Indigenous Healers and Stuttering

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ABSTRACT

Traditional beliefs and attitudes of Black South Africans to stuttering were investigated. Four Indigenous Healers (IHs) from different ethnic groups were interviewed about their beliefs as to cause and management of stuttering, as well as the outcome of their treatment. The data reveals varying degrees of concern about stuttering. The traditional beliefs of cause and management of stuttering show some similarities to current beliefs held by speech pathologists. Implications in terms of direction in therapy, cooperation with IHs and future research in this field are discussed.

OPSGOMMING

Die tradisionele opvattinge en houdings van Swart Suid-Afrikaners ten opsigte van hakkel is ondersoek. Onderhoude is met vier Tradisionele Genesers van verskillende etniese groepe gevoer om hulle geloofsoortuiginge te bepaal ten opsigte van die oorsaak en behandeling van hakkel, sowel as die resultate wat gekry word met hulle behandeling. Die data toon wisselende grade van besorgheid oor hakkel. Die tradisionele geloof rakende die oorsaak en behandeling van hakkel stem ooreen met die huidige menings wat gehuldig word deur spraakpataloe. Die implikasies van bevindinge word bespreek met behulp van terapeutiese riglyne, samewerking met Tradisionele Genesers en verdere navorsing.

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An important aspect of stuttering in relation to research and therapy is the attitude of the stutterer himself and that of his associates toward his speech symptoms. (Ammons and Johnson, 1944, p.39)

Although emotions and attitudes are highly individualistic, cultural beliefs and background will invariably influence them as "... culture is the indispensable factual background in relation to which the worker adapts his contribution to the situation before him." (Penalson, 1952, p.4). Culture implies meanings, ideas and values that constitute a way of life that pervades relationships, systems of belief and behaviour.

It may be assumed therefore that culture will influence attitudes towards stuttering as well as its development and treatment. Wendell Johnson (1944), in his studies of American Indians, was one of the first to investigate cultural influences on stuttering. He found no evidence of stuttering and no name for it was present in the languages of the groups studied. He interpreted this lack of a name as being the reason why stuttering did not exist, because it implied that stuttering was not significant in this culture. Later analysis (Wingate, 1972) identified methodological problems in Johnson's research and his results were discredited.

Subsequent studies, cited by Van Riper (1971) found stuttering among population groups as diverse as the Japanese and Eskimo, leading him to conclude that stuttering exists universally. Therefore, the cause is unlikely to be related to cultural attitudes. He does, however, cite Kluckhohn (1954) who states that "... impressive differences in the degree and incidence (of stuttering) suggests cultural influences are operative." (Van Riper, 1971, p.9.)

Wingate (1972) attributes this to the differences in the importance and expectations of a child's speech, across cultures. This sentiment is reiterated by Snidov (1947), Leith & Mims (1975), Leith (1986) and Shames (1989) who identify cultural factors such as stress on speech performance, and child rearing practices which are likely to influence the incidence of stuttering.

Having concluded that cultural beliefs influence the incidence of, and attitudes towards stuttering, and that these attitudes should be identified and explored in therapy, it is evident that the speech therapist needs to be familiar with the cultural beliefs of her clients. Shames (1989) states that "... therapy becomes an intercultural collision of values, attitudes, expectations and definitions". Owing to the disproportionate ratio of Black speech therapists to Blacks in South Africa, one is faced with a situation where the majority of trained therapists are unfamiliar with the cultural backgrounds of their clients. Current trends in therapy derive from America and Europe with an orientation not designed to meet the needs of cultures as diverse as that of Black South Africans. The success of therapy may therefore be hindered by the denial of, or failure to acknowledge a client's cultural beliefs through lack of knowledge, and his being forced to conform to those proposed by modern theories. Refuting beliefs about cause and treatment may serve only to alien-
The writers have, therefore, undertaken to study an aspect of the attitudes and perceptions of a sample of Black people in South Africa to stuttering. In order to attain an understanding of traditional cultural beliefs it was decided to focus on Indigenous Healers (IHs) for this information as they have been described as "...psychologist, physician as priest ... tribal historian" (Holdstock, 1979, p.119). The IH is a highly respected member of the tribe, a reservoir of traditional beliefs and one who has the power to modify customs (Hammond-Tooke, 1989). He is that indispensable member of the society who is consulted by an estimated 70% of the black population of S.A. (Mzinyathi, undated, p.144). In 1977 the Soweto Society for Marriage and Family Life concluded that the majority of people in Soweto believe in the power of the IH (Holdstock, 1979). The World Health Organisation (WHO) estimated that IHs form the essential core of primary health workers for nine tenths of two billion rural dwellers in Third World countries (Holdstock, 1979). Once urbanised, a black person may well consult an IH as Hammond-Tooke (1974) predicts that an urban dweller's clientele consists of traditionalists, professionals, middle-class Blacks and even Whites. IHs may, therefore, be considered a valuable source of information on cultural beliefs about stuttering as well as on the traditional treatment for stuttering.

According to Hammond-Tooke (1989) there are two distinguishable types of healers, i.e. diviner and herbalist. The herbalist is one who has not been mystically called but is a master of medicines. He is one who has knowledge of plants and roots. The diviner, on the other hand, has been described by Hammond-Tooke (1989, p.104) as one "...clothed with power and knowledge ... called to the profession by the prompting of the ancestors". He, therefore, likens the diviner to a doctor, and the herbalist to a pharmacist. A diviner is consulted in the case of a long-lasting illness in order to establish a cause and a remedy for the illness. The diviner was, therefore, considered to be the more suitable subject for this research report.

The aims of this study were twofold:
1. To probe the cultural beliefs and attitudes of IHs to stuttering.
2. To investigate whether they treat stuttering clients and, if so, what this treatment would comprise.

Subjects

Because of time and other practical constraints the size of the sample had to be restricted to five subjects. An attempt was made to choose subjects reflecting the population of the IHs which is divided into the Nguni, Sotho, Venda and Tsonga groups (Hammond-Tooke, 1989). Unfortunately, no Venda subject was available. Two subjects had rural, and three urban practices to reflect possible differences in approach. All subjects were diviners, as it was considered that they would be the more likely IHs to be consulted in the event of stuttering.

All subjects were contacted through the African National Healers Association (ANHA), as Freeman (1992) cautions against consultation with IHs who may not be authentic. For a description of the individual subjects please see Table I.

Procedure

The survey was conducted through interviews because of the "richness and spontaneity of information" (Oppenheim, 1966, p.32) which is obtained through this method of data collection. Interviews yield a high response rate and decrease the number of "don't know" and "no answer" responses (Young, 1966). The flexibility of an interview was felt to be particularly appropriate in this instance as English was not the home language of any of the subjects and it was therefore sometimes necessary to rephrase, explain and probe. Interviews do not require reading or writing ability on the part of the subjects. This was an important consideration according to the African National Healers Association (unpublished) not all IHs are literate.

An interview is prone to a number of sources of error...
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Table 1. Description of Subjects

<table>
<thead>
<tr>
<th>Subjects</th>
<th>Professional Name</th>
<th>Years in Practice</th>
<th>Rural/Urban</th>
<th>Calling</th>
<th>Training</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tsonga (Female)</td>
<td>Mungome</td>
<td>22</td>
<td>R</td>
<td>Fell ill. Couldn’t eat. No improvement till consulted Mungome who told her it was a calling.</td>
<td>8 months with Mungome. Communicated with ancestors in visions.</td>
<td>Specialist in childhood health problems. Others - infertility, insomnia due to witchcraft. Ulcers. Trains novices.</td>
</tr>
<tr>
<td>2. S. Sotho (Female)</td>
<td>Ngaka</td>
<td>22</td>
<td>R</td>
<td>Became ill. Taken to IH.</td>
<td>Inaugurated via rituals - slaughtering goats. Drinking or smoking medicines.</td>
<td>Specialist in childhood disorders - diarrhoea, vomiting, swollen feet, sores under tongue, nail biting, failure to speak. Trains novices.</td>
</tr>
<tr>
<td>3. Xhosa (Male)</td>
<td>Igquira</td>
<td>7</td>
<td>U</td>
<td>Fell ill. Untreatable by orthodox medicine.</td>
<td>1 year under IH. Gained ability to communicate with ancestors and to predict events before they occur.</td>
<td>Treats mental disturbance, body sores, visual defects, stomach ache, female problems, birth difficulties.</td>
</tr>
<tr>
<td>4. Zulu (Male)</td>
<td>Inyanga</td>
<td>9</td>
<td>U</td>
<td>Fell ill. Called to profession by his deceased grandfather.</td>
<td>1 year and still consults his trainer. Throws bones to formulate diagnosis.</td>
<td>Ability to cure VD, nausea, vomiting and bewitching given as a few examples.</td>
</tr>
</tbody>
</table>

and its scientific utility is limited. It does, however, offer a means to establish contact with the subjects and to assess the appropriateness of this source of information.

Question Construction

The order and sequencing of questions was controlled (Young, 1966). Most questions were open-ended as these provide the best opportunity to obtain the maximum amount of information from each question. Guidelines outlined in the literature (Babbie, 1973) were followed in the construction of questions.

Pilot Study

Following a pilot study, conducted with a Southern Sotho IH, several changes were made to the sequence and content of the questions. At the end of the interview the respondent asked if she could ask the interviewer some questions. This proved to be valuable as her questions provided insight into her frame of reference and beliefs about stuttering. This procedure was then incorporated into the construction of questions.

Interviews

It was felt that the respondents would feel more relaxed and discuss their thoughts and practices more openly in familiar surroundings. Subjects 1 and 2, who practice in a rural area, were interviewed at a private residence of their choice in the area in which they live. The other three subjects were interviewed at the offices of the ANHA. The interviewer told the subjects to decide in terms of where to sit, i.e. at a table or on the floor.

None of the respondents could speak English well and they were, therefore, joined by a member of the African National Healers Association (not an IH himself) who acted as interpreter. Kahn and Cannel (1957) caution against the use of an interpreter as it creates a barrier in the establishment of a rapport between respondent and interviewer. In this case it was felt that the interpreter actually set the respondents at ease and facilitated more open responses. An interpreter should merely be a medium through which questions and answers are transmitted (Young, 1966). In order to ensure this, sources of error such as prompting or leading the respondent’s answers were discussed with the interpreter before the first interview. He showed a knowledge and understanding of the protocol for research.

During the third interview, the interviewer became aware that the interpreter was leading the subject. When this interview was analysed by a Sotho speaking speech therapy student her suspicions were reinforced. It was, therefore, decided to exclude this subject from the study. Following this the process was rediscussed with the interpreter and he was reminded of his role before completing the remaining two interviews.

None of the subjects was present at interviews other than their own and they were asked not to discuss their interviews with the other subjects.

Die Suid-Afrikaanse Tydskrif vir Kommunikatiewykeings, Vol. 40, 1993
Analysis of the Data

The contents of the interviews were reported upon as "... precise summaries of the data" (Forcese and Richer, 1973, p.213). As this research was descriptive, results were categorised according to the questions, tabulated, and discussed qualitatively in order to compare the salient features.

Results and Discussion

The subjects' views on stuttering, i.e. name, cause, management, outcome and attitudes are presented in Table 2, and will be discussed below.

Name and Description of Stuttering

All the IHs had names for stuttering, which corresponded with those found by Aron (1966). S1 and S2 also gave alternate names. S1 (Tsonga) originally spoke of treating "lilele", which from her description may or may not have referred to stuttering. However, when asked to translate "stuttering" she used the term "konkoretsa" and demonstrated this as syllable repetitions.

It is interesting to note the similarity between this word and "korakoretsa" the term used by S2 (South Sotho) as these two languages are not related.

All the names used were onomatopoeic as are the names for stuttering in many languages, e.g. "tuhuhtuhuh" - Egyptian, "gimgeim" - Hebrew and "howdodo" - Ghana (Van Riper, 1971).

The IH's descriptions of stuttering all corresponded with the description of characteristic stuttering symptoms, i.e. syllable repetitions, complete blocks and sound prolongations given by Peters and Guitar (1991).

Table 2. Summary of Data

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Cause</th>
<th>Management</th>
<th>Outcome</th>
<th>Attitude of Stutterer</th>
<th>Attitude of Society</th>
</tr>
</thead>
<tbody>
<tr>
<td>S1</td>
<td>(Lilele)</td>
<td>Syllable repetitions</td>
<td>- Heredity (Accumulation of coagulated milk in throat.)</td>
<td>- None</td>
<td>Not a problem</td>
<td>Accepting Status unaffected.</td>
</tr>
<tr>
<td></td>
<td>Konkoretsa</td>
<td></td>
<td></td>
<td>- Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S2</td>
<td>Kgakgametsa</td>
<td>Syllable repetitions Prolongation Visible and audible tension</td>
<td>- Heredity - Baby left out in first spring rain</td>
<td>Medication - Prayer and ritual medication. - Parental counselling.</td>
<td>Slow speech - Easy prolongations</td>
<td>Problem Low self esteem - Accepting Status unaffected.</td>
</tr>
<tr>
<td></td>
<td>Korakoretsa</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S3</td>
<td>Thintitha</td>
<td>Syllable repetitions Blocks</td>
<td>- Heredity - Failure to inform ancestors of imminent child-birth - Witchcraft</td>
<td>Prayer Medication Rituals Parental counselling - As with mental disorder</td>
<td>Slow speech</td>
<td>Big problem handicapping - Accepting Status unaffected.</td>
</tr>
<tr>
<td>S4</td>
<td>Amalimi</td>
<td>Repetitive clicks (syllable repetitions)</td>
<td>- Heredity</td>
<td>Medication applied to cuts on throat area.</td>
<td>Slow speech</td>
<td>Big problem - Accepting Status affected</td>
</tr>
</tbody>
</table>

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Outcome

Subjects 2, 3 and 4 were agreed that their treatment would not cure the stuttering but would lead to slower, improved speech. Therapists in many parts of the world report programs based on slow easy speech as helpful for stutterers (Peters & Guitar, 1991).

Subject 2 claimed that "there will be some noticeable change in the child". When asked to demonstrate the change, she showed easy prolongations in place of the effortful blocking she had shown as symptomatic of stuttering. Van Riper (1973) and others, advocate modifying the symptoms of stuttering to easy prolongations.

There is no objective proof that the IH's treatment of stuttering is as successful as reported. It is likely, however, that the treatment could bring relief to the patients, at least partially, through indirect suggestion. Indirect suggestion forms part of any stuttering program. A patient seeking therapy, goes with an anticipation and expectation of relief from his stuttering. This strong faith and desperate need are able to bring about a certain amount of relief (Van Riper, 1973). Van Riper attributes the success of suggestion to the intermittent, variable, fluctuating nature of stuttering, spontaneous recovery and the fact that temporary fluency is easily established.

Whether or not any known medication has proved successful in treating stuttering is questionable. Van Riper (1973) cites many experiments done to assess the efficacy of certain drugs but criticizes their methodologies. He concludes that placebos may produce the same effects as drugs, because the therapeutic value of drugs often comes from the patient's faith in his physician. Van Riper (1973) gives credit for success in therapy, to the therapist's love and concern for the patient's well-being, or other factors.

IHs provide "... warm, nurturant, total acceptance of their patients" (Hammond-Tooke, 1989, p.147). This, coupled with a belief in their powers of healing and a need to be cured, may be effective in relieving some of the symptoms, e.g. tension, associated with stuttering.

Counselling parents also plays a significant part in the therapy provided by speech therapists. The principle of guiding parents towards a change of behavior towards a stuttering child, is reported by some of the IHs. Given the warm empathetic environment that an IH can provide, parents may discuss their anxieties and become open to suggestions regarding the treatment of their children (Van Riper, 1973). It is not uncommon for parents to report a dramatic cessation in stuttering once they have removed certain pressures from speaking situations (Van Riper, 1973). Strategies, e.g. use of simple language, reducing time pressure, providing a fluency model and not calling attention to the stutter are some of the suggestions that Peters and Guitar (1991) make reference to in a summary of the parent counselling of theorists such as Van Riper, Bloodstein and Luper and Mulder. S3 makes similar suggestions, e.g. "... they shouldn't shout at the child, they shouldn't speak fast to the child", and cautions that "... imitating him to tease him creates a big problem ... this shouldn't be done".

The success of the IHs treatment may, in some cases, not be attributable to their efforts at all. Research has indicated that 50-80% of children who stutter, recover before puberty, without any treatment (Peters and Guitar, 1991). Although they commented that the methods of gathering this information were not entirely reliable, Peters and Guitar (1991) conclude that spontaneous recovery can occur.

Attitudes

S1 did not feel that konkoretsa was a problem. The other three concluded that stuttering was a problem which would handicap the individual or cause him to develop a low self esteem. However, only S4 felt that the stutterer would be prevented from attaining a position of status such as a tribe leader. This duty requires proficient, confident speech which is beyond the reach of the stutterer.

Implications

Aron (1991) estimates that only a fraction of the more than 3 000 000 people in South Africa who require speech therapy, receive it, due to the small number of speech therapists working in this country. As a solution she proposes a community based approach to speech therapy, i.e. training community workers to provide basic therapy and knowledge of when and to whom referrals should be made. IHs are already recognised and consulted by most Black South Africans. They may, therefore, provide the untapped resource needed to make services accessible to more people with communication disorders, one that includes an awareness of "linguistic and cultural forces that operate on the individual" (Shames, 1989, p.74). Co-operation between speech therapists and IHs in the treatment of stuttering appears viable, not to undermine or eradicate cultural beliefs, but to share information and establish a system of referral.

The beliefs held by IHs have proven to be a fertile and accessible area and more research is indicated in:

- IH's beliefs as to cause and management of other communication disorders, e.g. hearing loss, strokes and cerebral palsy were mentioned by these subjects;
- the outcome of treatment by an IH from the patient's perspective;
- interviewing greater numbers of IHs in order to generalize common trends in their beliefs about cause, management and attitudes to stuttering;
- a comparison of the views of rural and urban IHs. Although no marked differences appeared in the views expressed by the subjects in this study, it must be noted that the two rural subjects lived relatively close to an urban area. Possibly subjects living in more remote parts of the country might offer different ideas;
- the efficacy of modern stuttering therapies for Black South Africans.

Conclusion

At a conference in Geneva in 1987, the WHO resolved to develop traditional medicine in its member states as IHs constitute the most abundant health resource in many countries. In order to utilise and maximise this existing resource, the WHO has suggested national research strategies into traditional medicine (Akerere, 1987).

South Africa too is scrutinising its National Health Policy in order to address primary health needs (Aron, 1991). These could be satisfied by community workers familiar with the particular linguistic and cultural background of the community. The IH may be considered ideal...
in filling this role.

This article is limited in terms of its scope, i.e. only stuttering was investigated and only a small sample was used. However, it indicates that communication disorders are recognised and treated by IHs, and more research into this field is necessary.

Further research may strengthen the conclusion that co-operation between IHs and speech therapists is possible as "... knowledge and sympathetic understanding ... combine in ongoing dialogue, with the interests of the patient as the overriding concern" (Hammond-Tooke, 1989, p.155).

Acknowledgments

The writers wish to thank the following:

1. The African National Healers Association for assistance with information and obtaining subjects.
2. Mr Rakaluta the interpreter.
3. The subjects who participated willingly in the research and shared their knowledge generously.

REFERENCES


Appendix

Interview Format

A) Biographical Information
1) Name, ethnic group.
2) How did you become an IH?
3) Did you receive training?
4) For how many years have you been practicing as an IH?

B) Stuttering
1) Tell me about the work you do.
2) Have you ever been consulted by a patient with a speech problem? Tell me about this case.
3) Do you know what stuttering is?
4) What word do you use for stuttering?
5) Have you ever treated a stutterer?
   - Cause
   - Management
   - Outcome
6) Does your treatment differ if the patient is male or female?
7) Would a stutterer's status be affected because of the stuttering, e.g. could he be a tribe leader?
8) How would you rate stuttering: As a big, small or no problem?
9) Do you have any questions that you would like to ask me?