Psychiatry 2003;182:105-116

Harpley MS, Hutchinson G, McKenzie K. Understanding the excess of psychosis among the African-Caribbean population in England: review of current hypotheses. British Journal of Psychiatry 2001;178:s60-s68.



Janzen, John M. *Lemba, 1650-1930 : a drum of affliction in Africa and the New World* / (New York : Garland Pub., 1982

King M, Nazroo J, Weich S, McKenzie K, Bhui K, Karlson S, Stansfeld S, Tyrer P, Blanchard M, Lloyd K, McManus S, Sproston K, & Erens B. Psychotic symptoms in the general population of England. A comparison of ethnic groups (The EMPIRIC study). *Soc Psychiatry Epidemiol* 2005; 40: 375-381.

Kola Abimbola (2001). "Spirituality and Applied Ethics: An African Perspective." *West Africa Review*, 3(1): 1-29.

Kola Abimbola (2004). 'Yoruba Diaspora' in Ember, M, Ember, C.R. and Skoggard, I, *Encyclopedia of Diasporas. Immigrant and Refugee Cultures Around the World*, (New York: Kluwer Academic Publishers.)

McCabe, R and Priebe, S. Explanatory models of illness in schizophrenia: comparison of four ethnic groups. *British Journal of Psychiatry* 2004; 185: 25-36

Morgan C, Hutchinson G, Bagalkote H et al. Pathways to care and ethnicity. 1: sample characteristics and compulsory admission. Report from the AESOP study *British Journal of Psychiatry* 2005;186:281-289.

Morgan C, Hutchinson G, Bagalkote H et al. Pathways to care and ethnicity. 2: source of referral and help-seeking. Report from the AESOP study. *British Journal of Psychiatry* 2005;186:290-296.

Steven Feierman and John Janzen (eds), *The social basis of health and healing in Africa* / (Berkeley; Oxford: University of California Press, c1992.) YC.1993.b.1897

# Appendix B: advisory group members

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**Malcolm Phillips:** Director/ Manager, Oremi Centre

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