Somatic and psychological influence of bewitchment and spirit possession: Exploring differing health beliefs with South African Muslim medical practitioners

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Abstract

The biomedical model adopts a view of illness and health from a standpoint that depicts a body and mind distinction. Despite the support this differentiation has received, many cultures incorporate the belief in the concept of the soul or spirit. In various non-Western cultures, illness and health are viewed as stemming from a myriad of interplays between the body, mind and soul. This is evidenced in folklore such as witchcraft and spirit possession, believed to impact on the manifestation of psychological and somatic symptoms alike. These beliefs stem from religious and cultural networks. Islam for example, incorporates witchcraft and spirit possession in its belief system. Medical practitioners are trained in accordance with the biomedical approach that depicts a body-mind distinction. Yet, these practitioners may adhere to a particular religio-cultural belief system that may impact their views of illness and health. This study explores Muslim medical practitioners’ perceptions of illness and health. Content analysis was applied to the transcribed interviews and four categories were identified: understanding of psychological disturbances; understanding of spiritual illness; the impact of religious belief and treatments or healing of illness. This study highlighted the role religio-cultural beliefs may play in perceptions of health and illness. The need to explicitly incorporate the beliefs of people into the biomedical approach was also highlighted.

Keywords: biomedicine; disease; illness; psychological disturbance; religio-cultural; spirit possession; witchcraft

Before the eighteenth century, terminology such as sickness, illness, and disease were used interchangeably to describe human suffering (Jennings, 1986). Despite this interchangeable use, a distinction between the terms exists. Disease can be defined as a deviation from medical norms (Levinson & Ember, 1996) and can be said to be in line with the biomedical model that focuses on observable behaviour and symptoms. Illness, however, differs from disease in that ‘illness is the experience
of impairment or distress, as culturally defined and constructed’ (Levinson & Ember, 1996, p. 5). Illness can be said to depend upon cultural models of health. Kleinman (cited in Kleinman, Eisenberg, & Good, 2006), who initiated the distinction between disease and illness, says ‘illness experience is an intimate part of social systems of meaning and rules for behaviour; it is strongly influenced by culture’ (p. 141). Illness furthermore, is considered to be the cultural expression of the experience, perception and coping mechanisms applied to understanding disease (Kleinman et al., 2006). By this is meant that explanations of disease symptoms may be perceived through one’s social and cultural positioning. Illness is thus the personal experience of physical or psychological symptoms expressed by an individual from within a particular system of thought. Therefore the cause of illness may lie in social and spiritual realms and may include sorcery, soul loss and spirit intrusion (Levinson & Ember, 1996).

The understanding of disease is based on the biomedical approach that does not incorporate the social construction of illnesses. Rather it provides an understanding and treatment for ailments in a manner that focuses on the body and the mind. As suggested by Kleinman et al. (2006), biomedicine adresses the recognition and treatment of disease, thus placing a focus on curing; whereas the treatments of illness (primarily a concern in developing countries) is concerned with treating human experiences of disease. Given that illness differs from disease, the universal applicability purported by the biomedical model is fundamentally flawed. As evidenced by the decision of the American Psychiatric Association (2004) to acknowledge the cultural nuances of an individual in psychological diagnosis and treatment, medical practitioners are acknowledging the importance of holistic health care in the alleviation of disease and illness.

This article aims to explore and highlight the need to understand, diagnose, and treat individuals from within their belief systems. This is essential if one is to holistically treat an individual. With a focus on medical practitioners, the author attempts to understand the role that religio-cultural beliefs may play in understanding physical and psychological symptoms.

BEWITCHMENT AND SPIRIT POSSESSION: THE NEED FOR CULTURAL DIAGNOSIS

Belief in witchcraft can be traced back to early times (Burne, 1914; Hole, 1940) and can be said to be a feature in most societies at some point in their history. Witchcraft can be defined as the deliberate use of magic or enchantment to cause harm to another person (Summers, 1945). In many societies accidents, sicknesses, and death are thought of as being intentionally caused by witches. The symptomatic features of bewitchment include lethargy, lack of motivation, social withdrawal, lack of appetite, intense agitation, terror, sleeplessness and, in some instances, trancelike states (Dein, 1996).
2003; Dwyer, 2003). Individuals experiencing a state of bewitchment may also have their personalities and character controlled by malevolent sorcerers, who do so by taking over the individual’s body (Niehaus, 2005). Failure in business or education can also be ascribed to ‘witches’ by some communities (Igwe, 2004). Therefore a host of psycho-social and physical symptoms are attributed to bewitchment.

The belief in spirits and spirit possession is also rife in many cultures around the world. Stafford (2005) indicates that evidence of spirit possession exists in both Western and non-Western cultures. Symptoms of spirit possession include supernatural strength, agility or self-destructive behaviour, rolling eyes, fetid smells and screams, as well as changes to the personality, physique, and voice (Dwyer, 2003; Stafford, 2005). Evidence also indicates that those recovering from an experience of possession will not remember the behaviour displayed during that period (MacNutt, 1995). Therefore, out-of-the ordinary experiences or altered states of consciousness are typical to the experience of spirit possession. These symptoms are similar to physical and psychological states indicative of a psychological disturbance.

According to Komiti, Judd, and Jackson (2006), ‘individuals who experience psychological disturbances are often confronted with stigma, fear, discrimination and rejection in the wider community’ (p. 378). They are often the victims of some form of discrimination, stigma or prejudice, from either family or friends or from society as a whole. This may inevitably impact on community members’ seeking of help from appropriately trained professionals, such as psychologists. The belief in witchcraft or spirit possession therefore serves a social function by enabling a reduction in the stigma, discrimination, and prejudice faced by those experiencing a psychological disturbance (Igwe, 2004). It fosters an acceptance of their illness as not stemming from individual culpability, but rather from an ‘imbalance’ in society, which is restored once the afflicted person has been released from bewitchment or possession. Such beliefs are inherent to certain cultures across the world. Culture can be said to comprise the beliefs, attitudes, religious belief, and needs of a group of people that enables them to adapt and survive, as well as to pass on these beliefs to future generations, through stories, myths, legends, and folk lore (Swartz, 1998).

In particular, Islamic culture incorporates belief in witchcraft and spirit possession and this is evident in the Koran and the Sunnah, being the teachings of the prophet Mohamed. These are the two main sources of influence in the life of a Muslim.

The Koran states in one verse that one needs to be weary of and seek refuge in Him from the evil that He has created, from the evil of darkness as well as from the evil of women who blow on knots. (The Koran, cited in Abdussalam Bali, 2004). In the Koran God also says: ‘Verily he (the Devil) and his soldiers from the jinn or his tribe see you from where you cannot see them . . .‘ (The Koran, n.d., p. 27). This is provided here as evidence from the Koran of the existence and influences that witchcraft and jinn can have on human beings. Given the acknowledgment of
witchcraft in the Koran, belief therein is most likely to influence the perceptions of health and illness of Muslim individuals.

The second major source of influence in the life of a Muslim is the Sunnah. According to Mawdudi (1985) the Prophet Mohamed was bewitched. He was believed to have walked upon an evil that was set in his path to cause him harm. It is also reported that the Prophet said that seven sins needed to be avoided. Sorcery was amongst those mentioned (Abdussalam Bali, 2004). Underpinning this is that if the Prophet could be affected, then ordinary Muslims could also be affected. Therefore its existence to Muslims cannot be denied.

Symptoms of bewitchment in Islam include changes in physical features, headaches, marital problems, infertility, lethargy, bad dreams, and even hallucinations (Abdussalam Bali, 2004; Ally & Laher, 2007; Eldam, 2003). Psychological and somatic symptoms thus characterise experiences of bewitchment. Spirit possession in Islam takes the form of jinn possession. Jinn are created of smokeless fire and exist in a realm parallel to our own (Ashour, 1993). Even though they are not visible to the naked human eye, jinn are believed to be able to exercise influence in the lives of Muslims. Schizophrenia and mania, convulsions, utterances in strange, unheard of languages, and altered tone of voice, are believed to be the symptomatic features of a jinn possession (Ally & Laher, 2007; Dwyer, 2003; Stafford, 2005). With this stated, it can be suggested here that symptoms resembling the likes of psychological and somatic features are inherent to both experiences of bewitchment and spirit possession in Islam.

Given that Islam acknowledges witchcraft and spiritual influence as a reality, it becomes evident that individuals, who hold this belief system, may believe in the existence of these entities as well as the influence posed by them. Therefore, symptoms that may be diagnosed as stemming from the body and mind from within the biomedical model may be believed to be influenced by spirit possession or bewitchment. In addition, the similarity of symptoms between disease and conception of illness provides a further justification for a need to incorporate elements of the biomedical and the social construction of illness from within the community in question. This will enable a holistic approach to understanding, diagnosis, and treatment.

THE BIOMEDICAL APPROACH: THE PREDOMINANT CULTURAL MODEL?

To biomedically trained practitioners, the symptoms of witchcraft and possession outlined above may point to a specific psychological dysfunction or a medical condition, while in many other societies these symptoms are taken as evidence of bewitchment or the influence of a spiritual entity. Spiro (2005) adds to this by stating that different diagnostic systems may lend themselves to different diagnoses.
For example, a person with schizophrenic symptoms may be called schizophrenic by biomedicine, or seen as bewitched from an African indigenous healing system or even as possessed by the devil in a Pentecostal Church. In addition, ‘Western’ notions of behaviour and experiences are limited in non-Western communities as, for example, ‘there is a tradition among Africans of applying spiritual or supernatural explanations and interpretations to anything that happens . . . misfortune is the spiritual handiwork of some enemy’ (Igwe, 2004, p. 74). Western theoretical explanations of psychological and physical symptoms may thus need to incorporate constructions of illness held in communities where supernatural belief systems provide culturally acceptable understandings (Ratele, Duncan, Hook, Mkhize, Kiguwa, & Collins, 2004).

According to Erinosho (1977) explanations of the mentally ill or physically ailing as possessed by spirits existed from biblical times. However, the emphasis on a spiritual aetiology shifted towards physiological ones as a consequence of scientific growth. This is best expressed in current literature and understanding of mental illness and understanding of mental illness and psychological disturbances that indicate physiological, psychic, social and cognitive experiences and processes as the causes of these disturbances (Sternberg, 2003; Sue, Sue, & Sue, 2003; McWilliam, 1994).

Biomedicine can be regarded as the medicine of the twentieth century Western world and has come to influence health and healing practices of human societies worldwide (Hahn, 1995). The ideal biomedical diagnosis views the body as a ‘machine’ and states the gathering of a specific set of symptoms and signs as indicators of an underlying disease (Swartz, 1998). ‘Disease’ manifests itself as a malfunction in a particular area, while the treatment would imply a focus on a ‘chemical or biological agent specifically suited to attack or render harmless the germs or biological malfunction that caused the disease’ (Guttmacher, 1979, p. 16). One realises that the body-mind distinction purported by biomedicine may not holistically apply in many non-Western communities, as it is evidenced that many people treat their somatic or psychological ailments through spiritual treatments. Ally and Laher (2007) found that Muslim individuals frequent faith healers for the treatment of physical and or psychological symptoms, believed to be the cause of bewitchment or spirit possession. Hindus too, approach Temples and healers with the aim of expelling the effects of bhuts or spirits that can posses the body (Stafford, 2005). In African communities, it is accepted that illness sent by the ancestors or the witches or caused by pollution cannot be treated within the Western system, and it is only when such treatments are unsuccessful that Western services are used (Swartz, 2002).

One has to bear in mind though, that a suggested move away from the biomedical model is not being made. As Boonzaier and Sharp (1988) state, it is not possible to provide a ‘Western’ treatment for ‘Western’ people and ‘non-Western’ treatment for ‘non-Western’ people as in any context multiple resources exist and this enables
different systems of care to adequately address particular problems. Spiro (2005) states that the resources people use to treat illness are not unidirectional. Scheper-Hughes and Lock (1987) inform us that the mind-body distinction is also related to other oppositions in Western epistemology, such as that between nature-culture, individual-society, and passion-reason. Freud (1914), for example, stated that the individual is at conflict within himself, in relation to the domesticating requirements of the social and moral order; Marx (Marx & Engels, 1970) postulated that the natural world existed as an external, objective reality, transformed by human labour; while Durkheim (1915/1961) stated that the body was the storehouse of emotions, that directed human behaviour (Scheper-Hughes & Lock, 1987). However, alternative aetiologies to the predominant Western inclination toward dichotomies of comparison exist and ‘. . . one of these is surely the view that culture is rooted in (rather than against) nature (i.e., biology)’.

Given this and despite the advances that bio-medical scientists have made in their stride to cure disease, culture should not be viewed as dichotomous to scientific notions of understanding disease and (or) illness. To illustrate, Islamic cosmology, encompasses a synthesis of Greek philosophy, prophetic revelations set down in the Koran as well as Judeo-Christian concepts. Islamic cosmology depicts humans as having dominance over nature, yet at the core of Islamic belief, is the unifying concept of Towhid, which should be understood as encompassing all existence as essentially monistic (Scheper-Hughes & Lock, 1987). ‘Guided by the principle of Towhid humans are responsible to one power . . . and the achievement of unity through the complementarities of spirit and body, this world and the hereafter, substance and meaning, natural and supernatural, etc’ (Scheper-Hughes & Lock, 1987, p. 12). In China for example, social transformations and economic reform have seen, as in the West, increased social and mental health problems, including mood disorders and increased suicide rates (Zhang et al., 2002). Despite psychotherapy not having found popularity, Chinese psychiatrists are blending psychiatric theories, often based on Western principles such as individuation, self control and self-efficacy with aspects of Chinese culture. Indeed it is recognised that an approach that combines elements of the body, mind, and soul provide a holistic treatment plan.

Kundera (1984, in Scheper-Hughes & Lock, 1987) states that scientific knowledge is premised in such a manner, that with advances and progressions in understanding disease, one becomes less clear in seeing the world as a whole, because scientific knowledge is divided into specialised areas of knowledge. One can thus state that in order to effectively understand and treat an individual, one has to bring together the divergent views that are purported by different models. Biomedicine has made strides in the past few years, in terms of understanding disease, yet many people still adhere to their belief - which directs the treatment of illness. This understanding comes at a time when an increase in witchcraft beliefs and faith healing practices is reported around the world (Dein, 2003; Smith, 2005). Reports of witchcraft have
emerged in the Caribbean and in Australia (Dein, 2003), Africa, New Guinea, and India (Smith, 2005).

As such, the importance of incorporating both faith healing practices that stem from the individual’s belief system with Western modes of treatment will enable the holistic treatment of the individual. This brings together very different theories and practices that have at their focal point the individual and not the medical system. A solution to this is ‘indigenisation’, where theoretical and methodological frames are combined with the culture in question (Ratele et al., 2004). Furthermore, this is needed given the rapid changes and cross pollination of ideas between people, that have come to characterise much of the twenty first century. Western science can no longer ignore the existence of worldviews other than what has become dominant. What is needed now is for these views to be incorporated into the medicalisation of illness and health.

Given that most medical practitioners are trained in accordance with the biomedical approach, the implication is that understandings of illness would be in line with conceptions of the body and mind. Illness is therefore seen as stemming from a complex interplay of only the body and the mind, when in fact many cultures subvert much causation to aspects of the soul or spirit. One can state that the influence of culture does not surpass medical practitioners. Erinosho (1977) for example, indicated that medical students in Nigeria, regardless of the modernising influence of Western education, believe that mental illness can be influenced by witchcraft. Thus culture can be said to influence the beliefs and thinking of people. Matsumoto and Juang (2004) state that culture may shape the expression of psychological disorders and physical illnesses and may also play a role in the emergence of culture-specific syndromes.

The Diagnostic and Statistical Manual for Mental Disorders-IV-TR (American Psychiatric Association, 2004) also supports this, by stating that unfamiliarity with an individual’s cultural framework may result in an incorrect psychological diagnosis. Despite this however, cultural veneers of the individual are often overlooked when a diagnosis is made.

This study attempted to explore the possible role that cultural beliefs may have on South African Muslim medical practitioners’ perceptions of both, psychological and physical symptoms displayed by a patient. As an aim, this study attempted to highlight the need for inclusion of different systems of healing into the frame of biomedicine if holistic treatment is to be offered.

**METHOD**

**Sample**

A non-probability convenience sample of five Muslim medical practitioners was used. The medical practitioners had different levels of experience with patients,
evidenced by the number of years that they had worked with patients (see table 1). All five medical practitioners were South African Muslims of Indian origin. It needs to be emphasised and acknowledged that the perceptions presented in this article are not solely located within an Islamic culture. Rather, the perceptions presented by the medical practitioners are a combination of different ideas and experiences that originated from Islamic, Indian, and local tradition.

Table 1: Sample demographic breakdown

<table>
<thead>
<tr>
<th>Participant</th>
<th>Years practicing</th>
<th>Gender</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1</td>
<td>8</td>
<td>Male</td>
<td>34</td>
</tr>
<tr>
<td>D2</td>
<td>15</td>
<td>Female</td>
<td>47</td>
</tr>
<tr>
<td>D3</td>
<td>8</td>
<td>Male</td>
<td>32</td>
</tr>
<tr>
<td>D4</td>
<td>3</td>
<td>Male</td>
<td>26</td>
</tr>
<tr>
<td>D5</td>
<td>5</td>
<td>Female</td>
<td>29</td>
</tr>
</tbody>
</table>

Instruments

A semi-structured interview schedule consisting of 24 questions was used. The questions in the interview focused on issues pertaining to the understanding, aetiology, and treatment of psychological and spiritual illness; as well as on the scope of practice of the doctor. A case study that depicted a psychological disturbance formed part of the interview.

The interview schedule was formulated from the results of a study by Ally and Laher (2007), that focused on Muslim faith healers’ perceptions of mental illness in the same community from which the medical practitioners were drawn. This interview schedule was adapted to suit the current study in that some of the questions that dealt with spiritual illness were incorporated, while others were excluded. Others still, were added based on the literature that emerged from the current study, particularly, regarding the disease-illness distinction. The schedule was piloted on one Muslim medical practitioner prior to conducting the interviews. Appropriate changes to a few questions to ensure clarity were required. Once these changes were made, the interview schedule was used in interviewing the Muslim medical practitioners.

Procedure

Medical practitioners were identified and telephonically informed about the study. A request for their participation was made and a suitable time for the interview was arranged. The practitioners were briefed about the study and were informed about the recording of the interview. The practitioners were also informed that their
participation in the study was voluntary and informed consent was obtained. Of the 11 practitioners that were approached, five agreed to participate in the study. All participants were assigned a code, for example D1 or D4. All participants were thanked for their participation.

**Data analysis**

Content analysis was used as an analysis technique, as it enabled the researcher to sift through the recorded data collected from the medical practitioners (Babbie & Mouton, 2005). The process of selective reduction enabled the researcher to focus on specific words/patterns that were indicative of the research questions (Henning, 2004). This technique allowed for the data to be placed into broader categories and for relevant issues to be highlighted. The use of this qualitative methodology is recommended in research of this nature due to the depth of understanding and detail that it elicits (Greenwood, Hussain, Burns, & Raphael, 2000). Of importance to note is that, based on the limited sample size and limited responses received, generalisation of results was not possible. Answers to questions were provided as ‘summaries’ It was therefore not possible to elaborate on the deeper understandings that may have been present. The qualitative information from the interviews could at most be used in a descriptive sense. As such, themes were not identified, but rather responses were arranged according to pre-selected categories. This analytic technique can best be described as ‘descriptive’ content analysis.

The researcher read and re-read the transcribed data to identify common trends. Pre-selected categories were based on the literature that was reviewed. The researcher attempted to link the data to the literature that exists so as to either support or contrast what knowledge exists.

**RESULTS AND DISCUSSION**

The perceptions of the medical practitioners fell into four categories: understanding of psychological disturbances; understanding of spiritual illness; the impact of religious belief, and treatments or healing of illness.

**Understanding of psychological disturbances**

The medical practitioners presented views of psychological disturbances that indicated an educated and academic understanding thereof. This was indicated by responses to the case study presented in the interview schedule, that depicted a manic episode. The medical practitioners identified *mania* (D1; D4; D5) and *manic behaviour* (D2; D3) as reflecting the individual’s behaviour. As D1 (male, 34) stated, *It is clear that Faheem does seem to present err symptoms that can be said to be manic or mania type of behaviour by . . . if you look at how he is jumping around and*
he never did that before . . . Also, . . . you know what, in psychology, you should know this will be seen as a manic form of behaviour and it could be caused by certain umm events or even bodily err changes . . . (D3, Male 32).

It can be stated that the medical practitioners interviewed were aware of and could identify an individual who displayed symptoms of a psychological disturbance-appropriately. As further elaborated, a psychological disturbance was described as having its roots in maybe a childhood . . . developmental problem with err an absence of a parent or maybe abuse. This can affect a child I mean think about it you should know that when a child or anyone for that matter goes through a difficult err say abuse it affects them in different ways and it may be that because of this it is affecting his behaviour (D5, Female, 29); its very possible that a chemical imbalance in the body may result in disturbed behaviour. So in the case of Faheem umm maybe he is taking some form of drugs or also the medication he is on potentially could be err causing the imbalance in the chemicals; a chemical imbalance which is known to affect behaviour (D3, Male, 32) Furthermore, I think that the most important contributor to a psychological condition is the use of drugs or excessive alcohol that err has this impact on the brain . . . which then disturbs behaving (D1, Male, 34).

The implication of this is that psychological disturbance was understood as being caused by a variety of psycho-biological factors that manifested in overt behaviour. These understandings provided by the medical practitioners were similar to conceptualisations of psychological disturbances in the literature (McWilliams, 1994; Sternberg, 2003; Sue et al., 2003). It can be stated that the understandings of psychological disturbances by the practitioners were parallel to current views and trends within the field of psychology. It follows that the treatment recommended for an individual diagnosed with a psychological disturbance would follow the above understanding. As suggested, a person would require professional psychological evaluation and therapy and possibly also medication. But this would have to be pursued by the person in that they would have to commit to a treatment plan which is often more difficult than stated here (D2, Female, 47). This view echoed across the interviews and psychiatric interviews, evaluations, psychotherapy and medication were recommended. Of importance to note is that the practitioners were not forthcoming with information. However, the conceptualisation of psychological disturbances provided was in line with Western theoretical models. This followed logically, based on the medical training received by the medical practitioners.

Understanding of spiritual illness

A spiritual illness was understood by the interviewed as being attributed firstly, to the soul and secondly, to bewitchment and possession.

D1 said, I think that a spiritual illness is more on a personal level between an individual and God. And err prayer is influential in this connection between God and an individual. If you mean witchcraft or spirit possession by spiritual illness
then it involves possession by Jinn which would then try and take control of your thoughts and actions (Male, 34). It was further highlighted that a spiritual illness is a sick soul . . . err deprived of any divine blessings. This would err occur when the soul is possessed by a supernatural force (D3, Male, 32).

A spiritual illness was understood as deriving from religious belief. This can be linked to the literature that indicates that the concept of the soul or spirit has connection with God as a basic premise (Hill et al., 2000; Zinnbauer, Pargament, & Scott, 1999). Further elaboration on this understanding was obtained when the characteristics of a spiritual illness were sought. It emerged from the data that symptoms such as excessive strength, aggression, personality changes, changes in voice, physique and thoughts; vomiting, loss of appetite and unexplained aches and pains were believed to be the symptoms typical of a spiritual illness. These symptoms are however, reflective of somatic and psychological symptoms that may point to a manifest medical condition or a psychological disturbance. As further support to this, it was indicated by the medical practitioners that medical and psychological illnesses can be caused by a spiritual illness. It was the view of one practitioner (D4, Male, 26) that . . . medical illness cannot be brought on by a spiritual entity, but that a psychological illness can. Also, I don’t know about a medical illness because if you think about it one can determine that okay I have an infection or a pain and if you treat it with the right medications it will the pain will recede. But if you take a psychological err the behaviour of a person it may just be like with Faheem difficult to determine if it’s caused by a err physical thing or maybe by a spiritual element (D2, Female, 47). This is interesting as the medical practitioners interviewed, despite their understanding of a psychological disturbance and despite training in accordance to the biomedical approach, depicted a view indicating the presence of the influence of spiritual entities on psychological disturbances.

This may suggest that illness may be conceived as stemming not only from the body-mind dichotomy purported by the biomedical approach, but also that the concept of the soul forms an integral role in the interpretation and understanding of illness, especially psychological disturbances as held by the Muslim medical practitioners.

Further evidence to support this was provided by the medical practitioners who believed that the causes of spiritual illnesses fell within the domain of witchcraft and spirit possession. I have personally seen patients with possession and witnessed their treatments. Witchcraft is mentioned in the Koran and err is practiced in many cultures even today (D1, Male, 34).

This view was echoed by the other medical practitioners, except for the view of one who stated that no, I do not believe in this but it exists but cannot be carried out without God’s will . . . everything comes from God only (D4, Male, 26). Even though this practitioner was not of the opinion that the causes of spiritual illness lay in explanations of bewitchment and or possession states, it was acknowledged that these entities do exist and that through the will of God, can exert an impact
on one’s life. As further stated by D2, yes, I do believe in this err jaadoo and jinn as I err seen many people affected by it and err it is mentioned in religion in the Koran (Female, 47). This may point in the direction of a possible spiritual, other than biomedical belief held by medical practitioners from diverse cultures regarding illness and health. This belief can be said to stem from religion.

Impact of religious belief

The medical practitioners who were interviewed indicated that witchcraft and spirit possession are mentioned in the Koran and that the prophet Mohamed was affected. Mawdudi (1985) states that two primary sources of influence in the lives of Muslims are the Koran and the Sunnah (teachings of the prophet). It can be said that because the Koran and the Sunnah indicate evidence of witchcraft and bewitchment, these beliefs may impact on the perceptions of illness held by the medical practitioners. This was most evident in the influence jinn and witchcraft has on psychological disturbances.

Based on this, it can be derived that the concept of the soul or the spirit seems to be integral to the understanding of health and illness as evidenced by the responses from the medical practitioners. Furthermore, as indicated by Erinosho (1977), the influence of religion in the lives of medical students cannot be understated. It was identified that medical students held beliefs indicative of the influence of witchcraft, believed to manifest in ways typical of a biomedical understanding. An assumption held about persons in the medical profession, is that they adhere solely to the training received, which more often than not, is reflective of a biomedical approach.

Method of healing

For the symptoms of a spiritual illness, of which psychological and somatic symptoms were provided as descriptors, the method of healing was attributed to the concept of the soul, that is spiritual healing was recommended by all medical practitioners. As indicated by D1 (Male, 34), . . . once identified err especially in the case of spirit possession, the patient can be referred to certain gifted persons who can relieve them of their problems. These persons will read from the Koran or they will use certain things like maybe lobaan (incense). This was highlighted by Ally and Laher (2007) who found that faith healers would be approached by persons who were referred to by medical practitioners, as the medical treatment was proving ineffective to the patient. The importance of this acknowledgment of the role of faith healers or gifted persons by the medical practitioners suggests again that different communities will have different understanding and interpretations of illness, based on the interplay of religious and cultural beliefs. The implication of this is that any treatment that purports only to a particular theoretical position may not yield holistic
and consequently, effective treatment. Thus, diagnoses can be said to determine the choice of treatment pursued by an individual.

**Collaboration with faith healers**

Collaboration with alternative methods of healing was indicated by the medical practitioners who stated that *first exclude any medical or psychological conditions and then send the patient to a spiritual healer* (D3, Male, 32). It was further stated by D2 (Female, 47) that *by a combined effort of both medical and non-medical interventions the person will err be relieved of the illness they are experiencing*. These views point in the direction of possible collaboration of healers and gifted persons with non-Western practitioners (healers and gifted persons). This is similar to the findings from Ally and Laher (2007) that Muslim faith healers acknowledged the important role played by the medical profession in assisting patients.

According to the faith healers, because spiritual illnesses manifest with somatic or psychological characteristics, it is important to rule out a medical diagnosis as aetiology. This view was echoed by the medical practitioners who stated that *as there is no clear cut distinction between jaadoo (bewitchment) and all these things my opinion err is that a combination therapeutic approach should be undertaken. So the person who believes that he is affected by jaadoo should also go to a doctor or a psychologist and this will give them the opportunity to be diagnosed on two levels* (D2, Female, 47). Consequently, it can be said that in order to reduce the confusion between the various paradigms, attempts to blend Western theoretical frameworks with the unique elements of the culture in question should be pursued (Mkhize, 2004).

**CONCLUSION**

This study elaborated on the understanding and perceptions that five medical practitioners presented regarding psychological disturbances. Even though the practitioners were not forthcoming with the information they provided, the following can be stated: First, it showed that the participant Muslim medical practitioners shared similar understanding of the aetiology of psychological disturbances that ties in with trends in psychology. Thus, if a patient does present symptoms indicative of a psychological condition, it can be assumed that the appropriate interventions would be suggested. It is obvious that this understanding follows the biomedical training received by the practitioners, which highlights influence of a Western model of application. Second, this study highlighted the role that religious belief plays in perceptions of health and illness, regardless of exposure to alternate schools of thought. It is assumed that if one is to provide a holistic treatment plan for the patient, contextual and local beliefs of the patient or community have to be incorporated into
the traditional biomedical treatment and diagnosis. Given that most of the medical practitioners who participated in this study believed in the somatic and psychological influence of bewitchment and spirit possession, it follows that collaboration of theories may be needed. That is, Western conceptions of what constitutes science need to be aligned with ‘cultural science’ if one is to effectively understand and treat patients.

RECOMMENDATIONS AND LIMITATIONS

This research is limited in that it only focused on five Muslim medical practitioners. This is limiting as the practitioners were not forthcoming with their responses and did not provide sufficient elaboration on the issues presented. Given the sample size and the amount of data collected, generalising the results of this study would not warrant any validity.

More important than generalisation, this study should be used as a platform from which future studies of the medical profession, from the standpoint of religion and culture, should be undertaken. It is hoped that this study opened the avenues for future research.

NOTE

1. The case that the practitioners refer to in the results section is based on their analysis and understanding of the case study presented to them, and is not of actual patients.

BIOGRAPHICAL NOTE

Yaseen Ally has an MA Research Psychology degree from Wits University. Currently pursuing a PhD in Psychology at Unisa, his research interests include religion, culture and psychopathology, gender-based violence, psychoanalytic theory as well as the social experience of bewitchment. He is currently employed as a junior researcher at the Unisa Institute for Social and Health Sciences.

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