

Chapter 9 Ritual and the management of misfortune

CASE STUDIES

Case study: colour symbolism of Zulu medicines, South Africa

Ngubane's description⁹ in 1977 of the symbols used in healing rituals by the Zulu people of South Africa illustrates the multivocal and bipolar aspects of ritual symbols. In this community, it is the *colour* of the medicines rather than their pharmacological properties that is considered the most important attribute. This colour symbolism is particularly important in medicines used for prophylactic purposes, or in dealing with illnesses thought to have a supernatural origin. The medicines are divided into three groups – black (*mnyama*), red (*bomvu*) and white (*mhlope*) – and each colour is associated with a cluster of meanings, physiological, social and cosmological. Black represents night-time, darkness, dirt, pollution, faeces, death and danger. Defecation, dirt and death can be seen as antisocial elements, all of which should be absent from normal social encounters. Also, night is the time when people cannot see, when they withdraw from their usual social activities; at night, sick people become sicker and sorcerers are said to work. Ancestral spirits visit their descendants in dreams, so that sleep is a point of contact with the dead. Ngubane states that sleep 'may be regarded as a miniature death that takes a person away from the conscious life of the day'.⁹ In contrast, white symbolizes the good things of life, good health and good fortune. It represents daylight and the events that take place during it, such as eating or social

interactions. During the day, people participate in social activities and live their lives. They see clearly, and there is no sense of danger. White represents the social values of life, eating and seeing. The third colour, red, symbolizes the states of transition between black and white, much as sunset and sunrise are between day and night. It represents an in-between position, slightly more dangerous than white but less so than black. It also stands for other states of transition or transformation, such as growth, regeneration or rebirth. The association of blood with states of transition (such as birth, or a fatal wound) is also relevant here. In treating an ill person the Zulu traditional healer aims to restore health, which is seen as a *balance* between the person and the environment. This is achieved by expelling from the body what is bad by the use of black and red remedies, and then strengthening the body by the use of white medicines. The medicines are always used in a fixed order: black, red, white. This is meant to achieve a transformation from illness to health, 'from the darkness of night to the goodness of daylight', from death to life, from danger to safety, from antisocial to social behaviour. As Ngubane states: 'the daylight represents life and good health. To be (mystically) ill is likened to moving away from the daylight into the dimness of the sunset and on into the night ... The practitioner endeavours to drive a patient out of the mystical darkness by black medicines, through the reddish twilight of the sunrise by red medicines, and back into daylight and life by white medicines'.⁹

Case study: changes in Japanese funerary practices since World War II

Suzuki^{21,28} in 2003 described the major changes in Japanese funerary practices since World War II, especially the shift from 'funeral rituals' (*sôshiki*) before the War to 'funeral ceremonies' (*o-sôshiki* or *osôgi*) today – a shift not only in funerary practices but also in the values surrounding death itself. In pre-War 'funeral rituals', the funeral was a highly elaborate ritual, predominately Buddhist in character, and took place gradually in a series of clearly-defined stages. Death took place mainly at home, and the funeral itself was a very public event involving much of the community. It reflected the participants' fear of death, which they believed caused the release of malevolent spirits (*koku-fujô*) that could be dangerous to them, as well as to their deities. The purpose of the ritual was to usher the

deceased's spirit safely to the next world – converting it from a malevolent (*ara-mitama*) to a peaceful (*nigi-matama*) state – and to strengthen the relationships between surviving family members, and between them and their community. The actual funeral was carried out by a Buddhist priest, and by members of the local mutual-aid group (*kôgumi*), drawn from five to seven nearby households. In contrast, in contemporary Japan, death has been transferred from home to hospital. For most people it now takes place among strangers, and in an unfamiliar environment. Responsibility for the funeral, too, has been increasingly transferred to professional undertakers, and cremation has become more common. Whereas traditional rites were dedicated to protecting both bereaved and deceased from evil spirits, the modern commercialized funeral ceremony is less concerned with this, and instead 'centers on beautification of the

deceased life and memories', as if the deceased remained 'alive' until the moment of cremation. Japanese undertakers have adopted an industrialized, standardized, mass-produced model of funeral practices (she call these 'McFunerals'), which are often

rushed, and follow rigid time schedules. Unlike traditional funerals, 'McFunerals' are characterized by efficiency, predictability, standardization, and a precise price range for different types of funeral.

Case study: curative rites among the Ndembu of Zambia

Turner⁴¹ in the 1960s described curative rites among the Ndembu people of Zambia. The Ndembu ascribe all persistent or severe ill health to social causes, such as the secret malevolence of sorcerers or witches, or punishment by the spirits of ancestors. These spirits cause sickness in an individual if his or her family and kin are 'not living well together', and are involved in grudges or quarrelling. Because death, disease and other misfortunes are usually ascribed 'to exacerbated tensions in social relations', diagnosis (divination) takes place publicly, and becomes 'a form of social analysis', while therapies are directed to 'sealing up the breaches in social relationships simultaneously with ridding the patient ... of his pathological symptoms'. The Ndembu ritual specialist or traditional healer, the *chimbuki*, conducts a divinatory séance attended by the victim, his kin and neighbours. The diviner is already familiar with the social position of the patient, who his relatives are, the conflicts that surround him, and other information gained from the gossip and opinions of the patient's neighbours and relatives. By questioning these people, and by shrewd observation, he builds up a picture of the patient's 'social field' and its various tensions. Actual divination

takes place by peering into medicated water in an old meal mortar, in which he claims to see the 'shadow soul' of the afflicting ancestral spirit. He may also detect witches or sorcerers, who have caused the illness, among the spectators. The diviner calls all the relatives of the patient before a sacred shrine to the ancestors, and induces them 'to confess any grudges ... and hard feelings they may nourish against the patient'. The patient, too, must publicly acknowledge his own grudges against his fellow villagers if he is to be free of his affliction. By this process, all the hidden social tensions of the group are publicly aired and gradually resolved. Treatment involves rituals of exorcism to withdraw evil influences from the patient's body. It also includes the use of certain herbal and other medicines, manipulation and cupping, and certain substances applied to the skin. These remedies are accompanied by dances and songs, the aim of which is the purification of both the victim and the group. Turner doubted whether the medicines he saw used in these rituals had much pharmacological effect, but he pointed out the psychotherapeutic benefits, to both the victim and the community, of the public expression and resolution of interpersonal conflicts, and the degree of attention paid to the victim during the ceremony.

Case study: consultation with a general practitioner in the UK

In Britain, the consultation between the average general practitioner (GP) or family physician and his or her patients is markedly different from the Ndembu example, but it too is a form of healing ritual. General practitioners are part of the National Health Service, and access to a GP is free and unrestricted, though most prescriptions have to be paid for. Consultations take place at defined times and places (the office or *surgery*), and are governed by implicit and explicit rules of behaviour, deference, dress and subject matter to be discussed. Events take place in a fixed order: entering the surgery; giving one's name to a receptionist; sitting in a waiting room; being called in turn to see the doctor; entering the doctor's room; exchanging formal greetings; and then beginning the consultation. From this point onwards, Byrne⁴⁵ described six stages in the procedure:

- 1 The establishment of rapport between GP and patient.
- 2 The doctor discovering why the patient has come.
- 3 The doctor's verbal and/or physical examination.
- 4 Both parties' 'consideration of the patient's condition'.
- 5 The doctor detailing treatment or further tests.
- 6 The termination of the consultation, usually by the doctor.

The patient's symptoms and signs are recorded, during the consultation, on the medical card, and the present condition is seen against the background of previous illnesses recorded there. Particular attention is paid to questions such as 'when did the pain begin?' and 'when did you first notice the swelling?' as part of the verbal diagnosis. As Foster and Anderson⁴⁶ point out, this historical approach is characteristic of Western diagnosis; in other cultures, the healer is expected to know all about the patient's condition without asking so many probing questions. As well as gathering clinical information by taking a history, physical examination or tests, GPs – like the Ndembu *chimbuki*

– use informal knowledge gathered over the years in the community. As a result, assessment of a patient is based not only on the consultation but also on the GP's knowledge of the patient's environment, family, work, past medical history, pattern of behaviour and the culture of the neighbourhood.

The consultation is characterized by privacy and confidentiality, and usually involves only one patient and one doctor at a time. Its form is the ritual exchange of information between the two; symptoms and complaints flow in one direction, diagnoses and advice in the other. The patient receives practical advice (e.g. 'Spend a day or two in bed') or a prescription for medication. The prescription form itself resembles a contract, with the name of the doctor, the name of the patient and the prescribed medication linking the two written on it. It is assumed that the authority of the doctor extends beyond the consultation, because the drug must be taken as prescribed once the patient gets home (e.g. 'Take one tablet three times a day, after meals, for 7 days'). As with other healing rituals, the consultation takes place at specified times and in a setting set aside for this purpose. The GP's room, although designed for a technical purpose, includes

many objects that will not be used in a particular consultation, and can therefore take on the significance of ritual symbols. These may include: a framed diploma on the wall; a stethoscope, otoscope and ophthalmoscope; a sphygmomanometer; tongue depressors; scalpels, forceps, needles and syringes; a glass cabinet full of instruments; bottles of antiseptic and other medicines; one or more telephones; a bookshelf filled with impressive-looking textbooks or journals; a large desk; family photographs; sheaves of special forms or notepaper; an ink pad and rubber stamps; and a pile of previous patients' medical cards. Most GPs now have a computer on their desks – an object that plays an increasingly important role in the consultation, and which can now be regarded as ritual symbol in its own right (see Chapter 13).

In this formalized setting of ritual time and place, the patient's diffuse symptoms and signs are given a diagnostic label and organized into the named diseases of the medical model. As well as prescribed medication, the most powerful drug administered in this setting is faith in the healing powers of the doctor.²³

Case study: 'Doctor John' – an innovative traditional healer in Transkei, South Africa

Simon⁴⁷ in 1991 described the setting and healing rituals of 'Doctor John', a Xhosa traditional healer in rural Transkei, eastern South Africa. 'Doctor John' used many of the ritual symbols and practices of Western medicine, but blended them with certain aspects of traditional African healing. Situated in a village back street, his consulting room was in a small, dilapidated shack. Although without formal qualifications, a lavishly painted sign hung outside proclaiming: '*Dr John: Homeopath, Naturopath, Herbalist. Welcome*'. At any one time, 20–30 people were waiting for him, some standing in the courtyard outside, others sitting in his tiny waiting room in which an assortment of herbs, bulbs, roots, dried skins, and calabashes were crammed onto makeshift shelves. Many of the bottles of herbs had labels with popular brand names; others had illegible instructions scrawled on them. Within the actual consultation room (its door labelled '*Dr John's Office*'), the healer sat behind a desk, dressed in a white coat, a suit and tie, and wearing a pair of green-tinted spectacles. On the table, illuminated by two candles, lay a number of significant ritual objects: burning incense, small calabashes, beads, a stethoscope, a syringe and a stack of medical publications, ranging from scientific journals to home doctor books. His assistant was an elderly woman, who also wore a white coat. All the patients who entered the room were asked how they were

feeling, and then each one was examined with the stethoscope. Then 'Dr John' announced that he would implore his *amakhosi*, or spirits, to aid in the diagnosis and discover the cause of the patient's illness. Afterwards, he told the patient that he would use a 'doctor's book' to find the most appropriate treatment for them. He then read out a passage from one of his books, translating its meaning to the patient. To strengthen the effect, he often repeated sentences aloud from it in English. He then scribbled instructions on a piece of paper (the 'prescription'), and asked the patient to hand this to his assistant, who then dispensed the appropriate herbs. Like other traditional healers in that area, he always also included one or two pharmaceutical products in the prescription, such as cough mixtures, aspirins, laxatives or milk of magnesia, which he kept in a small closet nearby. Simon noted that his syncretic mix of Western and African healing practices, his 'commitment to the parallel utilization of medical traditions, and not a singular devotion to either form of practice', had made him a popular and effective healer locally.

Whatever the success or otherwise of his treatments, the case of Dr John and his ritual setting shows that in the modern age traditional medicine is not static. 'Like any form of therapy, local (traditional) healing is a dynamic, changeable profession, with shifting ideas and practices tailored to suit the times.'