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An Exploration into the Experiences of South African Psychologists working with patients who consult Traditional Healers/Sangomas

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MA Research Report

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An Exploration into the Experiences of South African Psychologists working with patients who consult Traditional Healers/Sangomas.

Declaration

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Signed: Boipelo Tagana

Date: 12 December 2024

Ethics Clearance No: MCLIN/22/07

Dedication

I would like to dedicate this thesis to all the Indigenous healers who have been misunderstood and misdiagnosed with mental conditions.

Acknowledgements

To my supervisor: Dr Makhosazane Nomhle Ndimande-Khoza and my former supervisors Lynne Goldshmisdt and Hopolang Matee. Your guidance, knowledge and support in carrying out my research has been invaluable.

To my participants, Thank you for your participation in my study. Without your valuable experiences, this research would not have been possible. I truly appreciate your courage and vulnerability, and I trust that your experiences will provide essential knowledge for those with similar experiences.

Ba ga Tagane, thank you for holding me up, pushing me and supporting me through all the trials, the grief and the joy that came during the pursuit of this degree

To my friends, my sisters and brothers, you have made the journey so much fun and for that I would like to say, thank you.

Abstract

The current mental healthcare system in South Africa is predominantly influenced by Western ideologies, which often fail to cater to the needs of the culturally diverse population. Consequently, there is a growing preference among South African clients for psychologists who integrate spirituality in their psychotherapeutic work, either directly or through referral systems. This integration of conventional and complementary therapies is known as medical pluralism. The increasing demand for medical pluralism raises the question of how psychologists currently work with traditional healers and clients who ascribe to indigenous knowledge systems. This study explored how South African psychologists work with traditional healers and clients that adhere to indigenous knowledge systems. The data was collected using semi-structured interviews with open-ended questions to gain an in-depth understanding of the psychologists' experiences, the interaction of Western and African worldviews in therapy, and to develop frameworks that integrate both worldviews. Data was analysed using an interpretive phenomenological analysis to explore participants lived experiences. Results indicated that psychologists felt inadequately trained to address African spiritual beliefs. The study revealed institutional challenges, such as the medical model's tendency to conflate African ancestral callings with psychosis. Cultural considerations were reportedly dismissed due to the fast-paced, diagnosis-focused environment. The findings underscore the need for integrating African epistemologies into psychological training and practice. Additionally, collaboration with local communities and thought leaders in African Psychology is crucial for creating a culturally sensitive and inclusive mental healthcare system. Overall, the study highlights the importance of developing frameworks that honour spiritual beliefs and community contexts that promote holistic approaches to mental health care.

Keywords: Traditional healing, Sangoma, Mental healthcare, African Psychology, Indigenous knowledge systems.

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CHAPTER 1: INTRODUCTION

1.1 Background

South Africa is a landscape comprising of people from diverse contexts and cultures. This diversity is evident in the different cultural and ethnic groups among South African citizens. Given South Africa's complex legacy of colonialism, there is a hierarchy that fails to reflect the diversity of its citizens in the socio-political and economic systems of the country (Matoane, 2012). This is also reflected in the healthcare system that is historically inflexible of African-centred and indigenous belief systems (Holdstock, 1981; Edwards, 2011). The current mental healthcare system is driven by Western ideologies that do not cater to the majority of the population in South Africa, that is, Black Africans (Lappeman et al., 2021; Statistics South Africa, 2022). The mental healthcare system, for instance, faces challenges in providing culturally and contextually sensitive care (Edwards, 2011). This calls for a desperate measure from the profession of psychology to realign its goals and practices to reflect a democratic South Africa. There are, however, challenges as mental healthcare institutions in South Africa are under-resourced due to minimal fund allocation to the research and development of African Psychology (Dockrat et., 2019). Consequently, outdated Western systems of psychology that are out of context are perpetuated and insensitively applied to mental healthcare users. This is evident in the inadequate understanding and misrepresentation of psychological presenting problems that do not consider the local context (Matoane, 2012). Another one of the major issues is a lack of access to mental healthcare, particularly by Black people from marginalized and lower income groups. This is due to poverty, geographic location or long travelling distances to healthcare facilities and a lack of information about mental health facilities (Koen & Roberston, 2020; Moshabela et al., 2016).

As a result, many of the Black South African citizens from lower socio-economic status are unable to seek out Western mental healthcare. However, there has been an increasing recognition of the importance of culturally relevant care in the Western healthcare system. This recognition has driven initiatives of cultural competence and community-based services that attempt to address these issues, however the lack of resources and inadequate infrastructure on a systemic level have delayed this process (Koen & Robertson, 2020; Ebersöhn et al., 2018). Moshabela and colleagues (2016) stated that marginalized groups who can successfully access Western healthcare tend to consult traditional healers as well. This concurrent use of both Western and traditional African healing systems calls for a more contextually relevant African

Psychology that accommodates the traditional and spiritual beliefs of patients. This kind of system would greatly serve a South African population who draws on the strengths of both systems to receive more dynamic and holistic treatments for their mental health.

1.2 Rationale

In South Africa, there is a prevalence of patients who seek out mental health services and traditional or spiritual healers simultaneously (Padayachee & Laher, 2012; Burns & Tomita, 2015; Moshabela et al., 2016; Nduna et al., 2020). Of these patients, there are those who are Indigenous healers or undergoing training to become healers. Thornton (2017) states that Traditional African healers often have a psychological or psychiatric history, particularly those who had not known of healers in their lineage. Often traditional healers and other mental healthcare clients have their own conceptions of health and well-being that are often informed by indigenous religious and spiritual beliefs (Moshabela et al., 2016). Unfortunately, it is often the case that Western based systems of psychological well-being have been unwarily applied to non-western clients who do not exclusively ascribe to these systems (Ebersöhn et al., 2017). Consequently, South African psychologists have received a lot of criticism since the apartheid era on account of the lack of critical application of psychology in a country that is culturally diverse (Dawes, 1985 in Matoane, 2012). The criticisms range from cultural insensitivity to the dominance of western epistemologies that fail to adequately address issues of apartheid and colonialism in a practical way that goes beyond theory (Ratele, 2019)

Recently, there has been growth in the rate of South African clients who prefer psychologists who integrate spirituality in their psychotherapeutic work, either directly or through referral systems (Nduna et al., 2020). This ability to understand and embrace both conventional and alternative complementary therapies alike is known as medical pluralism (Moshabela et., 2016). The increasing demand for medical pluralism raises the question of how psychologists currently work with clients that ascribe to beliefs that are deeply entrenched in Indigenous knowledge systems. It is crucial to gather knowledge on the unique experiences of South African psychologists that work with clients that bring cultural /spiritual material in the therapy room. There is currently a dearth of literature available regarding this. Additionally, psychology training programmes introduce African Psychology at undergraduate level, with little integration of African Indigenous Knowledge systems at post-graduate professional degrees, thus emphasising Western Mental Health models in professional workspaces. It is

surmised that the findings from this study may be of value to inform and contribute towards a more relevant psychological practice within the South African context. Furthermore, the study findings could assist other psychologists who work with clients presenting with Indigenous spiritual beliefs while also enhancing collaborative relationships between psychologists and traditional healers in the field.

1.3 Aims and Objectives

The overall aim of this study was to explore the experiences of psychologists who work with clients who are also consulting traditional healers/ Sangomas (or are being urged by their family to consult with Sangomas)

Specific objectives were

1. To gain an understanding of the experiences of psychologists who are working with clients who also consult traditional healers/ Sangomas
2. To gain an understanding of how Western psychology and African Spirituality interact in the therapy room
3. To gain insight into psychologists' ideas towards building a framework of working with both Indigenous/Spiritual and Western psychological worldviews

1.4 Research Questions

1. What are meanings derived from experiences of psychologists who work with clients that also consult Sangomas?
2. How do psychologists navigate the interaction of Western psychology and African Spirituality in the therapy room?
3. What are psychologists' ideas about a framework that could be helpful or has been when working with clients who also consult Sangomas?

1.5 Key Concepts

African Spirituality: African Spirituality is a holistic concept rooted in the historical, cultural and religious heritage of the indigenous African people. It encompasses various traditions, beliefs and practices including the belief in ancestral spirits (Edwards, 2011).

African Spiritual patients: Patients who ascribe to African beliefs systems and practice African customs as a way of life despite multiculturalism as a norm.

Mental illness: Mental illness refers to clinically significant disturbances in the cognitive, emotional and behaviours spheres that result in distress or impairment (Koen & Roberts, 2020).

Sangomas: Respected indigenous healers in South African communities that heal using their diviner-mediumship skills to restore physical, emotional and spiritual balance to individuals experiencing disharmony in their lives (Bakow & Low, 2018)

Traditional healers: Traditional healer is an umbrella term for various healers who ascribe to indigenous knowledge systems and African spiritual concepts to restore health and balance in the lives of community members (Thornton, 2017).

Thwasana/ithwasa*:* Someone who is undergoing the training to become a Sangoma (diviner-medium) and under the tutelage of a qualified uGobela (Edwards, 2011; Molot, 2017).

Western Psychology: Western Psychology is the study of the mind and human behaviour and is mainly based on scientific observation rooted in methodologies rooted in Europe and North America. It includes the study of the mind to evaluate and understand behavioural patterns, thoughts, emotions and motives American Psychiatric Association (2013).

1.6 Structure of the thesis

This thesis comprises several chapters each which focus on a specific aspect of the research. This is the first chapter which introduces the topic, it provides a contextual background, rationale, research aims and the research questions. It also defines the key concepts of the study. Chapter two is the literature review, and it explores the relevant literature on the topic under study. It highlights key concepts relevant to Western trained psychologists working with African Spiritual clients in South Africa. The third chapter discusses the methodology used to conduct the research in detail. This provides a clear outline of how the research was conducted. The fourth chapter is dedicated to presenting the findings from the study. The thesis is concluded in the fifth chapter which is centred on assessing the implications of the research. It presents recommendations for psychology and training institutions as well as suggestions for future research that could be carried out in this area.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The following chapter presents a review of literature that is relevant to the study. The scarcity of literature directly related to this study has led the researcher to discuss other appropriate topic areas which include the defining of Sangomas, Mental illness in traditional healing systems, Sangomas conceptions of mental illness, Psychologists conceptions of mental illness, Critical African psychology, similarities and differences in Western and traditional African worldviews. This is an attempt to add broader and rich thought to the topic, with the hope that the results of this particular study, will add richly to the limited resources.

2.2 Mental illness in traditional healing systems

In traditional African healing systems, mental illness is defined as more than intrapsychic conflict but is understood as a breakdown between the individual and the relationships with their community (Kwate, 2005; Sow, 1980 in Juma, 2011). These interrelationships could be understood at three different levels, the first being the *macro-cosmos* where individuals connect with God during everyday mundane activities. The second is the *meso-cosmos*; the area of spirits such as ancestors, malevolent entities, and nature spirits. These spirits are thought to have a hand in the events of a person's life, for instance, when there is discord in the *meso-cosmos* misfortunes, conflicts, death, failure, illness, and accidents occur whereas when there is balance one will receive protection and blessings from the ancestors (Edwards, 2011; Sow, 1980). The last level of interrelationship is the *micro-cosmos;* this represents one's community such as family, friends and other social circles and it is here where collectivism is highlighted (Juma, 2011; Sow 1980). This kind of collectivism is embedded in South African culture and can be found in the common Zulu saying: "*umuntu ngumuntu ngabantu*" which translates to 'a person is a person through other people' (Edwards et al., 2009).

As mentioned above, Ancestral reverence is highly important in African communities and honour is placed upon all those who are connected to ancestors in an intimate way. In South Africa, ancestors are thought to live and breathe through the Sangoma, and this is reflected in the saying "*ukuphefumulela amadlozi*" (Edwards, 2009, p. 2) Sangomas are thought to possess the power and sagacity of the deceased beings that serve as a guiding and healing force to many Black South Africans. *Sangomas*, are therefore highly respected and sought after in traditional

African communities whenever there are illnesses and misfortunes (Edwards, 2011). It is estimated that approximately 80 percent of the African population seek traditional healers before western medical doctors, especially in the rural areas of Kwa-Zulu Natal (Gumede, 1990).

2.3 Who are Traditional healers?

There are various kinds of traditional healers in South Africa. The most popular types of Indigenous healers are '*Inyanga*' (herbalists), '*Umthandazi*' (faith healers) and '*izangomas*' (plural of *isangoma*) (diviner-mediums) (Edwards, 2011; Molot, 2017). In this literature review, emphasis is placed on Sangomas as they are the most common Indigenous healers in South Africa. Sangomas undergo a strict initiation process called ukuthwasa: a term referred to as an answer to a calling brought about by one's ancestors (Bakow & Low, 2018; Thornton, 2017). This calling is characterized by hearing voices, dreams, and visions: of the deceased, sacred medicines, or animals as well as social withdrawal and several other physical symptoms (Hammond-Tooke, 1989; Thornton, 2017; Viljoen, 2006). When the *thwasana* (Sangoma apprentice) experiences these symptoms, they are taken to an experienced Sangoma who confirms whether their symptoms are characteristic of an ancestral gift or whether there is another imbalance happening (Ngubane, 1977 in Wozniak, 2009). In Western medical settings, Edwards (2009) and Van der Watt and colleagues (2021) report that gifted people who receive the call have often been diagnosed with depression and at other times schizophrenia, due to the hallucinatory symptoms that accompany the calling. Most of the distressing symptoms dispel after student Sangomas accept their calling (Bakow & Low, 2018). When the *thwasana* accept their calling, they go through a metamorphosis where they are reborn as a Sangoma, following the death of their old ways of life (Edwards, 2010).

During their initiation *amathwasana* (Sangoma apprentices/student Sango ma) are trained by their *Gobela* (their spiritual parent/teacher) to be able to uplift and entrain the ancestor spirits that the *thwasana* already possesses within him/her (Thornton, 2017). This can be done through *ukuphahla* i.e., communicating with the ancestors, dancing, and drumming, performing rituals, river cleansings and other various practices, depending on the kind of ancestral gift that the student Sangoma possesses. Once the student Sangoma has successfully gained control over the ancestor, they can then receive messages from the ancestors that will inform how they diagnose and help their patients (Hammond-Tooke, 1989; Thornton, 2017).

Other parts of the initiation process include diagnosing clients i.e., identifying an illness based on the cluster of symptoms, the use of herbal medicines, dream interpretation, entering altered states of consciousness and interpreting extrasensory information, though a large part of this is informed by the ancestor spirit (Louw & Edwards 1997).

When clients consult a Sangoma, the Sangoma calls upon their ancestors to guide them so that they can receive messages about the client. In other circumstances, the Sangoma uses their psychic powers of knowing to diagnose the client's problem, before the client expresses it (Ogana, 2009). Messages in the healing space are received through the use of divination tools such as bones which are very symbolic, they inform the healer where the discord lies in a client's life and consequently where the illness originates (Thornton, 2017). Healers usually investigate all areas of functioning such as physiological functioning, interpersonal relationships, financial position, sexual matters, ancestral and other external influences (Burns & Tomita, 2015).

2.4 Sangomas conceptions of mental illness

There is quite an overlap in belief systems with the broader traditional African model of illness and that of Sangomas although slight nuances might exist. For instance, *Izangoma* might explain the breakdown in the meso-cosmos as a manifestation of illness brought on by a displeased ancestor, or an ancestor who might be trying to receive the attention of the mentally unwell person or their family (Bakow & Low, 2018). The mental illness might push the unwell person and their family to consult a *sangoma* or other traditional healers to receive the relevant message from their ancestors (Crawford & Lipsedge, 2004). A disturbance in the micro-systems could look like relationships that are in turmoil or envious relationships which could then result in bewitchment (Molot, 2017). These are the few ways in which a person can be bewitched; *umeqo,* when *muthi* (potent medicine) is buried or sprinkled in the walking path of the person and they step over, *ukudlisa*; when the persons food is poisoned. *Ukuphonsa* or throwing is witchcraft that happens at a distance or through dreams (Crawford & Lipsedge, 2004)

Sangomas realise the causes of mental illness as distinct based on the physical and psychological symptoms. To Sangomas, a person who is mentally ill is one who displays a range of behaviours like uttering nonsense statements, confusion, derangement, aggression, destruction of things, overthinking, abusing substances, reckless and hypersexual behaviour, restlessness and social withdrawal (Crawford & Lipsedge, 2004; Mufamadi, 2001). It is also

believed that mental illness can be hereditary (Bakow & Low, 2018). The calling for *ukuthwasa* is hereditary, as it passes down from older generations to newer generations.

In a study conducted by Sorsdahl et al., (2009), it was found that traditional healers considered psychotic illness and behavioural disturbances as representations of mental illness, while non-psychotic illnesses like depression and anxiety were considered as stress. When vignettes of people suffering from depression, somatization disorder and agoraphobia were presented, none of the traditional healers believed the patients were suffering from mental illness but attributed the symptoms to psychological stress, bewitchment, hypertension, bad spirits, and Human Immunodeficiency virus (Edwards, 2009). When cases of schizophrenia were presented, the symptoms were attributed to *ukuthwasa*, witchcraft and *amafufunyana:* possession by an evil spirit. Psychosis was differentiated from *ukuthwasa* in that *amathwasana* (or *amathwasa* – plural for *ithwasa*) did not suffer from a lack of hygiene and inappropriate and bizarre behaviours (Sorsdahl et al., 2010). The traditional healers reported treating mental illness by administering different *muti* (herbal medicine) to sniff, drink, and bathe in. Some of the *muti* contains laxative and emetic properties in order to cleanse the client from within (Edwards, 2011). It is sometimes necessary for the family to slaughter an animal to appease the ancestors where illness is brought on by discord with the ancestors (Ogana, 2009)

2.5 Psychologists conceptions of mental illness

Psychologists are of the notion that individuals have a predisposition to mental illness that could be triggered or intensified by stressful life events. This theory aligns with the biopsychosocial model which posits that there is an interaction in the biological, psychological, and social environment of clients which influences their well-being (Koen & Roberts, 2020). Psychologists from areas like South Africa, Tanzania and America also attributed mental illness to hereditary and biological attributions (Bignall et al., 2015; Knettel et al., 2018; Padayachee & Laher, 2012) In a study conducted by Knettel et al. (2018) in Tanzania, it was found that 14 of the 29 mental healthcare workers were not familiar with either the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5) or the International Classification of Diseases 10 (ICD 10). These workers' conceptions of mental illness are informed by the biomedical model and the knowledge they have on the somatic symptoms of mental illness. They also attributed mental illness to religious and spiritual beliefs such as imbalances in the body, soul, and mind (Padayachee & Laher, 2013). These imbalances are thought to cause a lack of inner peace which is thought to increase the risk of mental illness (Knettel et al., 2018).

South African psychologists are now more open to the role of religion and spirituality in psychotherapy as they believe this serves their clients better (Padayachee & Laher, 2013; Moshabela et al., 2016). For instance, in a study conducted by Padayachee & Laher (2013) South African Hindu psychologists found that their clients, even those who were not Hindu by religion, referred to concepts such as 'Karma' and 'Astrology' as important in understanding mental well-being and those who were from African backgrounds were interested in how their ancestral relationships had an effect on their mental illness (Bignall et al., 2015; Nduna et al., 2020). There was also some consensus among psychologists around the similarities of spiritual based illness and mental illness such as the trance states experienced by the Tamil people and shamans in South America and in South Africa. For some psychologists, their religious beliefs and their western training has caused identity conflicts due to the differing frameworks of their personal and occupational lives (Wozniak, 2009). While others were comfortable with being flexible and adapting their psychotherapeutic work in ways that were culturally appropriate to the client

Although there appears to be more openness towards integrating spirituality within psychology, psychology is still dominated by Western and Eurocentric white middle class male perspectives that have been exported to African contexts without proper reflection and reflexivity (Marovic, 2020). There is still to a large extent, the misconstruction of the realities of non-western people. This is evident in the dismissal of Indigenous psychologies which are still referred to as out-dated and immature (Gergen et al., 1996).

2.6 Critical African Psychology

Critical Psychology is also rooted in Western epistemologies and methodologies and should therefore, be applied cautiously to African psychology (Ratele, 2019). Critical Psychology narrates European lives, and concerns of the global south are addressed only superficially, hence the need for a critical African psychology. Ratele et al., (2021, p. 432) posits that Critical African psychology "is willed towards a fundamentally humanising, political, and ethical set of practices that bring notions of psychosocial liberation into social, economic, political, cultural, epistemic, and interpersonal justice." In so doing it aims to alter what is considered to be legitimate psychological knowledge by drawing in political, economic and cultural projects by and for Africa into the psychological space. Ratele et al., (2021) offer

three pathways into cultivating a Critical African psychology, namely: collective thinking and writing, transdisciplinarity and affective community building.

According to Ratele et al., (2021) thinking and writing in a collective manner is helpful in distributing knowledge to everyone so that it is not safeguarded and kept for scholars. Reframing knowledge production as the responsibility of the collective debunks the idea that knowledge creation is the privilege of the academic and it will help us shift from individual voices of thinking and writing to collectivism. Current psychology and knowledge creation uses systems where the detached mind of the Master thinker (Western psychology) is separate from the people (in this case the population seeking psychological services). Collective thinking and writing often brings about psychological discomfort, defence and conflict which enhance the dialectical process of teaching and learning and can therefore disrupt epistemic and ontological hierarchies. Although this may be challenging for the reasons stated above, it is our responsibility as clinicians to create spaces where this becomes a possibility. Collective thinking provides a means through which transdisciplinarity can occur. Transdisciplinarity refers to something that is flexible and fluid in its ability to adapt to our society. Transdisciplinarity rejects and defies the boundaries of the rigid current systems of thinking and the politics of exclusion and differentiation. It blends together knowledge systems, similar to the knowledge that Fanon (1967) produced by blending philosophy, history, psychology and psychiatry. Through a transdisciplinary attitude we can engage in affective community building by making efforts to understand psychosocial ills and taking social action from a politically informed stance.

Psychologists have a duty to concern themselves with the connections between the psychic and political (Williams 1977). It is also important to identify the way in which power differentials shape how different groups experience affect and ways of feeling in dynamic social contexts. This can be done by engaging with orders of feeling, which can be defined as the symbolic and normative orders that shape *when, how* and *if* feelings are communicated (Stodulka, 2019). Orders of feeling are socially, culturally and politically prescribed feelings and they display rules that are classed, raced and gendered (Ratele et al., 2021). This means that we must consider whether a subject's everyday feelings are filtered or altered by social factors and how or where they can feel what. Orders of feeling are important to consider as they can drive action and challenge oppressive structures. This is something that should be considered regarding the mental health professionals who are working hard to generate and cement African psychologies and how their efforts are met within the profession. The rejection

and debunking of the pseudo universality of psychology can be met with resistance. This resistance may be exacerbated by Critical African Psychology's rejection of psychosocial priorities in Africa as residing in conventional psychological spaces like clinical and private practices. Instead, it advocates for inclusion of knowledge generation in the psychological space by African Spiritual leaders, community members, professionals within and outside of the psychology field.

2.7 Similarities and differences in Western and traditional African mental health systems

Matoane (2012) notes the differences in the two frameworks by stating that psychotherapy is meant to restore structural dysfunctions in personality whereas traditional healing systems aim to restore the whole organism and his/her social relations to balance. Contrastingly, Bodibe (1992) notes the similarities between western psychotherapy and African traditional healing in building rapport and safety in therapeutic relationships, enhancing positive functioning in client's lives and in integrating personality and expression of feelings. Bodibe (1992) also offers a comparative model for the differences in the two modalities below:

Indigenous healing utilises a more subjective approach and history taking which includes information about community, ancestors and the land. Its psychologies and cultures are oral, narrative and intuitive and they include other forms of extrasensory experience and non-ordinary forms of consciousness whereas Western science has shown consciousness as limited to the brain. Additionally, African healing modalities are symbolic and intuitive whereas western modalities are mostly scientific and logical (Bodibe, 1992). There is also a contrast in the way practitioners work in that African healers give instruction as a way of delivering messages from ancestors whereas western psychotherapists are non-directive (Bodibe, 1992). African healing is holistic and focuses on body, mind, and spirit and this plays a significant role in diagnosing and treatment whereas western psychotherapy focuses on feelings, thoughts, and behaviours (Bodibe, 1992; Bojuwoye & Sodi, 2010; Crawford & Lipsiedge, 2004**).** Additionally, African healing focuses on the integration of the person into the community whereas western psychotherapy is more individualistic (Bodibe, 1992; Juma, 2011**).** African healing also has an emotive component of dance, song, and prayer whereas western psychotherapy is cognitive and abstract (Bodibe, 1992; Thornton, 2017).

2.8 Integrating spirituality in therapy

There are a lot of differences in opinions between Western practitioners and traditional African practitioners on mental illness. This is due to the discrepancies in how these different systems understand and treat mental illness, however, Black South Africans continue to use both systems simultaneously with success (Moshabela et al., 2016; Nduna et al., 2020). This shows that there are no major conflicts in the concurrent use of these systems on the grander scale of things (Louw Pretorius, 1995; Wozniak, 2009). There have been debates among scholars regarding the inclusion of local theories and concepts into psychology however, this has left a number of scholars unsatisfied as fitting these concepts into an already westernised psychology may prevent a formal indigenisation in psychology (Azuma, 1984; Adair, 1999 in Matoane, 2012). An indigenous psychology is conceptualised as a psychology that is based on native knowledge systems that account for the intersubjective, epistemic, cultural, political, and economic factors in the psychological space (Ratele et al., 2021). It is not transported from other regions but is rather native and reflecting the original thought systems of that area (Kim & Berry, 1993). According to Azuma (1984), Indigenisation has stages of development; the introductory stage where there is the desire to learn and understand the technical knowledge of Western psychology in order to understand it within one's context.

The second stage is translation and modelling, this occurs when one forms their own theories that are relevant to their context, creating the possibility of indigenisation which then leads to the final stage of integration; a stage free from Western concepts of human behaviour (Azuma, 1984 in Matoane, 2012). In indigenisation there is the centrality of culture in defining human functioning using that culture's theories, methodologies, and concepts (Matoane, 2012). It is proposed that culturally specific DSM paradigms be included for treatment models that are tailored to the context (Kwate, 2005). This is important since some clients do not meet the criteria for diagnosis in the DSM, and without a diagnosis, they cannot be reimbursed by the health care system (Kwate, 2005) Therefore, integrating cultural understandings of psychological well-being is important for financial reasons, especially in a country where most black people are not economically empowered.

Thornton (2002) believes an indigenised psychology might be too difficult to reach, considering that the epistemological differences in Western psychotherapy and traditional healing systems are too great for there to be an integration. This is seen as favourable as these systems can then complement each other, which allows for holism, without compromising the core foundations of each paradigm (Louw & Pretorius, 1995; Matoane 2012). A practical

example of complementarity would be the use of referral systems by both Western psychotherapists and traditional healers (Nduna et al., 2020). Louw & Pretorius (1995) found that traditional healers already use referral systems, therefore Western practitioners need to take it upon themselves to become more culturally competent in order to know when to refer to traditional healers.

Multi-cultural competence is seen as possessing enough self-awareness, knowledge, and skills to work well with people from other cultures (Constantine et.al., 2007). Knowing the historical backgrounds of clients, their worldviews, the structures that marginalize or oppress them, their culture specific values and subjective experiences lead to more personalised and therefore, suitable treatment plans (Constantine et al., 2007). This is especially necessary for clients who have not adopted western living styles as they might fare better with therapists that have an indigenous understanding of their issues or those who can facilitate an indigenous healing method (Constantine et al., 2007). Being culturally aware will also allow the practitioner to feel confident in addressing the clients' issues effectively.

Traditional healing practices are considered to be "worlds apart" from Western healthcare methods due to the significant differences in their models of healing and health (Moodley, 2008). These differences are slowly being bridged with the integration of some eastern techniques such as meditation and mindfulness being adopted in Western psychological therapies. The traditional Cartesian conception of the body mind split is being challenged and brought to an integration as there is an emerging interest in holism where healing of the body, mind and spirit is taking place (Moodley, 2008). This Holism is reflected in Indigenous healing practices that not only provide an anti-Cartesian way of engaging with clients but also establish 'a critical discourse of resistance against the neo-liberal systems that prevail in health care systems" (Moodley, 2005 pp 155). In Buhrmann's work (1986, p. 29) with Zulu people, she observed that they do not divide their 'illness' into different categories of somatic, psychological and psychosomatic; they do not split themselves into good and bad parts, but express their distress as ''when part of me is ill, the whole of me is ill, irrespective of what the illness is."

2.9 Helpful frameworks when working with both worldviews in the therapy room

A multicultural psychology that embraces the indigenous conceptualisations as well as the varying ways of gathering knowledge can be achieved through dialogue. (Gergen et al., 1996) state that the limitations of these dialogues include a rigid loyalty to any particular

methodology or framework. He states that no particular paradigm should take precedence over the other and that attempts to improve or enlighten the other would be patronising. Gergen et al., (1996) recommends the creation of a space for others to be able to adopt the appropriate ideas that are specific to that context. He advises that Western science should be more flexible and open to pluralism and tolerant of the ambivalent while maintaining respect for other cultures, customs and traditions. Additionally, he recommends a recognition of the limitations of each paradigm as this invite's humility, a process necessary in dialogue and learning. Marovic (2020), suggests eclecticism which is the openness to a broad and diverse range of worldviews, ideas and beliefs.

2. 10 Psychotherapy and spiritual worldviews

Corey (2013) states that often issues of spirituality are not brought up in therapy as therapists do not address these issues, and this makes it difficult for clients to bring them forward, especially African clients who do not subscribe to the Western religious and spiritual views (Ebersohn et al., 2018). Plumb (2011) states there is a lack of training in counselling that makes therapists insecure about how to handle clients who present their spiritual problems. This is a gap that needs to be bridged as there are numerous benefits of incorporating spirituality in counselling. Spirituality provides a deep sense of meaning and purpose in a client's life, it also helps put the client's life problems in context and offer hope in these circumstances (Corey, 2013; Koen & Roberts, 2020; Mvelashe, 2020). Spirituality in therapy can be used as instrument to promote healing and well-being, it increases the rates of well-being and life satisfaction, and it is correlated with decreased rates of suicide and substance abuse (Plumb, 2011). Therefore, it would be helpful to incorporate Indigenous and cultural knowledge systems that offer precepts that are relevant across cultures such as deep respect for self, others and nature. The above-mentioned knowledge systems promote harmony and balance as well as sustainable and spiritually grounded relationships (Solomon & Wane, 2005). In support of this, Craven et al., (2016) found that the Integration of Australian knowledge systems and positive psychology lead to thriving where thriving is characterised by the interconnection of psychological, educational, physical and community aspects using respect, responsibility, reciprocity and relationships.

2.11 Theoretical Framework

For the purpose of this research, the researcher chose the African Indigenous Spiritual theory as the foundation on which to construct the research findings. A discussion on the main concepts of this theory will be discussed below.

2.11.1 African Indigenous Knowledge systems

South African Indigenous healing systems are grounded on the importance and oneness of Spirit and ancestral consciousness, which is thought to permeate all things (Myers, 1993). The main ontological assumption of African cosmology is that Everything is Spirit, and spiritual energy pervades all phenomena (Myers, 1993; Edwards, 2010). Ancestral consciousness informs how the Self is comprehended and acknowledges the Self as extending into transpersonal realms i.e., one's sense of identity extends beyond (trans) the individual to encompass wider aspects of humankind, life, psyche or cosmos. (Walsh & Vaughan, 1993). As such, the Self in African cosmology includes the individual self, familial and universal ancestors, the unborn, community, nature, and the cosmos where "everything is interrelated, and every part is a microcosmic replica and reflection of the whole." (Edwards 2010, p. 212)

2.11.2 African Spiritual healing

The reasoning in African Spiritual healing embraces polarities which yield 'both/and' conclusions, and emphasises the connectedness between the communal, human and spiritual spheres (Edwards, 2010). Healing in African spiritual worldviews is thought to be a reflection of these interrelationships which reflect the African family unconscious. Bynum (1999) describes the African family unconscious as an active, intense and shared energy field consisting of affective interactional patterns, communal dreams, telepathy and other psychic phenomena. In his work, Bynum (1999) presents the idea that the deepest aspects of the psyche have a collective origin which he traces back to ancient African mysticism, dating back to Kemetic Egypt (3500 BC). He proposes the idea that primordial or foundational mental patterns shared by all humans originate from our common African ancestry and he further highlights the overlooked influence of African spirituality on Western religious doctrines and psychoanalytic traditions. Bynum argues that as African mysticism was brought to the New World, it evolved into various new forms but was fragmented due to racial discrimination and cultural assimilation (Graham, 2016). By examining the modern versions of these original African spiritual practices, Bynum (1999) argues against materialism and calls for a profound spiritual awakening that reconnects us with our energetic and spiritual roots. This reconnection

affords us the ability to access the memories (or make conscious) the phenomena in the African family unconscious. In Southern Africa, particularly the San and Nguni tribes, the deep knowledge and memory of the African family unconscious is commonly accessed through communication with ancestors and sacred practices such as rituals and ceremonies (*imisebenzi*) (Edwards, 2010). These rituals are also thought to strengthen the connection to God and to foster a sense of belonging in the (spiritual) community (Edwards, 2010).

2.11.3 Healing through Song, Rhythm and Dance

Primary information about the early history of Southern healing practices originates from rock art dated thousands of years back. The rock paintings of the !Kung people (the first inhabitants of the Southern Kalahari) depict dances which were thought to be sacred and healing (Edwards, 2010). !Kung healing is conceptualised as an integrating and intensifying energy force that is far more essential than medicinal healing. This kind of healing is invoked through dances that are thought to bring about healing on the spiritual, psychological, social and physical levels. These dances are a common occurrence and are initiated by rhythmic singing, clapping and dancing. As the dance intensifies, there is an energy (n/um) that is activated in healers which is followed by a painful transition into an enhanced state of consciousness called !ikia. This energy permeates all those who are present and therefore results in healing for everyone (Edwards, 2010; Katz & Wexler, 1989). At the outset, the healers are said to experience empathy as a physical sensation in the gut (n/um energy) which then travels up their body during !kia. This then opens and unwinds the healer energetically in a process similar to what the Nguni people refer to as *Umbilini* and yogic practitioners as *Kundalini* (Nel & Ngoyi, 2015). When the San healers reach the !kia energy state, they can then pull-out sickness from others.

2.11.4. Indigenous healers

San and Nguni healers are revered in their communities and they often take up various roles within the community such as that of the protector, herbalist, law official, counsellor, ecologist, priest and medium for ancestors (Edwards, 2011). There are various kinds of healers including herbalists, diviner-mediums and faith healers, all with their own varieties within each class. Indigenous healers' curative approach includes the universal tenets of healing such as healing dialogue and healing exchange and one of the ways in which this is achieved is through the different forms of empathy, namely: interpersonal empathy, social empathy, and

transpersonal empathy. The latter being a feeling of unity with the spiritual world of God and ancestors. An example of transpersonal empathy is what has been described above as !kia energy which clears blockages for healing to occur while social empathy involves the recognition of one's humanity and self in others.

2.4 Conclusion

This chapter explored key concepts relevant to the study, including the conception of mental illness from the perspectives of psychologists and traditional healers. Definitions of Sangomas and traditional healers were provided and distinctions were made between the common types of traditional healers in South Africa. This section also addressed Critical African Psychology, outlining the necessary steps for developing an African-centred psychology. A comparison was made between Western mental health healing modalities and traditional African spiritual healing, with a discussion on integrating spirituality into therapy. Additionally, a theoretical framework of African indigenous knowledge systems was introduced, covering concepts which include the Self, the collective African unconscious, and African spiritual healing practices and customs. The next chapter will focus on the methodology, detailing the research design, study setting, sampling, data collection, and data analysis, while also addressing ethical considerations.

CHAPTER 3: METHODOLOGY

3.1 Introduction

This section provides an outline of the methodology of this study. A description of the chosen research design will be specified. Subsequently, there will be a discussion of the steps in the research process with reference to sampling, data collection and data analysis. The researcher will then conclude by discussing reflexivity and the ethical considerations pertinent to this research.

3.2 Research Design

The study employed a qualitative methodology using an interpretative phenomenological approach (IPA). Qualitative research is concerned with the quality of the experience of the participants rather than causal relationships (Willig, 2013). The ontological assumption of qualitative research is that of nature as having multiple realities therefore, there is a consideration of the unique realities of the individuals under study (Tracey, 2013). The researcher attempted to capture this by using the actual words of participants in the data analysis section in order to capture the different perspectives that demonstrated the uniqueness of each participants' experience. The epistemological assumption of qualitative research requires that the researcher gets as close as possible to the individual’s view since it places emphasis on how participants make sense of their experience and is therefore emic in nature (Tracey, 2013; Pietkiewicz & Smith, 2014).

The qualitative method was appropriate as it allowed the researcher to gain a rich and meaningful description of the experiences of the psychologists. Denzin & Lincoln (2018) state that the value of a qualitative IPA research study lies in the ability of the researcher to try and understand the subjective experiences of participants while also considering how the researchers own personal understanding influences the interpretation of the participants presented stories. In qualitative research, the researcher focuses on an emerging and inductive logic rather than basing data on previous theory (Willig, 2013). This method was appropriate as it allowed the researcher to observe and conceptualize the emerging patterns in the data analysis phase. The researcher then made inferences and drew conclusions to develop detailed knowledge of the topic being studied.

The interpretative phenomenological (IP) design was used as it allowed the researcher to place focus on how the participants constructed meaning in their personal and social worlds (Smith et al., 2009, as cited in Shinebourne, 2011). Phenomenology places emphasis on consciousness and experience, therefore, to be phenomenological means there is a stepping back from being immersed in the activity and reflecting on the experience of it. One of the founders of phenomenology, Husserl (1927) refers to phenomenological inquiry as linked with intentionality, i.e., being attentive to the object of consciousness (Smith & Osborn, 2008). From this position a person places focus on their perceptions, memories, and judgements of a phenomena so that they can share the experience in a language that is subjective to their life. Husserl refers to this psychical reflection as 'bracketing' and this can advance our understanding of how things appear to the participant (Husserl, 1927 in Smith & Osborn, 2008).

Writers like Heidegger take phenomenology a step further to develop an interpretative phenomenological approach that is psychological in nature by introducing hermeneutics. The hermeneutic level focuses on interpretation and meaning where meaning is seen as ever-changing and continues to allow new insight, revision, and reinterpretation (Tuffour, 2017). In interpretation, participants are seen as beings that actively partake in interpreting objects, events, and people in their lives. Participants' mindset and worldview helps the researcher to understand the context from which the interpretation is expressed (Denzin & Lincoln, 2018). The researcher has taken the double- hermeneutic nature of IPA into consideration. This means the researcher is aware that her own personal understanding of the participants own interpretations, influences how participants interpretations are relayed (Pietkiewicz & Smith, 2014)

Another important aspect of IPA is that it is idiographic; it focuses on the details of the individual and places value in the nuances that each individual presents before integrating the individuals' sentiments with those of the similar group (Denzin & Lincoln, 2018; Pietkiewicz & Smith, 2014). The researcher will engage in an in-depth analysis of single cases to examine the uniqueness of each case. This is something that was explored during data analysis. One of the assumptions of IPA is that language is a representation of a person's experience, however this may not necessarily be true in light of people who may not have the language to express what they think and feel (Smith & Osborn, 2008). This is something that was considered throughout the data analysis since the topic at hand includes a retelling of Sangomas experiences' which consist of metaphysical and transpersonal phenomena which may be

difficult to articulate. Additionally, some experiences may only be defined in the native tongue, meaning they could lose their essential meaning when translated to the English language.

3.3 Study setting

This study was conducted in South Africa, among participants based in two different cities, namely Johannesburg and Durban. The study was conducted between the period of 2022 and 2024 among participants who had been interns and qualified psychologists. The four interns were working in the public hospitals while the four qualified psychologists had been working in private practice. Of the four qualified psychologists, three of them completed their internship training under the Wits circuit hospitals. Durban is situated in the province of Kwa-Zulu-Natal (KZN). 52% of the KZN population is considered poor based on the Lower bound poverty line (Statistics South Africa, 2022). KZN is one of the most high-risk regions in South Africa for mental disorders due to several factors. It has the highest proportion of people living below the poverty line, the highest poverty gap, the second-highest level of income inequality, the third-highest unemployment rate, the highest prevalence of HIV/AIDS, and the second-highest murder rate. All these factors are recognized as significant risk factors for mental illness (Burns, 2010). Gauteng, on the other hand has the highest population of people in a South African province despite being the smallest province (Statistics South Africa, 2022) Additionally, Gauteng has the highest rate of inequality and about 45,6% of people living in Gauteng are homeless (Statistics South Africa, 2022). Homelessness, poverty and a lack of access to basic healthcare resources place people at risk for mental health problems.

3.4. Sampling and sample

Non-probability sampling was used in this research to identify study participants. The sample being studied is a presumably, niche group, therefore, purposive snowball sampling was used so that participants could identify similar participants that fit the eligibility criteria of the research (Smith & Osborn, 2008; Tracey, 2013). The research participants included are psychologists and intern psychologists (n = 8) (Table 1) who have worked with clients that also consult traditional healers or have a traditional calling. These participants were all required to be registered with the Health Professions Council of South Africa (HPCSA). To recruit participants, email invitations for study participation were sent out to the mailing list consisting of psychologists who had completed their clinical psychology training at Wits university and the mailing list of the psychology staff at University of KwaZulu Natal (UKZN). Two

participants responded to the researcher after receiving an email about the study from the Wits mailing list. A recruitment flyer (pamphlet) (Appendix B) was created and distributed on a WhatsApp group named ‘Boards and Psych’ – this platform yielded one participant. The rest of the participants were obtained from the referrals of interviewed participants. The sample size fits the requirements of IPA research, however, due to the small sample size, the results will not be able to be generalized to the larger population but will be valuable to obtain in-depth information on the topic.

3.5 Data collection

The goal of IPA interviews is to understand how participants make sense of their psychological and social worlds (Smith & Osborn, 2008). Willig (2008) states that semi-structured interviews are good rapport builders and are helpful when researchers aim to receive personalized and subjective information. Additionally, they are flexible and enable the researcher to be active in the dialogue. They also create room for the alteration of questions by following the direction of responses where interesting and novel information surfaces (Smith & Osborn, 2008).

In light of what has been stated above, the researcher used semi-structured interviews which consisted of open-ended questions. Participants who met the inclusion criteria were sent emails informing them about the nature of the study as well as consent forms prior to their interviews. They returned the signed consent forms to the researcher via email before the interviews were conducted. During the interviews, open-ended questions used to allow the participants to share their experiences freely while also allowing the researcher to probe and ask further questions where new information emerged. This was helpful in generating rich and descriptive data and in gaining a deeper understanding into the participants' experiences (Willig, 2013). The researcher conducted two of the semi-structured interviews in-person and six online via Microsoft teams since some participants were in other provinces while others had busy schedules. The interviews ranged between 50-90 minutes and all of them were recorded and transcribed.

3.6 Data Analysis

Each participant's data was analysed individually in order to honour the idiographic nature of IPA research. In IPA research the analyst is interested in learning about participants' psychological worlds and the meaning that is ascribed to them (Smith & Osborn, 2008). Thus, the researcher followed the steps in IPA analysis as recommended by Smith and Osborn (2008). The researcher read and re-read unfocused notes to find associations, observations, questions, and language for each participant. From there on, the researcher identified and labelled the themes of each individual case by summarising, paraphrasing, and looking for connections. Subsequently, the researcher structured groups of themes and subthemes and created a summary table of clustered themes (Table 2). The participants' themes were then compared for a cross-case analysis where a list of master themes were created in an attempt to capture the general essence of experience among participants (Smith & Osborn, 2008; Tracey 2013). Finally, the cases were interpreted by the researcher who was conscious of keeping an empathic level of understanding so as to enter into the world of the participants (Smith & Osborn, 2008).

3.7 Reflexivity

Reflexivity in research refers to a researcher's awareness of his/her own assumptions, viewpoints and prejudices that might be unconsciously projected onto the participants and the data (Tracey, 2013). This awareness is important as it creates honest and transparent engagement with participants (Willig, 2013). In conducting this research, I am acutely aware of my own assumptions, viewpoints, and biases that have inevitably shaped the study. Having been raised in a Christian home, my initial worldview was rooted in Christian values and beliefs and this background undoubtedly influenced my early perspectives on traditional healing, often viewing it through a lens shaped by my Christian upbringing. However, as I grew older, my path took a significant turn when I was led to Eastern Spirituality, which felt deeply resonant for me. During this time, I had strange experiences, only explained to me as a spiritual calling. I then trained in a Japanese healing technique but was eventually led to African traditional healing. I often had chance encounters with several traditional healers, who recognized and affirmed my traditional spiritual gifts. Although this is something I initially resisted, it eventually altered my perspective in a profound way. This personal journey allowed me to appreciate the richness and depth of indigenous knowledge systems, yet it also introduced a complex dynamic into my professional practice as a psychologist. The complexity was exacerbated by virtue of me being new to both worlds.

My dual identity as both a psychology trainee and someone with a spiritual gift created a unique, albeit challenging, standpoint from which to conduct this research. The splitting of myself into a psychological and a spiritual practitioner was not a natural division for me; it was fraught with internal conflict and tension. This dichotomy often left me feeling frustrated and misunderstood, particularly within the professional psychological community, where my spiritual experiences were sometimes misinterpreted. Owing to these experiences, I initiated my initial research study, originally intended to explore the experiences of traditional healers who are also psychologists. However, due to challenges in recruiting participants, I shifted the focus of my research to the current topic. Interestingly, it took six months to recruit all the participants which led me to wonder what created this difficulty in recruiting participants? Was the flyer not clear enough? Was it merely that it was a niche audience? Were psychologists scared to share their views? Had psychologists not known that their patient ascribes to both belief systems? had their patients been pathologized and, therefore? Nonetheless, I eventually found all the participants and proceeded with the research - one that I found immensely engaging.

The parallels between my personal struggles and those of the participants in my study were striking. One participant, the educational psychologist, had been playing a dual role, that of therapist and healer while the Hindu intern had spiritual experiences which intensified her work with her patient. Their experiences in therapy with their clients felt all too familiar, especially that of increased sensitivity to other spiritually gifted people. Other participants presented with an uneasiness when advocating for their African Spiritual patients and going against the opinions of their seniors. The psychologists I interviewed expressed feeling inadequately trained and unequipped to work with clients consulting traditional healers, primarily because their formal education lacked integration of indigenous knowledge systems. They also shared experiences of cultural incompetence among their colleagues, leading to misdiagnoses and dismissive attitudes towards their professional experiences. These themes resonated deeply with me, as I too have felt the repercussions of a training system that does not fully embrace African knowledge and healing practices.

Given my background and personal experiences, I approached this research with a strong empathetic connection to the participants. While this allowed for a deeper understanding and rapport, it also introduced the potential for bias. My own frustrations and challenges in navigating the intersection of psychology and traditional healing may have influenced my interpretation of the data. However, this could have been mitigated by the use of IPA research

which allows participants to express and interpret their own experiences. Further attempts to reduce bias included ongoing reflexive practices throughout the research process. This entailed maintaining a reflective journal where I documented my thoughts, feelings, and reactions to the data. I also sought regular feedback from supervisors, peers and mentors who could provide an external perspective, helping to ensure that my interpretations remained balanced and grounded in the data itself rather than my personal experiences alone.

This research journey has been as much about exploring the experiences of South African psychologists as it has been about understanding my own positionality within this field. The insights gained from this study are undoubtedly shaped by my dual identity and the conflicts it engenders. While this reflexive awareness highlights the subjective nature of qualitative research, it also underscores the importance of acknowledging and transparently discussing the researcher's influence on the study.

3.8 Ethical considerations

Researchers are governed by ethical principles which require honesty and integrity, protecting the participants from harm and upholding other ethical conducts such as informed consent, confidentiality, and privacy of the participants (Tracy, 2013; Willig, 2013). This study received ethics approval from the University of the Witwatersrand human research ethics committee for permission to conduct the research (Appendix A). Before the interviews were conducted, the researcher remained adherent to the ethical principles and sent participants emails informing them about the nature and purpose of the study (Appendix D) as well as consent forms (Appendix E) which notified the participants of their right to withdraw from the study in the event that they had changed their minds. They were also informed that their interviews would be audio recorded for transcribing and analysis. To ensure confidentiality, the recordings were stored in a password protected device that only the researcher had access to. At the end of the research study, the recorded data will be destroyed while the transcribed data will be kept in the researcher’s password protected cloud for four years. Confidentiality was also ensured through the use of pseudonyms for all the participants in order to conceal their identities. Additionally, the participants were treated with respect and dignity and their cultural and spiritual values were considered throughout the research.

3.9 Conclusion

This chapter elaborated on the qualitative methodology, focusing on the interpretative phenomenological approach. It provided context by detailing the study setting and sample information. The chapter discussed the use of semi-structured IPA interviews to explore participants' perceptions of their experiences. It also explained how IPA analysis was employed to identify relevant themes, while also acknowledging the researcher's perspective in a reflexive sectio. The chapter concluded with ethical considerations. The next chapter will present the recurring themes and relevant discussion points.

CHAPTER 4: RESULTS AND DISCUSSION

4.1 Introduction

The purpose of this study was to find out the experiences of psychologists working with patients who also consult traditional healers/Sangomas. It should be noted that although this was the initial purpose, the results indicate that most of the patients who were consulting traditional healers/Sangomas had previously been or were currently in their own process of initiation as a traditional healer. This chapter presents the description of the study participants, key findings, themes and sub-themes that emerged during the data collection process. The themes are then discussed and integrated with the relevant literature presented in chapter two of this report.

4.1.1 Participant description

The study consisted of eight participants, five females and three males. Most (7 of 8) were clinical Psychologists aged between 27-52 years old, while the other participant was an educational psychologist. The majority (7 of 8) participants were black and trained at Wits university. All the participants had worked with patients who consult or have an African spiritual calling including trained Sangomas, apprentice Sangomas and those with a calling to be a prophet. One psychologist (Ntokozo) who was interviewed also happened to be going through her own training as a traditional healer at the time of the interview. See table 1 for details.

Table 1: Participant demographic Information

Pseudonym	**Race**	**Participant Gender**	**Participant Age**	**Psychology Category**	**Years Practicing**	**Patient**	**Training Institution**
Olivia	Caucasian	Female	47	Clinical	4	1 consults sangomas	Wits
Thomas	Black	Male	52	Clinical	26	1 thwasana and sangomas	Wits
Tshepo	Black	Male	41	Clinical	1 (Intern)	1 sangoma 1 prophet apprentice	Wits
Zanele	Black	Female	28	Clinical	1 (Intern)	1 sangoma	NMMU
Banele	Black	Male	27	Clinical	1 (Intern)	1 thwasana	Wits

Prisha	Indian	Female	27	Clinical	1(Intern)	1 sangoma	Wits
Sanelisiwe	Black	Female	32	Educational	3	2 children with callings	UKZN
Ntokozo	Black	Female	33	Clinical	1 (Intern)	1 prophet	Wits

Table 2: Themes and Sub-Themes

Main Themes	**Sub-themes**
4.1 Psychologists' experiences of working with clients who consult traditional healers	4.1.1 Limited professional development and training 4.1.2 Seeking external resources for therapeutic work 4.1.3 Navigating medical hierarchies: Challenges in Integrating African Spirituality in Psychological Practice 4.1.4 Navigating Transference/Countertransference
4.2 The Interaction of the Western Psychology and African Spiritual knowledge in therapy room	4.2.1 Advocating for patients by recommending complementary systems 4.2.2 Complementary systems not embraced 4.2.3 The interaction of African spirituality and Western psychology in the therapy room
4.3 Cultural Competence	4.3.1 The Importance of culturally relevant care in Western healthcare 4.3.2. Cultural hierarchies and dismissal in hospital teams 4.3.3 Lack of confidence in colleagues of different racial groups
4.4 Frameworks and treatment strategies for African spiritual patients	4.4.1 Alternative diagnosis and treatment methods

	4.4.2 Involve Knowledgeable People and thought leaders 4.4.3 Assisting clients with practical strategies to proceed with calling 4.4.4 Referral networks to traditional healers

4.2 Psychologists' experiences of working with clients who consult traditional healers

There are reportedly significant difficulties faced by intern and qualified psychologists when working with patients who consult traditional healers. All the participants faced both personal and countertransferential challenges as well as issues with their institutions of training. These included feeling unequipped to work with their patients, experiencing psychodynamic theory as restrictive for African Spiritual work, feeling dismissed and experiencing the hierarchies in hospital systems as a significant obstacle to effectively working with patients who also consult traditional healers.

4.2.1 Limited Professional development and training

The lack of adequate training, skills and supervision was a recurring theme in the participants' experiences. Participants reported feeling unequipped or partially equipped when working with clients who also consult Sangomas. They attributed this feeling to a lack of adequate knowledge, skills and supervision to work with such patients. As a result, they had to rely on their personal wisdom, supervisors and external sources. for guidance. For example, ***Tshepo, a 42-year-old male intern psychologist***, described a lack of professional training and having to rely on his own personal knowledge and beliefs to understand and work with his Sangoma patients. He stated:

> *"No. In terms of our training, we are not equipped, but in terms of me as a Black African man, I felt equipped because I also do believe in traditional practices you know".*

As noted above, the identities of the psychologists and their supervisors played an important role in the therapies with the interplay of identity, training, and cultural awareness significantly impacting the therapists' ability to address African Spiritual healing practices. As depicted above, *Tshepo (*a Black man who shares a belief system with his patient) was aided by his personal knowledge. On the other hand, ***Prisha*** **(a 27-year-old Hindu female intern**) also felt ill-equipped to assist her patient but relied more on her supervisor for guidance. Whom she felt he was not equipped to deal with such patients. Prisha stated that she found her supervisor's

advice, to treat African Spirituality as any other difference, insufficient as working with her traditionally gifted patient requires understanding metaphysical tenets from the African worldview. To treat African Spiritual topics and beliefs as other areas of difference undermines its importance, especially in a context where it is so relevant. She remarked:

> *"It was completely different, like, I felt completely ill-equipped to deal with it. Uhm, I think also because (long pause) I was working with, like under a white supervisor, right. And I think when I bring up these struggles in supervision, as kind of receptive and open as he was to it, there was also a sense that like he also didn't know what to do and I think that made it really hard because then I was like, OK! He was like, at the beginning obviously like: "you treat it just like you would any other area of difference. You know you kind of acknowledge the difference. You speak about it. Umm and you kind of just approach it with curiosity and openness and kind of try to step into the client's world" right! And I think in the beginning, I really did try to do that, but then I think there's a lot of aspects that weren't actually covered in our training … I really was not equipped to deal with it at all because it felt like it was dealing with like very like metaphysical concepts."*

The above comment echoes what Greenfield (1997) discusses in the concepts on non-equivalence and non-transferability. She highlights that many psychological concepts were originally developed in Western contexts; therefore, superimposing them onto non-Western cultures poses significant challenges as there may be a dilution or distortion of the unique cultural perspectives. Additionally, the experience of the participant highlights the potential pitfalls when supervision is sought from professionals who may not be adequately trained or knowledgeable about traditional healing practices.

As indicated in several of the extracts above, training and supervision were not always an informative space. Nonetheless, supervision spaces were emphasised, also out of a sense of helplessness from the trainee psychologist. Furthermore, the participants' experiences reflect a fragment of a larger issue in institutions of training with regards to the lack of knowledge and information taught about African Spiritual philosophies and beliefs (Chitidingu & Mkhize, 2016). The transformation of the curriculum is a necessary step as African Psychology must be derived from African philosophies. However, one participant reported a more constructive and fruitful supervision space enabling her to assist her patients. Sanelisiwe, indicated that she was advised by her supervisor to refer the patient to an Indigenous healer.

> *"With my supervisor at the time, she suggested that we discuss it, and she had then suggested that we refer him to a Sangoma at that point. In as much as therapy was necessary and it was going to be helpful for him, we can't also then dismiss and deny the fact that he is having these dreams (of people dying) and they are coming true"* ***(Sanelisiwe, 32, female, intern psychologist)***

As someone who was trained at UKZN, *Sanelisiwe* had quite contrasting experiences from the Wits trainees (refer to table 1). She was immediately directed by her supervisor to refer to an Indigenous healer, which demonstrates an awareness and acknowledgement of the weight of her patient's culture in therapy. Due to her supervisor's guidance, she felt more confident in approaching her work with her patient. These findings reflect how various universities offer diverse forms of training, which have distinct impacts on therapeutic work. For instance, the participant who studied at UKZN reported that she found the training approach to be inclusive of African Spiritual beliefs. Contrastingly, training from the Wits university focused on a Western-oriented modality, namely psychodynamic theory, which is perceived as elitist. The findings further suggest that the different therapeutic modalities could have influenced the participants' confidence and experiences in treating the patient population. ***Banele, who is a 27-year-old male intern,*** emphasized the need to intentionally accommodate traditional and spiritual practices alongside psychodynamic theory as it is not included in the training. He shared his experience and spoke about relying on sources outside supervision for insights.

> *"It is kind of a process to know how to make room for it [traditionally gifted patients] um working psychodynamically because I guess it's not part of what we (short pause) are taught? So, I think I had to ask for a lot of outside supervision, a lot of outside guidance uhm in terms of how to manage (short pause) that and make room for that appropriately."*

Ntokozo, a 33-year-old female intern shares her choice of deliberately straying away from psychodynamic theory as she felt that it would have been inappropriate to use this modality to understand her client. She stated:

> *"The more that I formulated, not even psychodynamically, I could go there. Because it would do the patient an injustice, because I was gonna try to make the patient fit into a psychodynamic formulation rather than actually letting the patient's symptoms and psychology explain it for itself."*

Ntokozo's account speaks to the idea that psychodynamic theory is primarily Western in a way that does not accommodate or understand perspectives that are African centred without distorting them. Hence, the formation of an Indigenous psychology is extremely important as each culture has its own explanatory models and modes of treatment for responding to illnesses. Additionally, an Indigenous psychology acknowledges the importance of cultural beliefs and traditions in shaping an individual's experience and behaviour (Bodibe, 1992). This is not to dismiss any efforts from the Western psychological worldviews in recognising the influence of culture in the psychotherapeutic relationship since writers like Rosen & Frank (1962) and Jackson (1987) have been pioneers in cross-cultural psychotherapy. In South Africa, there are books such as *Psychodynamic Psychotherapy in South Africa: Contexts, Theories and Applications (*Smith, Lobban, & O'Loughlin, 2013). In the book mentioned above, the authors successfully address the context of the local community, recognizing the impact of social and economic structures in the individual's psychological well-being. However, the ways in which African Spirituality is interpreted in a Chapter from the book indicates an inherent misunderstanding of African philosophies. ***Olivia,* a 47-year-old female psychologist** that trained at Wits, reported that the only academic source materials she had access to was Gavin Ivey's work. His writing focused on *Comparing psychoanalysis and African Indigenous healing, however, it* lacked adequate comprehension of African epistemologies. *Olivia* stated:

> *"There are not enough papers on it even. In fact, I was trying to find a paper to help with it on this case. I think I found Gavin Ivey but that was about it."*

Similarly, ***Thomas, a 52-year-old male clinical psychologist***, highlighted that his initial thought about the lack of counsel from lecturers in relation to African spirituality was due to lack of evidence-based materials, but he later discovered some helpful literary sources regarding this subject throughout his career. He expressed:

> *"Uhm so what that basically means in my training, thinking about it now… I used to say, no, there are not enough readings that talk about this particular area {patients who are traditional healers} and I was saying that in particular because I did not have guidance! Not because there are no readings…Now that I am teaching at the university, I feel robbed"*

As a lecturer, *Thomas* now shares and teaches on African philosophies as he wishes his teachers had done before.

Having sources that are primarily psychodynamic in understanding African Spiritual concepts can perpetuate inaccurate conceptions of African knowledge systems amongst students. Another important point of discussion is whether the act of trying to understand and fit African concepts into Western methodologies slows the progress of forming an Indigenous psychology (Azuma, 1984; Ratele et al.,2021). There are larger issues at play which affect the lack of adequate training and education on African Indigenous Knowledge systems as one participant relayed:

> *"I don't think that it's the people in training positions that, for lack of a better phrase, it's people in training positions that matter. I think people that change, I suppose, the rules of the structures, that decide on what's important and what's not. It doesn't feel like we have enough people who are clued up in this area"* ***(Banele, 27)***

Banele noted the need for individuals in positions of power to value and prioritize African traditional knowledge. For this to occur, there would need to be various people who are well-versed in African epistemology, spiritual leaders and psychologists, that come together to create knowledge. This is a sentiment shared by Ratele et al., (2021) who wrote about thinking and writing in community with thought leaders and people with relevant knowledge and experience in African psychology. Overall, the development of an Indigenous psychology is an important step towards decolonizing psychology, acknowledging the diversity of human experiences and perspectives, and promoting social justice and equality.

4.2.2 Seeking external resources for therapeutic work.

In their work with African Spiritual clients, the participants needed to draw on specific resources to enhance their cultural competence. These resources included both formal training and experiential learning, which enabled them to navigate the complexities of spirituality, indigenous healing practices, and ancestral connections. Several participants reported having used several resources to help them in their work with their patients. In his extensive search for African literature, *Thomas* found some valuable resources, he stated:

> *"The book that I was using which is Edwards (1983) erm to draw from traditional err or what is referred to as CBS (culture bound syndromes) or er CBPS (culture bound psychiatric syndromes). I still went on to use the same book again now teaching. It's the only book that may have a form of a list of culture bound cultural or psychiatric syndromes" (***Thomas, 52)***

Although *Thomas* found the above resources helpful, it is noteworthy that throughout his years practising psychology, he has referred to sources of literature outside of the formal curriculum of psychology which indicates a lack of formalisation and inclusion of African literature in the psychology curriculum. This is supported by the findings of a study conducted by Chitidungu and Mkhize (2024) where the Black psychologists who were interviewed reported exclusion of Indigenous epistemologies and philosophies in their training. Similar to the participants of the mentioned study, *Banele* reported having to rely on external knowledge to access relevant material in working with his African spiritual clients.

> *"Sources right now, it's kind of like they're any podcast that I listen to that I try to get knowledge from that is informative. There's a YouTube channel as well, um the (long pause) Gogo Dineo yes um there's a YouTube channel as well I think her Instagram page as well and uhm Anele Siswana"* ***(Banele, 27)***

On the other hand, *Tshepo* combined his personal knowledge and the assistance of his supervisor who is both a Sangoma and a psychologist. This was helpful for him, however only few people can access this help as the population of Sangoma-psychologists are few and far between, particularly in academia.

> *"I wouldn't say I'm an expert uhm but I do have general knowledge, but I do also consult and luckily for me, when I was doing my M1 Uh, my supervisor was both a Sangoma and a clinical psychologist and I know also that they do offer a course at UKZN where you can learn more about the African belief systems and also how to incorporate them into your work"* ***(Tshepo, 41)***

Sanelisiwe who completed her training at UKZN stated that she only incorporates the African worldview when there is no Western psychological understanding of what is happening. She states:

> *"In those situations, I then rely a lot on professor Nwoye's writings on African Psychology and how to navigate that, which I have found quite interesting."* ***(Sanelisiwe, 32)***

Overall, the limited inclusion of African epistemologies in formal psychology curricula, forced practitioners to seek external resources. Books, podcasts, and mentorship from culturally knowledgeable supervisors and professors were critical for developing cultural competence.

4.2.3 Navigating medical hierarchies: Challenges in Integrating African Spirituality in Psychological Practice.

Psychology interns and trainees face unique challenges when working with hospital patients that have African ancestral callings. The persisting hierarchies within the larger healthcare system may be an obstacle that affects how professionals engage with traditional healing practices. As such, cultural competence in multidisciplinary teams (MDT) might be able to diffuse hierarchical ways of working and establish better alliances amongst the team members which could be more effective in treating patients. *Tshepo* shares his difficulties of working in a hospital as a psychologist intern:

> ***"****Even in the clinical space where I work, you know, people want the formulation, people want the diagnosis, so the space itself forces you sometimes to even dismiss certain things so if you hear something, you latch on to it. You know if you hear somebody saying: 'No, I have prophetic powers,' You're like OK, fine. I can give you a diagnosis of a delusion you know. So, I can give you a psychosis diagnosis with delusions of grandiose features (be)cause we look for a diagnosis...It's hard because you're going against yourself because DSM says."* ***(Tshepo, 41)***

The above quote shows how *Tshepo* overlooked important information and succumbed to diagnosing the patient with psychosis to align with the professional environment. This was done out of a need to be accepted as a competent and worthy member of the MDT at the hospital where he was trained. This presents an internal conflict between the best interest of the patient versus the need to be accepted and viewed as a competent emerging psychologist. *Tshepo's* cognitive dissonance drives him to compromise the patient's well-being in favour of conforming to the norms of the hospital setting. The quote also underscores the challenge of speaking up and voicing opinions in multidisciplinary teams (MDT). Perhaps, there is a need to better understand the dynamics of pressures that prompt intern psychologists in certain work environments to maintain silence or conform to expectations. *Banele* shares his experience of working in an academic hospital.

> *"It doesn't always feel like it's safe to bring those ways, African ways of knowing into certain spaces in the psychology field… Umm, I think now I'm still able to seek my knowledge but I don't think the knowledge is acceptable to write I suppose…I don't think it's inappropriate, but I think it's inappropriate for what the medical model is expecting from a psychologist versus what I feel like I can write in my process notes*

> *once I'm qualified and kind of not necessarily affiliated to any of the hospitals" (**Banele, 26)***

Banele's predicament highlights his hesitation to discuss and enlighten the MDT on African spiritual information. His take on this information being perceived as inappropriate in the medical model indicates the lack of openness or accommodation of Indigenous knowledge systems in the hospital context. Additionally, some challenges arise from the medical model's tendency to conflate African ancestral callings with psychosis as they may appear similar for those who are uninformed in African ancestral callings. The participants reported that the medical hospitals are often fast-paced and diagnosis-focused environments where staff members in multidisciplinary teams tend to concern themselves more with treatment rather than understanding the core issues of patients. This can hinder proper client treatment, particularly as it pertains to clients who have ancestral/spiritual callings. There is a large population of patients in psychiatric wards who claim to have ancestral callings, for that reason it is crucial for healthcare professionals to be educated enough to distinguish an ancestral calling from psychosis (Edwards et al., 1983; Niehaus et al., 2004; Shezi & Uys, 1997; Van der Zeijst et al., 2021). This further highlights the increased need for cultural competence, which can help minimize the risk of pathologizing spiritual experiences and missing key aspects of a patient's narrative.

Overall, these findings underscore the need for increased attention and education on African Spirituality and ancestral calling "symptoms" for psychologists and staff members who work closely with psychologists in multidisciplinary teams. Without adequate education and supervision in this area, psychologists may struggle to effectively integrate African traditional concepts into their therapeutic work and risk failing to meet the needs of patients who consult traditional healers.

4.2.4 Navigating Transference/Countertransference

Therapists working with traditional healers as patients often experience significant countertransference reactions, marked by confusion, doubt, and a fear of imposing their beliefs. *Tshepo* expressed a sense of hesitation in introducing spiritual ideas, due to his limited knowledge on the topic. He pondered how venturing into areas outside of his expertise could pose a risk to the therapeutic alliance:

> *"And if I introduce it, am I not gonna maybe risk the therapeutic alliance? Let's say I introduced African Spirituality, and she's open to it and she's like 'okay, guide me what to do next, you know? So, it's not my area of expertise"* ***(Tshepo, 41)***

This highlights a common concern about the boundaries of professional competence and the potential impact on the client-therapist relationship. Another therapist, *Olivia*, initially avoided referring a patient to a psychiatrist for medication as she feared this would cause a rupture in the therapeutic relationship.

> *"I didn't think she was ready...I think I was scared there would be a rupture."* ***(Olivia, 47)***

This indicates how therapists' attempt to be culturally sensitive may increase the therapists' apprehension to refer, thereby delaying the referral process. It also indicates the challenges posed in balancing medical interventions and cultural considerations. Another challenge that participants grappled with was their own spiritual identities, which intensified their countertransference reactions. For instance, *Prisha* who is of Hindu faith reported:

> *"working with this particular client, um (pause) hooked a lot of my own stuff in terms of my own religious identity. I think it's very hard to not move into the realm of like what is real versus what is not real, right"* She further stated: *"I've always grown up within Hinduism and I remember when I was like 15 or 16, there's like this practice also of like (pause)I don't know how to explain it, but it's like basically you're in temple and you're praying and then you become like possessed by like a divine being right. This is something that happens. And the priest told my grandmother it would happen to me, and I remember feeling very anxious about this… I used to try and understand. Like, is this like a dissociative state or like, what is going on and like really trying to rationalize it also because of my own anxiety. And I remember like a couple of years later, someone telling someone telling me that if you don't actually like um (short pause) allow for this experience, like bad things will start happening to you in your life"* ***(Prisha, 27)***

Prisha's Hindu background intersected with the client's experiences of possession and spirituality. In their therapy, *Prisha* and her patient navigated the complexities of cultural and

spiritual beliefs. *Prisha's* extract underscores the importance of therapists' self-awareness regarding their spiritual identities, which can impact their clinical decisions and interactions with clients. Additionally, *Sanelisiwe* (who is currently undergoing training to be a traditional healer), treaded carefully in her work with the patient in regard to the spiritual calling.

> *"I am comfortable with working with a client with a calling because I'm aware of it, I understand what's going on; I however, do not bring it up to patients unless they bring it up first because I don't want to feel like I'm imposing my beliefs of my understanding of the world onto my client"* ***(Sanelisiwe, 32)***

Additionally, therapists may feel torn between their clinical training and the cultural or spiritual needs of their clients. *Sanelisiwe* acknowledged a deliberate avoidance of imposing her beliefs onto the client by separating clinical intervention from traditional healing to respect the family's Christian background. Despite her training and experiential knowledge with traditional healing, she feared that bringing it up might repel the clients' parents, reflecting a tension between professional boundaries and cultural sensitivity. The act of raising the African Spirituality topic as the therapist was controversial among the participants, with most of them avoiding the topic. *Thomas* stated:

> *"but as I'm getting older now, I'm warming up to the idea of checking whether the client has an African Spiritual calling, uhm there's nothing wrong with checking"* ***(Thomas, 52)***

There appears to be a need to defend or justify the decision to bring up traditional/ cultural material in the therapy room, which perhaps is a reinforcement of the complexities of openly embracing and bringing up traditional healing content in therapy. For others, their anxiety in bringing up the work is personal while others contemplate the ethical dilemma that bringing up this work may present. Overall, the psychologists working with African Spiritual patients often navigate complex countertransference reactions involving doubt, fear of rupturing the therapeutic alliance, and challenges with integrating their spiritual identities with clinical practice. These reactions underscore the necessity for therapists to seek ongoing education and self-reflection to approach such cases thoughtfully and effectively.

4.3 The Interaction of Western Psychology and African Spiritual knowledge

The interaction between Western psychology and African spiritual worldviews in therapy is complex and ongoing. There is a growing recognition of the need to incorporate diverse perspectives into therapy, while also acknowledging the need for psychologists to work within their scope. There is no doubt that the integration of African spiritual worldviews into therapy can bring balance and holism to the process. Still, it is crucial to understand when referrals may be necessary and when active engagement with spiritual practices is appropriate. Ultimately, a collaborative and culturally sensitive approach to therapy is essential to meet the needs of the population who continue to seek services from both Western Psychologists and African Spiritual healers. The continued consultation of both Western practitioners and Indigenous healers brings forth questions as to why African patients choose to do so. *Thomas* provides his perspective as to why patients continue to seek both healing modalities:

> *"They try to consult to try and make a balance with the spiritual world. It's who and what we (Black Africans) are, we cannot pretend as if that will go away... it's not even biopsychosocial. It's biopsychosocial cultural erm spiritual. I may go on to explain to you as to why that is...because it is in our worldview." (**Thomas 52)***

Thomas references the importance of holism to the African people as multiple aspects of self-need to be stimulated and understood with depth, as conveyed in African epistemology. (Edwards et al 2009; Myers 1993). There is a need for the spiritual aspect to be included in African people's healing processes as this address's intergenerational trauma in a direct way and it allows for ancestral reverence, which sustains intergenerational connections that offer protection, well-being, and harmony within individuals, families, and cultural contexts (Edwards et al., 2009). One example of this is the cleansing rituals of deceased spirits in family lineages as a common practice for African Spiritual people.

This is representative of the belief that healing is done in community, and this includes those who have passed on (Bakow & Low, 2018; Edwards et al 2009). Such practices are the scope of traditional healers as they have a greater understanding of these rituals as well as access to the spirit world. There also tends to be a sense of familiarity and community among traditional healers and their patients based on several factors such as location, language spoken and similar belief systems. Therefore, we can assume that pluralism will continue in South Africa, indicating that frameworks that encourage complementarity should be developed.

4.3.1. Advocating for patients by recommending complementary systems

Three participants reported a need to fight for the inclusion of African psychology as it is the basic right of the client to assimilate their culture into the therapy without dismissal and ridicule. *Tshepo* expressed how he tried to advocate for his patient by asking permission to invite a Sangoma to the psychiatry ward round for a better understanding of the patient's presentation. This did not come to fruition due to restrictions presented to *Tshepo* as ethical dilemmas.

> *"As an intern, I had to go through the senior psychiatrist to say, I would actually like to call a Sangoma, a specialist just to help us with this presentation… but because this treatment system isn't normalized, there has to be all sorts of protocols followed. We have to worry about the person's safety. What if that person comes and the patient attacks them or something? then we have to worry about the legal implications and all of that." (**Tshepo, 41)***

Comparably, ***Thomas*** stated:

> *"So, for me that {calling a Sangoma to assist} has just remained a wish that can be done. Obviously, I was working within a particular environment that has its own rules in regard to this. So when I was there, I was agitating really some of the people, so I was very happy to meet someone that was open…I encountered for the first time one of the psychiatrists who were open to the idea of allowing err these clients of ours err to consult alternative service providers" **(Thomas, 52)***

The psychiatrist that *Thomas* had been working with permitted him to bring in a Sangoma to assist with the patient. Although it is quite evident from *Tshepo's* extract that those who challenge old systems may be perceived as problematic and sometimes unethical. This is problematic as people who oppose old systems or try to create more inclusive ways of thinking are perceived as controversial rather than progressive.

4.3.2. Possible challenges in implementing complementary systems

An interesting point of exploration is the cause of the hesitation towards the application of complementary systems from the psychologist cohort, healthcare workers and the system at

large i.e., government funding for mental health, research funding, universities and other institutions. The reports from the participants indicate ambivalence on the part of psychologists regarding the scope of psychologists' work with traditional healers. *Thomas*, for example, wondered whether it was enough for psychologists to be knowledgeable about culture bound syndromes as that presents its own complexities, such as pathologizing cultural norms. The complex nature of the work that is done with African spiritual patients seemingly presents anxieties about what this connotes for psychological work regarding where psychology ends, and African Spiritual work begins. Another perspective, as demonstrated by *Olivia's* experiences, indicates that there are African psychologists who actively decline or refer African Spiritual patients to other psychologists out of fear, disbelief or the notion that spiritual content is overwhelming in the therapy space.

> *"So weirdly my African colleagues, whenever a referral would come up that was traditional, they'd always say give it to Olivia she's good with that…Olivia do you want this? its uh (scared facial expression) you know? And I said, Oh but I thought you didn't believe in this, and they'd say: 'no we don't believe in this'. But they were scared! Also, they'd say "even if you think you don't believe it's still going to be a bit of a scary thing." And I'm like so if you're scared then maybe you do probably believe in it."* ***(Olivia, 47)***

Although other psychologists might have fears around working with this client population, others feel that the work belongs particularly to traditional healers who are experts on the topic. They had sentiments that the work would not remain sacred in the event of collaboration with Western therapy. *Banele* added a layer to the discussion, noting that the timing and function of therapy are important factors to be considered. He shared how he felt at odds about how to help the patient as she was not able to share everything freely with him.

> *"She {the patient} has to check if it's alright with her new gobela {Sangoma trainer} so it's kind of a thing of the therapy isn't, or it doesn't sound like the therapy is an automatically safe space…Mm I think I'm questioning it kind of in the context of like, I'm not allowed to know some things which means I'm not allowed to help with something… we don't know what function does the therapy serve except I can imagine that it supports" (****Banele, 27****)*

The above quote may raise questions about what kind of work is to be done with African spiritual patients, particularly those who are spiritual healers or those undergoing the training

to become a healer. Moreover, these questions have issues accompanying them that extend beyond the clinical spaces into larger structures which impact the financial and institutional aspects of the work. ***Tshepo*** highlights below:

> *"The diagnosis problem is big. It's not just in the clinical settings. Even now when it comes to your medical aid? Your medical aid wants to know what is your diagnosis? And they want the code. And they look at that code and they want to pay that code the ICD10 code. So, if I say to them uhm no, this person is presenting with a calling, African calling or Sangoma calling symptoms, there is no medical code for that, so medical aid won't pay for that you know so the problem is not limited to the private practices or even the clinical settings or hospitals. Even the third parties that are involved in the process, they also reject the belief system." (**Tshepo, 41)***

In many clinical settings, diagnoses are standardized using codes such as the (ICD-10) or the DSM-V. These codes help streamline communication between healthcare providers, insurance companies, and other stakeholders. However, the limitations become apparent when dealing with conditions that do not neatly fit into existing diagnostic categories. The issue Tshepo raises is twofold. Firstly, the **Lack of Specific Codes**: When someone presents with symptoms related to an African spiritual calling or "illness", there is no specific ICD-10 code for that. As a result, medical aids may not cover treatments related to these belief systems. Secondly the **Rejection of Belief Systems**: Beyond clinical settings, even third parties (such as medical insurance companies) may reject claims related to belief-based conditions. This reflects a broader challenge in recognizing and respecting diverse cultural and spiritual perspectives. Addressing this problem requires a more inclusive approach, one that acknowledges the complexity of human experiences and integrates cultural beliefs into healthcare systems. As Kwate (2005) noted, Diagnostic categories aligned with African spirituality promote communal healing and resilience while recognizing that mental health is intertwined with social, cultural, and spiritual factors. The development of these categories would provide a more inclusive framework that honours spiritual beliefs, community context, and holistic well-being by challenging the status quo and enriching mental health practice. Overall, the interaction between Western psychology and African spiritual worldviews in therapy is complex and ongoing. While there is a growing recognition of the need to incorporate diverse perspectives into therapy, there is also a need to recognize and work within the limitations of psychology.

4.3.3 The interaction of African spirituality and Western psychology in the therapy room

The therapeutic work with patients possessing ancestral callings was a challenge to all participants; however they noted that the use of both-and thinking, validation and non-forceful approaches was helpful and grounding for the patients while directive and challenging strategies invoked anxiety.

> *"So, what I was doing is I was holding both as valid so both-and. I think at one point I said to her, also from my point is that seeking therapy is like the last port of call if you follow traditional ways… You've also come to me, a white Western therapist so uhm race was quite a big discussion often but it was lovely."* ***(Olivia, 47)***

Olivia's approach of holding both African spirituality and Western psychology as valid is essential for a conducive therapy. Her inclination to highlight therapy as a last resort may help the client feel that the therapist understands the importance of her cultural beliefs while also creating a space where both worldviews can coexist. Moreover, literature has shown that the validation of Spiritual beliefs increases the likelihood of better therapeutic outcomes (Corey, 2013; Koen & Roberts, 2020). Additionally, Olivia's awareness of her role as a white Western therapist is essential as the discussion around race acknowledges the potential impact of identity on the therapeutic relationship. In South Africa most qualified psychologists are white (Canham et al., 2007; Matoane, 2012); therefore, race is an important subject matter in therapies due to the history of racial injustices brought on by apartheid. Olivia reported addressing racial issues, describing them as a pleasant experience with her patient, although she initially, *"felt like she wasn't open to it but that could have been my fear as well."* This is reflective of the anxieties of significant differences between the patient and therapist. If ignored, points of difference could negatively affect the therapeutic relationship and result in early termination (Joshua et al., 2018). In support of this claim, *Tshepo's* patient expressed how the racial disparity in her previous therapy was an issue for her.

> *"She had therapy last year, and which was from the perspective of cognitive behavioural therapy (CBT), so we started exploring what worked, what didn't work. So, one thing she brought up was the issue of race that the therapist was white. So, she didn't want to go to that place where she's even exploring and linking her presentation with this calling."* ***(Tshepo, 41)***

In the above extract, we see that the patient was unsatisfied and felt misunderstood by her white therapist who linked her overall presentation to her calling. Another point of question is whether the modality of therapy: Cognitive behavioural therapy (CBT) was the appropriate therapy for the patient. In a study conducted by Iony and his colleagues (2022) regarding CBT treatment for patients with depression, it was found that black patients with depression responded poorly to CBT as compared to white patients. Although the reasons for this disparity were not clear, it was noted that Black patients responded better to validation strategies. This is important to consider as people with a calling experience severe mood disturbance, social isolation, changes in speech, complications in relationships, financial troubles, and persistent misfortune, which overlaps with depressive symptoms (Bakow & Low, 2018). This was echoed by ***Tshepo's*** **patient** who stated, "*if you don't answer, if you don't do things properly, there will be repercussions like loss of relationships, anxiety, depression, loss of jobs."* All which they believed were caused by ancestral spirits, intrusive spirits or negative events, however patients with a calling experience symptom remission after undertaking the calling as ***Zanele's*** **patient** reported, *"I used to experience this but the minute I started with the gobela, all the symptoms disappeared."* Factoring what has been stated above, it is important to understand the root of one's depression as this significantly informs treatment. In his treatment approach, *Tshepo* differed from his patient's previous therapist and took on *"a very slow and non-forceful approach"* which worked for this client. He added:

> *"I would ask, OK, if you maybe research by speaking to people. Understand Umm, what type of calling you have. Because initially I think she also thought that she was meant to be a Sangoma like her grandmother."* ***(Tshepo, 41)***

Tshepo helped the client explore her calling by encouraging his patient to do research. His knowledge and understanding on the types of spiritual callings guides the patient in a way that demonstrates care and sensitivity to her spiritual journey, while also encouraging autonomy. Additionally, Tshepo highlighted the different spiritual callings noting that there are variants within the different types of Ancestral callings for example, there are *uMndau, Amakhosi, uMnguni, Inzunza* among others (Ndlanzi Institute of Spiritual Healing, 2024). Interestingly, the presence of the ancestral spirits in the therapy is a shared experience between ***Zanele, a 28 year old black intern psychologist*** and *Banele, with Zanele* experiencing internal conflict and confusion in terms of negotiating who holds authority in the family system therapy.

> *"remember someone who is a Sangoma {traditional healer} in their system obviously, even if maybe um they are young but because of the Idlozi (ancestral spirit) that they would have, that is probably much older, then like, it becomes challenging in the room. Um they would still, for them probably want to be seen as that {the elder} but remember in the room it's the patient even if you also have to take into consideration their spiritual thing as well."* ***(Zanele, 28)***

According to the conventional African viewpoint, the elderly members of the community are highly esteemed and acknowledged for possessing remarkable wisdom that is transmitted to the younger generation. Thus, it is customary for the younger individuals to seek advice and guidance from their seniors (Matoane, 2012). Conversely, in Western psychology, African cultural norms do not apply which may lead to client behaviours and presentations of *Ubuntu* being misconstrued, for instance, in cases where African clients are friendly, respectful or refer to professionals in familial terms, they may be perceived as overfamiliar or controlling among other things. Therefore, the consideration of the patient in terms of who they are as a whole being is of utmost importance. In the excerpt below *Prisha* shares the complexities of working with multiple aspects of a patient as she grapples with what to prioritise in terms of her treatment plan.

> *"I think also the fact that she has borderline tendencies, so kind of her own personal dynamic also then makes it harder because of her own tendency to split me and the therapy at times. It's like you have to tread even more cautiously when it comes to this…Umm, (short pause) so I think all of those things, kind of layer within the room and they all kind of factor what needs to be taken into consideration when working with spiritual difference specifically, I think it's really hectic*." (**Prisha, 27)**

This poses an important question when working with patients who present with an overlap of Western diagnosis and African Spiritual gifts. In such cases do we work with the psychiatric diagnosis first? Do we delay this as it may be an effect of the spiritual calling? Do we use Afrocentric theories that recognise how the spirit, mind and body are integrated? Additionally, it is important to consider the dissociative states that healers such diviner-mediums may experience when channelling different ancestral spirits. The more subtle channelers may be perceived by Western clinicians as having an unintegrated sense of self, when there is in fact a spiritual reason for the patient's behaviour. Moreover, the participants reported what felt like a disruption from ancestral spirits in their therapeutic work.

> *"Sometimes I wonder if it's kind of um (short pause) like not being permitted by spirit but also sometimes I wonder if it's kind of just maybe me not feeling like she's engaging with the therapy and then just kind of like logging off." (***Banele, 27).**

> *"It's just also about how to navigate around this to make sure that their spiritual part, sort of like does not affect what it is that has to be imparted to them... Because then they might end up not benefitting from therapy because of that thing, that whole aspect." (**Zanele, 28)***

The above extracts display what was implied to be spiritual interference in the therapy. Perhaps these were communications that meant something or could have been made sense of in the African worldview. However, it is interesting that there is a spiritual aspect that is alluded to which is perceived to be outside of the 'self' of the patient, demonstrating the inherent differences in Western and African worldviews in definitions of the self. In the quote below, *Tshepo* provides further illustration on some of the clashes between the different worldviews as he relays the different perspective he held from his colleagues at his hospital of training.

> *"He was not objectively psychotic in terms of If he's talking to himself, he would be praying, you know. Oh, maybe the process wago phahla you know! So, he'll be doing that once in a while, but from somebody who's looking from outside, it could be seen as having those auditory hallucinations and he's responding to them*" ***(Tshepo, 41)***

As indicated in Chapter 2, *ukuphahla* refers to a ritual where an individual invokes their ancestors for various reasons such as asking for guidance, expressing gratitude, asking for blessings, and communicating significant life events with ancestors (The ritual of prayer, 2018). Tshepo states that those uneducated on the process of *ukuphahla* may perceive it as a response to auditory hallucinations. This could have dire consequences for a patient as it could affect what diagnosis, medication and dosage of the medication that the patient receives. It is also important to consider that during their training, Sangomas are prescribed herbal remedies to decalcify their pineal gland and clean their system of acquired toxins (Bakow & Low, 2018). This is done to heighten perception and vivid dreams for the purpose of clear communication with ancestors.

In light of what has been discussed above, it is important for psychologists to approach African spirituality with cultural humility, openness, and a willingness to explore both perspectives. The task of balancing clinical techniques with spiritual beliefs requires sensitivity and ongoing dialogue with the client. The findings of a study by Chitidingu and Mkhize (2024) report a lack

of integration of Indigenous knowledge systems, something that has been reflected in the experiences and anxieties of some of the participants.

4.4 Cultural Competence

4.4.1. The Importance of culturally relevant care in Western healthcare

Cultural competence is defined by Cross et al., (1989) as a complex process requiring collaboration among different institutions, systems and individuals such as the policy makers, administrators, practitioners and consumers. In clinical work, cultural competence refers to the ability to understand the differences between clinicians and patients from different ethnic-cultural backgrounds and ensuring that there is cultural sensitivity in how the therapy is conducted (Schouler-Ocak et al.,2015). As part of the requirements of the HPCSA, multiple healthcare workers are expected to be trained in cultural competence to increase awareness of the contextual factors that affect patients. As such we can assume:

> *"that on some level or another, we all have learned about cultural sensitivity, competence, especially in the South African context…Umm, we all have been trained in that, whether you're a psychologist, an OT (occupational therapist) or Reg (registrar) Dr, (doctor) They all have to go through some sort of training that incorporates that with it." (**Ntokozo, 33)***

In a study conducted by Mathews and Van Wyk (2018) 98% of students who were interviewed expressed a desire for principles and practices that included cultural competence as part of their Baccalaureate of Medicine, Bachelor of Surgery (MBChB). There is a consensus among practitioners in our healthcare system of racial disparities and preferential treatment at some healthcare facilities (Mathews & Van Wyk, 2018). This was reflected in the reports of the participants who experienced their working spaces as lacking cultural competence, raising questions of whether the problem is the lack of training in cultural competence or other compounding factors. In the psychiatric and psychological spaces, the DSM-V provides a guideline to ensure the consideration of cultural and contextual factors before any diagnosis is made. As a result, there is a heavy reliance on gathering collateral information from families for patient cases and presentations that concern African spirituality. *Ntokozo* shared her frustrations with the team's sole reliance on collateral, as she found collateral alone (in the absence of critical thinking) to be insufficient. In her clients' case the family agreed that the

patient was exhibiting strange behaviours, and that the patient was delusional; however, *Ntokozo* states that the team neglected to recognise that family members can have differing belief systems. This is important to consider since it is not uncommon that Sangomas who come from families with strong Christian backgrounds tend to be abandoned or rejected for their traditional calling, while others experience breakdowns in their relationships with close companions (Bakow & Low, 2018). In the extract below Ntokozo paints a picture of her patient's presentation who was initially misdiagnosed with delusional disorder of the grandiose type. She requested a session with the patient to flesh out his symptoms as she found the patient's presentation to be reflective of the symptoms of a prophet/faith healer's calling.

> *"...It sort of happens, you know, and then another symptom was the wandering around, and the patient was, you know, but wandering around is "*because at home we have conflict between my mom and my brother. What I would then do, I would spend most of my time with lobaba wase ZCC {senior prophet} so that he can guide me. If I'm not there, I'm by the river, I'm praying and I am bathing there, so when I get home" - *that's where the gap comes in. When he gets home, they don't know where he was the whole day. They see it as he was wandering and he's not bathing at home because he's bathing in the river, but according to them he's not bathing, so poor self-care, you know how that MSE {Mental status examination} is starting to look now, you know. Talking to self, making noises, grandiosity, wandering and, umm, poor self-care, that MSE is starting to look very much as a person who's unwell. Again, I say context in which he's describing these symptoms gives us of more of a traditional formulation, and that's what it is, so that's one of the things that I thought would sort of like be clear, since he explained it, but then the Reg {psychiatry registrar} went further to say that no, it's not traditional because the family said that they're not traditional."* ***(Ntokozo, 33)***

In the case above, it was not taken into consideration that the family held different spiritual beliefs from the patient and the psychiatric registrar, therefore, rendered the patient psychotic. It is important to note that a lack of understanding of African spiritual beliefs in the family may result in them experiencing the patient as psychotic, in the same way that medical professionals may. It should also be considered that multiple factors such as hierarchies in the hospital teams, personal dynamics, pressures of working in hospitals with limited resources, etc. might influence such reactions. This makes it difficult to flesh out whether the issue is a lack of cultural competence or various factors which make the application of cultural competence

difficult. Another interesting point raised by **Ntokozo** is how the client's behaviour as presented in the extract above, looks psychotic when evaluated through the MSE.

> *'...with this patient, psychiatrically, if you think about it, the MSE does sound like the patient is unwell, but if again you take the context in which he's describing the so-called symptoms, you would hear a picture of someone the traditional aspect"* ***(Ntokozo, 33)***

This further highlights the differences in the conceptualisation of behaviour in African and Western ideology as well as the frameworks used to describe such behaviours.

4.4.2 Cultural hierarchies and dismissal in hospital teams

There are persisting cultural hierarchies in the healthcare system, affecting how professionals engage with patient care. This was highlighted by all the participants but was emphasised by those completing their internship. They reported feeling frustrated due to being dismissed by the senior psychiatrists and medical staff when challenging the misdiagnosis and pathologizing of their Sangoma and prophet patients. Interestingly *Ntokozo* and *Tshepo,* who completed their training at the same hospital, reported that their advocacy for African spiritual patients faced resistance from staff members of different racial backgrounds. In a working team consisting of a white consultant, two registrars, and an Indian senior psychologist, *Ntokozo* and *Tshepo's* attempt to incorporate African knowledge systems were disapproved.

> *"So, I did mention it {patient has a calling} before the patient came in {for discharge interview}, but I got the reaction like oh it's a psychologist you know, you don't know what you {are} talking about. There's Reg's and there's doctors and stuff like that… "So after the disappointment was the frustration of trying to explain it to her and then she's saying no, the patient is psychotic and almost wanting to move on to the next thing and not really hear it."* ***Ntokozo, 33***

This is reflective of the idea that Western psychological practice draws heavily from middle-class Western values, significantly influenced by American and European perspectives in both its theories and practical applications (Edwards 2011, 2000; Matoane, 2012; Ratele et al., 2021). Their reluctance to consider the patient's worldview highlights systemic failures in accommodating patients' needs beyond Western medical norms. *Ntokozo* grappled with understanding how the patient's given diagnosis aligned with the context.

> *"My question was what is it that we're medicating on? because none of what I'm hearing from him meets these criteria… There was also more confusion of how you could get it wrong? Not only for the MDT (Multi-disciplinary team), but also for my trainer, my supervising psychologist, I was like, how can you get it wrong? Like it is not out of judgment, but it's more of I'm not understanding how you got here versus the symptoms."* **(Ntokozo, 33)**

4.4.3 Lack of confidence in colleagues of different racial groups

Three of the Black participants expressed a lack of confidence in the cultural competence of their colleagues, particularly those of different racial and ethnic groups. They reported concerns about the willingness to learn and adapt to working in alternative ways that are considerate of their patients' belief systems. *Zanele* and *Ntokozo* share their perspectives on the knowledge and openness that their colleagues display, stating:

> *"I'm just gonna say it like um like I could, you know even from my different sessions what would come to my mind is that if a white person received this patient maybe individually, or even for group. When certain things do come out, if you don't have experience, or you don't understand things from an African perspective, they would just say like no this person is psychotic."* **(Zanele, 28)**

> "*So, after the disappointment was the frustration of trying to explain it {the patients symptoms as they relate to an African spiritual calling} to her and then she's saying "no, the patient is psychotic" and almost wanting to move on to the next thing and not really hear it."* (**Ntokozo, 33)**

The tone and manner in which *Zanele* expressed this sentiment reflects anxiety and hesitation towards calling out her white colleagues. It resurfaces the issue of the lack of safety in professional environments to address the salient matters relating to cultural competence or the lack thereof. *Ntokozo*, also shares her frustration and disappointment with how her Indian supervisor handled the misdiagnosis of her patient. Moreover, there was shared consensus among *half of the participants* that a culturally competent psychologist is characterized not only by their mastery of Rogerian skills, which prioritize empathy, congruence, and unconditional positive regard, but also by their ability to work flexibly for the purpose of transcending cultural boundaries.

4.5 Frameworks and treatment strategies for African spiritual patients

4.5.1 Alternative diagnosis and treatment methods

One of the major issues of working with patients that have traditional callings or those that ascribe to African beliefs has been misdiagnosis. As such, some psychology professionals believe it is critical to develop a systematic framework of inquiry to assist in identifying these patients without pathologizing their gifts. *Thomas* shares his views on this below:

> ***"****Should we include some questions on the MSE {mental status examination} that should help Western trained professionals to pick up whether there is in any way a spiritual definition or err conception of that condition? Should we be doing that? I don't know! Those are the questions that we need to be addressing as psychologists!"* ***(Thomas, 52)***

Thomas, who has extensive experience in lecturing African Psychology, provides some valuable insights and possible solutions to help identify patients with a calling. Although Thomas' suggestion is progressive and poses a practical solution, we need to consider the salient point raised by *Ntokozo* on how the use of an MSE in a traditionally Western psychiatric environment may lead to the pathologizing of patients. Therefore, it is important that an alternative and Indigenous friendly MSE is developed to prevent the erroneous equivalence or transference of Indigenous and Western concepts. Additionally, it is important that research and funding are directed towards progressive initiatives like that of *Thomas* so that they can be formalised and integrated into curriculums for maximum reach amongst clinicians. In a study conducted by Mabaso & Kotze (2020), it was reported that the population of South African psychiatrists and Psychiatry registrars were not aware of the Cultural formulation Interview (CFI) until it was incorporated into the DSM-V. Thus emphasising the importance of formalisation of progressive ideas among professionals in the field.

4.5.2 Involve Knowledgeable People and thought leaders

In order to create an Indigenised psychology, an integration of Western and African knowledge systems is important (Ratele, et al., 2021) believes this could be achieved with the collaboration and participation of the local community and thought leaders in African Indigenous knowledge systems and in psychology. Banele agrees with this sentiment, stating that:

> *"... I also think there's so much and I do imagine that that's kind of how things used to be from my knowledge of the way we used to live culturally, things would get discussed with the elders and I'm sure amongst all the elders"* ***(Banele, 28)***

What Banele presents above speaks to the idea of having thought leaders and knowledge makers of Indigenous knowledge systems to be included in the development of creating a psychology inclusive of African epistemology.

4.5.3 Assisting clients with practical strategies to proceed with calling

In the realm of psychological treatment strategies and plans, the idea of practical strategies in assisting patients navigate their calling emerges as a pivotal area of focus. It is within this context that psychologists are tasked with devising pragmatic approaches that not only honour the spiritual journey of their clients but also facilitate multiple roles which the patients take up in society as healers, parents, employees etc.

> *"...but assisting her to access the kind of help that she said she wanted to have, to the point where yes we were able to manoeuvre, able to find a common ground between her days at work as well as what the employer wanted, and in that negotiating rule, she was able to do undergo her training and with what I know now, I can tell you she is quite flourishing as both a healer and an employee".* ***(Thomas, 52)***

Thomas' experience with his patient sheds light on the delicate balance required in such cases. Through careful negotiation and understanding, he was able to assist his client in finding a harmonious middle ground that accommodated her professional obligations and her spiritual training. This exemplifies the potential for clients to thrive in both domains when given the appropriate support. The practical strategies employed in this case underscore the importance of empathy, cultural competence, and collaborative goal setting between therapist and client. By prioritizing the client's expressed needs and desires, and navigating institutional constraints, psychologists can play a crucial role in enabling individuals to embrace their calling as Indigenous healers while maintaining their responsibilities in the workplace.

4.5.4 Referral networks to traditional healers

The integration of Western psychology and African spirituality in treatment plans emerges as a critical consideration. *Thomas, Tshepo and Sanelisiwe* referred their patients to Indigenous healers, and this illustrates the collaborative potential between modern mental health practitioners and traditional healers. The decision to refer the clients to healers reflects a treatment strategy that values the client's cultural context and spiritual needs. This approach necessitates that psychologists not only possess an understanding of psychological disorders but also an awareness of cultural syndromes and spiritual callings that may be better addressed by traditional healing healers. The referral itself signifies respect for the client's belief system.

4.6 Summary of Findings

The experiences of psychologists working with patients that consult traditional healers were marked by significant challenges that were not only but institutional but personal as well. These challenges included feeling unequipped to work with traditionally inclined spiritual patients, finding psychodynamic theory restrictive for African spiritual work, feeling dismissed within hospital hierarchies, and lacking access to information and adequate training. The latter was reflected in the disappointment expressed by the participants for not having had sufficient and informative academic and supervision spaces. This, however, was not the experience for the University of Kwa-Zulu-Natal (UKZN) psychologist, who felt more supported in integrating African spiritual beliefs in her therapeutic work. Interestingly those who trained at Wits University felt inadequately trained regarding African spiritual work as African philosophies and epistemologies were reportedly not sufficiently included in the curriculum. Wits university mainly teaches Psychodynamic theory, which is predominantly Western, and this was thought to be inappropriate for understanding African perspectives by the participants. A participant reported that she deliberately avoided using psychodynamic theory as she felt it would distort the patient's experiences.

In hospital settings, psychology interns faced challenges due to the medical model's tendency to conflate African ancestral callings with psychosis. The fast-paced, diagnosis-focused environment often led to the dismissal of cultural considerations resulting in internal conflict and frustration for some participants. One participant reported pressure to diagnose a patient with psychosis without careful consideration of an ancestral calling and another hesitated to present African spiritual knowledge in the ward round, assuming it would be deemed inappropriate for the medical model (hospital setting). Additionally, the cultural hierarchies in the healthcare system affected how professionals engaged with patient care. This was visible

in a few of the participants experiences, particularly those who faced resistance from the multidisciplinary team members after advocating for spiritually gifted patients. Another instance of this was when a participant questioned the diagnosis and treatment of a patient whose symptoms did not align with psychotic behaviour in context of their cultural beliefs. The lack of open-mindedness and resistance from the team underscores a lack of cultural competence and is reflective of the systemic failures in accommodating non-western worldviews in patient care. In addition to the institutional challenges, the participants often experienced significant countertransference reactions, marked by confusion, doubt, and fear of imposing their beliefs. As such, navigating these complex reactions highlight the need for ongoing education, self-reflection, and systemic changes to better integrate African spiritual practices into psychological training and practice.

What has proven to be a challenge in the application of complementary systems in the hospitals where the participants trained, is the lack of normalized Indigenous treatment protocols and potential ethical dilemmas when attempting to accommodate Indigenous treatment methods. Some participants also expressed confusion regarding the definition and differentiation between the scope of psychological work and African spiritual work in therapies with African Spiritual patients. Furthermore, there were reports of African therapists referring African spiritual patients to others due to fear or contradicting belief systems to that of the patient. This highlights the need for education and understanding of African spiritual beliefs and customs within psychological frameworks. Additionally, the lack of specific diagnostic codes for spiritual conditions amplifies the rejection of African belief systems beyond clinical settings. Third parties such as medical insurance companies may reject claims related to belief-based conditions, reflecting a broader challenge in recognizing and respecting diverse cultural and spiritual perspectives. As such, a more inclusive approach is needed to respect and integrate cultural beliefs into healthcare systems. This requires challenging the status quo and developing frameworks that honour spiritual beliefs and African communities to enhance mental health practices and outcomes.

Cultural competence is a crucial aspect of Western healthcare, particularly in diverse settings like South Africa. It involves understanding and respecting the cultural differences between clinicians and patients, which is necessary for effective therapy. Despite the HPCSA's requirement for healthcare workers to receive cultural competence training, gaps remain when practitioners are in practice. This was reflected both in the experiences of participants and the studies that reported a significant desire among medical students for more culturally competent education, highlighting existing disparities in treatment across racial lines. The DSM V's

guidelines stress the importance of cultural and contextual factors in diagnosis. In the experiences of the participants, cultural and contextual knowledge was mainly obtained by gathering collateral information from the families and the patients, yet collateral without critical assessment can still lead to misdiagnosis, as in the case of a patient who had a different belief system from his family. The participants cases illustrate how a lack of understanding in African spiritual beliefs can result in the misinterpretation of culturally specific behaviours as psychotic symptoms, underscoring the need for a nuanced approach that considers different belief systems in psychological practice.

Concerns about cultural competence extend to interactions among colleagues of different racial and ethnic backgrounds, for example, some participants reported a lack of confidence in their non-African colleagues' ability to understand and work with African patients' cultural contexts. This is a major obstacle in moving towards an African centred practice as the continued discomfort among colleagues in addressing these issues openly exemplifies them. This is compounded by the limited inclusion of African epistemologies in formal psychology curricula, forcing practitioners who recognised the gap in information to seek external resources for support. The participants relied mainly on books, podcasts, and mentorship from culturally knowledgeable supervisors to develop their knowledge in African traditional practices. These efforts illustrate the ongoing need for a more inclusive and comprehensive approach to cultural integration in healthcare curriculums, which respect and integrate diverse cultural perspectives to improve patient care.

According to the participants, one way of addressing the lack of integration of Western and Indigenous treatment methods is through developing effective frameworks and treatment strategies for African spiritual patients in Western healthcare systems. This is essential to prevent misdiagnosis and ensure culturally sensitive care. Another proposed solution is to incorporate questions into the Mental Status Examination (MSE) that identify spiritual presentations without pathologizing them. However, due to the non-transferability of Indigenous concepts into Western psychiatric environments, the need for a specifically Indigenous-friendly MSE ought to be developed. Therefore, research and funding should focus on generating and formalizing progressive ideas to integrate them into psychological curricula, promoting wider acceptance and understanding among clinicians. Studies have shown that many South African psychiatrists were unaware of the Cultural Formulation Interview (CFI) until it was included in the DSM-V, highlighting the importance of integrating culturally relevant tools into professional training.

Additionally, collaboration with local communities and thought leaders in the subjects of African Psychology is vital for creating an indigenized psychology that respects both Western and African knowledge systems. Moreover, referral networks to traditional healers demonstrate the collaborative potential between modern mental health practitioners and Indigenous healers, emphasizing the need for cultural competence and respect for clients' belief systems. Another point from the participants was that supervision was crucial, but the supervisors often lacked the adequate skillset to address African spiritual issues in therapy, revealing a gap in valuable knowledge about traditional practices. Despite these challenges, supervision spaces offer critical support, emphasizing the necessity for a more robust and culturally informed system to aid therapists in navigating complex intersections between Western and Indigenous healing practices.

4.7 Conclusion

This chapter explored the themes that emerged from the study while incorporating relevant literary sources. It examined the experiences of psychologists who worked with traditional healers as clients, detailing their internships and current careers. Participants highlighted their experience of the interaction between Western and African worldviews in various contexts, including countertransference experiences, patient care, and the roles they occupied in the institutions they worked in. Major issues, such as the lack of cultural competence among colleagues, were identified although frameworks and potential solutions were proposed to address these challenges. The chapter concluded with a summary of the results and findings. The next chapter will present recommendations, limitations, and implications for future research

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the conclusion of the study. It will discuss the limitations of the study, the contributions of the study and recommendations which contain implications for psychological practice and suggestions for future research.

5.2 Research Overview

The current research study aimed to explore the experiences of South African Psychologists working with clients who also consult Sangomas/traditional healers. There is currently a dearth of literature available regarding therapeutic work with African spiritual patients and how to work with them. The current mental health care system in South Africa is predominantly driven by Western ideologies and often fails to cater to the culturally diverse and predominantly Black African population. Despite the increased recognition of the importance of culturally relevant care, the healthcare system remains under-resourced, perpetuating outdated Western psychological practices that are insensitive and out of context for many South Africans (Dockrat et., 2019; Ebersöhn et al., 2018; Koen & Robertson, 2020). The significant barriers to accessing mental healthcare, such as poverty, geographic location, and a lack of information, particularly affect Black people from marginalized and lower-income groups (Matoane, 2012; Koen & Robertson, 2020; Moshabela, Zuma, & Gaebe, 2016). However, there have been efforts towards community-based services, though these are often hindered by systemic resource limitations (Koen & Robertson, 2020; Ebersöhn et al., 2018).

Additionally, there is a notable trend of South Africans simultaneously seeking mental health services and traditional spiritual healers, highlighting the need for a more integrated and culturally sensitive approach. (Padayachee & Laher, 2012; Burns & Tomita, 2015; Moshabela et al., 2016; Nduna et al., 2020). This phenomenon, known as medical pluralism, underscores the necessity for a psychological practice that embraces both Western and traditional African healing systems (Moshabela et al., 2016). Moreover, the increasing preference for psychologists who integrate spirituality in their therapeutic work indicates a shift towards a more holistic and inclusive mental healthcare approach (Nduna et al., 2020). To address these issues, this study sheds light on the experiences and knowledge of South African psychologists working with clients who bring African spiritual content into therapy. The participants also provided insights into developing a more relevant and effective psychological practice that could foster better collaboration between psychologists and traditional healers in South Africa.

They expressed how they navigated the interaction of both worldviews in the therapy room and presented insights into their ideas towards the relevant frameworks and treatment strategies for working with traditionally gifted patients.

The findings indicated that the psychologist's experiences were fraught with significant challenges, both institutional and personal. The psychologists reported feeling unequipped and inadequately trained to work with spiritually inclined patients. Those who studied at the University of the Witwatersrand (7 out of 8 participants) were trained predominantly using psychodynamic theory and interestingly, they felt inadequately trained to work with African spiritual patients in therapy. The Wits trainees reported that African philosophies and epistemologies were not included in their curriculum, and they found psychodynamic theory restrictive for African spiritual contexts. The exception was a psychologist from the University of Kwa-Zulu-Natal (UKZN), who felt well-supported in integrating African spiritual beliefs into therapeutic work. Notably, this was prior to her own calling as an Indigenous healer which recently occurred in 2024, whereas she has been practicing psychology professionally for 3 years. Nonetheless, in their therapeutic work, participants experienced significant countertransference reactions, marked by confusion, doubt, and fear of imposing their beliefs onto their patients. These complex reactions highlight the need for ongoing education, self-reflection, and systemic changes that allow for the integration of African philosophies into psychological training and practice.

During their internships, the participants felt dismissed within the multidisciplinary teams, something which they attributed to the prevailing hierarchical systems in the hospital. The findings also demonstrated that the psychology interns faced additional challenges due to the medical model's tendency to conflate African ancestral callings with psychosis. In addition, the participants reported how the fast-paced, diagnosis-focused environment often dismissed cultural considerations. This was a source of internal conflict and frustration for the intern psychologists who were culturally aware, as demonstrated by a participant who had “betrayed” himself and his patients out of a need for approval from the team. The lack of cultural competence and open-mindedness from the multidisciplinary teams underscores systemic failures in accommodating non-Western worldviews in patient care. In tandem, the application of complementary systems in hospitals is hindered by the lack of normalized Indigenous treatment protocols and potential ethical dilemmas in collaboration with traditional healers. On the smaller scale, participants expressed confusion about the scope of psychological versus African spiritual work in terms of where psychological work ends and where traditional

spiritual work begins. When these dilemmas were coupled with fear and contrasting belief systems to those of their African Spiritual patients, psychologists referred their patients to fellow colleagues. On a larger scale, the lack of specific diagnostic codes for spiritual conditions were thought to perpetuate the rejection of African belief systems beyond clinical settings as medical insurance companies reject claims related to belief-based conditions. Therefore, a more inclusive approach is needed to integrate cultural beliefs into healthcare systems, and this requires policy makers and psychology professionals to challenge the status quo and develop frameworks that honor spiritual beliefs and community contexts.

The participants' reports illustrated how a lack of understanding of African spiritual beliefs can result in the misinterpretation of culturally specific behaviors as psychotic symptoms, underscoring the need for a nuanced approach that considers different belief systems. This raised concerns about cultural competence among colleagues of different racial and ethnic backgrounds as participants lacked confidence in their non-African colleagues' ability to understand and adapt to African patients' cultural contexts. Interestingly, there were reports among participants highlighting discomfort in addressing cultural competence issues openly further indicating how unsafe the working environment felt for the intern psychologists. Other issues were the limited inclusion of African epistemologies in formal psychology curricula. This forced practitioners to seek external resources of support through books, podcasts, and culturally knowledgeable supervisors to develop their knowledge of African traditional practices.

The development of effective frameworks and treatment strategies for African spiritual patients in Western healthcare systems is essential to prevent misdiagnosis and ensure culturally sensitive care. A relevant proposition is the incorporation of questions into the Mental Status Examination (MSE) that assist in identifying traditional gifts. However, due to the non-transferability of Indigenous concepts into Western psychiatric environments, an Indigenous-friendly MSE should be developed. Accordingly, research and funding should be geared towards integrating progressive ideas into psychological curricula in order to promote wider acceptance among clinicians. Moreover, collaboration with local communities and thought leaders in African Psychology is vital for creating an indigenized psychology that respects both Western and African knowledge systems. Referral networks to traditional healers demonstrate the collaborative potential between modern mental health practitioners and Indigenous healers, emphasizing cultural competence and respect for clients' belief systems. Supervision is crucial, but supervisors often lack the adequate skillset to address African

spiritual issues in therapy. Despite these challenges, supervision spaces offer critical support, highlighting the need for a more robust and culturally informed system to aid therapists in navigating the complex intersections between Western and Indigenous healing practices.

5.3 Limitations of the study

One limitation of the study is that most of the interviews were conducted online instead of in-person. This could have taken from the richness of the data as the opportunity to fully observe participants body language was not possible. Another limitation of the study is the lack of generalisability due to the small sample size. Therefore, the experiences of the psychologists and intern psychologists who were interviewed cannot be generalised to all the psychologists who have worked with this patient population. Additionally, seven of the eight participants were African psychologists, and this is not reflective of the racial statistics within the population of the psychology profession. However, the demographics of the population of psychologists working with African Spiritual patients is unknown. The population of this study could however pose an interesting data point about the kinds of participants who were able to recognize their patients' presentations as traditional callings rather than pathology. With limited exposure to African epistemologies, it is not uncommon for psychologists to fall into an entirely Western paradigm of viewing things.

Although the study provided valuable insights into the experiences of psychologists working with African spiritual patients, half of the sample included intern psychologists who were completing their training. This could have significantly affected the results as it is not uncommon for interns and trainees to experience doubt and confusion in their therapeutic work. This experience of feeling unequipped to effectively work with patients who also consult traditional healers, could have been a conflation of a lack of training on Indigenous Knowledge systems and the normal uncertainties experienced by trainees. Although the participants expressed that the sense of feeling unequipped was related to the lack of adequate training on African worldviews, there was no separate measure or question to ensure that the participants experienced adequate training in other areas of their clinical work. It is, however, notable that even those who had professional experience also reported feeling unequipped, with no reported changes in feeling inexperienced between their internship and current experiences. This interestingly reflects how their professional experience did not bridge the gap of feeling inadequately trained and skilled to work with African spiritual clients over time. Additionally,

it should be noted that the experience of psychodynamic theory as being insufficient for African Spiritual contexts is limited to the psychodynamic theories that the Wits trainees were taught. These theories excluded the work of psychologists like Carl Jung, who was intentional about learning and exploring African cultures and religions.

5.4. Recommendations

The findings of the study indicated that there was a lack of information regarding Indigenous knowledge systems (IKS) and African philosophies in the psychology academic curriculum, therefore, it is recommended that African Indigenous knowledge systems, including traditional attributions of mental illness, are formally integrated into the academic syllabus of psychologists since African patients make up the majority of psychology patients in South Africa. Institutions of training could also invite thought leaders in African psychology or Indigenous healers to give lectures so that students may have the necessary information moving forward. In addition, the experiences of the intern participants in their hospitals of training indicated a lack of cultural competence among multidisciplinary team members, particularly about the symptoms of African callings, therefore, it is recommended that Indigenous healers who are registered under the Traditional Health Practitioners Council of South Africa (THPCSA), the African National Healers Association (ANHA), or the South African National Traditional Healers Association (SANTHA) are integrated into the multidisciplinary teams in the psychiatric wards. This will educate and familiarise the teams with African IKS, the symptoms of African traditional callings, and it will do away with confusion about the patient's calling as healers could assist with the verification of this information. This kind of implementation might minimise misdiagnosis and will promote holistic care for the patients and increase cultural competence among healthcare workers. Moreover, research and funding in South African mental health should be geared towards the development of an Indigenous Psychology as this will assist in developing the appropriate treatment strategies for patients who ascribe to African Indigenous belief systems. Effective and progressive frameworks, such as the MSE idea proposed by a participant, will assist in identifying traditional conditions in ways that a Western trained psychologists can detect.

Moreover, the formation of collaborative relationships between Western mental healthcare workers and traditional healers is important for referral networks. Establishing referral networks between psychologists and traditional healers may affect treatment outcomes

for clients whose issues are deeply rooted in cultural or spiritual domains. Perhaps the creation conferences or group discussions between traditional healers and Western mental healthcare workers will foster these collaborative relationships and enlighten the individuals involved. It would enhance culturally competent therapists who can discern when psychological interventions are sufficient and when it is appropriate to engage with traditional healing modalities, thereby providing holistic care that honours the entirety of the client's experience.

5.5 Implications for future research

Given the lack of literature about the experiences of South African psychologists working with traditional African patients, it is recommended that research is continued in this area. Perhaps even a dyadic research study exploring the experiences of supervisors and their trainee psychologists who are working with traditional healers (as patients) would be a worthy undertaking. This could enable us to gain a fuller understanding of the different dynamics at play. Additionally, in consideration of the need to Integrate Indigenous knowledge systems into the psychology curriculum, it might be helpful to explore the perceptions of psychology curriculum makers in incorporating African Indigenous knowledge systems and literature of African psychology as part of curriculum. Lastly, a study following the treatment outcomes and experiences of traditional healer patients who consult both psychologists and traditional healers would be helpful in understanding the needs of the patient population and how to best serve their needs.

5.6 Conclusion

Shedding light on the experiences of South African psychologists who work with African spiritual patients has proven to be an important task, not only for clinicians in the profession but for the African Spiritual client population, who often fill up mental institutions. With increased documentation of these enlightening experiences, powerful and progressive discourses might emerge around healing practices and what they would mean and look like for African spiritual patients. The frustration, helplessness and dismissal that was felt by majority of the psychologist participants seemed to reflect the experiences of some of the African spiritual patients who are at times deeply misunderstood. Interestingly the participants who eventually found some sense of grounding and confidence in their work with patients were those who were met by their supervisors with a benevolent curiosity and an interest in truly

understanding and making sense of their experiences. This also paralleled the experience of a patient whose psychologist (a participant) met them with the same demeanour, that is, a deep desire to understand their patient and a willingness to feel uncomfortable in the process. Perhaps this is a call for psychologists and other healers to challenge and rewrite outdated and discriminatory systems while also leaning into the discomfort and growth that comes with this.

References

Akhurst, J. (2020). A South African Perspective on Community Psychology Practice Competencies. *Journal of Community Psychology*, *48*(6), 2108–2123. https://doi.org/10.1002/jcop.22410

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th Ed.). American Psychiatric Association. https://repository.poltekkes-kaltim.ac.id/657/1/Diagnostic%20and%20statistical%20manual%20of%20mental%20disorders%20_%20DSM-5%20(%20PDFDrive.com%20).pdf

Bakow, B. R., & Low, K. (2018). A South African experience: cultural determinants of ukuthwasa. *Journal of Cross-Cultural Psychology*, *49*(3), 436–452. https://doi.org/10.1177/0022022117753546

Bion, W.R. (1962). A theory of thinking. *International Journal of Psychoanalysis*, *43*, 306-310

Bodibe, R. C. (1992). Traditional healing: An indigenous approach to mental and health problems. *In J. Uys (Ed.), Psychological counselling in the South African context (pp. 112–123)*. Maskew Miller Longman.

Buhrmann, M. Vera (1984). Living in two Worlds. Cape Town: Human & Rousseau.

Burns, J. K. (2010). Mental health services funding and development in KwaZulu-Natal: A tale of inequity and neglect. SAMJ: South African Medical Journal.

Burns, J. K., & Tomita, A. (2015). Traditional and religious healers in the pathway to care for people with mental disorders in Africa: a systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology: The International Journal for Research in Social and Genetic Epidemiology and Mental Health Services*, *50*(6), 867–877. https://doi.org/10.1007/s00127-014-0989-7

Bynum, E. B. (1999). *The African unconscious: Roots of ancient mysticism and modern psychology*. Teachers College Press.

Canham, H., Kiguwa, P., & Kometsi, K. (2007). Equity and transformation: Changing contexts of academia in South African Psychology. Paper presented at the 13th South African Psychology Congress, Durban, South Africa.

Chitindingu, E., & Mkhize, N. (2016). Listening to Black African Psychologists' Experiences of Social and Academic Inclusion: Incorporating Indigenous Knowledge Systems into the Curriculum. *Alternation Journal*, (18), 72-98. https://journals.ukzn.ac.za/index.php/soa/article/view/1355

Constantine, M.G., Hage, S.M., Kindaichi & Bryant., R.M (2007) Social Justice and Multicultural Issues: Implications for the Practice and Training of Counselors and Counseling Psychologists. *Journal of Counseling & Development*, *85*(1), 24-29. https://doi.org/10.1002/j.1556-6678.2007.tb00440.x

Corey, G., & California State University. (2013). Theory and practice of counseling and psychotherapy (9th ed., Student). Wadsworth.

Craig, A., Rochat, T., Naicker, S. N., Mapanga, W., Mtintsilana, A., Dlamini, S. N., Ware, L. J., Du Toit, J., Draper, C. E., Richter, L., & Norris, S. A. (2022). The prevalence of probable depression and probable anxiety, and associations with adverse childhood experiences and socio-demographics: A national survey in South Africa. *Frontiers in Public Health, 10,* 986531-986531. https://doi.org/10.3389/fpubh.2022.986531

Crawford, T. A., & Lipsedge, M. (2004). Seeking help for psychological distress: the interface of Zulu traditional healing and western biomedicine. *Mental Health, Religion & Culture*, *7*(2), 131–148.

Craven, R. G., Ryan, R. M., Mooney, J., Vallerand, R. J., Dillon, A., Blacklock, F., & Magson, N. (2016). Toward a positive psychology of indigenous thriving and reciprocal research partnership model. *Contemporary Educational Psychology*, *47*, 32–43. https://doi.org/10.1016/j.cedpsych.2016.04.003

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2018). *The sage handbook of qualitative research* (Fifth). SAGE.

Docrat S, Besada D, Cleary S, Daviaud E, Lund C. (2019). Mental health system costs, resources and constraints in South Africa: a national survey. *Health Policy Plan*, *0*(0): 1-14. https://doi.org/10.1093/heapol/czz085

Edwards, S.D. (2009). The Description and Evaluation of an African Breath Psychotherapeutic Workshop. Journal of Psychology in Africa, 19(2): 253- 260.

Edwards, S. (2011) A Psychology of Indigenous Healing in Southern Africa. *Journal of Psychology in South Africa. 21(3),* 335-348 https://doi.org/10.1080/14330237.2011.10820466

Edwards, S. (2010). On Southern African indigenous healing. *Indilinga African Journal of Indigenous Knowledge Systems*, *9*(2), 211–229. https://doi.org/10.10520/EJC61593

Edwards, S., Makunga, N., Thwala, J., & Mbele, B. (2009). The role of the ancestors in healing. *Indilinga: African Journal of Indigenous Knowledge Systems*, *8*(1). https://doi.org/10.4314/indilinga.v8i1.48234

Edwards, S. D., Grobbelaar, P. W., Makunga, N. V, Sibaya, P. T., Nene, L. M., Kunene, S. T., & Magwaza, A. S. (1983) Traditional Zulu theories of illness in psychiatric patients. *Journal of Social Psychology*, *121*(2), 213–221. https://doi.org/10.1080/00224545.1983.9924491

Ebersöhn Liesel, Loots, T., Mampane, R., Omidire, F., Malan-Van Rooyen, M., Sefotho, M., & Nthontho, M. (2018). An indigenous psychology perspective on psychosocial support in Southern Africa as collective, networking, and pragmatic support. *Journal of Community & Applied Social Psychology*, *28*(5), 332–347. https://doi.org/10.1002/casp.2371

Fanon, F. (1967). *The wretched of the earth. Penguin.*

Gergen, K. J. (1996). Social construction and the educational process. *In D. R. Olson & N. Torrance (Eds.), The handbook of education and human development: New models of learning, teaching, and schooling* (pp. 257–276). Wiley

Graham, A. (2016). The African unconscious: Roots of ancient mysticism and modern psychology. International Journal of Transpersonal Studies, 35(1), 157. https://doi.org/10.24972/ijts.2016.35.1.157

Greenfield, P. M. (1997). Culture as process: Empirical methods for cultural psychology. *In J. W. Berry, Y. H. Poortinga, & J. Pandey (Eds.), Handbook of cross-cultural psychology: Theory and method* (2nd ed., pp. 301–346). Allyn & Bacon.

Gumede, M.V. (1990). *Traditional Healers: A Medical Doctor's Perspective*. Skotaville.

Haine, P., & Booysen, D. D. (2020). Life after training: Professional experiences of early career clinical and counselling psychologists in South Africa. *Journal of Psychology in Africa*, *30*(5), 475-483. https://doi.org/10.1080/14330237.2020.1821317

Haine, P., Booysen, D. D., & Young, C. (2024). 'Crushed all over again': The professional experiences of early career counselling psychologists in South Africa. *South African Journal of Psychology*, *54*(1), 51-64. https://doi.org/10.1177/00812463231218002

Hammond-Tooke, W. D. (1989). *Rituals and medicines: Indigenous healing in South Africa*. Juta.

Holdstock, T. L. (1981). Psychology in South Africa belongs to the colonial era. Arrogance or ignorance? *South African Journal of Psychology*, *11*, 123–129. https://doi.org/10.1177/008124638101100401

Iony D. Ezawa & Daniel R. Strunk (2022) Working with Black vs. White patients: an experimental test of therapist decision-making in cognitive behavioral therapy for depression, *Cognitive Behaviour Therapy*, *51*(3), 229-242, https://doi.org/10.1080/16506073.2021.1970799

Ivey, G. (2013). *Unconscious meaning and magic: Comparing psychoanalysis and African Indigenous healing In C. Smith C., G. Lobban G. and M. O'Loughlin (Eds.), Psychodynamic psychotherapy in South Africa: Contexts, theories and applications (pp. 123-145).* Wits University Press.

Ivey, G., & Myers, T. (2008). The psychology of bewitchment (part II): A psychoanalytic model for conceptualising and working with bewitchment experiences. *South African Journal of Psychology*, *38*(1), 75-94. https://doi.org/10.1177/008124630803800105

Joshua K. Swift, Julie Spencer & Jonathan Goode (2018) Improving psychotherapy effectiveness by addressing the problem of premature termination: Introduction to a special section, *Psychotherapy Research*, *28*(5), 669-671, https://doi.org/10.1080/10503307.2018.1439192

Juma, J.O (2011) African Worldviews– Their Impact on Psychopathology and Psychological Counselling. [Master in Psychology, University of South Africa]. UIR: Unisa, Institutional Repository). https://uir.unisa.ac.za/handle/10500/5760

Katz, R., & Wexler, A. (1989). Healing and transformation: lessons from indigenous people (Botswana). *In K. Peltzer & P. Ebigbo (Eds.), Clinical psychology in Africa* (pp. 19–43). Chuka

Kim, U., & Berry, J. W. (1993). *Indigenous psychologies: Research and experience in cultural context*. Sage.

Knettel BA, Rugira J, Cornett JA. Mental Health Diagnostic Frameworks, Imputed Causes of Mental Illness, and Alternative Treatments in Northern Tanzania: Exploring Mental Health Providers' Perspectives. Cult Med Psychiatry. 2018 Sep;42(3):483-503. https://www.doi/10.1007/s11013-018-9565-z

Koen, V., & Robertson, N. D. (2021). A qualitative exploration of psychosocial well-being experiences in a South African rural community. *Journal of Community Psychology*, *49*(5), 1195–1211. https://doi.org/10.1002/jcop.22590

Kwate, N. O. A. (2005). The heresy of African-centered psychology. *The Journal of Medical Humanities*, *26*(4), 215-235. https://doi.org/10.1007/s10912-005-7698-x

Lappeman, M., Ndwandwa, E.-sethu, Hunt, X., Ned, L., & Swartz, L. (2021). South African clinical psychology practice: the challenge of local contextual change. *Professional Psychology: Research and Practice*, (20210603). https://doi.org/10.1037/pro0000401

Louw, D.A and Pretorius, E (1995). The Traditional Healer in a Multicultural Society: The South African Experience. *In L. Adler and B. Mukherji (Eds.), Spirit Versus Scalpel: Traditional Healing and Modern Psychotherapy*. Bergin and Garvey.

Louw, D. A. & Edwards, D. J. A. (1997). *Extract from psychology: An introduction for students in Southern Africa*. Heinemann.

Mabaso, D. J., & Kotze, C. (2020). Cultural formulation interview: Awareness and attitudes of South African psychiatrists and psychiatry registrars. *South African Journal of Psychiatry*, *26*(1). https://www.ajol.info/index.php/sajpsyc/article/view/241069

Marovic, Z. (2020). Cross-cultural indigenous training: the South African experience. *Culture & Psychology*, *26*(3), 605–621. https://www.doi.org/10.1177/1354067X20908529

Matoane, M. (2012). Locating context in counselling: the development of indigenous psychology in South Africa. *Psychotherapy and Politics International*, *10*(2), 105–115. https://doi.org/10.1002/ppi.1263

Molot, M, (2017). Discourses of Psychiatry and Culture: The Interface Between Western and Traditional Medicine in the Treatment of Mental Illness. *Independent Study Project (ISP) Collection.* 2582. https://digitalcollections.sit.edu/isp_collection/2582

Moodley, R., & West, W. (2005). *Integrating traditional healing practices into counseling and psychotherapy*. SAGE Publications.

Moshabela, M., Zuma, T. & Gaebe, B., 2016. Bridging the gap between biomedical and indigenous health practitioners in South Africa. *South African Health Review, 6*(1), 83-92. http://www.hst.org.za/sites/default/files/Bridging_the_gap.pdf

Mufamadi, J. (2001). A group of traditional healer's perceptions of and approaches to the treatment of mental illness. Retrieved from http://datalib.usak.ca/iportal/2007.10.17/IKC2001-Mufamadi.pdf

Mvelashe, P. (2020, March 11). *Local university offers Sangoma consultation to students.* News 24. https://www.snl24.com/drum/news/local-university-offers-sangoma-consultation-services-to-students-20200311#google_vignette

Myers, L. J. (1993). *Understanding an Afrocentric World View: Introduction to an Optimal Psychology* (2nd edition). Kendal Hunt Publishing.

Niehaus D. J. H., Oosthuizen P., Lochner C., Emsley R. A., Jordaan E., Mbanga N. I., Stein D. J. (2004) A culture-bound syndrome "amafufunyana" and a culture-specific event "ukuthwasa": Differentiated by a family history of schizophrenia and other psychiatric disorders. Psychopathology 37(2), 59–63. https://doi.org/10.1159/000077579

Nel, P., & Mlisa, L. N. (2015). Umbilini experiential knowledge and indigenous healing praxis in ukunyanga tradition. *African Journal for Physical Health Education, Recreation, and Dance*, *21*(3.2), 913-929. https://journals.co.za/doi/epdf/10.10520/EJC175500

Ndlanzi Institute of Spiritual Healing. (2024). Spiritual Teacher. Gogo Dineo Ndlanzi. https://www.gogodineondlanzi.com/spiritual-teacher/

Nduna, M., Molefi, S., Sefanyatso, K., & Olifant, B (2020, September 3). The Dawn of the Healer-Therapist in South Africa. *News 24*. https://blogs.bmj.com/medical-humanities/2020/09/03/the-dawn-of-healer-therapist-in-south-africa/

Ogana, W. (2009). Diagnostic practices of iZangoma in Durban, South Africa: indigenous knowledge systems, health, illness and healing. *Indilinga: African Journal of Indigenous Knowledge Systems*, *8*(2), 115–126. https://journals.co.za/doi/pdf/10.10520/EJC61577

Padayachee, P., & Laher, S. (2014). South African Hindu psychologists' perceptions of mental illness. *Journal of Religion and Health*, *53*(2), 424–437. https://doi.org/10.1007/s10943-012-9646-1

Pillay, A. L., & Nyandeni, L. N. (2021). Is post-apartheid South Africa training more black african clinical psychologists and addressing the historical imbalance? *South African Journal of Psychology*, *51*(1), 147-157. https://doi.org/10.1177/0081246320977985

Pietkiewicz, I., & Smith, J. (2014) A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Czasopismo Psychologiczne Psychological Journal*, *20*(1) 7-14. https://www.doi.org/10.14691/CPPJ.20.1.7

Plumb, A. M. (2011). Spirituality and counseling: Integrating religion and spirituality into clinical work. *Journal of Counseling & Development*, *89*(3), 240–245. https://www.doi.org/10.1002/j.1556-6678.2011.tb00074.x

Ratele, K., Malherbe, N., Suffla, S., Cornell, J., & Taliep, N. (2021). Three pathways for enlarging critical African psychology. *South African Journal of Psychology*, *51*(3), 430–440. https://doi.org/10.1177/0081246320963201

Schouler-Ocak, M., Graef-Calliess, I. T., Tarricone, I., Qureshi, A., Kastrup, M. C., & Bhugra, D. (2015). EPA guidance on cultural competence training. *European Psychiatry*, *30*(3), 431–440. http://dx.doi.org/10.1016/j.eurpsy.2015.01.012

Shezi E. N., Uys L. R. (1997) Culture bound syndromes in a group of Xhosa with psychiatric disorders. *Curationis*, *20*(2), 83–86. https://www.doi.org/ 10.4102/curationis.v20i2.1313

Shinebourne, P. (2011). The theoretical underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis*, *22*(1), 16–31.

Smith, J.A. and Osborn, M. (2008) Interpretative Phenomenological Analysis. *In J. A Smith, (Ed)., Qualitative Psychology: A Practical Guide to Research Methods*, (pp. 53-80). Sage.

Solomon, A.C., & Wane, N.N. (2005). Indigenous Healers and Healing in a Modern World. *In R. Moodley & W. West. (eds.). Integrating Traditional Healing Practices Into Counseling and Psychotherapy* (pp. 52- 60). Sage.

Sorsdahl, K., Stein, D. J., Grimsrud, A., Seedat, S., Flisher, A. J., Williams, D. R., & Myer, L. (2009). Traditional healers in the treatment of common mental disorders in South Africa. *The Journal of Nervous and Mental Disease, 197*(6), 434-441. https://doi.org/10.1097/NMD.0b013e3181a61dbc

Sow, I. (1980). *Anthropological structures of madness in Black Africa*. New York International Universities Press Reference list

Stodulka, T. (2019). Orders of feeling. In J. Slaby & C. von Scheve (Eds.), Affective societies: Key concepts (pp. 310-318). Routledge/Taylor & Francis Group. https://doi.org/10.4324/9781351039260-27

Sullivan, W. P. (2009). Spirituality: a road to mental health or mental illness. *Journal of Religion & Spirituality in Social Work: Social Thought, 28*(1-2), 84–98.

Tracy, S. J. (2013). *Qualitative Research Methods*. Wiley-Black Well.

Thornton, R. (2017). *Healing the exposed being the ngoma healing tradition in South Africa*. Witwatersrand University Press. Retrieved March 16, 2022, from https://public.ebookcentral.proquest.com/choice/publicfullrecord.aspx?p=5730660

Van Antwerpen, N., & Oster, C. (2020). Postmodern thought and the self: an interpretative phenomenological analysis. *Human Studies, 43*(1), 107–127. https://doi.org/10.1007/s10746-019-09534-2

Van der Zeijst, M., Veling, W., Makhathini, E. M., Susser, E., Burns, J. K., Hoek, H. W., & Susser, I. (2021). Ancestral calling, traditional health practitioner training and mental illness: An ethnographic study from rural KwaZulu-Natal, South Africa. *Transcultural Psychiatry*, *58*(4), 471-485. https://doi.org/10.1177/1363461520909615

Viljoen, E. (2006). An explorative study: mental wellness as perceived by black traditional healers within the South African context. [MA in Clinical Psychology, University of Pretoria]. ProQuest. https://www.proquest.com/dissertations-theses/explorative-study-mental-wellness-as-perceived/docview/2901812462/se-2

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Open University Press.

Wozniak, A. (2009). The professional identity of South African Clinical Psychologists who are also Sangomas [Master's thesis in Clinical Psychology, University of the Witwatersrand]. WiredSpace, Institutional Repository. https://wiredspace.wits.ac.za/server/api/core/bitstreams/a896ddc0-09c6-4c5e-a68b-a75f47e40e09/content

APPENDIX A – ETHICS CLEARANCE

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE:	**PROTOCOL NUMBER: MCLIN/22/07**
PROJECT TITLE:	An Exploration into the experiences of South African Psychologists working with patients who consult traditional healers/sangomas.
INVESTIGATOR	Tagana Boipelo (1636322)
SCHOOL/DEPARTMENT OF INVESTIGATOR	SHCD/Psychology
DATE CONSIDERED **DATE AMENDMENT CONSIDERED**	10 June 2022 13 September 2022
DECISION OF THE COMMITTEE	Approved unconditionally
RISK LEVEL	Minimal Risk
EXPIRY DATE	31 December 2024

ISSUE DATE OF CERTIFICATE 11 July 2022 **CHAIRPERSON** C Harvey
(Dr Clare Harvey)

ISSUE DATE OF AMENDED CERTIFICATE 05 October 2022

Cc: Ms Hopolang Matee (Supervisor)

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I fully understand the conditions under which I am are authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

Signature TBagana **Date** 05 / 10 / 2022

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

APPENDIX B- RESEARCH FLYER



PARTICIPANTS WANTED

MASTERS RESEARCH PROJECT

My name is Boipelo Tagana, I am a Masters student in Clinical Psychology at the University of the Witwatersrand in Johannesburg. As part of my studies, I am required to undertake a research project. This research project will explore the experiences of psychologists who have worked with clients that also consult traditional healers/sangomas

WHO CAN PARTICIPATE?

1. Psychologists or trainee psychologists who have worked with clients that also consult traditional healers/sangomas
2. Participants must be registered with the HPCSA
3. Must have had a minimum of 6 therapy sessions with the client
4. Between the ages 25-65

As part of this project, I would like to invite you to participate in a 60-minute online interview.

CONTACT: BOIPELOT98@GMAIL.COM

APPENDIX C - INTERVIEW GUIDE

1. What have been your experiences of working with a client who consults a Sangoma?
2. How do you think working with a client with strong cultural practices affects your (role) therapy in any way, if at all?
3. How do you approach the cultural material that comes up in the room?
4. How informed are you about traditional African healing and African cosmology?
5. How do you navigate the unknowns of traditional African healing when your client brings it in the room?
6. Do you have any experience with working with clients who have the calling or have avoided it? If yes, how do you navigate that in the room?
7. How do you make sense of the traditional material that is brought into the therapy room by your client?
8. How equipped do you feel to work with clients who bring traditional material in the room (especially from a training perspective)?
9. What is your approach to navigating the interaction of the psychological worldview and the traditional African worldview
10. What psychological techniques or methods have you found to be most helpful when working with your client that also consult Sangomas?
11. What psychological methods/techniques do you find your client best responds to?
12. What has your client's psychological presentation been so far? How have you made sense of it?
13. How do you experience your client in the room?
14. What are countertransference reactions that you have from working with clients who consult Sangomas? How do you make sense of them?
15. Do you have any ideas or suggestions around a framework that could be helpful or has been helpful for you for you when working with clients who consult Sangomas?
16. Do you know/have any Sangomas that you can refer your clients to?

APPENDIX D - PARTICIPATION INFORMATION SHEET

Private Bag 3, Wits, 2050
Johannesburg, South Africa
Tell: 011 717 1000

Dear Sir / Madam
My name is Boipelo Tagana and I am a Masters student in Clinical Psychology at the University of the Witwatersrand in Johannesburg. As part of my studies, I am required to undertake a research project. The aim of this research project is to find out the experiences of psychologists who work with clients who also consult traditional healers. The objectives of finding out how psychologists navigate the interaction of African and western psychological worldviews in the room? What are psychologists ideas about a framework that could be helpful or has been when working with clients who also consult Sangomas

As part of this project, I would like to invite you to take part in an interview. This activity will be done online via zoom, where a link of the meeting will be sent to you. The meeting will take around 60 minutes. With your permission, I would also like to record the interview using a digital device.

You will not receive any direct benefits from participating in this research, and there are no disadvantages or penalties for not participating. You may withdraw at any time or not answer any question if you do not want to. The interview will be completely confidential and as I will not be asking for your name or any identifying information, and the information you give to me will be held securely in a password protected device and not disclosed to anyone else. I will be using a pseudonym to represent your participation in my final research report. The researcher may email you in order to validate the accuracy of information, in order to check if your intended message was correctly reported. If you experience any distress or discomfort at any point in this process, we will stop the interview or resume another time. At the end of the research process, the researcher will destroy the recordings but will keep the transcribed data on her online cloud. All identifying information will be removed from the stored data.

If you have any questions during or afterwards about this research, feel free to contact me on the details listed below. This study will be written up as a research report which will be available online through the university library website. If you wish to receive a summary of this report, I will be happy to send it to you. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrec-medical.researchoffice@wits.ac.za

Yours sincerely,
Boipelo

Boipelo Tagana, boipelot98@gmail.com, 0712501314
Hopolang Matee, hopolang.matee@wits.ac.za, 0117170000

APPENDIX E- CONSENT FORM



Private Bag 3, Wits, 2050
Johannesburg, South Africa
Tell: 011 717 1000

Title of project: An exploration into how Psychologists who are Sangomas understand psychopathology from their different remedial perspectives
Name of researcher: Boipelo Tagana

I, ……..., agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. Please circle the relevant options below.

I agree that my participation will remain confidential YES NO

I agree that the researcher may use anonymous quotes in his / her research report YES NO

I agree that the interview may be audio recorded YES NO

I agree that the researcher may take photos of me (but not my face) YES NO

I agree that the information I provide may be used Confidentially by other researchers following this project YES NO

…… (signature)
…… (name of participant)
…… (date)