British Journal of Psychiatry (1986), **149**, 145–155

Review Article

Witchcraft and Psychotherapy

J. S. NEKI, B. JOINET, N. NDOSI, G. KILONZO, J. G. HAULI and G. DUVINAGE

Belief in witchcraft, which serves a variety of social functions and personal defences, is bound to emerge in psychotherapy with individuals from a culture that holds such beliefs; endeavouring to understand it can open up new therapeutic possibilities. The nature of witchcraft, the profiles with which it intrudes into therapy, and the socio-psychological functions it fulfills are considered. Referring such patients to witchdoctors is morally unjustifiable, but the witch-doctor's folk-image provides a floating transference, around which the therapeutic relationship can be built. In dealing with witchcraft-ideation, understanding is based as much on cultural as on personal empathy, and to enhance its relevance, therapy may appropriate some of the functional dynamics of the witchcraft system into its own therapeutic manoeuvres.

Increasing emphasis on availability and accessibility of mental health services to all populations in the developed world has brought into focus the centrality of racio-cultural interests. The training of the Western therapist does not equip him adequately to empathise with the attitudes and beliefs of cultural minorities, and it is being increasingly felt that white therapists should have some practicum and internship experience in black communities (Butts, 1972; Vontress, 1974). This is tenable *mutatis mutandis* with regard to any ethnic minority anywhere, and in developing countries, many of the strategies and techniques of Western psychiatry, especially those of psychotherapy, do not seem to be relevant to their belief systems (Pande, 1968).

Witchcraft-ideation stands out prominantly among such beliefs. A Western-trained psychiatrist experiences much difficulty in dealing with it, and therefore tends to dismiss it as 'one of those primitive superstitions'. By doing so, he may block the opportunity to discover the dynamics that might be causing, shaping, elaborating, or repressing symptoms. In therapeutic work, we have often encountered witchcraft-ideation, and believe that if one tried to unravel its dynamic significance, new therapeutic possibilities might emerge.

The authors are a multi-national team, engaged in psychotherapy with the Bantu population. Three (NN, GK and JGH) are native Tanzanians; JSN is an Indian psychiatrist who has worked in Africa for nearly six years; BJ a French national who has been a priest cum psychologist for 20 years in Tanzania; and GD a German clinical psychologist, working in Tanzania for over two years. We, therefore, bring together a variety of cultural perspectives—Western, Eastern, and African. By virtue of cultural contrast the non-Africans among us can more easily identify culturally significant phenomena in their Bantu patients, and offer hypotheses about them; their local counterparts provide the corrective feed-back from their indigenous vision.

What is Witchcraft?

Reviews of witchcraft are already available (e.g. Evans–Prichard, 1937; Robins, 1959, Parinder, 1963), so that we will only try to highlight those aspects which seem most relevant to our discussion. There are some differences of opinion about the definition: while most lexicographers (e.g. Little, 1956) do not distinguish it from 'sorcery', many anthropologists in fact do so. Evans–Prichard (1937) and, following him, Middleton & Winter (1963), Beattie (1964), Harwood (1970) and Mair (1974) among others, (especially those who have worked in Africa), make a distinction between the two terms. Witchcraft is defined as a 'mystical and innate power which is used by its possessor to harm people'; while sorcery is defined as 'evil magic against others' employing herbs, medicines, charms, etc. Yet there are other anthropologists, e.g. Raum (1967) who use the two terms interchangeably; in fact, these have been employed in a thoroughly chaotic manner, even within a single symposium

(Middleton & Winter, 1963). Many African tribes make a linguistic distinction between the two concepts: Kiswahili, for example, has the expression *ulozi* for witchcraft and *uchawi* for sorcery, while the same distinction is made by the Akan, Ashanti, Azande, etc. However, we propose to subsume both these terms under the rubric 'witchcraft', because both represent culturally appropriate responses, which function as alternatives in the same kind of situation (Farke, 1962), co-exist frequently in the same society (Harwood, 1970), and provide habitual explanations for misfortune (Lewis, 1976).

Witchcraft is a theory of causation: it does not deny natural or empirical causes, but seeks supernatural ones behind them. Two questions can be asked in the context of every misfortune: 'how' did it happen?, and 'why' did it occur at all?. The 'how' is answered by empirical observation; the 'why', *inter alia*, by witchcraft. Even if our scientific understanding of the 'how' increases, it will still not be able to dispose of the 'why' of a misfortune. Hence, the two beliefs may easily co-exist.

Figure 1 illustrates the place of witchcraft in the system of causality. Witchcraft shares this hierarchical position with sorcery, cursing and the evil eye. A witch-dominated world is essentially a closed world, where persons and human relationship and more important than material good, where everybody is somebody, and where moral identity prevails and group values receive emphasis. Two kinds of person threaten this closed world—the deviant and the alien—who are the sources of evil, since they may well be witches.

A witch is believed to carry out her art in secret, especially at night. The practice is socially proscribed in almost all African tribes, and anyone discovered practising the black art, is punished, ostracised, or even killed.

As a system, witchcraft can absorb empirical causality, and can also absorb and explain many of its own failures by virtue of what Evans-Prichard (1937) called 'secondary elaboration on belief'—successes will be remembered and failures explained away. An analogous situation can be discerned in psychoanalysis—if you accept an 'interpretation', well and good; if you don't, 'denial' is presumed to be at work. "Direct assault on a closed system of ideas is not easy, since the system absorbs the attacks and converts them to strengthen itself" (Gluckman, 1966).

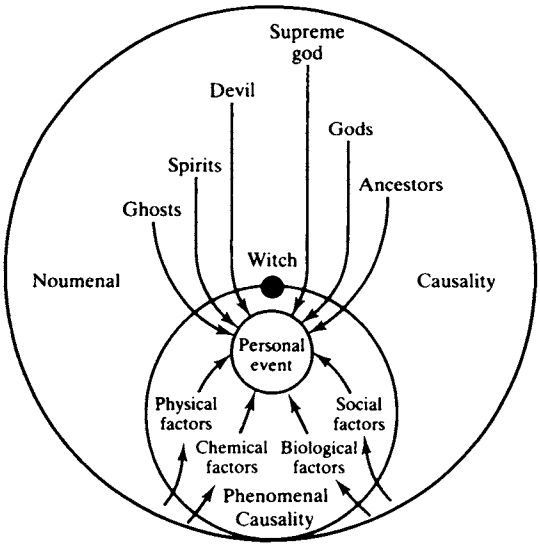

FIG. 1 The place of witchcraft in the system of causality. The witch sits on the borderlands between the two, and is human in form (thus subject to intuitional causality) but imbued with supernatural power (and hence wields noumenal causality).

Witches and anti-witches

The African witch is quite distinct from the European version in having no truck with the Devil and not holding Sabbath assemblies. In certain tribes, however, there is something like a Sabbath assembly, where the 'witch' is believed to ride snakes and hyenas. In fact, an African witch may not even be aware that he/she is one, until beginning to bring misfortune to those wished ill. It is the use of witchcraft, and not its mere possession which is despised by African tribes.

Three types of witches have often been distinguished: (i) *Stereotyped* or 'night' witch, with a cosmic dimension of evil, flouting all the rules governing property, sex, law, and decency. (ii) *Presumed* known about and feared by everyone, but somehow left alone. These include unpopular, asocial, arrogant people, as well as those with a staring gaze, with abnormal and ugly features, of mixed descent, and very advanced age (who have lived so long 'by virtue of witchcraft'). (iii) *Accused* indicted to have caused a misfortune; generally an avowed enemy or rival of the accuser.

In fact, these are not three different types of witches, but three stages of the process of witch-naming. Since witchcraft is not necessarily a voluntary act, and can even be exercised in sleep, without the person knowing it, no account is taken of the accused's denial of guilt or of any defence. Advantage always lies with the accuser.

The antiwitches or witchdoctors are benevolent witches, whose powers are superior to those of the malevolent, whom they can contain and control; through the power of oracle or divination, they can identify the malevolent witch responsible for a given act. They can also exorcise an evil spirit through their mystical power, ritual, or medication. They may be able to forewarn through foretelling oracles, and even intercede between the mortals and the spirit world; they have a medley of procedures at hand—rituals, spells, charms, potions, and even jugglery.

There is no clear distinction between a witch and an antiwitch, except intentionality. However, the witch-doctor is generally an intelligent person, competent in ritual knowledge, and convinced of the power of witchcraft and of his own powers. As he can bring harm to a man who is doing a moral wrong, he is held in great awe. In most of Africa, witchcraft is believed in not only by the uneducated and semi-educated, but also by well educated people—even doctors and scientists.

Emergence into Therapy

With the African, witchcraft ideation is a pervasive background belief which turns into a cognitive reality in times of stress. It may well be present at the very outset of therapy, having been generated prior to it, or may be unleashed by the therapeutic process itself. It may, at times, even be occasioned by the therapist who, on account of his appearance and demeanour, gets identified with the witch-doctor, or it may be part of the symptomatology of mental illness itself.

It generally emerges in one of the following ways:
(i) *As an explanation for all kinds of misfortunes* e.g. frustrations of life, failure in love, lack of success in business or examinations, or losses or deprivations of any kind. It may be spontaneously verbalised or brought out by encouragement. Sexual difficulties such as impotence are especially prone to be explained as caused by witchcraft. Prince (1966) reported that Yoruba males often dream of an assault against their genitals; alternatively, a witch is believed to have used an individual's penis in order to consort with his wife or with another woman, and then returned it in an altered and functionless form. Women consider witchcraft to be the prime cause for drying up of their breasts, for frigidity toward their husbands, and for sterility.

Witchcraft may also be a preferred explanation for bodily sensations such as the paraesthesiae of peripheral neuropathy and the phantom limb phenomenon after an amputation. It may also be the presumed cause for physical or psychic illness, ruptured social relations, physical disaster, and natural catastrophe.
(ii) *As a cause of the presenting symptomatology itself.* Actual or presumed bewitchment often generates intense anxiety and apprehensive foreboding. The physical and psychic symptoms that it produces only tend to confirm the suspicion and power of witchcraft, and further strengthen apprehension: a vicious circle sets in, and apprehension spirals up. Bewitchment anxiety, if unrelieved by traditional countermeasures, or if such measures are unavailable, may develop into "malignant anxiety" (Lambo, 1962), which may even lead to death, in a way that can be likened to 'vodoo death' (Canon, 1957). Occasionally, there is 'boomerang witchcraft': that practised on someone else having failed, the attempter begins to believe that the other person has superior powers, and might play counter-witchcraft. Patients with anxiety generated by suspected or boomerang witchcraft often look pale, sickly, and terrified, and are often perplexed or even confused. They verbalise their terror characteristically as 'a ghost has hit my heart'; 'a dragon is choking my breath', 'my life is being sapped away', etc. The onset is often traced back to some 'unusual' event, e.g. the skin of a snake lying outside one's door, or seeing a dead body in a dream.
(iii) *A symptom of illness.* The content of delusions is known to be subject to pathoplastic cultural influences and amongst people who believe in witchcraft, delusions of witchery are commonplace. The mentally ill, as much as the healthy express themselves in the idiom of their culture. A paranoid patient in the West may talk of people harming him through radio-waves, microwaves, or laser beams, while one from a witchcraft-believing culture will complain in witchcraft terms. In the latter, the complaint of witchcraft as such may not be clinically significant, but the embedded complaint of being persecuted is (Leighton, 1982). Basher, a Sudanese psychiatrist, said that to diagnose delusional witchcraft ideation, you have to "look for the knight's move" (Savage *et al,* 1965); in other words, there is some oddity which other members of the patient's cultural group sense in the patient, and do not consider to be identical with familiar witchcraft ideas. An astute clinician is generally able to distinguish between culturally prevailing non-delusional fixed beliefs and the delusional symptomatology of a pychosis, expressed in witchcraft terms. The delusional ideation of witchcraft is often mistaken as superstition, but a distinction has to be made between simply 'superstitious' and 'basically delusional' beliefs. Table I presents the distinguishing features of the two.

TABLE I
Differences between delusional and non-delusional witchcraft ideation

Non-delusional Witchcraft Ideation	*Delusional Witchcraft Ideation*
1. Little accompanying symptomatology – at most, symptoms of anxiety and apprehension, which seldom assume psychotic dimensions.	Symptoms of a psychotic disorder almost always accompany. These often include hallucinations and loss of contact with reality.
2. Symptoms generally subside after a diagnostic divination and prescribed corrective measures.	Symptoms remain unabated, even after a diagnostic divination and observance of prescribed corrective measures.
3. Accompanying behaviour defensive and guarded; often considerable reticence in expression witchcraft ideas.	Accompanying behaviour may openly be vindictive and hostile; e.g. acting on hostile impulse and assaulting the person who is suspected to have effected witchcraft.
4. Considerable acceptance of the patient's ideation by his social milieu.	Only a partial and often sceptical acceptance of his ideas by the patients' family and others around him.
5. Ideas seldom, if ever, get generalised and systematised, but may become vague and dissipated.	The ideas often tend to get generalised as well as systematised.
6. Ideas of witchcraft seldom appear suddenly. 'Evidence' accumulates over a period of time before crystallising into definitive witchcraft ideation.	Witchcraft ideas may suddenly descend 'like a bolt from the blue', thereafter showing secondary elaboration.
7. Ego-syntonicity of the ideas comparatively less rigid.	Ego-syntonicity is firm and rigid, and unamenable to influence.
8. Patient usually shows considerable concern about having been bewitched.	Patient may show a weird unconcern with his witchcraft-delusions, much like 'double orientation'.
9. Social withdrawal is circumscribed, i.e. only from the suspected person.	May be much more generalised social withdrawal than from the suspected person alone.

(iv) *As feigned or malingered.* The patient is consciously aware that no witchcraft has actually been practised, but feigns it, and imputes it with clandestine intention to some specific person; i.e. there is no real victim of witchcraft, but only a victim of imputed witchery. Such behaviour is indulged in generally for the purpose of 'distancing' from a person whom the patient finds emotionally offensive, but socially inescapable.

Sociodynamics

(a) Instrument of moral suasion

Witchcraft belief is a potent instrument of moral influences and checks members of the community from transgressing its moral codes. The fear that a transgression, even an inadvertent one, can lead to punishment through witchcraft keeps people from infringing taboos and moral sanctions.

It is not unlikely that 'guilt', 'shame', and 'fear of witchcraft' are prototypes of one another, in different cultural settings. In cultures with 'internalised' moral controls, *guilt* feelings are unleashed by moral transgression. In other cultures, where social controls are, by and large, external, *shame* is generated. In yet others, where such controls are supposedly exercised by 'supernatural' forces, *fear of witchcraft* and allied phenomena (hex, sorcery, etc.) tends to appear.

(b) Control of aggression and ambition

It is believed that one who attains any 'glaring success' comes 'into the people's eyes'; others

https://doi.org/10.1192/bjp.149.2.145 Published online by Cambridge University Press

become jealous of him, and may try to undermine his success and achievement. Therefore, people must try to keep their ambitions under check, and not outbid their neighbours, or it will evoke jealously, which, in turn, evokes witchcraft—'jealously comes first, witchcraft later'. A person who is exceedingly successful in life is suspected of possessing witch-power himself, while other aggressive tendencies are also believed to evoke counter-measures in the form of witchcraft.

The witch as a scapegoat also becomes an outlet for repressed aggressiveness of the group. In general, Bantu society represses aggression, permiting this, at best, to be symbolically expressed in joking relationships, and dances. However, it can occasionally gain a real hold upon a socially acceptable target: a thief, if caught, is often beaten to death on the spot, and so is a person accused of witchcraft.

(c) Solving relationship difficulties

Interpersonal relationships, especially within the extended family, are fraught with tensions of all kinds, which may exist between relatives who cannot be informally distanced. Imputation of witchcraft brings about a formal distancing, where this had not been possible—generally within the family—but it may also be employed for distancing real or suspected 'enemies'.

(d) Guide for action in disaster

In times of disaster, an oracle or divination is resorted to, which not merely serves to diagnose the presence (or otherwise) of witchcraft as the cause of disaster, but may also prescribe counter-measures to be taken. It thus provides guidance for action and thereby mitigates suffering.

Psychodynamics

(a) Ego-defence mechanism

Witchcraft is a socially accepted explanation, not simply for personal misfortune, but also for failures and weaknesses: a student failing an examination, a businessman incurring losses from indiscreet investment, a drunk driver causing an accident, a hunter unable to shoot any game may all impute their 'bad-luck' to witchcraft. Goldschmidt (1977) gives an instance of a Sebei young girl who 'cried the knife' when she was being circumcised for her initiation, and refused to let the operation be completed until she was held down forcibly; he had expected that she would have remorse over her behaviour and go into 'deep depression and self-hatred'. However, nothing of that sort happened, for the culture had provided her with an institutionalised ego defence: she knew who had made her 'cry the knife'—it was a man whose advances she had rebuffed, and who had performed witchcraft. Witchcraft ideation, as a coping mechanism, enables one to shelve responsibility for personal failings, and is a reason why feelings of guilt are so rare among believers in witchcraft.

It may also involved the dynamic of scapegoating. If witchcraft imputations are readily accepted by one's social milieu as a semi-serious alibi for personal failings, then witchcraft acts as a buffer against social sanction. However, if the imputation is taken seriously, and leads to a witch-hunt, it can end in catastrophic scapegoating.

(b) Institutionalised distrust and jealousy

Behind the ideation of witchcraft often lie distrust and jealousy, both of which appear to prevail in a veiled way throughout the social substratum, but during times of stress, these become unveiled in the form of bewitchment imputations. Alternatively, an individual presumes himself to be the victim of witchcraft because he disturbed the social harmony, by getting out of step with the others through high ambition or extraordinary success. In either case, witchcraft ideation serves to repress jealously and to preserve the adjustment of individuals to their social milieu. In another way, it actually institutionalises distrust. Goldschmidt (1977) found validity for this conclusion among the Kamba of Kenya, who are highly *gynophobic* men, hating and distrusting their wives with institutionalised fervour. Since it is considered bad for the man to give sexual satisfaction to his wife, the result, deriving no doubt from 'affect hunger' on both sides of the bed, is a great deal of clandestine extramarital sexual activity. The men who do not give their wives satisfaction seek and satisfy other men's wives, yet beat their own wives for being involved with other men. No wonder, they are all afraid of witchcraft from their own wives.

Much of the imputation of witchcraft is focussed on members of one's own family or immediate neighbourhood: co-wives out of envy, neighbours out of malice, and spouses out of spite, are easy targets. In fact, it is always 'the enemy within the gates', hiding behind the mask of kinship and friendship, that becomes the easiest target; it is the person with whom the ego's relationship is incorporative and not just transactional (Harwood, 1970).

(c) Externalised super-ego

Belief in witchcraft makes for externalisation of super-ego: children are sensitised to react to others. There is a double-pronged sensitisation—to those whom you trust and to those whom you do not: the former will put you to shame if you are found transgressing the social norms, while the latter will make you the victim of witchcraft. Whether it is shame about ridicule or fear of witchcraft, both these modes of functioning of the super-ego are external; there is no internal referrent—no feelings of guilt or sin. Many African languages have no word for 'sin' or 'guilt'—though they have for 'right' and 'wrong', 'good' and 'bad'. "This is not due to poverty of languages, but to the fact that the concepts expressed by the European words—'sin' and 'guilt'—do not exist in African thinking" (Castle, 1967).

With the African, "An act is not sinful until it is discovered by another person; there are no secret sins in African concepts of sin. It is not sinful for a girl to sleep with a man so long as they are not discovered by someone else... sometimes, however, 'sin' will manifest itself through sickness, psychical disturbance or other form of misfortune and people begin to trace the effect to its 'cause'" (Castle, 1967). This 'cause' may be a breach of customary behaviour, and if the interests of a third party have been injured in the process, fear of witchcraft will ensue.

(d) Relieving fear of the unknown

Misfortunes, if unexplained, cause tremendous anxiety because it is not possible then to take any remedial or preventive measures. However, through oracles and divination, one can know the cause: it may be witchcraft, an evil spirit, or a displeased ancestor, once the cause has become known, suitable measures can be taken.

(e) Denial

If one has really indulged in witchcraft, one is bound to deny it, out of fear of the consequences, but even in the case of a false imputation, one may be approached by the 'victim' to remove the spell. One may not deny having indulged in the practice then, for fear that one would not be believed, but might acquiesce in doing what is requested, perhaps, entering into a blood-contract with the 'victim' that he will keep the whole affair a secret. Thus, the imputed person, may be led into believing that he is really in possession of the power of witchcraft.

Management in Psychotherapy

Witchcraft ideation is so 'other-worldly' to Western psychotherapy that little room can be found for it in the latter's conceptual framework and techniques. Unfamiliarity with the nature of witchcraft concepts, their dynamic significance, and their social function, coupled with his own inability to manage them may force a Western therapist to retreat and perhaps refer the patient to a witch-doctor (Jilek & Todd, 1974). However, this is not always in the patient's best interests: the anti-witchcraft ceremonial remedies prescribed by the witch-doctor are often exactingly expensive, and in any case, referral is undesirable on moral grounds. Witch-doctors generally identify and 'name' a witch; this stigmatising fosters "labelling, mistrust, prejudice, ostracism and killing of persons who are guiltless of the crimes attributed to them" (Leighton, 1982). Also, there may well be a psychotic or neurotic condition behind the facade of witchcraft-ideation, which is outside the competence of the witchdoctor. The therapist-psychiatrist, therefore, should not shirk his responsibility, but rather enlarge his therapeutic competence to deal with witchcraft ideas, should these emerge in therapy.

Most Western therapies are essentially hidebound within Western culture, and conditioned to specific theoretical frameworks. "More than a phenomenon, it (Western psychotherapy) is a cultural institution of this (Western) society, deriving its roots from it and, in turn, affecting and transforming the soil and era in which it thrives" (Pande, 1968). It is therefore important for a Western therapist working in non-Western cultures to be aware of the ethnocentricity of the techniques he has learnt. What is required is a pliable, strategic therapy, able to function in diverse cultural moulds. The basic requirement is a therapist who should have the ability to work with diverse world-views, keeping his own under control, and not letting it intrude unnecessarily into the patient's.

This can be called *strategic therapy:* it has often to be carried out expeditiously, but at the same time cautiously, to be launched in the hostile territory of mistrust; and must focus on the here and now of the patient's problems, with neither the time nor the inclination to resurrect presumed causation in the dead past. It has to adopt realistic goals and avoid quixotic confrontation with the culture it faces; it chooses to be 'directional' or 'non-directional', as therapeutic exigency demands. it recruits allies, e.g. the patient's family, to further its objectives. The keynote of its theoretical orientation is relevance, with responsiveness to the patient's needs and

problems—the immediate ones first. Its operational mode is flexibility—maintaining an orientation compatible with the patient's and employing techniques with which he/she is not altogether unfamiliar.

Management of mistrust

Discussing the dynamics of therapeutic relationship in its cultural perspective (Neki *et al*, 1985a), we have observed that a patient tends to clutch at the most relevant of the 'floating transferences' in his social milieu. Thus, an African patient who believes in witchcraft tends to identify the therapist with the witchdoctor, to whom he seems to have an ambivalent attitude. "There is always a certain ambiguity regarding the status of the witch-finder, which is evident in the ambivalance with which Africans perceive them... Witchfinder and the witch share the same shadow world" (Sow, 1980) Paulme (1954) reports that the Kissi of the Guinea forest, where the witchfinder is identified with the witch, ask "how... would the witch-finder recognize witches and how would he combat them if he himself were not initiated into their secrets, if he himself were not a Kuino, a killer and eater of human flesh?" Thus, the African fears the witch-doctor as much he trusts him, and this ambivalence is easily transferred on to the therapist, who is also 'powerful and mysterious'. To this, is added the patient's distrust of hospitals in general and his lack of motivation to see a therapist. The therapist's foremost task, then, is to conquer the patient's fears and strengthen his trust. This has to be achieved rapidly, but any lack of tact undermines trust and reinforces suspicion; the therapist has to be cautious, yet natural. The patient's transference may swing to the extremes of both positive and negative, which needs deft handling.

In the West, it is customary for therapist and patient to sit in close proximity with one another—side by side, or face to face—with nothing intervening between them. However, most African patients would panic if the therapist sat next to them; it is important to let the patient sit opposite the therapist, across a table; even then, he will often draw his chair further back, to increase the distance. Careful spatial moves by the therapist, empathically monitored to patient-readiness, can bridge this distance and eventually bring about the desired proximity.

Notwithstanding the views of Sommer (1969), who considers this to be characteristic of competitive confrontation, we prefer an initial across-the-table meeting with the patient. Gardin *et al* (1973) maintained that this arrangement increases the chances of eye-contact, and signals liking, rather than competitive confrontation; the table provides a buffer of security to the suspicious, hostile, mistrusting or even ambivalent patient. Since there are great individual differences in patients' responses, each response should be mentally evaluated on a hypothetical scale of 'immediacy behaviour', i.e. interpersonal distance, amount of eye-contact, forward lean, and direction of shoulder orientation (Mehrabian, 1972). Exline & Fehr (1978) have experimentally confirmed that subjects reciprocate the immediate behaviour of interviewers, and further spatial dynamics must rest on mutual reciprocity.

One set of such moves are described here, as an example: although the therapist sat face-to-face with the patient, the latter, who was suspicious and distrustful, pulled his chair back and moved it to one side, to avoid direct confrontation. The therapist waited for a while before making his next move, trying to allay the patient's fears. After a short while, the patient was less ill at ease; he drew his chair closer to the table. Watching this, the therapist moved his chair sideways, so as to be face-to-face with the patient once again. As the interview continued, the patient began to lean forward on the table; then, the therapist, and following him, the patient, began to put their hands on the table. A little later, the therapist shifted his chair to bring it by the side of the table, sitting diagonally rather than in front of the patient; he thus created greater proximity with the patient, but left the corner of the table jutting in between the two of them so as not to reactivate the patient's much allayed suspicion and mistrust. As the interview further warmed up, and the therapist sensed further closeness, he chose an appropriate occasion to let reciprocal (and culturally acceptable) body contact be established, by stroking his hand over that of the patient.

In these dynamics, each step was taken after an emphatic assurance that trust had been sufficiently strengthened and fear sufficiently assuaged to make the move acceptable. The developing relationship can be injured if the steps taken are too hasty, but if, on the other hand, they are too slow, the patient—still ambivalent—might close his mind to any further therapeutic process. These moves were also performed in a natural and contextually appropriate way.

Such a step-by-step, carefully monitored spatial strategy in some way parallels Tinbergen & Tinbergen's ethological approach with autistic children (1972). In developing spatial (or 'proxemic') dynamics, interactive patterns that create effective affiliative bonding with the patient must be observed, with sensitivity at the same time to any stress caused to this bonding.

Should a patient enter therapy with negative attitudes and inappropriate expectations, the burden of responsibility to reverse these handicaps essentially lies with the therapist. The patient should be enabled to see him as an ally in this battle, which according the patient's world-view, is against 'witchcraft' but according to the therapist's is against an 'illness'. The adversary is essentially identical, but is conceptualised in different vocabularies.

(i) Avoiding quixotic confrontation with the system

Since witchcraft ideation is a closed system, it is advisable to avoid confrontation with it: we may not accept it ourselves; but must neither decry it, nor try prematurely to educate the patient out of it. This can be frustrating, because witchcraft is a belief deeply and firmly rooted in the patient's entire cultural environment. Any attempt to dislodge it only leaves the patient confused, helpless, and more anxious. Therefore, ideological confrontation must be avoided, and though patients occasionally ask "Doctor, do you believe in witchcraft?", it is best to return a cautious answer, such as, "I am aware of this belief, held by thousands of people, but I also know that many people have suffered a great deal on account of the witchcraft they they believe has been done to them. We have helped quite a number of such people". Non-confrontation means going along with the patient to the extent of 'understanding' his beliefs, but no more than that. Thus, the system can be utilised strategically, without entering it and without reinforcing it. Emphathic understanding is the best guide to avoid treading on the patient's sensitivities.

At the same time, it is important to explore the genesis and elaboration of the patient's witchcraft ideation, and to enquire what treatment he has already received or been recommended, and with what results. One should also enquire about his aetiological beliefs, and perhaps indicate one's own, though without entering into an argument. If an underlying psychotic or neurotic illness is suspected, an attempt should be made to disentangle if from the elaboration of witchcraft ideation.

The therapist may have to use active therapeutic techniques—directive, confrontative, and persuasive—for certain problems—but his approach should always be functional, never ignoring the most pressing issues of the moment. During the early phases, some medication may have to be prescribed, even if only a placebo, as well as such active intervention as assurance, advice, and environmental manipulation. The content of therapy has to be linked closely to the patient's current experience. These strategies have, in part, also been proposed by Harper & Stone (1974), Grier & Cobbs (1968), and by Gordon (1968) in therapy with black patients in the United States.

Setting Realistic Goals

The most realistic and least controversial goal of psychotherapy, is **relief of symptoms;** this has to be achieved expeditiously, even in the first session as much as possible. It serves to strengthen the patient's trust in the therapist's 'power', and to assure him that the power of witchcraft has been stalled. Symptoms most amenable to relief need to be picked up first, and the patient given a firm assurance of relief—"I am going to take away your pain or sleeplessness, or . . . (whatever it is)". If the pain has a physical cause, an analgesic should be given; if it is due to tension, relaxation exercises. For insomnia, a (placebo) pill can be given sealed in an envelope, and the patient asked to keep it under his pillow; should he not fall asleep within half an hour, he may swallow it. Relatively few patients really need an hypnotic, which may be prescribed for a night or two to break the vicious circle. Judicious use of neuroleptics for psychosis, anti-depressants for depression, anxiolytics for acute anxiety states, and vitamins, minerals or other nutrients for deficiency disorders not only relieve major symptoms, but also serve in this way to mollify the fear of witchcraft.

Commonly associated with fear of witchcraft are conversion symptoms: aphonia, astasia-abasia, paralyses, weakness, anaesthesia, and hyperventilation are commonly seen. One of us has employed modules of single-session therapy for a medley of such symptoms (Neki, 1985b); the dramatic relief experienced appears to the patient to be nothing short of 'magical', and this convinces him of the therapist's power against presumed 'witchcraft'.

Thus, the early phases of therapy are marked by active and energetic intervention, which may consist of direct assurance, advice, or persuasion, active or placebo medication, environmental manipulation, or crisis intervention. Crisis therapy, being brief, limited in breadth and depth of exploration, and focussing on the here and now, is readily accepted. However, if the therapist seeks to alter the patient's outlook, his socio-cultural reality has to be kept in mind. "Any changes sought contrary to the dictates of belief systems surrounding him are bound to prove self-defeating" (Thomas & Sillen, 1972). Such resistance to change may, in fact, be a sign of health, and since African patients generally resist reducing their illness to a psychological level (Morakinyo,

1985), providing insight as a goal is unpragmatic and elusive. Prince (1962) found that insight therapy was not possible with Yoruba patients.

Since the patient feels so 'powerless' and bereft of strength, due to witchcraft, a second goal of psychotherapy with such patients should be helping them to gain a sense of power. To achieve this, the patient must be helped to learn to feel needed, loved, and wanted, as well as useful to himself. This can be done by assigning him carefully graduated useful tasks, which can be easily carried out; doing them engenders feelings of satisfaction, and relieves the patient of his negative self-image, as well as his non-commitment.

It is advisable to focus on pragmatic life strategies, and persuade the patient to try them out. Patients soon realise then that they have more control of their dentiny; they have generally been unaware of the many options of action open to them, but making them aware of these, and helping them to exercise a suitable choice enables self-confidence to be regained.

Appropriating the functional dynamics of the witchcraft system

Whilst witchcraft should be neither confronted nor strengthened the functional dynamics of this system can be appropriated into psychotherapy. The witch-doctor 'understands'; he has no need to enquire, but informs. So our enquiries must be kept to the minimum, at least in the beginning, but through empathic understanding, the therapist tries to know what is happening to the patient, and to make him feel understood. What the patient may have only haltingly and inadequately expressed may be reformulated in clearer terms: 'mirroring' back to him his own thoughts, formulated more clearly, makes him feel understood. Thus, the therapist tries to make the patient feel understood, and clinical experience enables him to guess more than he has been told; communicating what one has thus guessed back to the patient is also reassuring.

Relevance, which is always the key note, has to be also in the patient's eyes, and not just in those of the therapist. Hence, detailed enquiry, especially about the patient's past, which is not seen by him to be immediately pertinent, is avoided. Later on in therapy, it is generally possible to delve into the requisite details of patients' lives.

The language employed by the therapist should be syntactical to that of the patient; this term is used in a broader sense than usual, and includes concepts, myths, ideas, etc. In other words, the 'idiom' of the therapist should be congruent with that of the patient. For instance, a patient said, "Doctor, I know a baby doctor, a bone doctor, but I never know psychia—what do you call it?. Yeah, psychiatrist. What kind of doctor are you?". The psychiatrist, who knew that the patient's culture is characterised by physical expression and human relationship rather than abstract thinking and intellectual discussion, answered, "I am a heart doctor. I help people with worry in the heart". The patient was then sure that she was seeing the 'right kind of doctor' for, as she explained, "my heart has lots of worry" (Tseng & McDermot, 1981). A useful form of explanation is—"I am a doctor who helps patients get rid of their . . . (here mention is made of the main symptom(s) of the patient), whether or not caused by witchcraft". All along, it is important to be open and direct, and to provide unequivocal feedback to the patient about what the therapist understands of his problems, and the instructions he wants to give him.

Since a witch-doctor generally prescribes ritualistic remedies, the patient in therapy also expects to be involved in a ritual of some kind. Most cultures have theor own remedial rituals—of handling grief, separation from the dead, restoring harmony with family or group, or combating fears—natural and supernatural. The patient may be encouraged to make use of these as a parallel to psychotherapy, without supplanting it, and some ritualistic activities may be incorporated into therapy. One of us (BJ) employs relaxation therapy for this purpose, while role-playing and modelling may also be utilised; these not only employ a physical, action-orientated style, but also stimulate introspection. Patients may even be given 'home-tasks'; one of us (JSN) asks his patients to record or remember their dreams, and to bring them to subsequent therapeutic sessions. Apart from the 'window' they provide into the patient's dynamics, dreams also have an esoteric meaning, so that the therapist who makes use of them makes the patient feel doubly assured of his prowess. The content of dreams can be used to lift a patient's morale; one had felt that he had been bewitched since he dreamt of having eaten at the hands of a stranger. Later, he had another dream, in which he found his house being cleaned and white-washed; this was interpreted to counter the significance of the first.

Recruiting allies

The patient's family can be great allies in therapy. Whether they have to be involved directly (family therapy), in the patient's 'home-work', to supervise his compliance, or just be kept in touch regarding progress is a decision which has to be taken in each

individual case. Family therapy, for example, was dictated by the needs of the following case:

A 25 year-old girl, suffering from pulmonary tuberculosis, came to the hospital, and the physician had her chest X-rayed; when she went to collect her report, the film could not be found. The same happened with repeat X-rays, taken twice more. She then gave up the chase, saying, "I know these X-rays are not going to be found. I have been bewitched, that is why!". On further enquiry, she averred having married a man against the wishes of her family; she had in fact become pregnant by him, even before marriage, and her grandmother had never been reconciled to this. The patient now felt that it was the grandmother who had bewitched her. Family therapy, involving the grandmother herself, led to the resolution of the conflicts and tensions.

In rallying allies for the patient, one has to scan his social network, and identify who can be the best source of support—father, mother, a particular sibling, employer, friend, priest, or traditional healer. Home visits provide a good avenue for studying the family dynamics.

For the sake of his patient, the therapist may have to plead with housing authorities, welfare agencies, employers, schools or courts of law. The witch-doctor has his extensions into the community, and if the therapist also has such contacts, his effectiveness becomes greater.

Studying the dynamics

The therapist studies the patients dynamics not with the objective of providing interpretations or insight, but to inform himself so as to be able to help the patient more effectively. To start with, the therapist must evaluate the patient's attitudinal dynamics: is he of a mistrusting or a dependent kind? Is he approaching therapy with interest, doubt, or apathy? The findings will determine what strategy the therapist must adopt.

It is also important to find out what sort of feelings lurk behind the expressed fear of witchcraft. Is it aggression, fear of punishment due to moral transgression, jealousy or fear of presumed jealousy, the desire to escape responsibility for personal failure, or the irksomeness of some relationship? Different feelings warrant different management strategies. There is a need to identify defensive denial of inner feelings of weakness, fear of being discovered, reliance on maintaining a false image, or malingering. All these require handling in a way that does not cause loss of face to the patient.

Reality factors often intrude into psychotherapy: conflict, jealousy, frustration, suspiciousness, or confusion may easily arise if the patient's aspirations collide with reality, and all can rekindle witchcraft ideation. The patient must be helped to appreciate alternative possibilities, and to fortify his adaptive skills; he may also have to be helped to 'accept' the world, in existential terms.

The therapist is often faced wih the dilemma of whether to lay emphasis on autonomy and self-actualisation, or on group solidarity and conformity. It is essential then to find out the sheet-anchor of the patient's personal values and to provide him with the means of making restitution toward that system of values. Empathy must not be with the patient alone, but also with his culture, and cultural empathy cannot be gained merely from academic information about any group. This has to be done by sharing actual life-experiences with people—visiting their homes, joining them in their ceremonies, breaking bread with them, and observing them in both formal and informal social occasions. It is only through such cultural empathy that proper understanding of culturally rooted problems can arise.

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*Professor J. S. Neki, MA, FRCPsych, FAMS, *formerly, Director Postgraduate Institute of Medical Education and Research, Chandigarh, India, WHO Consultant for the National Mental Health Programme of Tanzania.*

B. Joinet, *Chaplain cum Psychologist,*
N. Ndosi, *Lecturer in Psychiatry,*
G. Kilonzo, *Chairman, Department of Psychiatry,*
J. G. Hauli, *National Coordinator, National Mental Health Programme,*
G. Duvinage, *Clinical Psychologist*
Mental Health Resource Centre/Psychiatric Unit, Muhimbili Medical Centre, PO Box 65293, Dar es Salaam, Tanzania.

*Correspondence

(Accepted 27 November 1985)