

## The Etiology of Evil in the Shona Traditional Religion

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**ABSTRACT** The notion of “directing evil” implies that the occurrence of evil is not something that just happens but something that has a ‘direction’ and a ‘director’. This is the common sense pattern of thinking that most people subscribe to, especially on matters that relate to the bad, as well as the good things. Naturally humans prefer to predict, prevent and avert evil, and if that is not possible they like to explain and understand it and place it within a certain order and context. The paper thus explores the basic structures along which the evil of illness and disability is perceived and directed and what implications this may have for professional contacts with ill and disabled persons.

### INTRODUCTION

This paper pays special attention to one particular form of “evil”, that is illness<sup>1</sup> with the purpose to explore the basic structures along which the evil of illness and disability is directed and which implications this may have for the ill and disabled persons. In two summarised case studies, we describe the symptoms and source of evil/illness, its course and as well as the valuation of the different treatment options. The cases are drawn from the fieldwork material gathered in Zimbabwe, particularly in Mashonaland Province.<sup>2</sup>

In this paper when we refer to “evil” we try to make a distinction between the symptoms of evil and its cause. For instance, the problem of barrenness caused by negligence of the spirit of an ancestor, the affliction of barrenness itself is the symptom of the cause of the real evil, the alleged neglect of the ancestor spirit. At the same time it is clear that the cause of this barrenness has to be determined or diagnosed through interpretation and therefore a subjective factor. Whilst the barrenness may be interpreted as a sign of the ancestors, indicating that they feel neglected, it may equally be interpreted by others as a sign of witchcraft from a jealous rival. In our fieldwork findings, in most cases, removal of the evil through traditional medical techniques, had primarily a symbolic function, reflecting the successful solution of the underlying social problem.

At the same time when considering evil, its

symptoms and its causes, it has to be realized that this issue can be approached from two different levels; first, a ‘micro’ level at which the evil strikes the individual and the personal suffering that results. Second, a ‘meso’ level at which the evil and suffering takes place in inter human behaviour and between or within small groups. Finally, the issue may be studied at the ‘macro level’, global and general level of society at large. These different levels provide different outlooks on illness and disability and the reader should bear in mind that in the course of this paper we switch from one level to the other several times. It is outside the purview of this paper to give a full and detailed account of the varied ways in which the evil involved in illness and disability is being directed and explained in this area. Here it suffices to say that there is indeed a whole array of explanations and treatment options, ranging from traditional healing, to ritual/faith healing and to scientific medicine.

Although the medical practitioner may influence the choice of the patient as far as treatment options are concerned, the treatment preference tends to be obtained largely by the explanation and interpretation, which the patient, his family and/or community provide for the condition. A random sample technique was used in selecting two case studies in our study that represent two basic forms of illness or disability as experienced in a traditional setting in Zimbabwe. If, in turn, the treatment selected does not yield the expected result, they will adjust their explanation to the extent that other treatment

options come in scope. In the two case studies that follow, we will illustrate some basic structures that exist in this respect. In the analysis we will not dwell on the many interesting details that the cases provide, but we will concentrate on the general picture and its implications for the communication with these patients.

### CASE STUDY 1 (M.C)

M.C. is 30 years old and unmarried. He lives in the south-east of Zimbabwe, in north of Marondera. He is physically disabled and suffers from a left side hemiplegia as the result of an undefined abscess he had at the age of seven. In addition he suffers from mental disorder, depression, hallucinations and paranoid experiences. It could not be verified exactly when the mental disorders started and whether in any way they are related to the abscess.

On our visit M. seemed depressed and afraid. He was enclosed in the hut and we only managed to talk to him through the door of the hut in which he sleeps. He appeared later on but was not able to speak a single word. On our second visit he was rather vivid and was prepared to talk about his condition. As soon as he started to talk about his parents, he withdrew into sporadic convulsions.

#### Case History According to M

The first signs of mental disorder appeared when M. was still at school going stage. One day when he was walking home from school, he saw a very bright flash of light.<sup>3</sup> Immediately he saw two small short figures (*tokolotches*). They tried to talk to him but he could not hear anything. He ran home but the two short men chased him. He became very scared and was afraid of getting out of his hut anymore. He was afraid that the small men might get hold of and kill him. In the end he was taken to hospital for mental examination and treatment. But as soon as the hospital staff tried to talk to him, he closed his ears and shunned any possible conversation. He resumed his old trend of fear and hiding. From M's medical card, it showed that he was given very strong medication (major neurological) at the time that he was attended to at the hospital. However it seems he defaulted treatment as soon as he returned home.

*Tokolotches* are weird beings in the Shona

traditional spirit world. Whilst some believe they are spirits, others consider them as messengers of spirits. The spirits are a common phenomenon in the spiritual cosmos of the African peoples in Southern Africa especially the Zulu of South Africa. (A reference to such kind of spirits can be found in some studies by scholars such as Smith and Dale 1920: 132; Reynolds 1963: 65; Hunter 1936; Stefaniszyn 1964: 152; Cook 1975: 132; Gelfand 1962 and Chavunduka 1978). In these studies, *tokolotche* is depicted as having fully-grown human bodies, but they are very short. Others portray the spirit as *chidhoma* or *chitupwani* such as among the Karanga (Shoko 2007: 64). Most characteristics imply that they are semi-human, their bellies and faces are positioned at their backs, the limbs appear like reeds, covered with bee wax. The appearance of *tokolotches* is never a good sign.

#### Case History According to M.'s Parents

The parents consider the talk about *tokolotches* as diverting the real issues. They believe that the real cause of their son's problem is that the spirit of the grandfather (deceased family elder) wants to possess him, but that the rest of the family does not accept it. Already at an early age their son inherited the name of the grandfather. In that respect it was not unlikely, according to the parents that the spirit of the paternal grandfather chose to possess their eldest son. But his brothers declined that such an important ancestor spirit could possess a disabled person. According to the parents, the brothers of the father use all sorts of medicine, to prevent the spirit to possess their son. At the same time, some brothers claim that the spirit of the grandfather wants to possess someone different amongst their own children.

Asked whether it is a rule that, once a person has inherited the name of a deceased relative, that person will also inherit the deceased's spirit, the parents state that such a rule does not exist but that it is not possible to give a child the name of the grandfather without specific signs that the spirit of the grandfather wants to possess that child. In the case of M., the parents feel those signs were clearly there however, the other relatives disputed the value of the signs. M's parents were very vague about the marital status of their son, as was the son himself. They are confident that their son will be cured and that

afterwards he will be able to find a suitable marriage partner and raise a family of his own.

#### Case According to Other Informants

One of the informants said the explanation of M was unreliable. A *tokolotsche* cannot cause all that much pain. Besides there is a simple traditional method used to allay fears or cure the effects of *tokolotsche*. One has to burn a shrub and smear the ashes all over one's body. When this is done the *tokolotches* will stop their attacks. So if M had wanted, he could have applied this method and neutralize the attack of the spirit. One village elder said that M had to leave school after Grade 7. His father, a polygamist had just got married to a new wife. He could not afford to pay school fees for his enlarged family. From 1978-1980, M worked a decent job in his hometown and was doing well, taking care of his relatives as expected in the Shona custom. But problems came up at his work place when he ran berserk. He lost consciousness and this resulted in mental illness. Because of his protracted illness, his wife abandoned him and took the children along with him. This seriously affected his health problem. Finally M returned home, in a very pathetic condition. His relatives tried all forms of medical help by consulting *n'angas* (diviner-healers).

The practitioner played his part and explained what he perceived to be the source of the problem; an invading alien spirit but the relatives could not accept any explanation. Rather they changed and took the patient to the scientific hospital at *Ngutsheni*, a mental hospital in Bulawayo. After receiving medication, he recovered and was able to resume his work but he was retrenched when the company targeted some people they deemed as excess labour. The company argued that they were applying cost-saving measures in the light of hard economic conditions. But internal information from the workmates says that he had mental lapse at work that led to him losing his job. After being laid off he returned home and from time to time he relapsed. But medical indications are that these lapses were caused by his absconding dosage. At the moment he gets employed on casual jobs intermittently since he suffers from mental attacks and no one is prepared to engage him on full time employment. It appears M has become a social outcast, snubbed by people in the community. Since the departure of his wife he has led a miserable life and it seems its becoming

difficult to reclaim his wife from the in-laws. Also what makes reconciliation nearly impossible is that he has not paid up his *lobola* (dowry).

#### CASE HISTORY: S.M.

##### S's Explanation

S recalls that when he was young, he saw a sharp light flash, and then everything became dark. He could not remember everything that happened afterwards. All he recalls is that people told him that he had fallen ill. And since that illness he has led an uncomfortable life, everything had gone bad for him. When listening to the explanation that his uncle offered for his condition, we asked him whether he agreed with them. Then S only replied with laughter. The only thing he was prepared to say was that things would not be so bad for him if only he could find a wife. He wonders how he would survive on his own when his grandfather dies.

##### Explanation According to Grandparents

According to his grandparents, S's condition is the result of witchcraft that was sent by relatives from his mother's side. S's parents died when he was still young. But the reason for the divorce is not known. The grandparents do say that their daughter-in-law was from a very notorious family of the Korekore ethnic group. Their family is well-known for practicing witchcraft. When the mother of S returned home to her parents, at the time of divorce, she took S along. When no *lobola* (bride price) arrangements could be made however, the father came to collect his son. The very night before he was expected to come, S fell terribly ill (and that was the time that he saw a light flash). According to the grandparents the illness was caused by witchcraft on the side of the mother. According to them she might have thought "If I can not keep and delight in my son, you will not enjoy him either". So through witchcraft she has made her son fall ill. The fact that she could make her own son disabled, shows clearly that the mother must be a witch, because only witches can be so cruel to that extent. In addition, the mother never ever tried to get in touch with the child after the father had taken him. This also shows that she did not have a heart that means she was a witch.

Asked whether any form of healing was

pursued, the relatives, who were reported to be members of the Apostolic Church, said that there was no use to try traditional healing. They knew who had sent the witchcraft and they realized the witchcraft was very strong. They had tried to protect themselves from it but they had failed. They feel that witchcraft of that nature has no cure. It may be possible to cure the victim but the witchcraft will search and find another victim almost immediately. They did send their grandson to a faith healer (of the Apostolic Church) in Harare. There he stayed for a couple of months. He participated in the singing and praying but he was not cured and finally he returned home. The relatives did not undertake any further steps to pursue treatment since then. The grandmother says that sometimes she dreams that "everything is over", she hopes but does not really expect that this will ever happen.

#### **Explanation of other Informants in the Area**

The other informants in the area provide an explanation that concurs with that offered by the relatives. In the accounts of the people in the community the hopelessness of S's position is emphasized. Informants agreed that there was no hope for cure in his case. They are concerned about S's future. He is the youngest member of his family. He will have no one to support him with his grandparents when his uncle dies. Even more they are concerned about the future of S's spirit. If things remain as they are, there will be no one to welcome S's spirit back, after he has died.

#### **ANALYSIS**

In the above case studies, informants brought various causes of illness and disability forward. On the one hand, it appears the explanation for a particular condition may change over time, when a treatment option selected does not prove to be successful. On the other hand, it was demonstrated that the ill person, the relatives and other informants in the community might provide different explanations for the condition. All these changes and differences of interpretation are reflected in the way in which "evil" is being directed in these cases.

Before we start analysis of these cases mentioned above it should be mentioned that although they represent two basic forms of illness or disability as experienced in Zimbabwe, there is

still one more basic form to cover. It is very difficult however to give an extensive description of this form of illness.

This basic form of illness is described by Chavunduka, (1978) when he stated: "The presence of mild ill-health is regarded by many people as a normal part of life". According to his study only 15% of the people he interviewed believed that it was possible for a person to be really healthy. Chavunduka illustrated this point by quoting statements made by some informants: "I am not sick but I have a headache"; "I am alright but my body is not in a good condition" (Chavunduka, 1978: 35). The Shona people frequently make statements of this kind. They imply that, although some discomfort may be displayed, there is nothing seriously wrong. For conditions like these people either seek no treatment at all or they use simple herbal, or folk medicine.

Whereas people do not generally bother to do much about minor ailments, it is only when the pain or discomfort continues, that they will consider to seek treatment. Basically therefore minor ailments are believed to be either "not worth the bother" or the beginning of a more serious illness. People do not seek treatment for minor ailments, but they do sometimes use protective medicine to prevent any ailments, even minor ones, that might be of a more serious nature.

When the illness persists and does not disappear all by itself, or when the condition becomes more painful, causing more discomfort, people will start considering various treatment options. Sometimes they will just go to a nearby clinic or traditional healer, without thinking too much about the possible causes of the illness or disability. When people are uncertain about the cause of their condition or when they want to get their suspicions confirmed they might consult a traditional healer or diviner.

In his study of traditional healers Chavunduka had differentiated between illnesses with 'normal' and 'abnormal' causes. In a personal interview however, he has stated not to be completely happy with this terminology. The term 'abnormal' implies that the causes referred to are usual and besides the normal order, while in actual fact 'abnormal' causes are more 'common' than normal causes. When speaking Shona informants would not generally use abstract terms like "normal", "natural" or "abnormal". In his studies about life and death among the Karanga, Aschwanden (1987: 14, 73), mentions the term, "*chirwere*

*chaMwari*" (disease from God) as a synonym for "natural illness" (*chipo chaMwari*) (gift from God). For the so-called "abnormal illnesses" a variety of terms were used, most of them refer to one or two types of abnormal illnesses in particular. Informants did not often use more general terms like "*tsika*" "*magariro*" or "*tsika namagariro avanhu*" (tradition, culture, tradition and culture of the people). When speaking English however, informants were inclined to use more abstract terminology. They would speak of "natural" and "cultural" causes for their illnesses. These terms require some explanations as the terms natural and cultural have many connotations in western society. With the term "natural", informants referred to those causes that "come and go" without human beings influencing them. This might be because the illnesses are not very serious and only temporary in nature, that is, people do not bother to interfere, it might also be because people feel the condition is beyond the control of human beings. When we write "people" and "human beings" here, we actually speak about the area of influence that Shona informants referred to when they spoke of "cultural causes".

Culture may be defined as the organized system of knowledge and belief whereby a people structure their experience and perceptions (cf Keesing, 1975: 20). When they speak of cultural causes, the informants refer to only a small aspect of it, which transcends into the area that is generally considered "natural" (ancestor spirits) but that in the Shona cosmological system is still under the influences of humans. Cultural causes of illness and disabilities (evil) may be:

- Witchcraft or sorcery (i.e. being the victim of);
- The punishment for being a witch or a sorcerer;
- Neglect or offence against a family member or an ancestor;
- Refusal to accept the possession of a particular spirit;
- Breaking a taboo

In Shona culture, human beings are in the centre of all creation, hence their anthropocentric view of the universe. Through a network of religious leaders, such as the chief, the headman, spirit mediums, diviners, healers, midwives, rainmakers, witches etc. a link between the world of the living and the world of spirits is formed. The spirits in turn form the intermediaries between the world of the humans and nature. Whereas

the realm of culture is a conglomerate of good and bad influence, sometimes united in one person and open for different interpretations, the realm of nature, according to the informants, should be perceived at the beginning and end of this spectrum. In both cases the realm of "nature" is beyond the influences of human beings, their intermediaries and their spirits. In the first case, because it is not worth the bother and in the second case, because it lies beyond their control. A clear example of natural causes of the first kind is provided by Chavunduka, as was mentioned above. There is some discomfort, but the body is only superficially affected and generally no attempt is made to pursue treatment.

The case of M is a clear illustration of a condition that is felt to have a cultural cause. The fact whether a condition has a cultural cause and, if, so what exactly the cultural cause involves is open to many interpretations may change in time. Also there is no clear-cut relationship between a particular illness and a particular explanatory model and treatment option. Fairly identical cases of polio or epilepsy may be explained and treated in entirely different ways. While scientific diagnosis are generally involved with gradually narrowing down the possibilities, fever, virus infection hepatitis, hepatitis A etc., the diagnoses of traditional healers tend to be more general in nature and often refer more to social than physiological circumstances.<sup>4</sup>

Treatment of cultural causes by a traditional healer usually involves a number of steps: First of all a diagnosis has to be made. We will not elaborate here on the different ways in which this may be done. More often than not, the process of obtaining a diagnosis is not an individual affair. The patient is in most cases accompanied by relatives, in more important cases even by family elders. In some cases the relatives do not take the patient along, they simply bring a belonging of the patient to the healer. A diagnosis is provided by the traditional healer should be seen as a social statement of an experienced person and not as the 'undisputed truth' that a diagnosis in scientific medicine is believed to be. The diagnosis involves an interpretation of the social situation and the patient and relatives may agree with this interpretation or not. When the case is clear and when all parties involved agree on the diagnosis, it may be pursued immediately. It is not unusual however, particularly in the more complicated cases that the patients and even more the relatives

want some time to think about the consequences of a particular diagnosis. If they agree with it, they will return to pursue treatment, and if they do not, they may want to consult another diviner.

Also in the case of M, different hypotheses existed concerning the cultural causes underlying his condition. These hypotheses in turn are related to the psychosocial aspects of the somatic complaint revealed by the patient. The different treatment options pursued are landmarks in the struggle for the recognition of one's hypothesis. When the father decided to send his son to a mental asylum in Bulawayo, he might have done so out of despair, because no other treatment options were available. He might have opted for scientific treatment because he genuinely believed his son could benefit from this approach. At the same time however, by seeking scientific medical treatment he defied the diagnosis of the traditional healer, who spoke on behalf of the community and the ancestors. In fact that way the father's decision to pursue scientific medical treatment became almost a political statement. Although no immediate steps are being taken by the relatives to seek treatment for M again, it is clear, from the accounts of the relatives that they do not consider M's case closed.

The position of S is different in this respect. There is not much difference between the physical conditions of S and M and even their social and economic position is comparable. Still informants who knew both patients, stressed the fact that M was, in their opinion, somewhat better off than S. When asked to point out the difference between the two cases, the informants stated that the main difference was that S's case was "closed". The relatives used different terminology, they said: "We consider him (S) a gift from God". By saying this they implied the condition was beyond the control of human beings and that they would not be able to cure it. The phrase, "a child from God" or "a gift from God" is used in many counties in Southern Africa to describe disabled persons.<sup>5</sup> Unfortunately, reality is not always as tidy as we researchers would want it to be and therefore also statements were recorded that were not in accordance with the above described picture, i.e. disabled persons were referred to as "gifts from God" while their cases were not actually closed and when treatment was still actively being pursued. In these cases however, the statement seemed to reflect either some distance on the side of the informant or despair about the treatment

option pursued.

When we speak of the causes of illness and disability in relation to the cosmological order, there seem to be two main causes but in actual fact there are three. Illnesses in their mildest form are generally believed to have a natural cause. If they do not cease or become more serious, people look for a cultural cause. Some serious illnesses and disabilities as well, that could not be cured through human interference (either because they or their spirits did not have the power or because they held different opinions about the solution) are referred back to God again. Within the realm of cultural causation manipulation is possible. The illness or disability is considered a symptom of larger underlying social problems that can only be solved if some form of consensus or power balance can be reached within the community. The fate of the sick or disabled individual is subordinated to that of the group.

In societies where the group and the social control exerted by it is still considered to be very important, illness may still be conceived and treated in this way. However in the rural communities of Zimbabwe, a process of modernisation and individualization has started, that opens different treatment options altogether, that tend to be more beneficial for the ill or disabled individual.

In general, it might be said that, apart from the traditional healing, two more treatment options are open for the ill or disabled individual: faith healing and scientific medical treatment. It is important to note that these treatment options do not direct themselves primarily to the social group or family but to the individual. In the case of faith healing, the individual often has to cut ties with the traditional group that he/she belongs to in order to be allowed to become a member of a strong and tight group of believers. Although in faith healing churches, group membership plays an important role, emphasis is put on the responsibility of each individual to adhere to group norms. In the case of mainstream Christianity and scientific healing the membership of a congregation or the family of Christians is nowadays infused even more by a sense of individualism.

### **Theoretical Framework**

In the case studies presented above, a clear differentiation is made between the views of the

ill or disabled persons themselves, their immediate relatives and the community at large. A similar differentiation is reflected in some of the theories concerning illness and disability. On the one hand there are theories highlighting the reaction of society towards the ill or disabled individual, on the other hand there are theories that focus on the reaction of the ill or disabled person towards society. When we want to understand how evil is directed, we will have to consider both reactions, along the lines of the process of internalization and externalization as described by Berger and Luckman (1966).

T. Parsons (1972) provided a clear example of a theory of the first kind when he described the "sick role" as it developed within the American health care system. According to Parsons, the social essence of being sick is that one is no longer able to perform normal role behaviour; he/she is not (yet) given the status of a deviant. At the same time however the sick individual is expected to adhere to the so called "sick role" designed to control his/her potentially deviant behaviour. The behavioural norms set by society to control illness behaviour are, according to Parsons (1972: 99) governed by four main principles:

1. The individual is not to be blamed for the illness;
2. The individual is relieved from normal duties and responsibilities for the duration of the illness;
3. The fact that normal tasks and duties in line with the normal role model are not being fulfilled, is not considered as a sign of deviance, but legitimate in view of point 2;
4. The three aforementioned principles are accepted only if the individual makes an effort to get well and obeys the instructions provided by the medical profession.

In his theory, Parsons distinguishes between somatic and mental health. He calls them "the adaptive capacity of the human organism" and the "second line in defense" respectively (Parsons 1972: 78).

The question to be answered here is, to what extent, Parsons' theory throws light on the illness behaviour of ill and disabled persons in traditional societies<sup>6</sup>. As far as the Zimbabwean situation is concerned, it may be concluded that the role and position of the sick individual is quite contrary to that of the sick person in modern/American society, as described by Parsons. Whereas

Parsons' theory of the sick role might be applicable to faith healing and scientific healing processes in Zimbabwe, it does not apply to traditional healing. Within the framework of traditional healing it is not the individual sickness but the social problem, of which the sickness is a mere symptom or symbol that gets cured. This difference seems to be quite essential for our understanding of the ways in which evil/sickness is being directed in a more traditionally oriented type of society.

Whereas in western society the control of evil, illness or disability is preferably individualized and internalized, in a more traditional setting, from which the case studies were drawn, the opposite seems to be the case. The more serious a physical condition is believed to be, the more people will tend to turn that illness or disability into a social event. As far as their control of these events is concerned, their potential to control social events is much larger than that of western society, mainly because the system for social control is functioning well. If we consider a person suffering from tension headache due to severely disturbed family relations, this family problem often proved to be "beyond" control in western society, while it would be the focus of control in traditional society. While in western society they try to cope with the problem by individualizing and internalizing it, at the same time displaying a growing incapacity to exert social control, in the traditional society, individualization of the problem will be avoided at all costs. Hardly a worse position is possible, as when an ill person is left to fend for himself (as seemed to be S's prospect).

This leads to the discussion of the other perspective, the view of the ill or disabled individual towards the society that stigmatizes him/her as such. As mentioned before, in traditional society feeling concerning illness and disability are not individualized and somaticised. As mentioned before, the condition is believed to be a symptom of an underlying social problem. The family group generally caters for the ill or disabled person. There is however no strong tendencies to make up or compensate for the hardships encountered by the ill or the disabled individual, as some sort of a scapegoat for the rest of the family.

The social psychologist and behaviourist Rotter (1966) developed a theory to explain the attitudinal differences that has developed between people in their reaction to positive and

negative incidents in their life. He demonstrated that consistent attitudinal differences exist between individuals as far as perceived "locus of control" is concerned. Rotter differentiated between two basic attitudinal forms in his study; internal and external control (on the positive or negative reinforcer (Rotter, 1966).<sup>7</sup> In the first case the individual has the feeling to be generally in control of positive and negative life events, while in the second case the individual does not feel able to influence or exert control over his/her life. In actual fact, Rotter's theory is complicated, to the extent that apparently in western society many people feel they do control (and deserve credit for) positive life events, while they tend to blame external factors for negative episodes. This notwithstanding, it is generally considered a therapeutic ideal in western society to install in people a feeling of internal control. Not only is this a therapeutic ideal, the issue of internal and external control should also be understood in terms of a certain worldview. Rotter's theory therefore does not only provide implications for attitudinal patterns but also for "patterns of culture". Much more than in American society, as described by Parsons, in the traditional society illness and disability are externally controlled.

Ancestor spirits, alien spirits, witches and sorcerers and human beings are all heavily involved in their attempt to observe the moral code. In western society a lot of negative connotations are attached to these social and moralistic interpretations of disease. However, as Sontag remarked: "Ceasing to consider disease as a punishment which fits the objective moral character, making it an expression of the inner self, might seem less moralistic. But this view turns out to be just as, or even more moralistic and punitive" (Sontag 1979: 45).

The above provided analysis holds implications for the way evil is directed, illness is managed and treatment pursued. Insight in these processes is required by anyone who, for professional reasons, has contacts with ill and disabled persons. It may be assumed that traditionally oriented professionals such as the *n'anga* are well aware of the processes involved here. The more scientifically oriented professionals, such as the social workers, scientific health care workers may have some theoretical insight in the cultural background of the societies in which they work, but they do not always apply it in concrete situations where some form of aid

or assistance has to be provided. Too often also the insight is used only to facilitate and enhance the assimilation of patients to scientific medicine, without really appreciating the benefits of traditional medicine.

Let it be understood clearly here that it is not our intention to idealise traditional medicine.<sup>8</sup> Also we are not talking of the activities of quacks and imposters in this field. One of the commonly accepted premises of professional aid delivery that has been so thoroughly described by Rodgers, is that all therapeutic actions are directed towards a client but imposing our own views. The parallels between psychotherapy and development aid are quite striking in this respect.

Studies in the field of sociology of medicine have pointed out repeatedly that, just as society has individualized, scientific medicine has developed more and more towards control of the internal processes (in the field of internal control there is specialization, if it is too difficult to exert control of oneself at least one can afford to have it controlled).

On the basis of the above it may be concluded that the ways in which the traditionally oriented patient and the scientifically oriented professional feel evil is directed, are almost contrary. If we aim to assist traditionally oriented patients in a professional way, not only do we have insight in the ways he feels evil can be directed, we also have to respect these views and acknowledge the enormous therapeutic potential that social control still holds for these patients.

## NOTES

- 1 It is beyond the scope of this paper to discuss in detail the terminology and theories concerning illness and disease. Suffice it to mention Hahn (1984) who refers to A. Eisenberg (1977), L. Good and A. Kleiman (1988) and school of thought on illness and disease. Eisenberg defines illness, as opposed to disease and sickness. Whereas the term disease refers to a particular dysfunction of the body, the term illness refers to the way the individual and the relatives react to this dysfunctional, i.e. the subjective experience. The term sickness finally refers to the social dimension: "the ability to meet social obligations of group living" (Twaddle 1981: 1120, the compromise between the objective and the subjective aspects of the condition.
- 2 Information was gathered through cooperation with Dutch scholar and colleague, Dee Burck in Zimbabwe in the 1990s. Both were members of research group WAVU Amsterdam.
- 3 In the Shona experience, a light flash is sign of attack by severe illness.



- 4 Cf Hahn (1984) when he discriminates between diseases and disorder ideologies.
- 5 In Zambia for instance the term, "Tula Lesa" means only God can save him or her and is used to refer to disabled persons.
- 6 Cf Schoffeleers 1988: 15.
- 7 Behaviorists initially brought the issue of internal and external locus of control, forward from the social learning school. In theories of classical and operant conditioning, it is assumed that behaviour takes place because of the reinforcing effect of external stimuli. Pavlov's dog salivated because it had learned of the relationship between a piece of red meat and a bell or flashing light. Whilst Skinner's rats pressed the lever because they received grain when they did. Although red meat and grain may have a major reinforcing effect for most people, it is clear that human behaviour cannot be explained on the basis of rewarding external stimuli alone. Social learning theorists assume that somewhere along the line, extrinsic rewards are transferred into intrinsic rewards, i.e. social and personal values. In the process of toilet training, a child will initially perform the desired toilet behaviour because it is rewarded by the *ch's* and *oh's* of the entire family. Later in life, individuals generally perform this behaviour also without the encouragement of others but because of their own motivation. Motivation has to do with the reasons why we engage in particular behaviour, but it also has to do with the explanation we give for things that have happened to us.
- 8 J. McKee, Holistic health and the critique of Western medicine, social Science and Medicine, Vol. 26, no. 8, pp. 775-784

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