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Dual healing modality in psychological services: experiences of black healer-therapists in Johannesburg, South Africa

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Dual Healing Modality in Psychological Services: Experiences of Black Healer-therapists in Johannesburg, South Africa

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DECLARATION

I declare that, *Dual Healing Modality in the Psychological Services: Experiences of Black Healer-therapists in Johannesburg, South Africa* is my own work. All sources cited have been indicated and referenced fully. This work is being submitted in partial fulfilment of the requirements of a Master of Arts in Social and Psychological Research Degree at the University of the Witwatersrand, and has not been submitted previously for this degree or any other degree at any other university.

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Date: 01 September 2020

ABSTRACT

Dual healing is provided either by two different practitioners in two organisations or by two different practitioners in the same organisation. Psychological services do not typically include healing and healing does not typically include psychological services. One practitioner, *a healer-therapist,* can provide a dual service. A healer-therapist draws from two different knowledge systems in their work. Healing is a gift which is commonly confirmed through *ukuthwasa.* A psychologist is formally trained through higher educational studies. Studies have explored the collaboration between the western and African modalities of healing but some studies have acknowledged the existence and experience of healer-therapists in the psychology profession. Five semi-structured interviews with healer-therapists based in Johannesburg were conducted. Using a qualitative approach, audio-recorded interview data were transcribed and analysed using interpretive phenomenological analysis. The results demonstrated that the presence of ancestors and the nature of the case presented determined the level of involvement of the healer during the psychotherapy session. Healer-therapists attempted to separate the two practices, but it was impossible to separate the healer from the psychologist or vice versa. This approach required compromise and negotiation from both the client and the healer-therapist and came with various ethical dilemmas. There are certain similarities between healing and psychology, making it possible for the two approaches to co-exist. Healer-therapists managed to incorporate healing into psychology through their work. Healer-therapy is a necessary service to have especially where cultural variables are considered important. A proper breakdown of the ethics surrounding healer-therapy practice is needed.

Keywords: Healing, healer-therapists, dual relationships, decolonising psychology

GLOSSARY OF TERMS

African divination: This is "the skilled process of ascertaining the concealed infuriation and demands of ancestors or other spiritual agencies, underlying a given illness" (Nwoye, 2015, p. 311).

African healing traditions/worldviews: These refer to healing traditions that are representative of the beliefs, customs, attitudes, and practices, which all indicate African worldviews (Bojuwoye & Moletsane-Kekae, 2018). African healing traditions are the African worldviews that represents the conceptualisation of "meaning systems and cultural practices which indicate how people define human nature, 'ideal' human functioning, optimal quality of life or generally the conception of health and ill-health" (Bojuwoye & Moletsane-Kekae, 2018, p. 78). This includes the conceptualisation of mental health.

Ancestors: Those who have departed the physical world but their spirits live on. They use African healers to deliver message to different persons (Bojuwoye & Moletsane-Kekae, 2018).

***Badimo bare furaletse* (SeSotho); *Aba phansi base fulathele* (IsiZulu)**: This means that ancestors have turned their backs on someone (Bojuwoye & Moletsane-Kekae, 2018). This sometimes occurs because of a person who in Sesotho (*o lahla sestso*) or in IsiZulu (*o lahla amasiko*) or in English (has turned their backs on their traditions).

Black African: People who are of the African ancestral origins and are mostly from Sub-Saharan Africa (Agyemang, Bhpal & Brujinzeels, 2005).

Black people: People of the Indigenous African heritage (Hocoy, 1999). Specifically referred to in this document are Indigenous African people of South Africa.

***Boloi* (Sesotho); *Ubuthakathi* (IsiZulu); Witchcraft (English)**: Refers to sorcery or the use of super-powers to wish bad luck upon a person, usually an enemy (Bojuwoye & Moletsane-Kekae, 2018).

Diagnostic and Statistical Manual of Mental Disorders: A psychiatric classification tool developed by the American Psychiatric Association together with other mental health professionals used in order to categorise and distinguish between different psychiatric disorders (Sadock & Sadock, 2007).

Divination: This refers to "the revelation of knowledge from supernatural sources such as spirits or ancestors,

using a variety of methods including tossing of artefacts such as shells or bones, use of mirrors, animal sacrifice, drumming, trance or prayer" (Gureje et al., 2015, p.4).

Dual healing: From the African worldview, healing is perceived as arising from spiritual powers (Bojuwoye & Moletsane-Kekae, 2018). This definition is the opposite of healing from a mainstream psychological perspective. When there is a mixture of the two approaches, then we refer to dual healing.

***Ephehlweni*:** This is an initiation school where healers who are called go to be initiated. The school caters for healers with different spiritual needs (Makua, 2019, April 24).

Ethnicity: This refers to a group of individuals who share common identity, history, beliefs and ancestry (Sadock & Sadock, 2007).

***Go lahla setso* (Sesotho); *ukulahla amasiko* (IsiZulu)**: Failure to perform traditional or cultural rituals or practices (Bojuwoye & Moletsane-Kekae, 2018) as expected.

Healer: In the context of the present study, a healer is one who practices divination.

Healer-therapist: In the context of this research study, a healer-therapist practices as either a clinical or a counselling psychologist and as a healer.

Indigenous psychology: This refers to a discipline that speaks to how people have retained their own therapeutic knowledge; this is usually knowledge that had previously been colonised and marginalised (Bojuwoye & Moletsane-Kekae, 2018).

Indigenous healing: This refers to universal healing systems that originate from Africa and spread to the rest of the world (Edwards, 2011).

Indigenous healing (specific to Southern Africa): This refers to the involvement of the "spirit as a source of self that extends into transpersonal realms" (Edwards, 2011, p. 335).

Indigenous knowledge: This is the "sum total of knowledge, skills and attitudes belonging to, and practiced by a community over generations, and is expressed in the form of action, objects and sign language for sharing" (Ohajunwa & Mji, 2018, p.2524).

***Mafofonyane* (Sesotho); *Amafufunyane* (IsiZulu)**: This refers to being possessed by spirits as a result of witchcraft (Bojuwoye & Moletsane-Kekae, 2018).

Mainstream psychology: This refers to a psychology that is rooted in western 'scientific' knowledge and is objective (Bojuwoye & Moletsane-Kekae, 2018).

Mental health: The World Health Organisation (2014) describes mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community" (p.10).

Mental health care practitioner: This refers to a psychiatrist, social worker, occupational therapist, nurse, psychologist or any registered medical professional authorised to provide mental health care, treatment and rehabilitation services (Mental health care act [MHCA], 2002).

Mental health care provider: This refers to a person who provides mental health care services to mental health care users which includes mental health care practitioners (MHCA, 2002).

Mental health care user: A person who is receiving care, treatment and rehabilitation services, accessing mental health services at a health establishment aimed at enhancing the mental health status of an individual (MHCA, 2002).

Mental illness: This refers to a formal diagnosis of a mental health related illness, made by a mental health care provider in terms of formally established psychiatric classification tools, such as the DSM (MHCA, 2002).

Psychological approach to mental health care: This allows acknowledgement of biological as well as psychological and social determinants of mental health disorders, and acknowledges these in the treatment of mental health disorders (Ahmed & Suffla, 2013).

Traditional Healing (African healing; *ubungoma, bongaka*): The WHO as cited in Bojuwoye and Moletsane-Kekae (2018) define traditional healing as the knowledge and practices that are used in prevention, diagnosis, treatment of physical, mental or social imbalances that originate from African Indigenous knowledge systems handed down from generation to generation. For the purposes of this research, traditional healing will be replaced

with healing in order to represent the study as being rooted in African knowledge systems.

Psychosis: refers to "grossly impaired reality testing" (Sadock & Sadock, 2007, p. 272). When faced with impaired reality testing, individuals often cannot evaluate the accuracy of their own feelings, perceptions and thoughts even when faced with contradictory information (Sadock & Sadock, 2007).

Spiritualism/spirituality (spirit (Enlgish); *umoya* (IsiZulu); *moya* (Sesotho): Spiritualism according to Bojuwoye and Moletsane-Kekae (2018) refers to "a metaphysical belief that has various interrelated forms including that the world is made of matter and spirit and the relationship between them; that the universe is populated by spiritual entities such as the spirits of the dead, ancestral spirits, deities and mediums; and that which has to do with spiritual or religious aspect of human existence" (p.80).

***Ukuthwasa* (IsiZulu); *go thwasa* (SeSotho)**: The process of initiation where a person is trained to become a fully-fledged healer (Bojuwoye & Moletsane-Kekae, 2018).

Universal psychology: A psychology that attempts to represent the best of interest of humanity, science and the universe (Edwards, 2011). It includes all forms of psychology, including European and African psychology.

Westernised healing/health care: An approach to healing which is scientifically based and predominantly biomedical (Campbell-Hall, 2010).

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CHAPTER 1: INTRODUCTION AND BACKGROUND TO THE STUDY

Researcher positionality: The researcher is not opposed to African traditional approaches to mental health care, but being a psychology professional, will also opt for contemporary psychological approaches. The question here is why not both, and if both healing modalities can be administered by one person, then it is even more convenient. At the time of hearing about the existence of healer-therapists, the researcher became interested because a healer-therapist is exactly the kind of professional the researcher would consult with.

Introduction

South Africa was declared a democratic country in April 1994, adopting internationally recognised human rights protocols embodied by principles of *Ubuntu*, cultural diversity and non-racialism (Seedat & Lazarus, 2014). The road to cultural diversity and non-racialism in mental health care in the South African context would include, amongst other things, incorporating indigenous knowledge systems in psychology (Seedat & Lazarus, 2014).

In the past 20 years in South Africa, the profession of psychology has evolved (Cooper & Nicholas, 2012). The profession of psychology evolving is reflected in Black psychologists' increased participation in psychology forums, conferences, professorships, research and publications (Cooper & Nicholas, 2012). This was previously not the case, as under Apartheid, Black psychologists were not included on several platforms that presented professionals with the opportunity to engage and learn from each other (Cooper & Nicholas, 2012; Seedat & Lazarus, 2014). Some of the Black psychologists being trained are also healers (Cooper & Nicholas, 2012). These practitioners are referred to as healer-therapists in this study. The word *healer-therapist* was devised for this study to better reflect the identity of the practitioners in this study. The focus of the present study is on Black healer-therapists who reside and practice in Johannesburg, South Africa.

In South Africa, healing and mainstream psychology modalities are predominantly mutually exclusive and they operate independently from each other. Western and African paradigms of healings have worked in parallel to each other for a long time (Campbell-Hall et al., 2010; Wreford, 2005a; Zabow, 2007). They are also seen as *two conflicting paradigms of healing* which originate from two different knowledge systems that conceptualise

health and illness differently (Mashabela, Zuma & Gaede, 2016). These two paradigms can also be seen as two complementary paradigms of healing. The different conceptualisations bring to the fore that there can be no universal applicability claimed by a single modality (Sodi & Bojuwoye, 2011).

There are different types of dualities that exist in the dichotomy of psychological and healing health care. These dualities are briefly discussed below in order to illustrate the difference between the duality that is the focus of the present study from those that are not.

1. Several studies indicate that there are psychologists who, in their work, follow the allopathic model. They have been trained on how to use the Diagnostic and Statistical Manual of Mental Disorders (DSM) to treat and diagnose clients. However, some of these psychologists acknowledge the existence of African beliefs and will refer clients to a healer, with whom they have a professional relationship, where needed. Sorsdahl, Stein and Flisher (2010) suggests that healers who are well organised and trained could be a viable referral and treatment source for South Africans presenting with symptoms of a mental illness that could be explained using African indigenous knowledge (Campbell-Hall et al., 2010; Sorsdahl et al., 2010; Wreford, 2005a; Yen & Wilbraham, 2003a). In this modality, the mental health practitioners and African healers have provided a dual service through a referral system. Two people in two different settings and organisations have provided the dual service.

2. A study by Molefe (2001) indicated that there are mental health practitioners who work in the same centre as healers: a clinic or hospital setting where different practitioners work in different rooms and often, in different departments. The healers interviewed in Campbell-Hall and colleagues' (2010) study indicated a preference for a collaborative service that is located within the same organisation as this will lead to cross-referrals and might make collaboration more possible than it currently is. Ledwaba (2018, June 17) in the Sowetan newspaper interviewed a doctoral student whose study is focused on the psychology of mental health. The student is a drama therapist and a healer (a dual practitioner). The student expressed interest in building a centre that will have doctors, sociologists and African healers in the same organisation. Thus, this is an example of duality, provided by two persons within the same organisation.

3. Research also indicates the possibility of mental health practitioners and African healers working in the same consultation room so that their clients who believe in both modalities have the opportunity and advantage of a combined consultation. Mashabela, Zuma and Gaede (2016) argue that the merging of allopathic and indigenous knowledge systems can offer the client an opportunity for a plural health care system which can be seen as holistic and comprehensive. This is also a form of duality but one that is provided by two people, not one.

4. Few studies explore duality of psychologists in South Africa were found through a literature search (see Human, 2007; Naidu & Darong, 2015; Wozniak, 2009). The present study would like to explore the duality in one person where a professional is both a healer and a psychologist, referred to herein as a healer-therapist. As mentioned by Mashabela, Zuma and Gaede (2016), health care providers hold their own worldviews; most hold indigenous or religious worldviews irrespective of the paradigm they work within. These worldviews then affect the way in which illnesses are understood, explained and treated.

A healer-therapist practices from two different worldviews. They are able to understand, explain and treat clients according to two different knowledge systems which may affect the way that they practice.

Background to the study

Healing

Healing can consist of three different practices, namely, *sangomas* (plural) or *izangoma*, *inyangas* (herbalists or herbal doctors*),* and *umthandazi (*prophets*)* (Thornton 2009; Zabow, 2006). Even though there are different practices, it is not unusual for a healer to practise from more than one orientation (Zabow, 2006). This means that a healer can be both a *sangoma* and *umthandazi*.

A special calling from the ancestors comes in different forms and is required for one to become a healer. This often presents as an illness (specifically psychosis or schizophrenia) in western philosophy of diagnosis (Mokgobi, 2015; Wozniak, 2009). The illness presentation may also be seen as somatoform disorder. Receiving the calling through whichever medium leads to being initiated into becoming a healer through the process of *ukuthwasa* once a person decides to accept the calling. This means that healer-therapists embody the healing

gift and choose a profession which then results in them having a dual identity which might positively or negatively influence their mainstream psychology practices. The influence of their mainstream psychology practices also depends on whether the process of *ukuthwasa* began before or after becoming a psychologist.

Healers are often seen as providing services that are culturally entrenched (Campbell-Hall, 2010; Hall et al., 2010; Robertson, 2006). Although Sodi and Bojuwoye (2011) argue that all health care systems are culturally embedded, they are just embedded in different cultures that conceptualise illness, health and psychological discomfort differently indicating that no cultural conceptualisation of illness and health may be regarded as universal (Sodi & Bojuwoye, 2011). This means that all healing approaches originate from cultural knowledge systems that originate from shared ideals and principles from a group of like-minded individuals and societies.

Healers often treat illnesses with either herbs or divination through bone reading and calling on ancestral guidance. They adopt an approach comprising of indigenous knowledge handed down over many generations (Mokgobi, 2015; Wreford, 2005a). Some indigenous explanatory models of illness include spiritual understandings of causation, upset or angered ancestors, witchcraft and failure to perform rituals (Campbell-Hall et al., 2010; Sodi & Bojuwoye, 2011; Zabow, 2006). Diagnosis of a mental health problem by healers is often based on cultural interpretations and indigenous beliefs and knowledge of the problem (Gureje et al., 2015). Healing emphasises the spiritual world, supernatural forces or religion (Gureje et al., 2015) suggesting that in Africa, health is understood as being about mental, physical, emotional and spiritual stability of the individual, family, the community and ancestors by protecting those who are alive. A healer, as mentioned by Campbell-Hall et al. (2010), is able to provide psychosocial support as well as indicate areas of conflict in a person's life that need to be addressed.

Being a psychologist

Psychologists, according to the American Psychological Association ([APA], 2019, December 11), are professionally and clinically trained to assist people in coping with their life issues, stressful situations and mental health problems. Psychologists provide psychotherapeutic services based on various techniques and considering a person's unique personality, values, beliefs and characteristics (APA, 2019, December 11). Psychologists use a range of evidence-based treatment and therapeutic frameworks to assist in improving the

well-being of their clients (APA, 2019, December 11; Campbell-Hall et al., 2010). There are many different therapeutic frameworks that psychologists can choose to work from and this can be chosen based on the client and what they present with (APA, 2019, December 11). Some examples of therapeutic frameworks include cognitive behavioural therapy, humanistic therapy, and psychodynamic therapy (APA, 2019, December 11). Some conditions may require a combination of medication and psychotherapy, in which case psychologists would work with and refer their clients to other professionals such as psychiatrists who can assist.

A psychologist obtains a formal degree through higher education studies as opposed to a healer who attends initiation school (initiation schools are often at the home of the *gobela* – teacher). A psychologist chooses to become a psychologist as opposed to healers who do not choose to be called, although a healer can choose whether to accept or not accept the calling. A psychologist needs to have a professional masters degree and internship training to be able to register and practise as a psychologist in South Africa (Cooper & Nicholas, 2012).

Psychologists are guided by a diagnostic tool called the Diagnostic and Statistical Manual of Mental Disorders (DSM), the latest version being the DSM-5 of the American Psychiatric Association (Kawa & Giordano, 2012). The first edition of the DSM came out in 1952. There is a 61-year growth between the first and fifth edition of the DSM and the first edition only had 102 diagnostic categories which has now more than tripled (Rogler, 1997; Sadock & Sadock, 2007). This means that the DSM continues to evolve as psychology continues to evolve.

Merging the two

The worldviews and conceptions of the individual vary vastly between western psychology and traditional healing. Mashabela, Zuma and Gaede (2016) posit that literature indicates a conflict between the two paradigms of healing as one operates from a scientific knowledge system and another from an indigenous knowledge system. A healer-therapist, the present study assumes, is a practitioner who is able to see a client and draw from both knowledge systems depending on the client's needs and illness presentation. The challenge is that many activities related to modern and African philosophies reflect a division when looking at South Africa (Mokgobi, 2015). African health practices are somewhat rendered controversial by psychological sciences, specifically in

the world of mental health because of the 'claim' to alleviate symptoms of psychosis (see Yen & Wilbraham, 2003a). Psychosis, defined in Sadock and Sadock (2007), refers to "grossly impaired reality testing" (p. 272) where a person who has psychosis is unable to differentiate between external reality and their thoughts, perceptions and worldview.

A study conducted by Sorsdahl et al. (2010) revealed that some healers associate symptoms similar to those of psychosis with those of receiving an ancestral calling (*ubizo/pitso*) (also see Patel, 2011). Clients presenting with ancestral problems and a spiritual illness are likely to be diagnosed with a mental illness when treated by a mainstream psychologist (Campbell-Hall et al., 2010; Mokgobi, 2015). On the other hand, healers are consulted by a large number of clients with a potential mental illness diagnosis because symptoms similar to that of a mental illness, such as visual and auditory hallucinations, anxiety, sleeplessness, palpitations, disturbing dreams (nightmares) and neglect of personal hygiene, are most commonly linked to an ancestral calling (Campbell-Hall et al., 2010; Hall et al., 2010; Wozniak, 2009).

As a result of similarity in symptom presentations, it may sometimes be the case that those who should be diagnosed with a mental illness and treated with western science consult with healers and are not referred to mental health practitioners and thus may be misdiagnosed and treated incorrectly. The opposite is also true in that those with an ancestral calling who consult with allopathic practitioners, without being referred to be seen by a healer, might be misdiagnosed and treated incorrectly prolonging the process of becoming a healer. Robertson (2006) suggests that the state leading to *ukuthwasa* is not a diagnosis or illness per se, but can be medically sanctioned as an illness (for example, *amafufunyane* which refers to being possessed by evil spirits) given that a person attempts to ignore their calling. Robertson (2006) also highlights that even though the state leading to *ukuthwasa* might reflect symptoms of anti-social behaviour, anxiety or depression, the DSM is likely to look at these as culture-bound syndromes.

Some studies also point to controversies surrounding healing which are posed by fake healers, wrong diagnoses and other harmful practices and the solution to these problems being training healers about mainstream psychology (Sodi & Bojuwoye, 2011; Wreford, 2005a). There is hardly any mention of western allopathic practitioners needing to be trained by healers about African indigenous knowledge systems. Very few articles

mention malpractice by western allopathic practitioners. Western health care systems should not be seen as having power over African indigenous health care systems (see Yen & Wilbraham, 2003a).

Being a healer-therapist

The two modalities (healing and psychology) described above, together, form the practice of a healer-therapist. Healer-therapists simultaneously operate from healing and mainstream psychology paradigms. Considering that the two paradigms are different, it is important to understand how these two are blended together by one person in one healing session. A person who is a healer-therapist would experience their practice differently compared to those who are only psychology practitioners without the healing knowledge base or only healers without the psychology knowledge base. These practitioners have adopted a dual identity and are practicing as healer-therapists.

Mashabela, Zuma and Gaede (2016) in their study found, through a literature search, the existence of medical pluralism in South Africa "where there are multiple forms of understanding, explaining and treating illness" (p. 84). The present study is looking at dual practice provided by one person where the healer is able to deliver two services simultaneously. Sodi and Bojuwoye (2011) postulate that a healer, whether African or allopathic, must determine the causal agent of illness presentations, for example, anger by the ancestors or a traumatic experience. Both modalities target the source of the problem, but they just target different sources from different knowledge systems. They work from two different paradigms, confirmed by Mashabela, Zuma and Gaede (2016) who argue that the biomedical paradigm operates from a scientific knowledge lens while healing operates from an indigenous knowledge lens. It is important to keep in mind that psychological approaches look at the psychological, social and emotional aspects while healing looks more closely at spirituality (Mashabela, Zuma & Gaede, 2016). This would mean that a healer-therapist would look at the psychological, social, emotional *and* spiritual aspects of a mental illness.

Rationale

From the 1970s, there had been calls to recognise African indigenous healing as an important mental health resource (Swartz, 1996). Several research studies conducted in the 1980s have proven that it is possible for someone to have complementary views of illness and healing (Swartz, 1989). Much of what is found in

literature when supporting healing is because of individuals being unsatisfied with mainstream psychology and who considered other healing modalities (Swartz, 1996). Healing is mostly rooted in the cultural practices of Black people; it is a practice that has historically been surrounded by controversial views. Literature suggests that approximately 70% to 80% of Black South Africans use both traditional and psychological approaches for their mental health care (Berg, 2003; Jonker, 2006; Ohajunwa & Mji, 2018; Robertson, 2006; Wozniak, 2009).

Dual practice is already acknowledged through referral systems put in place by some healers and through different collaborative services ranging from collaboration between two practitioners in different organisations to collaboration within the same organisation. However, as pointed out by Mashabela, Zuma and Gaede (2016), the progress to date of the collaborative efforts do not represent a success story but rather the beginning of a long journey ahead. Therefore, if there is still a long journey ahead in terms of the duality of two people and two organisations, where are we in terms of discussing and accepting the duality in one person?

Research also suggests that all the dualities referred to above are continually being advocated for yet the efforts remain unsatisfactory and with little consensus on the way forward (Patel, 2011). In a study by Campbell-Hall et al. (2010), it was found that African healers were more receptive and positive to the idea of collaboration within the same setting and through a referral system compared to mainstream practitioners who were reluctant. Mashabela, Zuma and Gaede, (2016) in their study showed that the collaboration between allopathic practitioners and healers occurs against a backdrop of mistrust, tensions and unresolved issues.

Yen and Wilbraham (2003a) contend that collaboration has been discussed in South Africa for the last 30 years yet there is still a lack of practical application (see also Wreford, 2005a). The problems seem to be the biomedical field requiring African healing services to match and be integrated into their worldview (see Campbell-Hall et al., 2010; Wreford, 2005a; Yen & Wilbraham, 2003a). The present study looks at the experiences of a person who works from both paradigms of healing.

In a study by Wozniak's (2009) about the professional identity of clinical psychologists who are also *sangomas*, the majority of the participants did not want to be called either a healer or clinical psychologist. The healer-therapists preferred to be called either a healer, or a name that represented a person using both approaches without being labelled as one and not the other. This means that the healers preferred their identities not to be

seen as separate as they serve the same purpose, which is healing. With this mind, the healers preferred not to have a primary and secondary identity but an identity that resembles them belonging to both worlds. To symbolise their dualism, the participants are referred to as *healer-therapists* in the present study except where it is necessary to make the distinction between a healer and a psychologist.

Despite studies showing that healers are often located in rural areas, indigenous healers are widely consulted even in metropolitan cities (Zabow, 2006). Healers who are the focus of this study are those who are Black and based in Johannesburg.

Other dualities

Mashabela, Zuma and Gaede (2016) also refer to the existence of the duality between nurse-*sangoma* and *sangoma*-physicians. Dual practitioners of biomedicine and healing may be able to provide wisdom on how to reconcile differences between the two modalities of healing (Mashabela, Zuma & Gaede, 2016). Seemingly, healer-therapists are practitioners who continually attempt to reconcile the two modalities of healing in their practice.

Pretorius (1999) as cited in Jonker (2006) mentions that in South Africa there is at least one percent of Black nurses who are also African healers. However, this is an old statistic and the numbers would have increased by now. It is also possible to have other professionals such as occupational therapists, general practitioners, physiotherapists, gynaecologists, accountants, lawyers or any other professional be dual practitioners that are also African healers.

Research Aim

The aim of the research is to understand the experiences of Black healer-therapists in Johannesburg, South Africa.

Chapter outline

***Chapter 2*:** The focus of this chapter is on the framework the study will draw on. The chapter will begin by looking at the decolonisation of psychology including community psychology. It will then delve into the main concept of *cultural African psychology*. The chapter continues to look at additional concepts such as

spirituality, culture and tradition. The chapter concludes by looking at how mental health and mental illness are conceptualised.

***Chapter 3*:** This literature review chapter outlines similar studies to understand the history of studies conducted exploring healer-therapy services. The literature review presents an idea of what has previously been researched and where the gaps are. This is done by beginning with how a case may be approached from both frameworks, how the frameworks have continued to exist in parallel, and dual intervention of a collaborative and integrative nature. The chapter concludes by outlining studies that investigated dual practice provided by one person.

***Chapter 4*:** This methods chapter presents the research questions, describes how the research was approached from various dimensions, how data were collected, how participants were identified, and which sampling approach best suited identifying participants. The chapter continues to look at how the collected interview data and transcripts were analysed. Additionally, the researcher reflects on the purpose of the research, how the research came about and the entire research process to recognise researcher bias, where applicable, and identify strategies to reduce research bias and implement transparency. The chapter concludes by discussing the ethical considerations for the entire research process.

Chapter 5: This is the findings chapter and it begins by presenting a unique case of each participant, providing background behind each participant's responses. The chapter groups the participants' responses into themes. Some of the themes include how healer-therapists are able to embrace both modalities; the presence of ancestors and cases of a dual nature as a guide to the direction of practice; the differences between the two practices; and how a compromise is reached to continue with the psychotherapy session. The chapter concludes by looking at the advantages of being a healer-therapist.

Chapter 6: This discussion chapter focuses on the differences and similarities between healing and psychology then proceeds to group the themes in accordance to the research questions. The chapter continues to explore how psychology is viewed, the African perspective of psychology, ancestor guidance, identity negotiation and ethical dilemmas. The chapter concludes by exploring the implication healer-therapy practice has on collaborative services.

Chapter 7: The final chapter concludes the entire study, especially the findings and results. The chapter further outlines the limitations of this study and provides recommendations for future studies.

CHAPTER 2: CONCEPTUAL FRAMEWORK

Introduction

The healer-therapists' practices are closely tied to the ideological frameworks of both allopathic and healing modalities. The term 'healer-therapist' came about because of the focus of this research. A healer-therapist is one who is a dual practitioner who provides both African healing services and psychological services. A 'healer-therapist' comes from the practitioners identifying themselves as both and not wanting to separate the two identities as will be imminent in chapter five and six. Psychology, culture, tradition and the belief in the spiritual realm play an enormous role in understanding the worldviews of healer-therapists. These blended worldviews ultimately influence how the healer-therapist views and treats a client, which in turn shapes their experience of dual practice.

The central point of the experience of healer-therapists is incorporating spirituality during a psychotherapy session and vice versa. The concept of spirituality in African healing is related to cultural African psychology proposed by Ratele (2017). African psychology as a discipline partially explains the experience of being a healer-therapist because as mentioned by Ratele (2017), African psychology is not singular but it is broad and comprises of various bodies of knowledge. Ratele (2017) asserts, "African psychology is polyvocal, multilingual, multicultural and pluriversal" (p. 317). It is against this fact that African psychology is not singular that in the present study the choice was to use a *cultural African psychology* within African psychology to situate the experiences of healer-therapists.

Decolonising psychology

This chapter unpacks the decolonisation of psychology and how this has led to different branches of psychology, such as community and African psychology emerging.

The existence and practice of healer-therapy increases the growing argument related to decolonising psychology. Dual healer-therapy is an unconventional way of practising psychology where the healer-therapist merges aspects of western science with those of African indigenous healing such as divination during therapy sessions. Decolonisation was introduced because of a system that faultily privileges some knowledge systems

over others (Barnes & Siswana, 2018). The dominant knowledge system in psychology is the Eurocentric knowledge system that does not include components of spirituality or African indigenous knowledge systems.

The cultural African psychology framework fits into the decolonial framework as it attempts to decolonise psychology through attempting to rid the field of the cultural domination of western science (Ratele, 2017). In western psychology, the human being became the subject and object of scientific investigation, with risks involved, that is, scientific inquiry became the primary knowledge system where other knowledge systems were seen as subordinates thereof (Maldonado-Torres, 2017). This, according to Maldonado-Torres (2017), is referred to as epistemic colonisation. Furthermore, there is also the colonisation of being, referred to as ontological colonisation.

Ontological colonisation would be directly related to being a healer-therapist because of the dual identity and more especially because of the identity of the healer. The healer is often seen as the subordinate of other scientific health professions. The power dynamic that is created between the two modalities because of the dominance needs to be decolonised. Psychologists know that calls to decolonise the profession may be met with resistance by those who benefit from the status quo, and that such calls may seem like attempting to crack an impermeable space (Pillay, 2017). In decolonising psychology, there emerges certain frameworks such as cultural and liberation psychology (Pillay, 2017), which could be linked to the cultural African psychology framework proposed by Ratele (2017). The difference is that cultural African psychology is specific to the African indigenous knowledge system while cultural and liberation psychology might be related to general populations.

Yen and Wilbraham (2003a) in their discourse analytic study explore constructions of culture and illness in the talk of psychiatrists, psychologists, and indigenous healers engaging in the topic of collaboration in the mental health sector. They contend those different versions of cultures and constructions of what constitutes a disorder speak directly to negotiations of power between western scientific systems and African healing. The present study argues that all healing professions are legitimate and have equal power as the study showed how the power dynamics between psychology and healing are negotiated by the healer-therapists through their work.

Yen and Wilbraham (2003a) conducted studies that were divided into two parts looking at the discourses of culture and illness in South Africa's mental health care system and indigenous healing. The first part of the study was about western psychiatric power and the second part was focused on African mentality. The participants in Yen and Wilbraham's (2003a) study consisted of a psychiatrist, two clinical psychologists (who are White, male and English speaking) and two indigenous healers who had an association with a provincial hospital in a small city in the Eastern Cape. The mental health practitioners were selected based on having experience with dealing with clients who described their symptoms in the African worldview in the psychiatric hospital (Yen & Wilbraham, 2003a). The indigenous healers were selected because of having a collaborative relationship with the Eastern Cape hospital they previously referred clients to (Yen & Wilbraham, 2003a). The last participant according to Yen and Wilbraham (2003a) was a nurse who worked in a mental health setting and lectured at an academic institution who has also undergone *ukuthwasa.* In the context of the present study, the last participant has a dual identity.

There were no specific questions listed in this particular study, but the aims of the study were to explore how indigenous healing systems are positioned in relation to western healing system and to avoid the 'othering' of indigenous knowledge systems. The present study also aims to avoid the othering of African knowledge systems. Different psychologies have emerged in response to decolonising the psychology profession, such as community and African psychology.

Community psychology and African psychology

Community psychology stems from the recognition of the discrepancies of psychology as a discipline that previously marginalised non-western knowledge systems according to Seedat and Lazarus (2014). They also suggest that the psychology discipline represented racist ideologies reproducing racism, specifically in the South African context. According to Seedat and Lazarus (2014), the addition of community in psychology is an attempt at representing the African voice in literature, research and service provision in order to help close the gap created by the discipline's exclusionary and racist knowledge production, research and service provisions.

The aim of community psychology is to narrow the gap in the psychology field. The psychology field currently reflects and is based on challenges that were encountered by the white minority, hence producing solutions to

challenges in response to only those encountered by the white minority (Seedat & Lazarus, 2014). This can be referred back to the critique of the definition of mental health that it may only be applicable to those who helped shape the definition but not to others who were excluded. This suggests once again that the principle of universality does not apply in psychological science.

Current literature seems to compare African knowledge systems with other knowledge systems with less literature looking at African knowledge systems as an independent field of knowledge. As Seedat and Lazarus (2014) state, literature concerning the discipline of psychology continue to reflect and support the white minority's ideology and knowledge systems. As such, medically unexplained symptoms, such as those of an ancestral calling, continue to be called illnesses, where they are just unfamiliar expressions and behaviours to the discipline of psychology.

While South Africans fought to live in a democratic country and while the country was undergoing serious political changes, psychology as a discipline was also undergoing political changes (Seedat & Lazarus, 2014). Seedat and Lazarus (2014) also mentioned that the change was brought on by the realisation that the psychology discipline complies with colonialism, racist ideologies and promoted individual modalities. This is the opposite of the aims of African healing. African healing gravitates more towards community psychology principles. Seedat and Lazarus (2014) contend that community psychology also came about because of continued debates around the exclusion of Black people's knowledge systems. A question that needs to be asked, however, is if community psychology principles adequately cover African people's systems, why have other branches of psychology specifically looking at African knowledge systems like African psychology? African psychologies can be seen as a discipline that aims to advance or formalise African knowledge systems that have previously been excluded in western philosophies. Through African psychologies, the views of African people are acknowledged and shared with the world.

Cultural African Psychology

Baldwin (1986) raises questions surrounding African (Black) psychology: how it is defined; what it consists of; and questions around its authenticity and necessity. Black psychology refers to the development of theories of

behaviour extracted from the authentic experience of Black people and their African cultures (Baldwin, 1986). Baldwin recognises that even though some raise challenges in justifying the existence of Black psychology, there are some gaps in the applicability of western psychology to the experience of African or Black people. Baldwin also acknowledges that *African* and *Black* may have different meanings for some people, but in this context, they are used interchangeably to refer to the same identity.

Adams and Salter (2007) acknowledge that the African context allows for an examination of the relationship between cultural belief systems and health. This study believes that there are many facets to African psychology and will use Ratele's (2017) conceptualisation of African psychology. Ratele (2017) recently proposed four orientations to African psychology. The present study is about the experience of healer-therapists and therefore the relevant orientation under African psychology is *cultural African psychology*. Cultural African psychology, according to Ratele (2017), refers to the "study of persons as relay points of metaphysical, spiritual or cultural phenomena" (p. 320), such as healer-therapists. Central to the experience of the healer-therapist is being able to see the client as a spiritual being in addition to being an emotional and psychological being.

In his explanation, Ratele (2017) posits that cultural African psychology can assist with how healers "apprehend their own identities as experts" (p. 317). Although the present study is specifically about the identity of the healer-therapists as much as it is about their experience, healer-therapists harbour a dual identity professionally speaking. A healer-therapist can choose to identify themselves as one of the following depending on the context they are occupying at a certain moment:

1. A psychologist
2. A healer
3. A healer-therapist, which means a healer that is also a psychologist
4. A therapist-healer, which means a psychologist that is also a healer

An assumed professional identity is likely to influence how the practitioner practises and also shapes their experience of being a practitioner. Ratele (2017) maintains that cultural African psychology aims to shape

psychology as a vehicle that understands the way people see, speak and understand the subjects of psychology as inherently spiritual beings. He further asserts that cultural African psychology attempts to eliminate the cultural domination of the minority in psychology and rather resuscitate the culture of the Black African person. In this thesis, the term healer-therapist is used to refer to the duality. The practice of a healer-therapist might be seen as eliminating the cultural domination of traditional psychotherapy by including aspects of the culture of the African person during psychotherapy.

Cultural African psychology is concerned with spiritual, cultural and metaphysical phenomena in as much as it concerned with shared language, beliefs, values, knowledge, worldviews and philosophies (Ratele, 2017). It is also concerned with how people see, hear and understand psychology subjects as inherently cultural beings confirming that psychology does not sit outside of culture (Ratele, 2017). Cultural African psychology can be seen as a cultural critique of Eurocentric psychological sciences (Ratele, 2017). Ratele suggests that the problem that confronts African psychologists is how to become relevant and be seen as equal while incorporating cultural, spiritual and metaphysical phenomena from the South, in a profession that is dominated by western ideas.

Ratele (2017) further postulates that colonialism has a prominent feature in cultural African psychology. Colonialism refers to the "conquest and control of other people's land and goods" (Loomba, 1998. p.2). Colonialism recognises that traditional western philosophies have had cultural domination over the knowledge and wisdom of indigenous persons, which has been apparent in traditional psychotherapy (Ratele, 2017).

Cultural African psychologists are more concerned with cultural decolonisation, which aims to address the (de)colonisation of behaviours, thoughts and cognitions that deserve ongoing study (Ratele, 2017). Ratele contends that "African psychologists who orient work within this stance contend that there are particularities about Africa and its people that need to be taken into account in studies, therapies and community engagement" (p. 321). Dual practice of the present study aims to take into account particularities about Africa and its people particularly in therapies but also take it further into studies and community engagements as a form of creating awareness about dual practice.

Ratele (2017) also critiques cultural African psychology by saying that it often views Africans as an extraordinary united nation who agree on everything and fails to take into account certain harmful African practices. There are two critiques, one related to consensus and another to harmful practices. The present study aims to demonstrate a blend of African psychology practice of healer-therapists as well as the western psychological sciences rather than only reflect the importance of the African healing. The existence of a dual healer is not representing a failure of traditional psychology ideologies but rather its limited power in explaining illnesses of a spiritual nature embedded in certain Black African people's cultures. The strength of the argument lies in its intention to not criticise but add to existing knowledge. This study draws on cultural African psychology, which concentrates on the experience of being a dual practitioner and the ability of the healer to see the subject of psychology also as a cultural and spiritual being.

A possible limitation of the cultural African psychology framework is that it assumes Africans are a homogenous group. Africans are not a homogenous group owing to race, class, religion, geopolitics, and so forth.

The concept of spirituality in healing

In his paper, Ratele (2017) equates cultural African psychology to Nwoye's (2015) conceptualisation of African psychology. The African health viewpoint of understanding and dealing with mental health and illness of Black African people is usually seen as operating from the Africentric paradigm as Nwoye suggests.

The Africentric paradigm aims to narrow the gap between western psychological systems and African worldviews by contextualising African healing systems through the ideas and philosophical assumptions of Black African people and attempting to close the gaps of the psychological framework's view of illness and healing (Nwoye, 2015). Nwoye highlights that when looking at western knowledge systems of healing, particularly in the South African context, the traditional psychological framework is the main modality of understanding mental illness. Nwoye suggests that the main element missing from the psychological framework is the *spiritual* perspective embedded in the African healing modality. The spiritual perspective aims to look beyond the information the African healer receives from the person experiencing certain kinds of behaviour that might be seen as an illness of some sort.

Explanations of health and illness exist in certain interpretive contexts. Some of these interpretive contexts centre on the characteristics of people belonging to a certain culture, which are then seen as operating from the perspective of the African worldview, personality and mind (Yen & Wilbraham, 2003). The African healing modality practices from the premise that the physical world can communicate with the non-physical world through persons who are gifted to act as intermediaries between the living and dead in the interpretation of illness (Nwoye, 2015). These persons are healers or diviners. Nwoye further posits that the African healing view focuses on *who* is speaking and *what* is being said. Some people commonly approach African modalities of healing after following allopathic approaches that are not working for these specific people (Nwoye, 2015; Robertson, 2006). Nwoye suggests that the relevant person usually consulted who searches for such meanings behind communication from the ancestors to the family of the person affected by the illness is the diviner, who is seen as the intermediary. Therefore, the Africentric paradigm to illness and healing can also be called the *bio-psycho-social-spiritualist paradigm* to illness and healing (Nwoye, 2015). The Africentric paradigm promotes the idea of dualism and pluralism which is the focus of this paper.

The important point to take from Nyowe (2015) is about the *spiritual* element that is missing from traditional individualist approaches. This is influential because individualistic approaches to mental health have neglected the spiritual element in its healing approach. Nwoye suggests that looking beyond the Eurocentric paradigm allows the African healer to interpret messages received through the ancestors by the person who fell ill and what family members are expected to do in order to alleviate the illness. This indicates that African healing goes beyond the traditional individualistic psychotherapeutic approaches to the collective and the relationship between the person and their environment.

Conceptualising culture

Sociology defines culture as ideas or objects that are representative of a particular group or society (Open Education Sociology Dictionary, 2019). This means that culture is conceptually adaptable and not stagnant; therefore, culture has room for change. This highlights the reason for multiple conceptualisations of culture.

People who hold similar assumptions about the world and attribute similar meaning to the world around them are seen as part of a particular culture (Bladwin, Faulkner, Hecht, & Lindsley, 2008). Bladwin et al. (2008)

further postulates that individuals who share a similar culture often have certain expectations of each other in relation to aspects of their culture. These expectations include shared norms, language, behaviour and others that are usually passed down from generation to generation and are generally repetitive (Bladwin et al., 2008). A limitation with a culture having certain expectations is that culture almost fails to consider personal choice for a person who may not necessarily conform to group expectations. Ratele (2017) postulates that the challenge with cultural African psychology is that it assumes that Black African people all want to be seen as cultural beings.

Culture is defined and conceptualised by different schools of thought, such as anthropology, sociology and psychology. Anthropologists define culture according to German thought, originating from Johann Gottfried von Herder, the work of E.B Taylor in 1871 of primitive cultures, and Franz Boas together with his students from Columbia University (Bladwin et al., 2008). Franz Boas redefined culture:

> the totality of the mental and physical reactions and activities that characterize the behaviour of the individuals composing a social group collectively and individually in relation to their natural environment, to other groups, to members of the group itself, and to each of individual to himself (Bladwin et al., 2008, p. 150).

In conceptualising culture and looking at the South African context in particular, Swartz (1996) mentioned that South African anthropology made means to highlight the term culture as a social construct.

In psychological sciences, culture can be defined as encompassing the lifestyle, patterns of behaviour of a particular group or society, and exists beyond the lifespan of a particular individual (Sadock & Sadock, 2007). According to Ung (2015), psychology has long recognised the influence of culture on human behaviour although it has been a struggle for psychology professionals to adequately measure the concept of culture. Psychological sciences seem to be preoccupied with the idea of objectivity and scientific knowledge, although also recognising the unique nature of each individual. Ung (2015) contends that cultural diversity in societies will only continue to grow, which necessitates the interrogation of cultural belief systems as they relate to a person's psychological functioning.

Looking at the history of how culture has been defined over time, there are different definitions found, albeit, with similar concepts. The definitions of culture seem to centre around the idea of culture being related to *shared beliefs* and *perceptions* of a particular group of people with the emphasis being on 'human interaction' (Bladwin et al., 2008). Importantly, a group of healer-therapists belonging to the same culture are likely to hold similar beliefs and perceptions about mental health care, symptoms of a mental illness, explanations for symptoms, and preferable treatment.

Asmal et al. (2011) acknowledge that cultural ideologies have an influence on cultural belief systems as well as access to mental health care. Although this reference makes specific mention of schizophrenia, it could also be relevant to other mental disorders. The interpretation of mental illness varies across cultural groups (Asmal et al., 2011). Moodley, Sutherland, and Oulanova (2008) suggest that people conceptualise illness and consider treatment plans in accordance with their cultural beliefs systems and their cultural vocabulary. A healer might conceptualise certain signs and symptoms such as *amafufunyane* while a therapist conceptualises the same signs as schizophrenia, and a healer-therapist is able to investigate both options (co-existence).

South Africa is comprised of Nguni (Zulu & Xhosa), Sotho, Ndebele and Afrikaner people, to name a few, who all call South Africa home and all form the heterogeneous culture of South Africa (South African History Online, 2017). It remains impossible to fit diverse groups under one cultural identity because within people of different races, there are different tribes. For example, the Zulu nation is further divided into different types of Zulu tribal groups who then ascribe to different beliefs and traditions (South African History Online, 2017). The Batswana cultural group is further divided into tribes such as *Barolong, Bakgatla* and others. These subgroupings exist across the other dominant groups such as the vhaVhenda, amaXhosa, and so forth. South Africa is made up of so many diverse cultures; hence, it is referred to as the rainbow nation (South African History Online, 2017).

In order to understand that South Africa is a diverse country with varying cultural beliefs one needs to pay attention to debates surrounding concepts such as African healing as discussed in public and academic platforms (Mokgobi, 2015). This means that the relevance and significance of certain cultural beliefs and cultural practices are constantly under scrutiny. These practices may seem nonsensical to those who

misunderstand them. This is especially true concerning the treatment behaviours that resemble those of a mental illness by healers. Reality can be constructed and interpreted from different worldviews; the predicament arises when one worldview appears to be superior to other worldviews because, as Mokgobi (2005) contends, "the world is too large and complicated for anyone to claim to have the perfect perspective which could be regarded as universal" (p.5). No approach to health can claim to be superior because it would be impossible for one particular approach to incorporate the various diverse cultures in the South African context. The mere existence of a healer-therapist indicates that a single approach can never be adequate.

De la Rey (1992) argues that although culture plays a huge part in helping people adapt to the world around them, it is also restrictive and aims to control people's behaviours by expecting people to conform to cultural norms and values. The population of Black African people in South Africa is diverse and yet shares some similarities; chief amongst these is the belief in the supernatural. Although African healing is embedded in the culture of some Black African people, this does not mean that every Black African person shares similar ideologies related to African knowledge systems. A Black African client consulting a healer-therapist, unknowingly perhaps a psychologist but is presented with a healer-therapist, might not be delighted. A healer-therapist may be caught between cultures in their practice as psychology practitioners when they bring in elements of African healing and in their healing practice when they bring in elements of psychology. It could become a case of should I or should I not? When culture is invoked, the concept of 'tradition' always comes up and needs to be understood and differentiated from culture.

Conceptualising tradition

Tradition refers to the process of passing something down from generation to generation, from society to society, or from one individual to another (Grabun, 2001). This is significant because u*bungoma* is passed down from generation to generation and from one individual to another. This illustrates that becoming a healer-therapist is not a personal choice. Mainstream psychological knowledge is also traditional in that it can be passed down from generation through formal educational studies. Grabun (2001) contends that tradition is used to describe cultural aspects, which even when rapid change is taking place, would continue to be passed from one person to another. These cultural aspects include thought processes, vocabulary, language and behavioural

patterns.

The important motive behind tradition is for something (for example, a ritual) not to be forgotten and lost (Grabun, 2001). According to Grabun (2001) "The concept of tradition, literally from the Latin meaning *something handed over* in slowly changing societies is equivalent to inheritance" (p. 6). Grabun was seconded by Bruns (1991) who argues that tradition is a principle of inheritance: a view that tradition is also about the content of what is being handed down (Finnegan, 1991). This means that the word 'traditional' in healing derives its meaning from the latter definition because African healing is characteristic of inheritance through receiving an ancestral calling and the process of *ukuthwasa* or *ubungoma (initiation, bongaka, go thwasa).* African healing is but one example of tradition and involves being gifted with *ubungoma* or receiving an ancestral calling after which comes *ukuthwasa*. *Ukuthwasa* refers to the training African healers undergo, as Asmal et al. (2011) postulates that *ukuthwasa* is "a state of emotional turmoil a person goes through on the path to becoming an indigenous healer" (p. 368).

The modernised world is something that is a threat to tradition according to Grabun (2001) because it represents change - the opposite of what tradition aims to preserve. Psychological perspectives of mental health hold different worldviews compared to African healing perspectives that can sometimes be seen as a threat and would explain the dichotomy that is created between the two approaches. Whereas a healer would view a change in someone's behaviour as something related to a generational curse, a psychologist would view the change in behaviour as related to a certain stressor. A healer-therapist is able to see both worldviews, intervene and advise accordingly.

Modernity is what can be considered a breakthrough or the voice of reason to that which makes no sense or is irrelevant (Bruns, 2001). This 'voice of reason' can also be applied to traditional modalities such as mainstream or African psychological ideologies. Bruns (2001) also states "tradition is not the mere repetition but is the modern subject's mode of being historical" (p. 6). This means that a person being modern is not eliminating tradition. The concept of tradition is related to past ideals. As a result, the word 'tradition' or 'traditional' has often been associated with something ancient, inapt and something that is being replaced by modernity (Finnegan, 1991). The words 'traditional' and 'tradition' are used sparingly in this paper because of the

sometimes-negative connotations related to them. The paper will thus make reference to African healers and healers as opposed to the commonly used term 'traditional healers'.

A healer-therapist who is incorporating spirituality in a psychotherapy setting is not eliminating the importance of the tradition of mainstream psychological approaches nor are they undermining the traditional psychotherapy process.

Mental health

A commonly used definition of health by the World Health Organisation (2019b) refers to health as not only the absence of an illness but rather a state of being well physically, emotionally and mentally. In the African worldview, health is connected to relationships (Bojuwoye & Moletsane-Kekae, 2018). An African person has good health if they have a harmonious relationship with the universe, with other people, and with the local ecology such as plants and animals (Bojuwoye & Moletsane-Kekae, 2018).

The World Health Organisation (WHO) admits that its definition was formulated in 1946 and amended and agreed to in 1948. The definition of health has not been amended since 1948 (WHO, 2019b). This definition highlights the importance of mental health and well-being in the overall state of health. The WHO (2004) asserts, "There is no health without mental health" (p. 10). It is clear that mental health is a significant part of the definition of health and goes beyond the absence of a mental illness. The WHO (2014) further describes mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community" (p.10). Galderisi, Heinz, Kastrup, Beezhold and Sartorius (2015) critique the definition of mental health by arguing that mentioning the word 'well-being' could be confusing to the lay person as it may imply that a mentally healthy person does not experience negative emotions such as anger, sadness and unhappiness when presented with certain life situations.

The WHO further states that although mental health comprises of universal concepts, it is imperative to take into account different perspectives, cultural perspectives and different contexts. Galderisi et al. (2015) mentioned that the definition of mental health clearly indicates that it resonates with the culture of those who constructed the definition. This means that the mental health definition by the WHO was constructed through a

particular lens, although principles of universality are still important. This indicates that mental health is clearly not a term that can be generalised across cultures. The application of the definition of mental health has to be tied to specific contexts and cultures (Galderisi et al., 2015).

Mental health policies are meant to be the government's way of ensuring the delivery and implementation of mental health services, however, as reported by Omar et al. (2010) who conducted a comparative study of four African country's mental health policies including South Africa, these countries often lack such policies, or the policies either are inappropriate or outdated. This is further reflected by the fact that the mention of healers is generally non-existent in South Africa's Mental Health Act 17 of 2002, as is the mention of psychologists in the Traditional Health Practitioners Act 22 of 2007. The two polices do not interact with one another, let alone acknowledge the existence of duality.

The WHO (2004) asserts that a climate that protects human rights, including cultural rights, is integral to the promotion of mental health. This means that promoting mental health without the recognition of cultural rights could be detrimental to efforts of promoting mental health. With this in mind, the WHO (2004) refers to the importance of *spirituality* as contributing to the promotion of good mental health and stating that mental health can affect a person's spirituality. With this said, healers focus on spirituality as a component of health. This means that healers are integral to mental health.

Mental illness

Bojuwoye and Moletsane-Kekae (2018) assert that illness in the African worldview is a result of disharmony with the universe, the local ecology, between the person and ancestors, and with other people. This disharmony brings misfortunes to a person's life, which have historically been labelled an illness by those who could not understand the misfortunes. Thus, an illness (misfortunes) in the African worldview, as postulated by Bojuwoye and Moletsane-Kekae (2018) can be brought on by:

> Inscrutable acts of the spirits because of violations of some cultural taboos, or ritual rules of conduct, disobedience, or disrespect to the ancestors, or human agents, or generally, the individual does not perceive realities as culturally constructed (p. 88).

Illness, according to Boyd (2000), is defined as a feeling of being unhealthy and is completely intrapersonal; it may not be possible to initially identify and name an illness because sometimes discovering the presence of an illness might take a while. If a person is not mentally healthy then they are mentally unhealthy or mentally ill. Mental illness, as described by Morant (1995), is "an individual's inability to cope with aspects of personal or social life, or as a loss of functioning relative to what is acceptable to that person or to the norms of society" (p. 5-6). This relates to the definition of illness being intrinsically linked to the individual, only here the illness is specific to mental illness. Morant further explains that a person is said to have a mental illness when their symptoms start to disturb the person's chances of living a normal life. In order to understand mental illness, people draw on different experts' understandings and interpretations of their illness according to Morant. Most of these also come from cultural or African backgrounds and indigenous belief systems.

Globally, the mental health profession began to evolve in the 1980s with the third edition of the DSM (Mayes & Horwitz, 2005). The DSM-III was the DSM version that had significance as one could say that there was a "paradigm shift in the DSM-III" (Rogler, 1997, p. 10). Kawa and Giordano (2012) also called the DSM-III the "turning point in psychiatry" (p. 5) as its revision demonstrates that what constituted a mental illness at a point in time might not constitute a mental illness in present times because new worldviews are becoming more prominent.

In the history of the DSM, the change has been defining, excluding and including disorders and breaking down of previously included diagnoses (Rogler, 1997). In mental health, something might be seen as irrational and then classified as a mental illness when it is not fully understood, when it was unfamiliar or when it deviates from the norm. Once understood, it is important for revision of the classification of mental disorders to take place.

In the 1970s, the mental health profession was heavily criticised because of its emphasis on psychopathology, psychoanalysis and psychotherapy (Mayes & Horwitz, 2005). Karl Menninger, a psychiatrist criticised the mental health field for its heavy symptom classification (Mayes & Horwitz, 2005) arguing that because of differing worldviews, it is important for differentiation to take place in a psychotherapeutic context. The DSM allows the differentiation to take place in order to distinguish a mental illness from a spiritual calling. The

DSM-5 gives culturally specific instructions about culture bound syndromes that require mental health practitioners to consider cultural variables prior to diagnosis and treatment according to Paniagua (2018). Paniagua also asserts that the DSM-5 does recognise cultural variables and advises mental health practitioners not to diagnose people where there are potential cultural variables that could potentially have an effect on the diagnosis and treatment process. The DSM-5 has also come under heavy critique for lowering diagnostic threshold and adding in many new disorders (Paniagua, 2018). The ability of a healer-therapist lies in being able to make this differentiation. This awareness is important to note because it clearly recommends that mental health practitioners go through a differentiation process before diagnosing someone, especially with schizophrenia and psychosis since they may present with similar symptoms as *ubungoma*. There are culturally specific guidelines that are provided by the DSM-5 as mentioned by Paniagua, these are:

1) Diagnostic issues related to cultural belief systems across most mental disorders under the DSM-5,
2) *Cultural formulation*: provides an outline for the recognition of cultural factors contribute to the presentation of mental disorders and how these can be related to social, cultural and historical context,
3) The *cultural formulation interview* that is new to the DSM-5 and offers the mental health practitioner an opportunity to interview a person about the impact of cultural factors on the symptoms being experienced.

Conclusion

Cultural African psychology recognises the practice of healer-therapists as practitioners with the ability to see their clients as inherently cultural and spiritual beings. Healer-therapists would also be able to recognise that not every client wants to be seen as a spiritual being. Spirituality features prominently in the practice of healer-therapists because healers are those who belief in the supernatural. The healer-therapists can be seen as practising according to the *bio-psycho-social-spiritualist* paradigm to healing. Therefore, cultural African psychology services as an appropriate point of departure for understanding the experience of healer-therapists.

CHAPTER 3: LITERATURE REVIEW

Introduction

Allopathic mental health practice and African healing have often existed in parallel. However, there are points where general health practice meets with African healing practice. For example, two doctors in the Democratic Republic of Congo (DRC) opened a clinic that combines their medical practice and African healing, led by a healer who is also trained in medicine: a dual practitioner (Luneghe, 2016, October 19).

The majority of studies related to dual practice refer to integration or collaboration of services. These studies refer to dual practice where a client sees both a healer in the African context and practitioner in the western context either in different contexts or in the same facility or organisation. There are limited studies that refer to dual practice as provided by one person, specifically where the person is a psychologist and a healer.

Some of the studies centre on collaboration between African healers and primary health care staff. The majority of these studies are related to HIV/AIDS (for example, Mashabela, Zuma & Gaede, 2016; Mills, 2005; Wreford, 2005a) but there are those that speak to integration or collaboration in mental health (for example, Campbell-Hall et al., 2010; Jonker, 2006). Wozniak (2009) asserts that there is paucity of literature that examines the interactions between mental health professionals and African healers. A study of dual practitioners conducted by Human (2007) refers to the importance of healers in western science especially related to dealing with the HIV/AIDS pandemic in the South African context.

The aim of the present study is to look at the experiences of dual practice of a psychological nature provided by one person, not two people. A literature review search revealed three studies looking at dual practitioners (Human, 2007; Naidu & Darong, 2015; Wozniak, 2009). Either there have been few studies about dual practitioners conducted or there is little knowledge of the existence and practise of dual practitioners. It is important to note that dual practitioners exist in multiple professions and not just in psychology. Naidu and Darong (2015) conducted a study with nurse-*sangomas*, an example of dual practitioners. Human (2007) conducted a study with women who are initiated as *sangomas* but work in a hospital setting in a clinical role.

Currently, there is a small group of individuals who have crossed the bridge between being both a mental health professional in western science and an African healer, and have adopted a dual practitioner identity (Wozniak,

2009). This chapter discusses how health and healing is defined by African healing and psychology and how the understanding formed leads to a specific way of conceptualising unusual behaviours. The chapter further explores studies speaking to different dualities, one of collaborative nature, another of an integrative nature and the duality that is central to this study where one practitioner is qualified to provide both services.

Ateljevic (2013) proposed that the term *transmodernity* be used to refer to the emerging socio-cultural, political, economic and philosophical shift in the world. Transmodernity highlights a paradigm shift as humanity is currently undergoing a global mind change (Ateljevic, 2013). The work of healer-therapists and providing healing from both modalities seems to centre around transmodernity as this would highlight a paradigm shift from *traditional* psychology to include other forms of healing in the psychological space.

Healing from both modalities

Healing can be defined according to various worldviews. The common factor with the definitions of healing from different worldviews represents a particular worldview that observes a presence of a disease to arrive at a definition of healing. This is reflected by use of words such as 'dysfunctions' or 'disharmony' (see Sodi & Bojuwoye, 2011), 'treating an illness' (see Moodley et al., 2008), or 'alleviation of distress' (see Egnwe, 2005) in the description of healing. This suggests that there has to exist an anomaly for someone to want to receive healing.

Moodley et al. (2008) suggests that healing refers to the process of *treating an illness* through a chosen method seen as appropriate. Healing can be understood from different perspectives, some of which are described here. Firstly, healing in the psychological sense is defined as the *alleviation of distress* and can be described as "a process in the service of the evolution of the whole personality towards even greater and more complex wholeness" (Egnew, 2005, p. 255). Engwe also describes healing as the process of attaining a healthy balance between the mind, the body and spirit, and considering each aspect of equal importance. This definition is similar to the definition of health described earlier in the paper by the World Health Organisation (2019b).

Secondly, healing, when looking at religion, is an experience of spiritual wholeness (Boyd, 2000). Religion and African healing often go hand-in-hand, as is the experience of spiritual wholeness. Boyd suggests that healing

need not be associated with miracles, magic and sorcery. Allopathic concepts of care are seen as healing professions that historically claimed to be legitimate at healing through its approaches (Egnew, 2005).

Thirdly, in the world of African healing, the body and mind are not the only indicators of an illness but it rather also focuses on the environment and spiritual factors when looking at causes and treatment options (Moodley et al., 2008). Sodi and Bojuwoye (2011) refer to the African cultural model of healing as conceptualised according to physical, mental, spiritual and social *dysfunctions*. Similarly, Moodley et al. (2008) suggests that African healing focuses on the mind, the body and the spirit. This, however, does not mean that African healing has it all covered in terms of mental health care; it means that African healing modalities might view or approach mental illness differently to contemporary approaches.

Inherent in dual practice is being able to conceptualise an illness presentation according to two worldviews. The case study below illustrates how a change in behaviour can resemble depression according to western science and can be conceptualised differently according to the African worldview.

African healing and psychology existing in parallel

African healers, in all that they do, are guided by ancestral spirits (Mokgobi, 2015). Mokgobi contends that ancestors are considered the living spirits of physically dead people that are biologically related to those who believe in them and are interested in the lives of their relatives who are still alive. Mokgobi further postulates that ancestors are considered superior to the living and act as mediators between their living family members and God; referred to as *ancestor reverence*.

The term ‘African healer’ is an umbrella term for different types of healers who received different types of training and have different expertise further explained below. The present study is focused on divination, being a *sangoma* and faith healers.

- A diviner or *sangoma*, predominantly female, operates from a traditional religious context and is seen as a medium between the ancestral world and the physical world (Lange, 2018, February 7). Mokgobi (2015) also highlights that a diviner uses bones and connections to the spirits of ancestors to diagnose and treat physiological and mental health conditions.

- Faith healers usually belong to African churches and are Christians who heal through power that is received from God (Lange, 2018, February 7). Faith healers unite Christian and African belief systems (Lange, 2018, February 7).

- A herbalist or *inyanga*, predominantly male, uses mixtures of herbs when treating an illness (Lange, 2018, February 7). Unlike diviners, a herbalist chooses to become a herbalist and they usually train for a much longer period than diviners (Lange, 2018, February 7).

To explain further, the practice of divination refers to "the revelation of knowledge from supernatural sources such as spirits or ancestors, using a variety of methods including tossing of artefacts such as shells or bones, use of mirrors, animal sacrifice, drumming, trance or prayer" (Gureje et al., 2015, p. 4). To reiterate, the one differing factor of African healing through divination is that the practise itself is difficult to prove scientifically. How does one prove messages from ancestors using shells or bones? How does one prove the significance of animal sacrifice? These are some of the traditional ceremonies which are least understood as they conflict with other knowledge systems that can be scientifically proven.

Traditional ceremonies are often a topic of debate in relation to African healing because African healers perform certain ceremonies that allopathic professionals may not necessarily comprehend. One example of this is the slaughtering of animals (specifically goats) as highlighted by Yen and Wilbraham (2003), which is viewed as offensive and barbaric to those who do not belong to the African culture. The emphasis needs to be on cultural relativism, which refers to experiences and explanations of illness being dependent on culture (Mokgobi, 2015). The practitioner who does not fully understand might misinterpret and misidentify these behaviours by not fully understanding the cultural backgrounds of these individuals (Asmal et al., 2011). Most importantly, psychology professionals need to invest in the knowledge of African indigenous systems not as a means of practising or fully believing in the practice, but rather acknowledging that it exists and is helpful.

Robertson (2006) postulated that African healers operate from an existential approach whereas westernised healers operate from an evidence-based framework looking at the mind-body dualistic approach. African healing cannot be evidence-based or grounded in scientific knowledge. African healing systems cannot form

part of the community of evidence-based frameworks and should not expected to. African healing is unregulated and not empirically proven to be a success (Campbell-Hall et al., 2010; Meissner, 2004; Moodley et al., 2008) whereas approaches in the broader mental health care sector are regulated, scientific and evidence-based. The present study argues that these two modalities are different and African healing approaches should not be expected to function similarly, yet a common ground can be found.

Moodley et al. (2008) posits that African healing is about "recognising disturbances in the outside environment as playing a part in the affliction of the individual" (p. 157). This is not to say that some psychological approaches do not take the outside environment of the individual into account. There are various psychological approaches, depending on how they are applied, that do take the outside environment as having an influence on the individual into account. In order to facilitate a professional, mutually respectful and beneficial relationship between psychological modalities and African health modalities as dual practitioners do, it is important to understand the roots of both modalities (Berg, 2003).

The debate surrounding the combination of African healing and psychological modalities in mental health care can be divided into three viewpoints (Sorsdahl, Stein & Flisher, 2010). The first viewpoint is the classical view, which refers to the dichotomy between African healing and psychological modalities (Sorsdahl et al., 2010). This can be seen in dual practice where a mental health practitioner refers to a healer outside the organisation (collaboration). Secondly, Sorsdahl et al. (2010) postulates that there is the critical viewpoint which highlights psychological modalities having one way of looking at the world which is not necessarily superior to other approaches. It is necessary to have dual practice where a healer can be in the same organisation as other professionals to highlight that western psychological systems are not superior and may need the backing of African healing. The third and final viewpoint as mentioned by Sorsdahl et al. (2010) is the integrative viewpoint where both African healing and psychological modalities are seen as social activities that reflect a particular cultural view. All these viewpoints are important components of this paper, but the third viewpoint is the most important in terms of the core message, dual practice.

Explanations of unusual behaviour normally include issues such as neglected rituals which African healers are able to unearth with little emphasis on the actual symptoms or behaviours as opposed to the psychological

modality in mental health care (Gureje et al., 2015). The two modalities do not necessarily have opposing views; they actually theorise health and illness differently. The two modalities can co-exist and work towards narrowing the gap in each modality in the work of healer-therapists. There are mental health practitioners who acknowledge their limited understanding of African indigenous knowledge systems and upon coming across clients who require a practitioner with such knowledge then feel duty-bound to learn more.

Studies pointed to the first formal recognition of African healers as primary health care practitioners at an international level by the World Health Organisation in 1978 during an Alma Ata international conference on primary health care (Jonker 2006; Mills, 2005). These countries were obligated to look at how collaboration could best benefit the current health care sector and which gaps African healing systems could narrow (Jonker 2006; Mills, 2005).

A literature review search for dual healing yielded results related to how psychology trainees and fully-fledged mental health professionals often attempt to understand the role of African healing practices (see Jonker, 2006). In some studies, African healing appears to be *othered*. This results in the majority of studies, although recognising the importance of African healers, positioning their studies in a way that suggest that the western paradigm of healing is the dominant paradigm and the African paradigm is the alternative (for example, Campbell-Hall et al., 2010; Jonker 2006). This present study attempts to see these two modalities as equally respectable.

One of the reasons why psychological practitioners try to immerse themselves into the world of African healing and African worldviews is because of a recognition that the majority of South African Black clients believe in African healing and there is a high number of African healers in the South African context (Jonker, 2006). The study by Jonker (2006) titled "A study of how a *sangoma* makes sense of her '*sangomahood'* through narrative" was a study about understanding African healing approaches to illness and health and also mental health from the eye of a psychology trainee trained in the western paradigm of healing. Jonker's study attempted to understand both modalities and how they could form a collaborative approach from the standpoint of a psychologist in training.

Although it is admirable that a trainee psychologist would go through the process of understanding African worldviews of illness and healing, Jonker's study was more about understanding the journey of being a *sangoma* and how a *sangoma* makes sense of her '*sangomahood'* which is not the focus of the present study. Jonker's study indicates that western psychological systems and African systems exist in parallel but can still work alongside one another with the interest, acknowledgement and understanding of both worlds.

Conceptualisation of symptoms

Ngcobo and Edwards (2012) present a case study of a client from different conceptualisations namely cultural, intrapsychic, interpersonal, transpersonal, contextual, and personal. Their study indicates that there can be multiple conceptualisations and interventions for what can be seen as an illness according to western science and that there indeed is no universal truth. The case study as outlined by Ngcobo and Edwards (2012) is summarised, in paraphrase form, as follows:

> S is a 17 year coloured male who was referred by a local clinic for mental health services as he was presenting with symptoms including suicidal ideation. S attempted suicide on three occasions, had angry and aggressive outbursts occasionally directed towards his mother, mood swings, feelings of worthlessness and guilt. During his therapy sessions, S never mentioned a father figure. All S's anger outbursts were directed towards his mother.

In their study, Ngcobo and Edwards (2012) refer to S's behaviours in the African indigenous worldview as stemming from *ukucabanga kakhulu or ingqondo iyagijima or inhliziyo iphansi* [deep, persistent thoughts and feeling down] in IsiZulu. The African indigenous, transpersonal and spiritual interpretation of the problem, according to Ngcobo and Edwards, was related to the preoccupation and search for a certain truth, which can take the shape of depressive symptoms. There was a presence of darkness in S's life because of not knowing and not being united with his true African ancestral family from his paternal side. Healing took the form of a ritual to unite S with his true paternal African ancestral family which eliminated all disharmonies in his life. S was thankful for the journey to self-discovery.

According to western science, S might have had depression and would have been in need of psychotherapy. Ngcobo and Edwards (2012) suggest that S's life experiences, aggression and learned coping mechanisms, and

suicidal behaviour reflected a lack of a social support system. No father figure was present which could be a source of S's problem and something to explore further in the therapeutic sessions. Therapy concluded and S thanked the therapist for getting him to a point where he now knows who he is.

Both healing modalities and both worldviews seemed to be a true reflection of what S was experiencing. Both healing therapies worked well for S. A healer-therapist is one who is able to offer the above-mentioned conceptualisations without referring to another practitioner.

Dual intervention of a collaborative nature

Some comparative research studies show that some individuals prefer to see an African healer and a mental health professional for the same condition (Moodley et al., 2008; Robertson, 2006). It is not always possible to have a mental health professional and African healer in one person, hence the use of two service providers for the same condition is one form of a dual intervention (Campbell-Hall et al., 2010).

Dual intervention can offer individuals a comprehensive view of their illness presentations (Moodley et al., 2008). Moodley et al. (2008) further contends that dual interventions might not pose a problem because the relationship between a client and a mental health professional is different to one with an African healer and these relationships are usually kept separate from each other. These two different approaches often treat a person differently (Moodley et al., 2008). Considering this, it would be important to look at what happens when one professional provides both services to one client.

Despite ongoing debates and talks around the idea of integrating African healing modalities with westernised healing modalities in the broader health care system, this may, according to Janse van Rensburg (2009) prove to be an expensive implementation due to mental health resources that are already struggling to survive and a low budget allocated to mental health services in many countries.

The aim of dual practice is to bring about a collaborative practice, which can draw from fresh perspectives from different healing modalities including African healing (Jordan, 2016). Dual practice brings reconciliation to a previously divided system between indigenous and allopathic knowledge systems by combining indigenous wisdom with modern science modalities (Jordan, 2016). Integrative healing practices encompass advocacy

about multicultural perspectives, cultural sensitivity, social justice and health equity (Jordan, 2016).

There are discussions around African healing modalities in mental health care and about healer-therapists, albeit on social media. On Facebook, in January 2020 there were discussions around whether healer-therapists should be allowed to practice. These discussions were brought on by an advertisement by a healer-therapist speaking about their services (Mkhize, 2020). Mkhize (2020) mentioned in the advertisement that she has been on a journey of indigenous healing and is also qualified as a psychologist and can now offer perspectives from both modalities because this qualifies her as 'two-eyed seeing'. Most importantly, these discussions were brought on by the mention of being a healer in addition to being a psychologist. The person went as far as contacting the HPCSA about the existence of a healer-therapist (Mkhize, 2020).

Elsewhere, the discussions around healing modalities in health care have been incorporated into academic articles with international and national audiences. Janse van Rensburg (2009) conducted a literature review of the past 50 years (2006 and before) with the aim of exploring dual practice in mental health care with regards to African healing modalities in congruence with westernised mental health care practices. A noticeable difference in writing styles was noted on papers written and published in the 1970s and 1980s, which offered a more radical approach in terms of language use that pathologised unfamiliar expressions as opposed to papers written after the 1980s, which reflected more politically correct statements (Janse van Rensburg, 2009).

The difference in writing styles calls attention to African healers having a voice through knowledge production that can be a powerful medium to use. This is similar to the diagnoses of mental illnesses from the first editions of the DSM that seemed to irrationalise certain behaviours and as a result, made them diagnosable behaviours. Through education and awareness initiatives, the shift can happen. The shift can be reflected by the use of the terms 'traditional healers' and 'alternative therapies' in earlier academic papers which have, in recent papers, been referred to as African healers (replacing 'traditional') and referring to African healing as a respected practice on its own rather that it being an alternative.

The terminology used is very important and the review of terminology over time has resulted in positive results for both modalities. The one positive outcome has been the formally legislated and regulation of African healers practice in South Africa (Janse van Rensburg, 2009). Another observation made by Janse van Rensburg

was the fact that literature commonly consisted of work by white and allopathic doctors although there were still African authors represented by literature. This was problematic because allopathic doctors could have been writing from a critical point of view, as they were probably not fully immersed in the detail of African healing practices. An ancestral calling was seen as schizophrenia or psychosis because the behaviour of a person who had received a calling to become a healer was medically unexplainable and reflected abnormality.

Yen and Wilbraham (2003b), in their paper looking at discourses of culture and illness in the South African mental health system and indigenous healing highlight that evolution related discourses suggest that Africans have conceptualised illness according to traditional (viewed as irrational) belief systems particularly related to sorcery and the supernatural, while western systems look at rational and modern belief systems. Again, this reiterates that African conceptualisations of illness may have been viewed as irrational because these practices cannot be scientifically proven. Cook, Schwartz and Kaslow (2017) indicate that a practice needs to rely on research-based evidence and not solely rely on person opinion and this is how a practice is considered ethical.

This study would like to argue that African conceptualisations of illnesses do not have to be scientifically proven to be considered rational. Cook et al. (2017) argues that the reliance on treatment being scientifically proven might be problematic because in the majority of practices, the amount of evidence needed to scientifically prove a practice is limited or inaccessible. Additionally, the overemphasis on scientifically proven modalities often ignores the practitioner's own clinical experience making psychotherapy less client-centered (Cook et al., 2017).

Based on literature sourced, a person might be able to be referred to a healer by their mental health practitioner if their practitioner acknowledges African indigenous belief systems. This is recognised as a dual intervention of a collaborative nature. In contrast, other mental health practitioners work with African healers in the same settings, not separate settings. This then is dual intervention of an integrative nature.

Dual practice of an integrative nature

As alluded to before, studies around the collaboration of bio-medical perspectives and African perspectives began around the topic of HIV/AIDS in the South African context (Mills, 2005; Wreford, 2005b). A study

conducted by Campbell-Hall et al. (2010) observed the collaboration of African healers with primary health care workers in a community-based mental health setting. The study was part of a larger study by the Mental Health and Poverty Project (MHaPP) and aimed to explore perceptions of service providers of the current engagements and mechanisms related to the collaboration of African health and mainstream practitioners in delivering community-based mental health care services (Campbell-Hall et al., 2010). The study was conducted in rural KwaZulu Natal with participants consisting of African healers (two interviews and four focus groups), participants from a mental health non-governmental organisation (NGO) (one interview), and those from the formal mental health care sector (nine interviews, six focus groups). Participants also consisted of service users. Campbell-Hall et al., (2010) found that there were links between allopathic practitioners and African healers about HIV/AIDS in sub-districts but not so much in terms of mental health. The African healers in the study indicated a preference for a respectable collaboration between two practitioners working in the same organisation as this could also lead to cross-referrals.

Molefe (2001) conducted a study looking at the differences in the delivery of community-based mental health services. The facilities were two clinics and one NGO providing mental health services. The clinic works from the medical model and the NGO from a healing paradigm not centered on the medical model. Molefe found that there are *sangomas* who occasionally go to the NGO to work with the community there to allow the spiritual dimension to find expression. The NGO is located in a small, Black township in the Gauteng province.

Incorporated in the healing modality there are usually rituals of drumming where people find their spiritual connection and expression (Molefe, 2001). People attending at the NGO, according to Molefe, are usually afforded the opportunity to consult with *sangomas* and *inyangas* to learn about their pains and frustrations. The NGO, according to Molefe reportedly has a working relationship with *sangomas*, spiritual healers, amongst other professionals. However, this kind of service is not provided by one person but by different persons within a single organisation.

Dual intervention where a person separately consults both an African healer and a mental health practitioner for the same symptom presentation is not the focus of the present student, although it is nevertheless important as it highlights the advantages and gaps related to collaboration. The focus of the present study is dual practice

offered by one trained person who possesses the ability to do so. This practitioner is referred to here as a healer-therapist.

Dual practice provided by a healer-therapist

Human (2007) conducted a study whose aim was to explore the experiences of those who are initiated traditional healers and work in a hospital environment in a different capacity. The present study aims to explore the experiences of healer-therapists which is similar to Human's study (2007), the difference being that the healer-therapists in the present study are in private practice not based in hospital settings. Human (2007) did not specifically look at psychologists but hospital employees whereas the present study is specifically looking at experiences of healer-therapists. Human's study had a secondary aim namely how participants perceived the interface between traditional and western health systems and how their perceptions influence both their practices as healers and as hospital employees.

Human (2007) used snowball sampling to obtain five participants who were all South African women based in Gauteng who are initiated traditional healers but also work in a hospital setting in a different capacity. Human conducted two semi-structured interviews per participant, based on an interview guide. Human identified four research questions: 1) How do participants perceive themselves as traditional healers? 2) How do the participants experience and perceive their hospital work? 3) How do participants perceive the interface between traditional and modern health systems in a hospital context? and 4) How do participants experience the perceptions of the others that they work with?

Using a qualitative approach, Human (2007) was able to obtain an understanding about the participants' experiences of their duality, which is exactly what the present study aims to replicate, albeit with psychologists. Human used narrative and thematic analysis to present a thematic analysis of the participants' experiences in a story format to highlight their unique experiences. In her findings, Human explained that one of the participants, a medical technician, explained that they did not notice a difference between the healer in them and the professional working in a hospital environment. One of the participants also explained the need to work full-time in a hospital setting instead of full-time as a healer as motivated purely by a stable income. The participant also stated that there are also professionals in the hospital setting who regard themselves as

scientists and do not believe that healing can be effective but later changed their minds and actually enquired about healing.

Another participant, a doctor, in Human (2007) explained that they found it easier to convey ancestral messages about a certain client to a nurse rather than a doctor who might react negatively. The participant further explained that other colleagues in the hospital treat her differently because she is a healer and would sometimes ask her to offer divination to them. The same participant also indicated that other colleagues in the hospital sometimes associate healing with witchcraft and would encourage the participant to practise healing at home. The colleagues who are more positive towards healing are those who knew her before *ukuthwasa*.

Another participant, a nurse in the maternity ward, alludes to others being scared of her as she was visibly a *sangoma* and knows that people will sometimes fear the protection she has from her ancestors (Human, 2007). The participant also indicated that nursing goes well with healing as a profession. The participant has received less resistance of being a healer in the hospital space because there are other colleagues who are also healers and the hospital is based in the community serving a large proportion of African clients as opposed to other races. The participant did not experience conflict with being part of both worlds and indicates that it is more common to find healers who are nurses.

Another participant in Human (2007) mentions having to refer clients who come to *indumba* but they are perceived to be terminally ill and in need of medicine to the clinic. This seems to stem from the knowledge of someone who works with westernised systems of healing daily. The dual practitioner would encourage clients to go to the clinic and not abandon their treatment plans just because they are consulting with a healer (Human, 2007). Two participants in Human's (2007) study commenced their *ukuthwasa* in conjunction with their hospital work.

Naidu and Darong (2015) conducted a study looking at *sangoma*-nurses who are part of the ama-Zulu culture. The participants of the present study do not belong to a specific culture. The study by Naidu and Darong, explored the conflict experienced by *sangoma*-nurses because of their duality. The study took place at a private hospital, in Durban, KwaZulu-Natal where five *sangoma*-nurses (four females and one male) were interviewed

(Naidu & Darong, 2015). The study explored the perceptions of African healing practices through the lens of *sangoma*-nurses while the aim of the present study is to explore the experiences of healer-therapists and not necessarily their perceptions of African healing practices. The perceptions of healer-therapists are likely to come up in conversation.

Naidu and Darong (2015) found that the *sangoma*-nurses' conceptualisation of illnesses in the hospital setting to be dominated by their *ubungoma*. The *sangoma*-nurses stressed that healers do not look at illnesses in isolation at the hospital, as ancestors usually communicate with the healers during consultations (Naidu & Darong, 2015). Much of their views about ill-health were influenced by their cultural worldview rather than their formal training as nurses (Naidu & Darong, 2015). Findings in Naidu and Darong's (2015) study revealed that the *sangoma*-nurses struggled to navigate their duality and often had to suspend their African belief systems while working at the hospital. The *sangoma*-nurses indicated that as much as they had a calling to become *sangomas*, their nursing profession also became a calling for them to heal people. The *sangoma*-nurses viewed their qualification of being nurses as a form of a formal validation of their healing gifts.

Wozniak (2009) conducted a study titled "The professional identity of South African clinical psychologists who are also sangomas". There appears to be few studies of this kind that have been conducted, and specifically in the South African context and in an urban city like Johannesburg. Wozniak mentioned that five participants interviewed for her study were from Gauteng and one was from North West. The study by Wozniak (2009) was specific to clinical psychologists whereas this research study included counselling psychologists. The study looks at how these healers position themselves in relation to their identities. The difference with the present study is that it will look at the experience of being a dual practitioner. The focus will not so much be about professional identity of the healers but aspects of identity that came up in the process of data collection. The experience of being a dual healer might be influenced by the dual practitioner's professional identity.

Similarly, to Wozniak's (2009) study, this study drew on multiple concepts that could help shape the direction of the research and help explore the experience of being a dual practitioner. Wozniak drew from different theories, not concepts, the psychosocial theory of identity formation theorised by Erikson and Berzonsky,

constructionist notions of identity drawing on the work of Gergen, socio-cultural conceptualisations identity mainly from the work of Vygotsky, and dialectical notions of identity by Jenkins.

Wozniak's (2009) study included healers from different South African race groups, namely Black and White healers. Wozniak interviewed five participants of a convenience sample; two of the participants were African women, one white woman, two white men, and they were between the ages of 30+ and 60+. Wozniak suggests that the participants for her study were small because there are a few known clinical psychologists who are also *sangomas*. Wozniak also obtained her participants through a referral from the research supervisor and referral from clinical psychologists/*sangomas* that were known to Wozniak prior to the study.

The participants in Wozniak's study varied in terms of years of experience as psychologists and as practising *sangomas*. Of the two males, one was a practising psychologist and *sangoma* for over 30 years and the other was a psychologist for 21 years and a *sangoma* for 19 years. Regarding the women, one had been a psychologist for one year and a *sangoma* for three years, the other had been a psychologist for nine years and five years as a *sangoma*, while the final participant had been a psychologist for seven years and a *sangoma* for thirteen years.

Wozniak (2009) did not specify whether the Black African healer had 13 years of experience as a *sangoma* and 9 years of experience as a psychologist. One of the dual healers in Wozniak's study was also not practising as either a psychologist or a *sangoma* at the time of the interview and another participant identified her experience from the time of recognising an ancestral calling, before the process of *ukuthwasa*. Another reason is that it takes some healers a couple of years to accept their calling and perform rituals to say that they accept their calling but it does not mean that during this time they did not have visions that helped those they came across. This practice will make it difficult to determine how long someone has been a dual practitioner. Wozniak's (2009) study employed a psychoanalytic interpretive qualitative data analysis technique whereas this research study employs an interpretive phenomenological data analytic framework. There are clear distinctions between this research study and the research study by Wozniak, although with close resemblance.

Wozniak's (2019) study proposed four research areas that served as research questions that were related to four specific areas of professional identity. These were:

- The process of clinical psychologists becoming *sangomas* and how the transition of identity is experienced
- The perception that clinical psychologists who are also *sangomas* have about their professional identity
- How clinical psychologists who are also *sangomas* view the interaction between the two modalities of healing
- How clinical psychologists who are also *sangomas* construct their identity and how that influences their decision-making during diagnosis and treatment of mental illnesses.

In Wozniak's (2009) study, one white male participant was Jewish and has African ancestry. The particular participant in Wozniak's study admitted that race played a part in the difficulty to accept an ancestral calling, being a white Jewish man who 'claims' to have an ancestral calling to become a *sangoma*. The experience of being a healer-therapist across different races is something that the current research does not explore.

Wozniak (2009) contends that some participants experienced some degree of tension and conflict in holding a dual identity and attempting to combine two opposing modalities of healing. One participant in Wozniak's study suggests that the stigmatisation of mainstream psychology to confuse symptoms of an ancestral calling to those of psychosis is unacceptable.

Wozniak (2009) seems to mention that an identity shift was experienced by her research participants, that these participants experience a shift from being a clinical psychologist to being a *sangoma*. The primary identity in Wozniak's study is presented as a clinical psychologist by repeatedly stating the words "clinical psychologist who is also a sangoma." In her findings, Wozniak notes that all the participants seemed to have different experiences but they all experienced some identity conflict.

What is importantly noteworthy in Wozniak's (2009) study is that all the participants' experiences are presented as unique experiences which highlights that both Wozniak and this current study are dealing with idiosyncratic experiences.

Conclusion

The existence of health systems is shifting to more unconventional practices and settings. Where a healer would historically only practice in a residential area in a hut, there are now healers who practise from a hospital-based setting still as healers but as healers who have medical knowledge. These healers are then not opposed to medicine but see the need to integrate the two.

Dual practice of a collaborative and integrative nature are important because they represent a shift from the westernised and Africa healing systems existing in parallel. They ensure that these healing system do not have to exist in parallel but rather that they work alongside one another for the benefit of the recipient. Based on the above studies, it is clear that there are distinctions and blurred lines that exist between both systems which may be confusing to one's identity as either a health practitioner (nurses, doctor) or as a healer.

Colleagues and clients seen in various settings influenced the experience of dual practitioners. The experience is also shaped by the context of practice, be it in a private setting or a public setting, a rural or urban setting. Most importantly, these participants present unique experiences. There is a paucity of studies specifically investigating the experience of healer-therapists, where studies often investigate duality involving two people and not one.

CHAPTER 4: METHODS

Introduction

The methods chapter provides a description of the methods that were used to answer the research questions and a reflective account of how these methods worked for this context and content. The targeted participants were healer-therapists. Open-ended conversational style interviews were chosen as a method of data collection appropriate for the study.

Research paradigm

The research operated from the constructivist paradigm, which often manifests in phenomenological studies where participants can describe their experiences (Creswell, 2007). It is the process of 'describing' that constructs the reality of the phenomenon under study for the participant and the researcher. The researcher who employs a constructivist paradigm is a researcher who wishes to understand a particular social situation from the view that the participants hold about it (Mackenzie & Knipe, 2006). The study aimed to understand and offer an interpretive account of the experience of being a healer-therapist from professionals who are healer-therapists.

The study operated from the view that participants have a subjective meaning of the world they live in, meaning that the study relied greatly on the viewpoints of the participants (Creswell, 2007). Participants often had varied and complex explanations of phenomenon which are often based on history (Creswell, 2007). The varied and complex explanations is why the researcher considered the individual experiences of the participants during interviews. Bojuwoye and Moletsane-Kekae (2018) assert that the African cultural perspective views human nature as socially constructed, leading to the concepts of health and illness as also being socially constructed. The experiences of healer-therapists can be explored from the constructivist paradigm. The study was based on the worldview that the world is constructed by those who live in it and different people construct the world in accordance with their view of the world.

Research approach

The study employed an exploratory and descriptive qualitative research approach (Creswell, 2007). The study

explored the experiences of healer-therapists and also provided a descriptive account of these experiences. The study was designed and approached from an interpretive phenomenological worldview and a constructivist paradigm.

Study design

The study employed a phenomenological study design. A phenomenological design includes the study of participants' lived experience and the development of descriptions of the essence of these experiences (Creswell, 2007). This study looked at the lived experiences of healer-therapists through conducting semi-structured interviews. The study used Heidegger's interpretive phenomenological study design.

There are a few philosophical assumptions of phenomenology described by Creswell (2007), namely:

- *A philosophy without presumptions:* this phenomenological approach looks at erasing every judgment held by the researcher about a phenomenon until it is confirmed by participants. This was termed 'epoche' or 'bracketing' by Husserl. Bracketing or epoche is where the researcher set aside their own perceptions as much as possible in order to adopt a fresh approach towards the phenomenon under study. The possibility of the researcher erasing every judgment about the phenomenon under study is next to impossible, especially considering a literature search was conducted before conducting interviews. The researcher conducted semi-structured interviews and let participants guide the interview process by speaking about their experiences.
- *The refusal of the subject-object dichotomy:* this phenomenological approach holds the view that the meaning of an object depends on the meaning attached to it by an individual. The researcher allowed the participants to attach their own meanings to their experiences of being healer-therapists during interviews by allowing participants to lead the interview process with giving an account of their experiences. The participants' experiences guided the interview process.

The procedural steps in phenomenological research are as follows (Creswell, 2007):

- The researcher evaluates whether the research problem requires a phenomenological approach. The type of problem suited for a phenomenological approach is one where the study wants to understand idiosyncratic experiences of individuals in order to have a deeper understanding or influence practices

or policies. The present study explores the idiosyncratic experiences of healer-therapists.

- Data should be collected from those who have experienced the phenomenon. Data collected in phenomenological studies should preferably be in-depth interviews of multiple interviews with participants. The present study collected data by conducting one interview with each participant. It is recommended that at least five to twenty-five participants are involved in a phenomenological research study. The presented study involved five participants because there is not a large number of people who fall under the category of healer-therapists in Johannesburg, Gauteng. Some of the practitioners who may fall under this category are not open about it due to uncertainties about how the Health Professions Council of South Africa might react to their practices resulting in fear, discrete practices and self-censoring.

- Participants were asked two broad questions: What are your experiences of this particular phenomenon? And, what situations and contexts have affected your experience of this phenomenon? These questions were not asked directly but were incorporated into the interview schedule. Participants were also asked other open-ended questions over and above these two questions.

Research questions

The following broad research questions guided the interview:

1. How do healer-therapists practice?
2. What guides the direction of the dual practice?
3. How do healer-therapists negotiate and merge the differences between the two paradigms of healing?
4. What ethical dilemmas come up with dual practice, if any and how do they deal with these?
5. What are the advantages and disadvantages of dual practice?

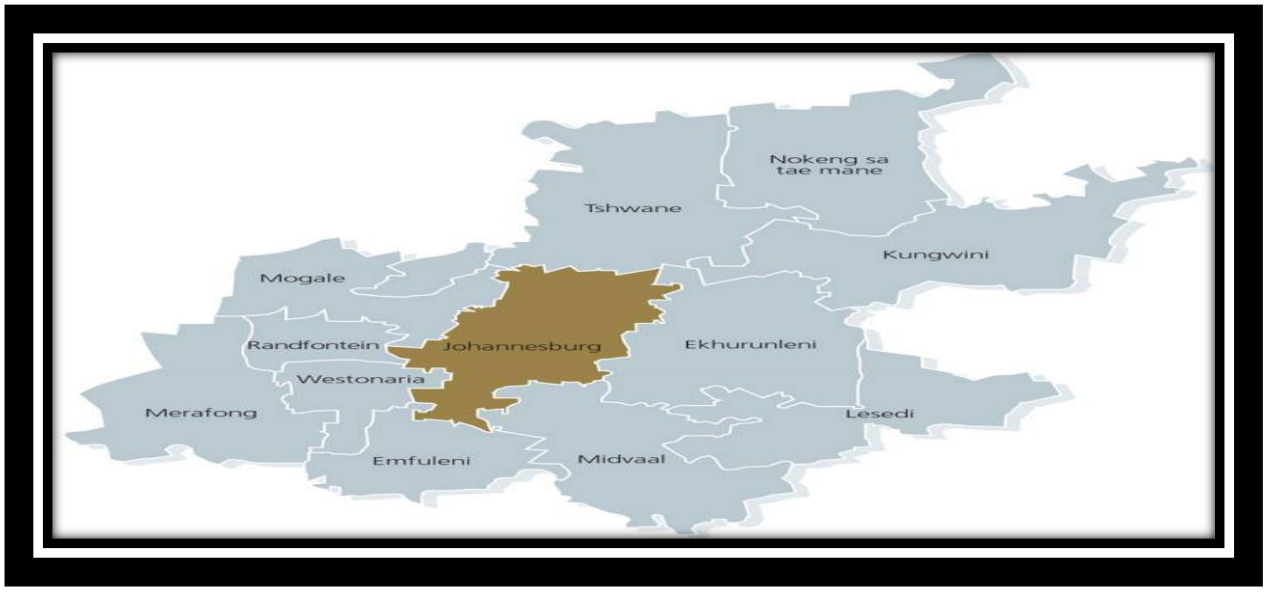
Research site

In mid-2019 Statistics South Africa (2019) estimated the South African population to be sitting at 58.78 million. The Black African population in South Africa comprises of 47.4 million people, approximately 81% of

the South African population (Statistics South Africa, 2019). The Gauteng province is the smallest geographically but the most crowded province in South Africa with approximately 15.2 million residents amounting to 25.8% of the South African population (Statistics South Africa, 2019).

Johannesburg, known as the *city of Gold* in the Gauteng province (Alexandra, 2019) was the research site. Johannesburg (see image below) is the capital city, where the provincial legislature is located (Alexandra, 2019).

Figure 4.1. (Johannesburg in the context of Gauteng, 2018).



In population numbers, Johannesburg is the largest city in the country, being the administrative capital of Gauteng (World Atlas, 2020). In 2019, the population of Johannesburg was sitting at (5,635,127) 5.6 million with the most common racial group being Black Africans at 76.4% (World population review, 2019).

The Health Professions Council of South Africa (HPCSA) iRegister (2020) revealed 732 registered psychologists in different categories in Johannesburg, by race and ethnicity. A survey conducted by the Health Professions Council of South Africa in 2017 highlighted that 73.8% of psychology practitioners are White, 12.3% are Black or African, 6.3% are Coloured and 6.8% are Indian or Asian (Health Professions Council of South Africa [HPCSA], 2017). The statistics of psychology practitioners presented above indicates that the majority of psychology practitioners in South Africa are White, yet some of the registered categories such as 35.0% of

counselling psychologists, 38.6% of clinical psychologists, and 45.9% of registered counsellors are reported to serve a large proportion of Black South Africans (HPCSA, 2017).

HPCSA (2017) contended that their survey results indicated that clients' ethnicity strongly linked to the ethnicity of the practitioner chosen. According to their survey, Black African practitioners have a client base of approximately 74% Black Africans and 8% to 9% of the other ethnic groups (HPCSA, 2017). White practitioners have a client base of 37% White and 35% Black African, coloured practitioners have a client base of 37% coloured clients, 36% Black African, 17% White and 10% Indian or Asian, Indian or Asian practitioners have a client base of 46% Black African clients, 25% Indian or Asian, 17% White and 11% coloured (HPCSA, 2017).

The HPCSA confirms in its 2017 survey that psychology practitioners are mostly White, female and English speaking between the ages of 30 and 40 years old. Of the survey respondents who are all psychology practitioners, 0.2% (5) speak IsiNdebele, 2.6% (53) speak IsiXhosa, 4.3% (87) speak IsiZulu, 2.3% (46) speak Sepedi, 2.0% (40) speak Sesotho, 2.7% (55) speaks Setswana, 0.0% (1) can sign, 0.9% (18) speak SiSwati, 0.6% (13) speak Tshivenda,1.1% (23) speak Xitsonga, and 3.2% (64) did not specify (HPCSA, 2017).

On the other hand, it is estimated, as outlined in an article by Sorsdahl et al. (2009) that there are approximately 200 000 healers in South Africa: an estimated 1 per 500 South Africans. The healers are not required by law to register with a specific professional body. The healers affiliate with different healer associations by choice.

Research population

The population of interest were Black (excluding Indians, Coloured and others) dual healers whose specific focus is on mental health, who reside and practise in Johannesburg, South Africa. These practitioners would be those with a dual identity of a healer and psychologist. Healers' training is non-formal, making it difficult for the researcher to verify that the participants were indeed healers. The one form of verification was by interviewing participants who are in the same circles, have known each other, and engage with each other on various platforms. Psychology professionals are required to register with the Health Professions Council of South Africa (HPCSA) which makes it easier to verify their credentials. The researcher varied these details with the HPCSA iRegister.

Sample and sampling

Participants were selected using non-probability, purposive sampling as well as snowball sampling (McIntyre, 2005). Purposive sampling refers to when a researcher wants to select a specific group with specific characteristics. The targeted participants are considered knowledgeable of the research topic and this is an important characteristic of that group; the researcher does not just want to do research with the average member of the population (McIntyre, 2005). The participants in a phenomenological study need to be carefully chosen so that the researcher can devise a common understanding of the phenomenon under study (Creswell, 2007). In this case, the present study targeted healer-therapists.

The participants required for this research were unique in that there are few healer-therapists who are known in the psychology sector. The study also used snowball sampling as the healers tend to know each other through their networks. According to McIntyre (2005) snowball sampling is a technique that involves identifying whi one member of the population is then asking them to identify another member who is also asked to do the same. Four of the healer-therapists in the present study knew each other and were able to refer the researcher to each other.

Target sample

The targeted participants were healers who specifically had training in psychology and were in practice. The healers could have either been in the private or public health sector to observe variance within the sectors. The healer-therapists were Black and saw their work as incorporating spirituality and divination in addition to aspects of formal mental health services. The targeted participants were Black healer-therapists because the role of healing in mental health is central to debates around treatment modalities in the South African context. Although, healing has been spoken of in literature, it is still an unfamiliar and mysterious concept to a large group of other racial groups (Swartz, 1996).

Exclusion criteria included mental health professionals who only practice from a psychological framework, even if trained as healers. Healers who are not practicing mental health professionals, even if they had the psychology training, were excluded. Herbalists were also excluded in order to include only those who are

healers by receiving an ancestral calling, are guided by spirits in their work, and are involved in communicate therapy rather than over the counter distribution of herbs. Dual practitioners who are White, Indian or Coloured were also excluded. Dual practitioners in other professions, other than psychology, for example, psychiatric nurses, were also excluded.

Recruitment of participants

To obtain participants, the researcher contacted various organisations whose focus is mental health and healer organisations. The researcher ended up with five participants. Participants' information was obtained by contacting the different organisations and asking for contact details using an organisational letter (see Appendix A) to access the personal contact details of healer-therapists. One of the participants (Sipho se Nkosi) contacted the researcher directly after receiving requests and referred the researcher to two other healer-therapists.

The first three interviews went smoothly and quickly, in a space of a month. The other two interviews were different because, (1) of (un)availability of suitable participants, and (2) the difficulty with finding a suitable time for an interview to take place. For one of the participants, the researcher met them through a work function where the healer-therapists was in attendance and the researcher requested to conduct an interview which took place over the phone.

Actual sample

The actual participants were three clinical psychologists and two counselling psychologists (one who also specialises in neuropsychology) who were all in private practice which might present as a bias. The South African public sector serves about 84% of the population; the rest of the population, which can be referred to as the affluent minority, is served by the private sector (Docrat et al., 2019). This amounts to 16% of the population that is served by the private sector and by the healer-therapists that are part of the present study. Some of the five participants were previously exposed to the public health sector through community service as intern psychologists and were able to offer a perspective from experience.

Research participants were practising in Johannesburg where the research study was located, although the participants were not originally from Johannesburg (see Table 4.1). The participants were from different gender

classifications: four women and one participant who identified as queer. Participants were between the ages of 29 to 52 with different years of experience as healer-therapists (see Table 4.1). The participants were all Black South Africans from different ethnic groups: IsiZulu, IsiXhosa, and SeSotho.

Table 4.1 below simplifies the characteristics of the healer-therapists. During the interviews, it was established that healers are gifted from a young age and are capable of communicating with and receiving messages from their ancestors to deliver to other people even before they accepted their ancestral calling and performed rituals to this effect. In order to quantify the number of years of experience as a healer-therapist, the researcher determined years of experience from the moment the healer accepted their ancestral calling and actually performed rituals communicating their acceptance to their ancestors until the interviews were conducted in 2019.

The researcher asked the participants to identify themselves as a type of healer as a result of the contestations around the word *traditional* healer. This was also done to give the participants an opportunity to identify themselves and not to give the participants an assumed identity. The participants gave an identity which they felt best suited their healing gifts (see Table 4.1), but where a participant did not specify the type of healer they would like to be referred to, they were then referred to as a healer. The participants also referred to the types of spirits they are associated with. The identities of the healer-therapists is further elaborated on in chapter five.

There are five types of spirits identified by Gogo Nokulinda Mkhize as reported in the Mail & Guardian (2016, July 25) which are blood spirits (*uMndiki, Mguni*) and water spirits (*umNdau, AbaLozi, IsiThunywa*). Gogo Noklinda Mkhize in the Mail & Guardian (2016, July 25) further breaks these down: blood spirits are related to a person through blood and consist of *uMndiki* (named after Mandinka, originating from West Africa, oldest blood ancestors) and *Mnguni* (named after Nguni, from Southern Africa, a family ancestor such as a great-grandmother and serves as a protector and guide). Gogo Noklinda Mkhiza in Mail & Guardian (2016, July 25) further refers to water spirits which are a result of relations through commerce and conquest and consist of *umNdau* (named after Ndau, from Southeast Africa, might be of European traders who interacted with one's ancestors), *AmaLozi* (named after Lozi, from central and Southern Africa, only *izangoma* have them) and *IsiThunywa* (prophetic spirit, *umthandazi*/prophet as seen in Zion churches, they do similar work to *izangoma*

but are not initiated in any particular way). Some of these spirits emerge in the training and specialities of the healer-therapists which will be elaborated on in chapter five.

Table 4.1: Actual sample characteristics

Pseudonym	**Age**	**Experience as a healer-therapist**	**Language**	**Home town**	**Gender**	**Type of psychologist**	**Type of healer**	**Types of spiritual guides**
Gcinisela Mkhabela (GM)	37	1 year	IsiZulu	----	Female	Counselling psychologist	African – based healer	---
Grace Nxumalo (GN)	33	1 year	Sesotho	Free State	Female	Counselling psychologist (also specialises in neuropsychology)	*Sangoma* / medium	---
Mildred Motaung (MM)	52	13 years	IsiXhosa	Gauteng, Mamelodi	Female	Clinical psychologist	Healer	All
Sipho se Nkosi (SN)	29	7 years	IsiZulu	Gauteng, Soweto	Female	Clinical psychologist	Healer	All
Patrick Ngoma (PN)	31	6 years	IsiXhosa	Eastern Cape	Queer/Gay	Clinical psychologist	Healer	Water spirit

Data collection

Data were collected using semi-structured, open-ended individual interviews. In practice, when adopting the abovementioned research paradigm, the questions asked to participants were as broad and as open-minded as possible (Creswell, 2007). The broad and open-minded questions allowed participants to be able to construct their worldviews of the phenomenon under study (Creswell, 2007).

Two pilot interviews were conducted with the aim of establishing the semantics of the data to come out of the interviews, and whether the data would answer the research questions and aim of the study. The pilot interviews were conducted with dual practitioners: one was a drama therapist and a healer, the other was a social worker in the mental health space and a healer. The pilot interviews further assisted with knowledge with regards to healing and being a healer-therapists, what work healer-therapists are likely to be involved in, and what the experience of healer-therapists, although unique to each individual, is likely to reveal. The data obtained from the pilot interview were not used for data analysis.

Four interviews were face-to-face and one interview was done through a WhatsApp voice call. The researcher did not struggle to make appointments with four of the participants. The researcher only struggled with arranging a suitable day and time for an interview with one participant where it took a period of four months for the interview to take place. The researcher ensured that participants were given a chance to construct their worldviews through choosing semi-structured interviews as a data collection method. The interview style allowed for flexibility during the interviews and for the researcher to ask questions based on the participants' individual experiences.

The interview method allowed for rapport building especially in face-to-face interviews. The interview conducted over the telephone was done as this was convenient, and the specific participant was at *ephehlweni* (the initiation school) at the time of the interview making it difficult for the researcher to visit and conduct a face-to-face interview. The healer-therapist suggested that *ephehlweni* would not be a good setting for the interview to take place.

Two interviews occurred at psychology practices. One respondent was visibly a healer through her own clothing and through objects inside the psychology practice like *imphepho* and candles. One interview took place at a restaurant at a shopping mall, another interview at a lecturer's office at a Johannesburg university. None of the interviews occurred at a practice of a healer (*indumba*) although healing took place at the psychology consulting rooms. The interview settings were chosen by the participants. The researcher asked the participants where they would want to meet for an interview and none of the healer-therapists chose to meet at their healer practices (*indumba*).

All interviews were audio recorded using a recording device for accurate data capturing and transcribed for the purpose of data analysis. The language used during the interviews was primarily English, but the researcher allowed for some flexibility for the respondents to use any other language especially in explaining cultural phenomena which might not be easily translatable to English. Sodi and Bojuwoye (2011) assert that the use of foreign language often distorts certain cultural phenomena and there are often no adequate English words to explain certain cultural indigenous phenomena. It was sometimes difficult for participants to describe aspects of African healing using English because some of the words or expressions were not available in English or had a

different meaning if English was used, therefore where needed, provision for code switching was made.

Data analysis

The researcher analysed the transcripts using interpretive phenomenological analysis (IPA). Husserl in 1900-01 introduced the philosophy of phenomenology, and was later joined by his student, Martin Heidegger (Giorgi & Giorgi, 2011). This researcher used Husserl's method of interpretive phenomenological analysis. Husserl believes that the first step should be description followed by interpretation when using the phenomenological analysis method (Giorgi & Giorgi, 2011). The study first described then interpreted the experiences of healer-therapists. The study employed a hermeneutic phenomenological approach. Hermeneutic phenomenology is concerned with lived experience as well as the interpretations of the texts of life (Creswell, 2007).

The study first identified the phenomenon under study, reflected on what constitutes the phenomenon, described the phenomenon and interpreted the meanings attached to the phenomenon (Creswell, 2007). When describing the experiences of those who have experienced a particular phenomenon, the researcher tried to make sense of the collective experience of the individuals (Creswell, 2007). The collective experience of the healer-therapists is elaborated on in chapter six. With the descriptions provided, the study focused on the 'what', 'how', 'why' and 'so what' of the experience (Creswell, 2007).

The study used the following steps when analysing data, outlined by Creswell (2007):

- The researcher went through interview transcriptions and highlighted specific words, phrases, or statements participants made in order to help understand the phenomenon under study. This step is called *horizonalisation.*

- This step was then followed by *clusters of meaning* where those words, phrases and statements highlighted were turned into themes.

- The themes identified were used to write a description of the experiences of healer-therapists (*textual description*), to describe the context that helped shape or influence the experience of healer-therapists (*imaginative variation or structural description*).

- The researcher tried to capture the essence of the phenomenon, called the *essential, invariant structure or essence*. The focus here was on shared experiences of the participants so that the researcher can form a common understanding of dual practice.

Mechanisms of ensuring rigour in qualitative research

According to Mays and Pope (1995) qualitative research has often been criticised for its lack of scientific rigour. Criticism levelled against qualitative research includes the idea that the majority of the information presented in qualitative research studies is subjective and therefore is strongly subjected to researcher bias (Mays & Pope, 1995). Qualitative research has also been criticised for lacking reproducibility because of how the majority of the topics seem to be personal to the researchers and lastly, that qualitative research studies lack generalisability (Mays & Pope, 1995).

Hadi and Closs (2016) provides strategies to ensure rigour in a qualitative research study and suggests that at least two of these strategies in any qualitative study to ensure scientific rigour. In this study, these methods were used:

Self-reflection/reflexivity:

Hadi and Closs (2016) suggest that self-reflection is very important in a qualitative research study in order to reduce researcher bias by providing the positionality of the researcher and how the researcher's personal feeling might influence the research findings. In the present study, the researcher provided a self-reflection section in order to attempt to reduce research bias. The researcher also provided a brief reflection before the introduction chapter in order to provide the positionality of the researcher.

Peer debriefing:

Haudi and Closs (2016) postulate that peer debriefing is one of the methods that can be employed to ensure scientific rigour. The researcher can use a qualified qualitative researcher to discuss data collection methods, data analysis and findings in order to maintain objectivity (Haudi & Closs, 2016). Haudi and Closs (2016) also suggest that the research supervisor can act as a peer debriefer to a research student. In the present study, the

researcher sought the assistance of the research supervisor as well as a research group who assisted in maintaining objectivity with the research findings.

Researcher reflection

The researcher studied psychology and worked in the mental health sector. The researcher noticed an enormous preference, positive attitude and support towards westernised approaches. African approaches, and not just healing, are seen by those who do not understand these practices as non-conventional methods or as unacceptable approaches to mental health care. If the researcher were to consult with a healer, the researcher would be more comfortable with someone who was not a *traditional* healer but someone who appears to be more modern not only in their approach but also visibly. This does not mean that the healers should not be in their traditional attires. Being drawn to someone who is more modern is why the researcher was interested in speaking to healer-therapist.

The researcher tried as much as possible not to impose her beliefs during the interview and data analysis process through bracketing. This is achieved through trying to gain an understanding about healing and psychology especially by having guiding questions (see Appendix B).

This preference also had an effect on the data collection method because the researcher found herself feeling more comfortable with the healer-therapists who were not visibly healers. If the researcher were to consult a healer, this is the type of healer the researcher would be comfortable consulting with. The researcher was a bit uncomfortable with the healer-therapist who was visibly a healer, with not only her clothing but also the practice was set up in a way that reflected the healer more than the psychologist. There was *imphepho* (incense) and it was actually burnt during the interview session as the healer-therapist mentioned that we are conversing about ancestors so we needed to burn it as a medium for her to partake in this research exercice. This felt a little bit uncomfortable and the researcher tried to picture herself as a client in that process. To say, if the researcher was a client, even though the client might have been comfortable conversing about ancestors, perhaps the client would not have been comfortable when *imphepho* was burnt.

The healer-therapist was visibly a healer-therapist as indicated by the clothes worn and some displayed in the

practice. At some point the regalia was sitting on the only chair where the researcher could sit and because of the knowledge of the sensitivity of healing mediums the researcher was unsure whether she was allowed to touch any of the objects. This made the researcher a little uncomfortable and the researcher had then had to ask the healer-therapist whether she can touch the material, to which the healer-therapist replied with no. The healer-therapist then asked the researcher why the interest in this topic, to which the healer-therapist told the researcher that it was impossible to just be interested in such a topic.

During another interview, a healer-therapist mentioned not asking for permission from ancestors before the interview happened. The healer-therapist then had to stop the interview and invite her ancestors to the interview. The healer-therapist did this by using snuff to call upon her ancestors, informed them about the interview where the researcher will be asking about them and will be using this information for research purposes. The challenge here was not knowing whether the ancestors will agree to the interview proceeding or whether they would not want to be part of the process. Thankfully, the ancestors did agree to the interview proceeding and the healer-therapist felt relaxed upon the presence of her ancestors during the interview.

In another interview, the researcher was asked by the healer-therapist whether the researcher has ever consulted with a healer in order to be able to articulate messages received properly. The researcher told the healer-therapist that she did not want to have a pre-conceived idea of their practice even though the researcher has seen a healer beforehand and had working knowledge of healers.

During the interviews, the researcher learned a couple of things about healing. Firstly, the researcher learned that she held a false belief about the identity of healers. Before the study, the researcher thought that a faith healer (*umthandazi*) is not someone who undergoes *ubungoma/ukuthwasa*. The researcher grouped a faith healer in a separate category compared to *isamgoma* and i*nnyanga*. A faith healer, to the researcher, seemed like someone similar to a priest and not so much someone who had an ancestral calling. Secondly, the researcher learned that all three types of healers form part of the participant group, with differences in how they practise. The misconception that the researcher held was that a healer could only belong to one category, however, the researcher learned throughout the interviews that a healer can be all three in one.

Ethical Considerations

Informed consent

Research participants have the right to be fully informed about the nature of their participation, the research focus, why the research is being conducted, how they feature within the broader context of the research, and the right to withdraw their participation at any time (Ryen, 2011). Before the interviews began, participants were informed about the research focus and the researcher also made sure that the participants were indeed dual healers before proceeding with the interview.

Participants were asked to read the participant information sheet (see Appendix C) for information about the intended purpose of the research before the interview began and ask any questions for clarity. Participants were asked to read the informed consent form, sign and date to ensure that they have been fully informed and consent to being participants to the research (see Appendix D).

Confidentiality

The healers referred to their previous clients' stories or experiences during the interview process. The healers did not mention anyone's name and they also did not tell of their clients' stories in much detail, only where an example of a previous case was being mentioned. It was necessary for the healers to tell of their clients' stories when they were speaking about their experience of being a healer. The experience of being a healer is connected to how your clients have experienced you as a healer and the effect that healing has made on those you have healed.

Any information given to the researcher by the dual practitioners was kept strictly confidential. Audio recorded interview data were kept in a locked Google drive folder only accessible to the researcher and supervisor. The audio recordings and transcripts will not be destroyed but stored in a password protected Google drive folder in case of publication at a later stage.

No identifying information was used during the interview process, in the transcripts and in the research report. Where direct quotations were used, participants were referred to using pseudonyms (see Table 4.1).

Anonymity

A researcher is obligated to protect the identity of research participants as well as where the research is taking place (Ryen, 2011). Protecting the location where the research study is taking place might also assist in protecting those who were involved in the research. This becomes difficult because at times the place where the research took place is important to the focus of the research. The researcher tried to be as vague as possible so as not reveal the identity of the healers as they are a unique group of participants and can be easily identified. For example, this research has taken place in and around Johannesburg. This was difficult because the researcher was being referred to other healers to interview, so the participants are likely to know who was interviewed but not all of the participants knew each other and pseudonyms might make it difficult for the participants to pin-point who is who.

Care was taken to ensure that no one other than the healers were present during the interviews. Two of the interviews occurred at psychology practices of the participants, one occurred at a Johannesburg university, one interview at a coffee shop in a shopping mall, and one over the phone.

Anonymity cannot be fully guaranteed because the participants were unique and can be easily identifiable, and additionally the researcher and supervisor will have access to the interview data as well as transcripts. Confidentiality can be assured with use of pseudonyms, as previously mentioned. Another reason why anonymity cannot be fully guaranteed is because the research supervisor also referred two participants to the researcher. These participants are known to the research supervisor.

Anonymity is especially important with this study where dual practice might not be fully accepted by the HPCSA. The HPCSA might want to further investigate healer-therapy practice and as a result, request the identity of the healer-therapists from the researcher. The researcher was able to uncover Facebook posts related to a healer-therapist who advertised their services and disclosed both identities, a healer and a psychologist (Mkhize, 2020). One particular person who commented on the post hinted at contacting the HPCSA to have the healer-therapist investigated (Mkhize, 2020). The same could happen after this study, forcing the researcher to give up the identities of the participants in the study and a result, compromising any anonymity promised to the participants.

Non-maleficence

The concept of non-maleficence requires researchers to "not inflict harm nor engage in activities that risk harming others and must minimise harm if it is unavoidable" (Allan, 2011, p. 113). The researcher minimised any harm by making certain that the healers were willing to participate in the study and talk about their journeys to becoming healers. The researcher provided details of organisations that provide counselling services (see Appendix C) should the participants have needed to talk to someone after the interviews took place or if the participants felt that the interviews elicited details that could be traumatic and needed to be dealt with through a counselling session. None of the participants reported needing to talk to someone after the interviews.

The justice principle

It was particularly important for the researcher to treat both modalities of African and westernised mental health approaches equally and not to see the one as being less than the other. It is particularly important because of the researcher's training as a psychology professional and a healer. This principle is about psychology professionals being able to treat different people equally and fair (Allan, 2011). During interviews, the researcher did not view either one of the modalities as being superior to the other. The researcher tried to divide the questions equally between those focused on healing and those focused on psychology.

CHAPTER 5: FINDINGS

The findings and discussion sections are presented separately in this research study. Burnard et al. (2008) suggested that when writing and presenting qualitative research data, the research is able to either separate the findings and discussion chapters. The research can do this by having verbatim quotations in the findings chapter and then linking these to existing research in the discussion chapter, as it is also done in quantitative research studies (Burnard et al., 2008).

Introduction

The present study investigated healer-therapists who had accepted their ancestral calling, went through *ukuthwasa*, studied and obtained a master's degrees in psychology and were registered with the Health Professions Council of South Africa (HPCSA) as either clinical or counselling psychologists. This is why they are referred to herein as **healer-therapists**. This chapter begins by presenting an individual account of each participant. This is to highlight the differences in their identities, experiences and how these informed their responses. Although the healer-therapists were asked additional questions based on their unique experiences, there were some common questions asked to all participants to enable the researcher to devise a common understanding of the phenomenon under study. Some healer-therapists appeared to give insight into some questions more than other questions as this reflected their own unique experiences.

The healer-therapists' experiences were vastly different. Their practices appeared to have some links and resemblances comparatively to each other with regards to their experience of being healer-therapists. This chapter presents similarities and differences amongst the healer-therapists, while also alluding to their individual idiosyncratic experiences.

The study assumed that the healer-therapists sometimes integrated both modalities into their practice and how they did so is explored in this chapter. The findings indicated that the healer-therapist sometimes placed their African beliefs foremost when providing counselling services. For example, the healer-therapists sometimes suggested the African mode of healing first to their clients before proceeding with the psychological mode where, in their judgement, the clients' presenting problem required both modalities. In their talk, the African worldview appeared to be more dominant than the psychological worldview.

All of the healer-therapists asserted that the element of spirituality was often incorporated into therapy unconsciously, wherein the ancestors communicated with the healer-therapists about an issue that was currently being discussed in therapy. For them, they said this made it easier to merge the two paradigms of healing and it helped the healer-therapist not to deviate from the issue at hand. It is possible that this was how the element of spirituality or divination in psychotherapy almost went unnoticed during the counselling process.

Four of the healer-therapists in this study were Christians and belonged to different denominations and church groups. The other healer-therapist did not mention anything about their religion. SN, PN and GM were discovered in church that they were meant to be healers.

Mildred Motaung (MM)

MM is a clinical psychologist. Her home language is IsiXhosa. She is 52 years of age and had 13 years of experience as a healer-therapist at the time of the interview. MM provided the longest interview (1:13:12). MM also had the most years of experience as a healer-therapist compared to all the other healer-therapists interviewed for the study. MM became a healer-therapist in 2007 where they graduated as a psychologist and healer in the same year. MM said, following a period of training, "*I also graduated as a traditional healer in 2007. Just two months apart"*. It took a period of three years for MM to complete their *ukuthwasa* process, "*if you calculate from 2007, I completed the process in 2010".* Despite these two professions occurring just two months apart, MM remarked that, "*the calling came first".*

MM is a healer who is guided by different ancestral spirits. MM also alluded to seeing signs of a calling to become a healer at an early age yet it took time to fully accept the ancestral calling until 2007. Even other healers said to MM, the process could have been undertaken much earlier:

> *different (pause) I don't know, ancestral wisdom, if I call it, if I can call it that (laughs). Uhmhm look- I have the ancestors who are Xhosa cause I'm Xhosa right? Ehh so they came forth to give me their wisdom ehh and then there's also abandawo who are the ancient ancestors ahh who came from the north of Africa, Zimbabwe, Mozambique and stuff. So I was being initiated in those and then also umnguni. And because in my process, like I said they said I waited too long. So which means, when I became sick…cause usually what will come forth is your- the very first type of ancestors that will come forth, it will be your biological*

ancestors, you know? Eh (pause) like my great grandfathers and stuff. So when I came forth I didn't recognise that they were here, that I needed to go for ukuthwasa. So when I look back now, I know I started seeing signs ehh the intensity of the signs. I think the year was 1994.

As a healer MM was initiated in accordance with different spirits: "*I was initiated in umguni nomdawo and thereafter I continued to be sick. I wasn't- I wasn't ok and which meant that I needed to still go for initiation as umthandazi eh as well as isiXhosa".* As a result of being initiated under the different spiritual guides, MM identified and preferred to be called a healer as MM can practice from multiple perspectives and not just one. MM suggested that a psychologist may also be classified as a healer: "*So I call myself a healer because I was initiated in all those modalities", "Also put in psychology though, and say these are healers"*.

According to MM, family background plays an enormous role when it comes to owning one's identity as a healer. Family background also plays a role in terms of offering a frame of reference for which a person may understand their own experiences: "*I came from a background that didn't prepare me to see myself when I was transforming into being a traditional healer so ehh whatever I went through my- I I understood my experiences in the western world".*

MM continued to tell about their family background of Christianity which added to confusion of the signs of an ancestral calling. This confusion lead to misunderstandings which in turn led to delaying the process of accepting an ancestral calling and going for *ukuthwasa* suggesting that people understand their experiences from their own perceptions and belief systems: "*coming from a Christian family, even when I told my parents what I was dreaming about, what I am seeing, what was happening to me. My parents always prayed for me".*

MM alluded to socialisation being the reason behind delaying the acceptance of their ancestral calling and also to the difficulty of self-acceptance as being a result of how people, especially parents perceived the gift:

When you have some experience and then you are prayed for, you know? That instills in you that, my being or certain things I can do- my abilities are demonic, you know? I think that explains why I couldn't recognise myself.

MM spoke about praying to God as a gifted child and learning how to pray and actually finding answers to their prayers. MM later found out that finding answers to prayers does not happen to every child and that MM might be a gifted child. The important thing also here is that the gift does not take away religion or does not imply that a person should not pray to God:

> *I would kneel in the middle of the room and I always faced east. No one taught me that and I would say something like God of my father and my mother show me one two three, you know? And I would find whatever I was looking for (laughs) but these are the things that are just-you know as a child you think you can do it and you think everybody is like that.*

MM spoke about her thoughts of possibly having supernatural powers similar to those of Jesus, "*When I used to listen to my father or anyone from school teaching about Jesus for example, I'd think, "What if? What if I'm like him?"*

MM further alluded to the challenge of being a Christian, in addition to being a master's student in psychology, when her symptoms became intense and she heeded the call to become a healer. MM said that she did not have the language to adequately comprehend what was going on at the time. MM also referred to the researcher during the interview as someone who probably struggled to have the language to articulate what is going on in the event of having an ancestral calling: "*If you had to start having the symptoms, you will not have the language to explain your own symptoms or your own experiences. I struggled. I didn't have the language cause I was raised as a Christian and I was a master's student".* For her, this was a clash of tradition and civilisation.

MM preferred to be referred to as "*a healer that practices in both modalities"* primarily because *"they are not really- exactly or really very very different".* From MM's experience, healing and Eurocentric psychology do not reflect much of a difference that necessitates the separation of the two identities. MM does not see much of a difference in what psychologists do and what healers do indicating that healers in their work are required also to intervene psychologically as cases present themselves, "*so people consult with traditional healers even when they have marital problems, and often that is not something that can be cured or fixed through medicine only. A spiritual intervention is needed and a psychological intervention is needed".*

Even though MM noticed a slight difference in the two modalities, MM preferred to keep them visibly separate from each other, describing that "*I have a clinical psychology practice and I have my indumba at home".* This is a result of fear of the practice of healers being frowned upon by the HPCSA if MM ever decided to fully combine the two practices mainly from the psychology practice. The separation is also as a result of government policies that do not cater for a dual professional identity when registered under different organisations. However, she was unhappy that she was not able to fully combine the two practices, *"I would love to combine the two (laughs). Especially my clinical psychology practice but we are not there yet right? Policy wise we not there yet (laughs). So I'm sure the HPCSA would be on my case if they ever hear that I was throwing bones and doing readings in my practice".*

MM alluded to people having the knowledge that she is a healer who is also a clinical psychologist and is therefore able to converse about certain things that someone who is just a healer might not be able to: "*when they come to indumba, some come to me because they know I am isangoma that is also a clinical psychologist. Therefore they hope they will be able to have a conversation with me about certain things".*

Patrick Ngoma (PN)

PN is a clinical psychologist, a lecturer at a university and a healer. PN is 31 years of age, originally from the Eastern Cape and identifies as queer. Unlike MM, PN came from a family background of healers and so they may not have struggled with their identity. One may assume that PN may have easily accepted an ancestral calling. PN might have also had the language to express what they were going through: *"I come from a genealogy of healers ah you may call them sangomas, prophets and any kind of spiritual realm that you can think of".*

The journey to becoming a healer for PN began in 2014 where there was an understanding of what was going, even though like MM, PN grew up as a gifted child: "*It began in 2014 as a highlight or as something that I began to understand but I have been told many times that I have always been considered as that gifted person or that gifted child".* As a child, PN used to be taken to healer ceremonies but at the time they did not understand what was going on. As a child PN also used to have moments where they saw themselves as a *sangoma*:

> *when I was around 6, 7 years old my grandmother used to take me to entlombeni where khona amagqirha akhona and all of that, and I never understood that world then cause I was a child but I grew up- I used to be a very self-isolated child and in those self-isolation moments, I used to have a lot of déjà vus. So it would be about quite a number of things but I remember one of the déjà vus I used to have would be around me being a sangoma.*

PN is a Christian and always wanted to become a preacher because of a burning desire to do spiritual work. They said: *"Uhm at some point I wanted to become umfundisi, minister in the church (name removed). I was 18 years by then but there was always this burning sensation or burning desire to work within the spiritual realm"*.

PN explained their journey to becoming a healer-therapist also through a journey of self-discovery where they were figuring out how dual healing would work mainly because of their gift as a healer. The gift of psychology already existed. The challenge was the introduction of healing that seemed similar to that of psychology. The identity of a healer brought dismay because PN was already a psychologist. PN likened their psychology practice to their gift of healing, which was *ukuthandazela a bantu* (a faith healer). He explained that: "… *Exactly already what I was doing as a psychologist, my healing is around that context which is it took time for me again to understand, what is this healing all about? Cause I'm already a psychologist"*. PN initially struggled with their healer identity because healing is already provided for through their own way of practising psychology which incorporates praying. PN was struggling to see the need for the healer when the psychologist identity proved to be sufficient.

PN is a type of healer associated with water spirits. He explained that for him:

> *It became fully blown in 2014 where I went to a divine healer, umthandazeli. Ekhaya ngama Zion so I went to umfundisi that I was familiar with and then he then told me that I have a gift as a healer, meaning that as umuntu o thandazela a bantu.*

PN is a healer who was told to not to go initiation school because their gift was a rather unique one. He described it as in line with healers who have water spirits as their spiritual guides, where the healers do not undergo any specific type of training as explained by Gogo Noklinda Mkhize (2016):

> *It really took time and so I used to go to him for consultations and he did indicate that andithwasi.*
>
> *It's an innate gift, nothing that you need to do to evoke it but because you belong to the two worlds, ubungoma and that, yobu thandazeli, more like the divinity part of things. What is more strongly from my side bobo- it's ubuthandazeli*.

The fact that they did not need to undergo *ukuthwasa* is what differentiated them from other interviewed in this study. Their initiation was different.

Even though PN did not have to go through the conventional way of initiation as some healers do, PN regularly consulted with their *gobela* in their journey to acceptance and becoming a healer. PN also expressed that they had water spiritual guides:

> *I had to go to ugobela wam and she told me you've got to go to e lwandle, that's one of the things that you should go through as part of your initiation…With me, I wear the blue one. Uhm symbolic of my journey, that ndingumtu wa manzi*.

PN was only required to perform certain rituals to indicate acceptance of their ancestral gift and calling but was not required to go *esphehlweni* like other healers reiterating what their *gobela* said. They told the interviewer that

> *She said again over time, the difficulty with you, you are not one of those people who go to esphehlweni and be trained. You are your own gift. You just need someone who will journey with you, to explain certain things, amaphupha uhm the sensations you feel*.

PN highlighted the confusion most people have with him having the gift '*yobu thandazeli'* yet not having to go for initiation. He reflected "*what's ideally confusing for most other people is, how come you have this gift but you don't go through initiation?"*

PN alluded to having a White ancestor who does not do things the conventional way, in terms of throwing bones and going into a trance. This ancestor is the strongest amongst all PN's ancestors. PN identified with this ancestor both as a healer and as a psychologist:

> *I discovered that in part of my lineage there's a white ancestor. Interestingly when we sit and consult, my gobela says that ancestor is always active. I don't- she doesn't throw bones with me, it's more therapeutic. She lights a candle, things get revealed over time as we speak. She doesn't go to these moments of trance and everything.*

PN views the white ancestor as one who is level-headed and educated similar to the psychologist that they are: *"Yah more like me, it resonates with me. It's more of idlozi that is educated and sensible"*. This can be seen as denigrating and othering.

PN described their identity by highlighting certain contradictions dictated by society that they were able to navigate around. When probed, PN said they did not find it difficult to negotiate their dual identity:

> *Being a psychologist. Being a preacher in the (name removed). I went through that whole phase of being initiated to become a preacher. Uhm I am a divine healer that is not conventional. I am gay. All of these- and I'm Christian above all. So there are contradictions in all of these things but for me I don't see any contradictions that I cannot manage.*

PN alludes to another dual identity where a connection with being part of the ancestral realm of things and the Christian way has to be found but PN referred to this as a perception: *"perception is, how do you conduct or connect the two? Ubungoma, that world is very ancestral and the Jesus way. And, for me it works"*.

One way of managing such contradictions and minimising confusion is to look at each gift or each identity from its own origin and meaning in one's life. Even in so doing, PN acknowledged that for him the powerful gift was that of divination. To this they said: "*I've learned to realise that this is a gift that is ancestral. Even there is the one to be a preacher that is there but the dominant one is the one from home, and then over time I've had to do certain rituals"*.

PN became a healer when they were already a psychologist, which was the cause of their struggle with understanding the journey to becoming a healer. A psychologist is a scientist. A scientist is one who bases everything on evidence. The gift to become a healer cannot be measured and there is no scientific evidence pointing to it. Because of having to merge the two realities, PN was curious of how a dual modality will work:

> *I'm at a stage now where again I can uhm I'm still waiting, the academic in me, the scientist always looks for, when is this happening? I'm looking for evidence and trying to make sense and I'm told unfortunately I'm at peace. There's no scientific evidence that can explain what is going on…so I'm at a point now where I'm trying to see, how is this gonna turn out to be? This dual modality thing.*

Gcinisela Mkhabela (GM)

GM is a 37-year-old female counselling psychologist who preferred to be referred to as "an African-based healer*".* GM is one who was visibly a healer-therapist, with both clothing and the psychology practice itself. The practice had objects which reflected a healer, like candles and *imphepho*. GM did not identify as a *traditional* healer because GM worked from different modalities within healing and did not view the specific type of healing as being *traditional*. *Traditional* healing may not be sufficient to refer to the many layers of being a healer that GM is, as she explained:

> *Traditional healer doesn't cover the many different things that I do. So uhm healing in African based philosophies and methodologies uhm which also incorporates prayer uhm so also using Africanised Christian methodologies so looking at- or integrating those philosophies into practice so prayer uhm using salt, using water, using candles uhm as a basis for healing.*

GM was not specific about her spiritual guides as in the case of MM and PN. Being a *traditional* healer might also translate to being irrelevant and old with no real value in the modern world. The *traditional* healer, according to GM is one who probably cannot relate to young people as they may practise based on old principles and might converse only in their home languages whereas young people these days mainly converse in English. GM considered herself a modern healer:

I'm not based in the old traditional clients, you know? I work with a lot of young clients. I speak a lot of English and I also have to find a way of modernising or bringing old philosophies or old practices into modernity like contemporary times.

In GM's experience, some clients knowingly consulted with them because of the knowledge of GM's dual identity. GM said that clients were somehow being directed to seeing either the healer or a therapist who is also a healer: "*Ah the majority have been like oh now it makes sense cause usually they've been directed, or someone has said in their lives, oh maybe you need to explore like the African way of doing things"*.

GM is one of the healer-therapists who, in their practice, seemed to first approach interventions spiritually before approaching them psychologically. This is not to imply that GM is unable to be a psychologist where required but African healing seems to take precedence. Explaining her order of helping she said that

when a spirit is sitting on your body, it can show up as psychological or emotional factors uhm but once wa- that is addressed and then some of the symptoms kind of go away then you can deal with the kind of psychological and emotional issues. So say for instance that your ah you haven't done- you haven't been introduced to your paternal ancestors.

Where spiritual difficulties were presented, these were explored as a matter of priority and then followed by the exploration of psychological difficulties.

Like PN, GM's healing abilities were discovered in a Zion church by the prophets. The prophets were able to see that GM was meant to become a healer. In an effort to discover her spirituality and her identity GM joined various churches prior to being discovered. She explained her journey of

…trying to find myself. Uhm I had left the (removed) church and I was in the first year of tertiary and I was going around in different churches trying to find peace or whatever. So I went to a Zion church and these people, yoh they went around me and then one of the prophets was like, yah we see beats on your legs and I see beats on your hands and I'm like, Ok yah I wonder what that means.

'Went around me' in this case refers to the circular motions in a leaping dance that is typical of Zionist worshipers and this leads to a trance. GM has experienced that there seemed to be an interest in healing-therapy

services as a result of inadequate psychological services and psychological theories that may be irrelevant to some people. In her view "*…there has been interest. So I think people do come up with situations where uhm psychological theories aren't- they aren't enough".*

GM recalled that she usually came across families, and not just the client who are not embracing healer-therapy services and are often shocked that their loved ones were meant to be consulting a psychologist and they then ended up consulting with a healer-therapist. She reckoned that it may be the attitude of the families that might sometimes present as a barrier to accessing healer-therapy services. Beyond just the consulting service she said:

> *So I have a lot of clients who need to thwasa and so that comes up in conversations and usually families are not receptive and them or partners or husbands will be like, but I thought you were going to see a psychologist and now there's this gogo, what on earth is going on?*

GM mentioned that she usually dealt with adults who were capable of making their own decisions and could actually "*pay their own way*" so the view of the family members did not seem to be much of a barrier. It might be a matter of dealing with the consequences of making such a decision outside of family approval that remained a challenge.

GM believes that there is capacity and scope for healer-therapists to practice. There is also a need for such services where African modalities are able to provide explanations for some spiritual concerns that may present themselves as psychiatric concerns as they have previously been conceptualised: "*there is capacity especially if you're looking at some of the psychiatric issues that even African modalities have a way of explaining and even working through*". GM further proclaimed that "*there are no limitations in African healing".*

GM refers to being a healer-therapist who is quite private and reserved:

> *I also am not very out there in terms of you know, this is what, I don't know, or I know there's other sangomas and psychologists who are on radio and doing all those things. I'm not- you have to kind of find me somehow.*

Even though GM considered herself a private and obscure person she was in fact on social media, the opposite. Some people found GM on social media following posts that imply that GM is a healer-therapist. When people

view such posts, they become intrigued in finding out more or consulting with a healer-therapist as they might be feeling that traditional therapeutic methods did not really cover much in terms of their whole self. Referring to her online visibility she said:

> *Or some of the posts that I do on Facebook and then I'll get inboxes and it's like, 'Please tell me more, what do think about this? Can I come see you?' Blah blah blah. So there is a need and I think there-there is a need particularly within our helping professions because people are are coming to us and sometimes it's even in the shadows because they are unsatisfied, they are not satisfied with the kind of healing that they get in traditionally western spaces even if I'm not saying like ah use umuthi but I'm saying just as a person holistically, this is what is going on with you. People want that and then they can pick and choose what applies to them*.

Sipho se Nkosi (SN)

SN is a 29-year-old female who is a clinical psychologist and a healer. SN did not specifically state whether they would prefer to be called a healer or not. In fact, SN used the word 'traditional healer' throughout the interview to refer to themselves. Very early into the interview, SN realised that their ancestors have not been informed about the interview that essentially discusses them. SN then had to inform their ancestors about the interview where they are the subject of study. After the ancestors were informed, SN felt their presence, "*Eh I'm even getting goose bumps my ancestors are here".*

Like MM, SN is also one who has different spiritual guides and also went through different trainings where the various spiritual guides were being acknowledged: "*there's different ancestors. So I went through umguni, I went through umdawo, I went through isthunywa*".

SN identified as Christian, and went on further to explain the differences between God and ancestors who made it possible for one to appease their ancestors and still be able to be pray to God while again acknowledging ancestors:

> *We don't pray to ancestors, we appease them, we acknowledge their existence. Uhm but yes we are Christian we pray, we just include our ancestors in the prayer*.

In the indigenous healing we believe ukuthi kuno nkulunkulu kube namadlozi, and then its nature and then it's us.

Like MM, SN went through their process of *ukuthwasa* while busy with their masters in clinical psychology and while an intern psychologist. As a result of her calling, she had a realisation:

so my experience of doing my masters was totally different. And then internship same thing, uhm so I was going through the process at that time. So I would be in (removed) during the week and on weekends I would be here in (removed) because my trainer, gobela is this side and I would see him on weekends.

SN was also one who had ancestors who guided her every path and decision about almost everything, including their career: "*we didn't know if I was gonna finish my master's degree or not but it turned out that my ancestors wanted me to finish*". As a result, SN, similar to PN only had *ugobela* as a guide, where needed, and did not need to go for *ukuthwasa* in the conventional way of staying with *ugobela* until the process of *ukuthwasa* was done: "*we will teach you and we just need him to guide you in the process but we are the ones that are training you so you don't need to stay at his house*".

Despite this view, SN went through a process of identity formation as a result of their duality: "*this was my life, but now who am I in this space of having this spiritual gift and also becoming a psychologist?"*

SN was one who particularly appeared to be mindful about the impressions that healer-therapy services would leave on the HPCSA: *"I think the struggle was when I was still trying to integrate the two worlds and being very careful with the HPCSA, trying not to get into trouble".* This could be as a result of the inability to separate the spiritual person from the psychologist, SN seemed to view this simultaneous training and practise as something that was meant to happen: "*I know I'm a spiritual person and I need to keep these separate but I realised that it's impossible"*.

Although the separation of the two identities seem to be impossible, the separation seems to be possible in some ways and not in others. Visibly, the separation is possible: "*hence you see I'm not wearing shoes? It is because now we speaking about them [amadlozi] but when a patient comes, I'll have to wear shoes".* So it is possible

that the attire is one of the aspects of the duality that healer-therapist have to contend with from time to time as the practice of psychology is formal and western, whilst that of healing is informal and African with a distinct attire that represents the healer's category.

In practice, as SN is unable to separate the spiritual being from the psychologist, SN always incorporated the two practices during therapy, but the spiritual part did not always reflect as spiritual but could be incorporated into the psychology practice perhaps unnoticed to the client. SN explained that "*I think it's more of a spiritual thing but how it happens is that immediately when the patient starts to mention that person, that person would come into the room".* SN further believed that "*the understanding of the patient makes them free to even talk about anything".* If a practitioner is able to consider the client's perspective then the client is free to talk about anything, which meant that the healer-therapist created a non-judgmental space.

SN referred to the importance and impact of shared language which is applicable to healer-therapy services where conversing about ancestors could be considered shared language between the healer-therapist and the client. This could either refer to speaking the person's home language or speaking about matters that resonated with them. *"Even if, like when you see a patient and you start eh speaking their language, that's when they connect with you".*

SN referred to a healer, who like herself, is not registered as a traditional healer and therefore cannot be held liable for their unethical behavior. Should a client need to complain or hold them accountable they would be unable to do, unlike with psychologists who can be held accountable. Alluding to bogus practitioners she said:

> *As much as ah as much as I would like to refer but I also need to be careful because of traditional healers that are not so genuine. With psychologists I can refer, if something happens then the HPCSA has them accountable.*

SN believed that healers like her are "*forming the integration and a lot of my other colleagues (inaudible) are also forming the integration. And I think there's still a long way to go but there's also so much hope."* This forges the integration between westernised psychology paradigms and the African healing paradigm through being a healer-therapist which other colleagues are also doing.

SN viewed her practice as a healer-therapist to be of an integrative nature. SN is hopeful where integration is cornered between healing and therapy. SN also referred to being hopeful as a result of ancestors making sure that those who are gifted with healing are also those who are interested in being educated. Being educated makes one occupy certain spaces which ultimately makes the gift of healing known to the population of educated people. *SN* expressed *"hope because of how now ancestors have become so clever that the people that now they go into, they also make sure that those people are educated so that they are also seen".* Ancestors want to be seen as making an impact in people's lives, they no longer want their work to be hidden. They are pushing to be seen by being in the lives of those who are part of the professions that are seen.

Grace Nxumalo (GN)

GN is a 31-year-old female who identified themselves as a neuropsychologist and a *sangoma*. At the time of this study their category neuropsychology was not yet official in South Africa, so this was not a HPCSA recognised registration category but a practice identity. GN is also a healer-therapist similar to GM who felt that the word 'traditional healer' did not adequately represent their work or identity as a healer. Her concern was that "w*hen you say traditional healer, that addresses some of the things but not (inaudible) what I do. So I prefer the word sangoma".* GN also identifies herself as a medium, over and above being a *sangoma*: "*so I can connect with people from the past life to the other world which is called being a medium".*

GN also spoke from the direction of being a healer who incorporated psychology in their practice, whereas the other healer-therapist primarily spoke from the point of view of being a psychologist who is also a healer. Advocating for the duality, she said: "*So what good enough for me to cleanse you, to give you imbiza whilst the mind can still create the situation".*

GN practiced African based mental health services because the DSM did not specifically address aspects of African mental health:

> *I practise as a sangoma and a neuropsychologist basically most- my passion is based on African mental health because of the experience that I had with DSM-5, which now we have 6. Which it does not really address the African mental health uh challenges that's why I decided to go into the profession of uh being a neuropsychologist and a sangoma.*

In her work GN never referred to having to separate being a psychologist or being just a healer. In all her descriptions, she presented herself as a healer-therapist practising from both modalities at all times. She contended that the advantage of her approach was that "*So as much as we do the work mentally, we also have to- within the spiritual we have to untie things, we have to unlock things".*

GN is a healer-therapist who has named the experience of having an ancestral calling and needing to unpack identity problems connected to an ancestral calling through psychology. Clients with identity questions, according to GN, would have spiritual depression, a depression connected to spiritual issues as GN said*:*

> *Spiritual depression is basically for those who have what you call a calling. They are called to be healers like me, izangoma. They are called to be abaprofeti, they are called to pass their (inaudible) in church. They are called to be izinyanga.*

GN appeared to be upfront in her approach to clients where she would advise client that they do need a particular type of treatment they are seeking but instead they need to get a different type of treatment based on their expertise and analysis of the problem at hand:

> *I've gotten to a place or I've experienced situations where I've said, no treatment as a sangoma all you need is to go and see a psychiatrist because you are not yourself, have burnout, you not thinking or functioning correctly so you need dualistic healing.*
>
> *I've found myself in situations where I say no to that treatment but saying yes to that treatment because of the situation of analysing it through western and through traditional ways.*

GN seems uncertain about the operation of a governing body for healers even though GN does have a desire for healers to have a governing body instead of just having associations: "*I'm hoping that ah soon we can be able to have a governing body but how it is gonna be set up I don't know because you can never govern yourself".*

As a result of the recognition of what the client needed, GN presented her dream in terms of integration.

> *I dream of dual or a 5-in-1 medical facility that addresses the person as a holistic to such an extent that when a medical doctor can see that, this is beyond my capacity can easily say, let me refer you to my*

colleague to help you with this problem. To such an extent when a traditional healer finds a TB patient and not give them imbiza that is not helping and say, no no no this is beyond me your CD4 count is low, can I refer you to this specialist that specialises in HIV? I dream of an institution that (inaudible) so that we assess you in a traditional way, we've assessed you in the western medical way but we've realised that you need mental health services. I dream of mental health practitioners saying, no but beyond me giving you counselling, beyond giving you medication, you need a life coach because you have a certain behaviour that continues to come forth that you need be helped in a meta-physical way because we need each other, one cannot exist with the other.

Do healer-therapists practice from a single paradigm and move to the next?

Some healer-therapists primarily positioned themselves as psychologists, and the healer identity was presented as a secondary identity. This was perhaps influenced by the interview settings. The healer-therapists indicated that they are often required to step out of being psychologists in situations where the healer was required and the psychologist was not required. The most powerful identity, although presented as secondary, was that of the healer where the healer-therapist indicated the impracticality of stepping aside from being a healer as this was embodied.

The healer was always present, therefore it presented a complex situation where the healer always creeped into the counselling session. This meant that the healer-therapist always incorporated both modalities into their practice. Incorporating both modalities required the healer-therapist to devise a strategy or have a certain approach in order to observe the boundaries between the two practices. The combination of both modalities was interpreted by the healer-therapists as offering a holistic healing modality.

In their experience, the healer-therapists often practiced from the western psychology paradigm to that of healing. However, the direction of practice was not clearly defined as dual practice often happened unknowingly. Healer-therapists therefore always embraced both practices instead of having a paradigm that they primary practise from.

Embracing both

The gift of healing can include that of psychology. It is not just the gifts of healing through divination but the gift of healing can also manifest in other forms. A psychologist is one who has a gift of healing, as GM stated*:*

> *So I was told that I was a healer first before I was ever a psychologist. Psychologist is just a western certificate, and I'm reducing it greatly but the gifts of healing and that is who I am. A psychologist is just one way of practising my healing gifts*.

Healing is complex and can be exercised in different contexts. Here, GM indicated that they are primarily a healer before anything else. Becoming a psychologist was just one way of having the ability to express their healing gifts in a different context.

SN, after struggling with the emergence of a dual identity, began to embrace the identity of being a healer-therapist. SN began to embrace their own duality because they said *"I think it's also because (name removed) I've owned up to my own identity and my own gift and I don't have shame over it that whoever does can just deal with themselves because I know where I stand".* Embracing one's own identity meant letting people deal with their own ignorance of duality. SN appears not to have the energy to deal with negative utterances of the identity of a healer-therapist.

It was meant to be that SN became a healer-therapist. Above that, becoming a healer-therapist was also informed by choice, in that, SN chose to embrace both and not take an either or approach. Instead of choosing to either become a healer or a psychologist, this healer-therapist chose to not choose.

> *SN: It wasn't a coincidence that I went through my process and then become a psychologist at the same time*.

> *SN: I chose not to choose because I wanted to embrace both.*

GM appears to share SN's sentiments in terms of not having an either or approach but rather incorporating both practices. GM was a healer-therapist who was unable to separate the psychologist from the African based healer in any context, in any situation. GM remains a healer-therapist regardless of what the context requires

contending that*: "I can't divorce myself of the psychologist and I can't divorce myself of the African based healer"*.

Dual practice was described as stemming from unconscious thoughts and intuition. Healer-therapists explained that even when trying to keep psychotherapy sessions in the realm of traditional psychology, somehow, the healer was always present because it was embodied.

> *PN: What I do and interestingly my therapeutic work, as much as I am trained as a psychologist but there will always be something that tells me to do something or ask this question. So it will even be more of an intuitive thing but I never thought it in that way.*

The ancestors were always there to guide the healer even when the psychologist was fully present. The healer had the ability to bring out things that the client had not yet brought up which is different from the role of the psychologist.

A healer-therapist was sometimes confronted with situations that required only the healer, requiring the psychologist to step aside. Even with the understanding that the client initially contacted the psychologist, the healer-therapist was able to judge what the situation required and had to be willing to let the psychologist step aside. Referring to a consultation where he had to do this, PN said:

> *PN: I said understand that I'm a psychologist, I understand my role but uhm, can we step out of that for a moment?*
>
> *PN: I would encourage for that to happen and if it needs be that it needs me to step out of being a psychologist and integrate that part, I would definitely do that.*
>
> *PN: One person came into my room and said, I think this is where God wants me to be. Psychologist in me separated, said don't entertain that but it resonated something to her cause she's Christian.*

A healer-therapist has to be flexible in their approach and be readily available to step out of one identity and into another.

PN: She's started like a sangoma now in the room, like how do I deal with this? The psychologist in me kept calm, I gave them a chance because the husband knows how to deal with her when she is in a trance state. Uhm something just said get a glass of water, prayed for it and she drank it and she calmed down and left.

Some cases required the psychologist to not only verbally step aside but physical as well. The psychologist stepped out entirely and the healer stepped in. The healer-therapist was then required to make the setting conducive to the healer. The healer-therapist always had to make space for either one of the identities to completely take over from the other.

PN: I have something you call isqamba in isbaqa in (removed) so it's a small one I just bought. She said there are going be times where you gonna step out from that formal chair, you put that and fold your legs like isangoma and start throwing ama thambo not ama thombo but I use sea shells and everything and anything else that would be revealed to me.

Completely stepping out of being the healer might prove to be impossible. The healer was forced to often re-direct their vision to fit into psychology. Here the healer was presented as the identity that takes precedence and may present subtly. GM cautioned that they did *"not really separate it unless there's an urgent need to separate it but even in the separation, underneath there's still the healer".*

Some healer-therapists rarely had the opportunity to plan for their sessions, whether it be the psychology session or the healer session because almost everything happened in the moment. Though they had an appointment, the direction that the consultation took was difficult to predetermine, so were the outcomes. As the healer was the dominant identity, even when the psychologist did not want to consult with a client, the healer would receive communication to consult with the client.

The study found that the *gobela* continued to serve as a supervisor for the healer-therapist. The healer always needed to use their psychology knowledge even where they were not entirely acting as psychologists.

PN: I have had a person who wants to consult with me and I said to her, I'm not in a position to do that but my gobela then said, you must go and see that person. So I will use my psychology hat but I would

not be a psychologist. That's how I think it would play out and you can't plan for when it will happen or how it will happen. It just happens in the moment and you take it from there.

The ability of the healer-therapist to approach a phenomenon using two worldviews, namely western and African ways, gives them the knowledge of the desirable treatments for clients which might be seen by some as eliminating the client-centred approach. For example, *GN* said that at times *"I've found myself in situations where I say no to that treatment but saying yes to that treatment because of the situation of analysing it through western and through traditional ways".* It may seem that the healer-therapist was denying the client the treatment they required but offering them the treatment they believe they needed.

On the other hand, MM saw herself as a healer-therapist who was able to separate the two identities. When the client required intervention from the psychologist then the client most probably met the psychologist. This is evidenced by MM*: "So if a person comes to me seeking to speak to a psychologist, they will meet a psychologist"*. MM had to ensure that the healer was not visible or present when the psychologist was sought for by just providing psychological services.

On the other hand, MM admitted to embracing both modalities all the time. A healer-therapist is unable to disengage the psychologist in a particular context or disengage the healer in a particular context. The healer-therapist attempted to present solely as a psychologist but the healer had a way of unknowingly creeping into the session. MM admitted that *"Oh yes sometimes I combine them. In fact I've- you see this is the tricky part. I think I combine them all the time".* All the time, the healer-therapist remained a dual practitioner where both modalities demonstrate to be synchronised.

It was probably impossible to expect psychologists to disconnect themselves of their healer identity and to expect a healer to divorce themselves of the psychologist identity. MM is a healer-therapist who expressed the impossibility of being oblivious to certain phenomena because of being in a certain context and in order to represent a particular identity at the time. She said: *"Because I can't leave u (name removed) the healer who understands traditional stuff or who understands spirituality and say, ok now I'm going to clinical practice, I will pretend like I am not aware of certain things"*. In practice, these two identities will always merge.

A healer and the psychologist in one person are forced to find a way to work alongside each other despite the differences of the two approaches. A psychologist is one who is led by the client during therapy but a healer is one who leads the clients by communicating with the client's ancestors giving them guidance. There are two extremes of the professions that are presented here where, in psychology, the client becomes the expert whereas in healing, the healer is the expert where a solution already exists, albeit in the spiritual realm. MM suggested a procedure where*:*

> *as the patient so you don't tell a sangoma what your problem is, a sangoma will tell you what your problem is and a sangoma will also tell you what you need to do. So they'll also give you advice, they'll also come up with a solution but in clinical psychology what do we do? We sit, the patient tells you what the problem is, you walk with the patient and help them find a solution.*

This presents a challenge for the healer-therapist where the boundaries of a psychologist and those of a healer would have to be clearly defined. It seems as if the healer-therapist is forever cognisant of the psychologist in the room and any interruptions to the psychologist-client relationship. SN explained what might be different with the healer: *"The one thing that we need to remember as a psychologist is that I can't introduce something to the patient. The patient always has to introduce something to me and we start reflecting on that"*.

When in a psychotherapeutic setting, ancestors communicated with a healer-therapist during the psychotherapy session. A healer-therapist most probably adopted a strategy to be able to deal with ancestors communicating during a counselling session. A healer-therapist tried by all means to be the psychologist and not the healer during this time, but the healer sometimes needed to intervene. In this case, the healer timed her interventions so that it does not appear as if the healer was interfering with the psychologist's interventions. A healer would need to disguise themselves as a psychologist in order to adjust to the clinical context. When asked how they differentiated, the respondent said that

> *MM: I think the difference comes in the intervention. So even if I see something about a patient in my clinical practice (pause), I will not- I will time my intervention and I will not tell a patient, like in therapy I will not tell a patient something that they have not raised or spoken about. I will not give them answers but does that mean I am not aware of what is happening? I am but I will wait. Interestingly, if I*

see something, if I'm shown something, a patient will then talk. So if they talk about it, then I will find a way to- to pose whatever I've seen either as a reflection or as a question as we normally do in psychology, [for example, ask] 'I wonder if you have ever thought or you know?

SN identified as a spiritual person. A psychologist was described as a person who is self-aware and is able to bring that self-awareness into the psychotherapy session. The self-awareness that was required of the psychologist made it difficult for SN to separate the psychologist from the spiritual person. Bringing the whole self means bringing the spiritual being. Reflecting on the potential conflict, SN said*:*

I know I'm a spiritual person and I need to keep these separate but I realised that it's impossible because as a psychologist, I have to bring my whole self into the room. So and including my spirituality because it is part of my identity.

Embracing both gifts of healing and psychology came with going through a journey of self-discovery on how to embrace a spiritual gift while also embracing being a psychologist. SN said they accepted that*: "This was my life, but now who am I in this space of having this spiritual gift and also becoming a psychologist? So for me it was also trying to fit the two together".* Directly related to owing up to a dual identity was figuring how the practitioner can co-exist.

While trying to embrace both worldviews, a healer-therapist like SN was doing so while being cognisant of her psychology code of ethics as prescribed by the Health Professions Council of South Africa. SN said: *"I think the struggle was when I was still trying to integrate the two worlds and being very careful with the HPCSA, trying not to get into trouble".* The phrase 'getting into trouble' indicated that the respondent anticipated that the HPCSA would frown upon those who are healer-therapists. This made it seem that the struggle with being cautious of the HPCSA was only at the beginning, where they were still putting the pieces of duality together which perhaps indicated that the struggle is no more. This can be confirmed by the fact that MM had practiced as a dual therapist for 13 years without attracting the attention of the regulatory body.

SN explained the need and importance to consult with one's ancestors and notify them of the space that a therapist is in. Ancestors needed to be informed of a different context that the psychologist practiced at even

when ancestors have gifted the healer-therapist with education and directed the healer-therapist towards studying psychology, as SN indicated*:*

> *With ancestors when you're able to speak to them to say, uhm I'm going into this process now and that, there is an understanding of that. I think at first it disturbed the process because I couldn't find my balance in it.*

There is acknowledgement that the healer and ancestors were sometimes seen as a distraction while in a therapeutic session. Nevertheless, ancestors were able to integrate into the psychologist's world making it possible to embrace both modalities. Embracing both modalities for some healer-therapists translated to the ability to provide holistic healing services. Providing holistic healing services meant that there was no need to practice from one paradigm and move to the next paradigm.

Some healer-therapists were of the view that because of their duality, they provided holistic healing. Some even suggested that African based approaches to mental health care were holistic in nature. This meant that African based approaches might not need assistance from other approaches in order to be considered holistic. Two of the participants said the following about holistic interventions:

> *GN: I started this year to do the holistic healing, because that's being the psychologist and being (inaudible) and I'm a sangoma*.

> *GM: So I usually say that I work in a- in a holistic ah healing perspective*.

GM indicated that incorporating African indigenous knowledge into mental health created a holistic understanding of health and illness for them. This required that the healer-therapist and the client share a common understanding and language of certain phenomena. GM contended that *"If it's applied in a way in which the language and understanding is shared then I agree in incorporating it into mental health because it just creates a holistic understanding of wellness and illness within uhm family, person, community"*.

MM viewed African approaches to mental health care to be a holistic in its approach. This would probably not include the psychological approach but just the African approach that is singlehandedly viewed to be holistic in its approach to mental health care. When asked to elaborate MM said the following:

It is good and it is one approach that is holistic. It's a holistic approach. It is firmly oriented and it is long term. It is financially affordable (laughs). You know? And and there's social support. So yah that it is my perception of uhm what do you call it? African traditional approaches to mental health care.

The application of African approaches to mental health care was dependent on the view of the receiver. The receivers were mostly described as westernised. The westernised clients were described as dependent on the context they were in. In this case it was difficult to incorporate African based approaches with clients residing in Johannesburg whereas it would have been much easier with those residing in villages because persons in villages were perceived to be cultural. This meant that those residing in Johannesburg were westernised and not so cultural. In describing the limitations of practising in Johannesburg MM said

…our patients, most of them, are westernised, to different degrees. Even though in villages, you might find people who are very cultural, who have very little knowledge of the western approach to mental health but if you practising in Johannesburg, there is always a challenge.

A healer-therapist obtained consent not only from the clients themselves, but also from the clients' ancestors. The healer-therapists' ancestors were the ones who needed to communicate with the clients' ancestors through the healer. Consent worked differently, as opposed to completing a consent form, the person who came to consult needed to be open to the healer-therapist communicating with their ancestors. The healer-therapist was guided by the client's sense of willingness to participate in the process of healing. GM referred to consent with the ancestors:

So consent is also very important if you want to work holistically cause the more open you are, the more I'm able- the more my ancestors are able to engage with your ancestors but if you closed off my ancestors are not gonna be like, kane what's the English word? Beloko becenga ah your ancestors to like share information so I don't work like that- we don't work like that.

Even when the healer-therapist was trying to separate the psychologist from the healer, the client, upon discovering the practitioner's dual identity was the one who requested responses of a spiritual nature. It seemed

that sometimes it was not the healer-therapist who embraced both, but the clients who wanted to embrace both worldviews. SN spoke about the clients who discover a dual identity:

> *I think with them finding out some of them would then want to tell me about their dreams, I had a dream like this so what do you think? What do you think I need to do? They push for that. So I always try to withdraw from giving that type of information. So I would try to explore it uhm psychologically but if something comes up as I say, I would use it as a question than to say this is what is happening*.

What guides the direction of the dual practice?

The guide of dual practice appeared to be the ancestors. The presence or absence of ancestors were a determining factor for the direction of practice. The presence or absence of ancestors determined whether the client was about to meet a healer, a healer-therapist or a therapist. The ancestors guided the healer-therapist, who in turn, used their communication with ancestors in the direction of practice.

Apart from the presence of ancestors, dual practice was guided by the client's understanding and own interpretation of their problem. The psychologist was able to let the client determine their own interpretation of the problem, and if the healer then needed to step in, they did so. The cases that are presented to the healer-therapists also served as a guide, whether the client needed the services of the healer, the healer-therapist or the therapist.

The presence of ancestors

In practise, ancestors sometimes showed up and if the client welcomed a spiritual connection and spiritual messages then a healer-therapist most often relayed such messages to the client. There was also subtle consent involved where someone was to receive messages from their ancestors. A client had to be spiritually open to receiving such messages and not just verbally consent. GM explained how she dealt with the presence of ancestors during a counselling session in general terms not connected to a specific client:

> *They would show up uhm in that kind of way especially if a person is open then I'll see images and whatever around them, then I'll ask them like, uhm are you opening to receiving particular messages?*

Say yes or no. Most often it's yes. Then I'll say ke I see a particular gogo. I see a particular mkhulu or I'm seeing the sea, what's your association with the sea?

SN explained how ancestors were always present in a healer's lives and often in their actions. A healer is one that relied on the guidance of ancestors and did not have much control over what would transpire in the healing session. Their actions were driven by an outside force being the ancestors. This was evident during the interview as SN did not initially inform their ancestors of the interview where they would be the topic of discussion so that had to happen, SN said: *"For me it's my ancestors talking to me during that process, and I'm able to listen to them while listening to the patient, I don't know how that happens."* Ancestors play a role in guiding the practice of SN as they were able to relay messages about the client during the session. SN also developed the ability to pay attention to multiple voices during a psychotherapy session but had no control over how she acquired this ability.

SN indicated that psychology is all about healing which made it easier for ancestors to be present in the counselling session. To the ancestors, psychotherapy is part of healing so there was nothing wrong with interrogating the spiritual aspects while simultaneously interrogating the emotional aspects. SN alluded to changing times, which made it possible for ancestors to work with a healer in a different context saying, *"times are changing and I don't think my ancestors would've worked with me here because the main focus is healing, isn't it?"*

It is almost like psychology and healing were not seen as separate entities by those who were also part of the spiritual world. The intervention of the psychologist was always permeated by the ancestors. The healer-therapist might have thought that they were working primarily as a psychologist but this might not have been the case as the ancestors were always present during the process. GM alluded to this dilemma contending the following:

Like what I've found out as I've gone deeper in my practice and understanding uhm my healing holistically is that even when I thought I was working traditionally as a psychologist, it's like the ancestors were saying, WELL have you noticed that you know like some deeper dark, not dark, some very deep stuff that people will be like, how did you know that?

PN explained that as a psychologist who had not fully embraced being a healer, the healer was always unconsciously present and engaging with the client. PN mentioned that *"I've been doing it without being conscious of it".* PN was unaware of the presence of a dual identity during therapeutic sessions. Just like PN, GM also shared the experience of having to unconsciously incorporate African based healing into their psychology practice. This implied that throughout their psychology practices, African based healing had been unconsciously incorporated into therapy. This meant that the two modalities were able to co-exist if they were able to be incorporated unconsciously. GM referred to her own experience of consciously and unconsciously incorporating African based healing which *"I started late last year incorporating- consciously incorporating ah African based healing into my practice".*

SN explained that a healer-therapist may not be an asset for every case. At times SN would have knowledge about a potential client, and again SN did not have control over the ability to know the client before meeting them. This meant that SN was able to spiritually connect with a potential client before the client has consulted with them. SN said *"so it's not every case. Sometimes for example I would dream of a patient ah before I see them."*

Ancestors were not always present, sometimes they were *absent* to allow the healer-therapist to still function as a *normal* human being. 'Normal' refers to functioning like other human beings who are not healers, that is, not having conversations with ancestors. It is not every case that required the presence of ancestors. A healer-therapist was still able to function as a healer-therapist even where ancestors had not showed up. Ancestors being absent did not eliminate the knowledge and ability of the healer-therapist to converse about ancestors. In elaborating about the absence of ancestors SN spoke about a client she once had:

> *I had a patient the other time that came and she was supposed to go for her process and I didn't know cause ancestors sometimes they don't show you everything cause I still need to be human. So I didn't know and we spent the whole session discussing her ancestors and where she is so in a more containing environment, but me not introducing things... but it's open.*

Where a psychologist was needed, a psychologist was available with limited interjection from the healer. Interestingly, boundaries were created with the psychologist but not with the healer. The direction of practice

changed upon the presence of the ancestors, until then, only the psychologist showed up. SN explained how she dealt with cases where ancestors were sometimes absent: *"If a message comes through and then that's when but usually the cases I deal with in a psychological way until something comes up"*

At times, the healer-therapist found that the client needed to address a spiritual issue during the psychotherapy process. Clients were willing to address these issues because African people are seen as loving and honouring themselves more. This made African people want to explore their African wisdom. When probed about whether clients were able to bring up spiritual issues MM said *"People are coming to terms or loving themselves more and honouring themselves more (laughs). You know? So people are not scared to ask me such questions but, yes to answer your question directly, for me, it's always the patient".*

MM referred to the clients being given the chance to make sense of their own experiences based on their worldviews. This gave the client an opportunity to also speak to their beliefs and values. This approach appeared to be similar to that of the psychologist where the client was the expert of their own experiences, as highlighted by the below quotations:

> *MM: Without fail, I always try to hear the patient's understanding of their symptoms. For me, that's important. Like to ask a person about their own beliefs, their own values, and it's a simple thing, what do they think of what they are presenting with?*

> *MM: My understanding what the patient- what sense they are making of their own experiences helps me to explore ehh information that can help me elicit whether the patient is psychotic or has a calling*.

The power of healer-therapy displayed in being able to afford clients the platform to talk about ancestral issues and be true to themselves. Whereas someone who is only a psychologist might not have engaged with ancestral cultural talk, a healer-therapist was able to engage with such material even where the healer-therapist was only presenting the psychology identity. To explain this, SN said the following:

> *I think with Black people that believe in the existence of ancestors, there's always certain rituals that they would say like, I haven't done this ritual and maybe that's why I'm in hospital. And it's important for them to be able to do that. And I think that integration is very very important but it's lacking and*

there's also health professionals that would, ok I don't understand this so I'm gonna disregard it because in my world it doesn't exist, and it puts the patient at a disadvantage because they want to be known for the person that they are.

A healer-therapist could understand the client's point of view without ridiculing anything they say. The healer-therapist created a space of acceptance, where it was acceptable to speak about ancestors, witchcraft and generational curses. SN spoke about a client's understanding as possible: *"When a patient comes and you're able to say, this is accepted here, you can speak about this. So that also helps the patient."*

The healer-therapists have experienced that those who came to them had usually been positive about the service they received, especially those who had knowledge about the dual identity of the healer-therapist. Clients did not usually fear the healer identity. When asked about how receptive clients are to seeing a healer-therapist, SN explains *"I've not had a client that said, you are a traditional healer so I'm not gonna see you. So I think it's more receptive. I've never had that and most of them know."*

Clients who were usually receptive to dual practice were enjoying the full benefits of it and there were few, if any, of the clients that had not been receptive to dual practice. The idea of being receptive to dual practice applied to both healing and psychology, it applied to the practice of being a healer-therapist. GM referred to clients who consulted with healer-therapists being those who had spiritually connected with their ancestors beforehand and have agreed to see a healer-therapist, which is why the clients did not feel uncomfortable being in the presence of a healer-therapist. GM spoke about this spiritual connection:

I haven't received any (inaudible), discomfort, you shouldn't be here, ah this is so freaky. Uhm but even when people say ukuthi, Oh gosh, ah (inaudible) they usually say LETS REBUKE THE DEMONS but because I've heard that and nami because I've been a born again Christian. It's like, oh ok. I understand where that comes from. I'm not moved or offended. Uhm or anything but also I think what you need to understand is that the people that come to me anyways- I think on a spiritual level have made an agreement with my ancestors or their ancestors. So I don't receive abantu who- who will be coming here to attack me in my practice. I've never received that before.

Healing occurred at a rapid rate where the recipient of healer-therapy services was open to engaging with the service received from the healer-therapist. GM also made the point of saying that in this regard, healing and psychology operated similarly, in that, if a client was open, fully engaged, and was accepting of the process of healing and therapy then the client was likely to heal quicker. GM said the following which shows this:

> *Which applies to therapy, the traditional therapy or psychology, that when you are open to being fully in the space and engaging with whatever it is that we're recommending or I'm saying to you, that you heal faster but when you're closed of or kind of resistant or it's like mmmm. Then the slowing… the the healing happens much more slowly. Which also applies with the African ways of healing. Ngoba the faster you- the more you open, the more you can grow, the faster you can heal.*

Being a healer-therapist meant having clients with contradictory views. The healer-therapist had to always be ready and willing to manage these views, depending on whether the person initially came to see the psychologist or the healer and ended up meeting a healer-therapist. GM recalled the following:

> *I have like, not a lot, a few kind of born again Christian clients and then it's like, eish yah eh this is going to be interesting uhm but then once they get to know me uhm we speak about it.*

The contradictory views were often towards the healer, and not the psychologist. Where the healer was quite visibly a healer in a clinical practice might have presented as a problem. The healer-therapist recognised the contradictions that might arise as a result of a client being Christian.

Sometimes clients were not necessarily those with contradictory views but those who were unfamiliar with healers and healing. Unfamiliarity did not always make the client resist that which is not known. Some clients welcomed that which is not known and actually proceeded with the therapy session. GM explained the process of negotiating with clients with contradictory view and questions asked:

> *…how you feeling about that? Uhm and then they'll say, no I'm not used to this way, uhm don't even do these things at home, I'm a born again Christian what what what what. Uhm and then usually they'll say, but ke let's see, I'll give it a chance and then I'm like yah let's see how it goes*.

There were those clients who were not receptive to dual practice, where at the slight mention of being a healer, the clients were immediately uninterested and never came back for consultation. PN admitted that *"immediately I mentioned something about ancestors and ubungoma and she switched off and she never came back until today"*. Some clients had confronted the healer-therapists about concealing their healer identities. It seems that should they have known; they probably would have chosen not to consult with a healer-therapist. MM explains how some clients preferred to be given a choice: *"Oh I've had some who then found out and then come back and say, when didn't you tell me? (Laughs). Yah those but those who become uncomfortable, I don't know. If there's some, probably they never came back (laughs)"*.

Cases of a dual nature

The healer-therapist referred to a case that would require both healing and therapy, but a case where the client is not someone who needs to go for *ukuthwasa*. The client is someone who presented with issues that needed to be dealt with in a spiritual way by a healer but also through counselling by a psychologist. This type of case was of a dual nature and the existence of such a case helped guide the direction of practice. GN explained cases of a dual nature:

> *...let's say for example a person who suffers from situational depression which ah DSM-5 doesn't uhm differentiate or keep touch of depression. They just state part of depression as depression but as I went on in my practise I realised that there are different kinds of depression so let's take situational depression for argument sake. Let's say a person went through rape for argument sake ok, and then you realise in the family that there's a pathology of ah the situation of a rape. You find that the great grandmother was raped, the mother was raped, and their going through it now. So now they got depressed because of the situation of rape right but when uhlola in the spiritual world you can pick up that the great grandmother went through it, the mother went through it and now she's going through rape. Which that is what... generation curse that we call in the spiritual world right. So now that family, it would not help me to only cleanse that spiritual grief in the family, it also requires me to offer counselling to the patient because they've suffered a trauma.*

GN referred to ineffectiveness where a client might only be healed in a spiritual way but not emotionally if only the healer intervened. This required the psychologist to also be present in order to deal with the emotional impact of the generational curse. GN proposed the following:

> *For me to cleanse them with only traditional medicine, it doesn't do good because this person still has thoughts that create situations because I was (inaudible) do you understand what I'm saying. So by her- by virtue of that suffering the rape situation that refers me to counselling as much as I would perform the ritual to what you call, to dismantle the rape pathology in that person. So that requires to what you call counselling.*

Even where a ritual by an African-based healer was recommended, the emotional turmoil might need to be dealt with. Because the healer-therapist is knowledgeable about emotional and psychological issues, they were able to recognise a need for this even where the healer is consulted. GM suggested that *"well just deal with ok, maybe abandonment issues around not being introduced to paternal side of the family and anger issues to mother who shot that conversation uhm or connection from happening"*.

The respondents were adamant during the interviews that there were cases that they had been presented with which were primarily psychology cases. These cases sometimes, upon interpretation, turned into African healing cases where ancestral and spiritual problems were identified. These cases were then sometimes identified by the client who sought psychological help first and thereafter asked for assistance of a spiritual nature. The client would have made an observation that the psychologist was also a healer, they then came back to the healer-therapist to ask for divination. GM referred to their experience with a client:

> *…he was wanting psychological uhm help. But then later uhm because there was uhm spiritual issues, he did come back and said like actually please can he have a reading. So then we went myself and his aunt and him to my gobela to do a reading and there were ah ah ancestral issues and other spiritual issues which we- which he had to deal with. So we gave particular recommendations and then he also had to do a cleansing ah which I then ah conducted. Uhm but he also had psychiatric issues so he's also still consulting his psychiatrist.*

Here the psychologist disappeared and the healer stepped in where ancestral rituals like cleansing rituals were conducted.

At times, spiritual problems took precedence over psychological problems where the healer-therapist recognised the need. This, however, did not mean that psychological problems were not dealt with at a later stage. It seems it was much easier for the healer-therapist to first concentrate on spiritual problems where the client was deemed a spiritual person. If the client was a spiritual person, they were less likely to object to spiritual connection and divination. GM confirmed this and gave the following example:

> *One who come…who came in like two or three months ago with headaches uhm, uhm ears ringing, like very sad and crying all the time uhm she came in to see a psychologist but ke she- she's been gifted. She's a medium, she didn't know. Uhm and so first session shem it was lit (laughs). It was lit. I was like, OK uhm your people are here, so I'm not going to go the traditional psychology right now. Can we hear what it is that they are saying? She's like, yebo gogo, let's do it. So people spoke, they asked me to lay hands on her, uhm her her- her lentuzas, what's this? Her ears were blocked, they opened up uhm she cried. She was burping all over here ah I gave her some water with uhm holy ash. After that, she was feeling a bit relieved, she's still with me right now because there's things that we still need to sort out. She's done e cleansing eh we talking about her emotional and psychological issues with her mother.*

Cases of a dual nature were often those where a client was someone who had an ancestral calling, but who actually booked a consultation with a psychologist but ended up meeting a healer-therapist. This is similar to the case presented above. The healer-therapist was then able to use details of the client's spiritual journey in a psychological manner. PN highlighted a case of dual nature where

> *this person who came for marital conflict resolution and then it became evident that this is about ubungoma bakhe or her spiritual journey so my take now when she comes back, I would tap into that as to what has been the process like and use that in a more psychological space yeah.*

A healer-therapist in this case was able to identify the client with an ancestral calling and also help them deal with accepting the calling in a psychological way and help clients deal with the emotional burden that comes with having an ancestral calling. PN said:

> *I've been having patients that have to do with a spiritual calling and they come from very far. They would say, we heard of you or I've heard of you on radio and I searched- there's a woman who searched for me for over a year and she found me.*

The practitioner explained that a client searched for the healer-therapist for over a year because of the dual identity and the possibility of being assisted psychologically and spirituality.

Cases of a dual nature were cases of people who had an ancestral calling but somehow wanted to consult with a psychologist because the ancestral calling threatened being in conflict with their identity. So the client was not necessarily seeking a practitioner to unpack their ancestral calling but a practitioner who can unpack what having an ancestral calling means for their identity. It became beneficial to then meet a psychologist who also had an ancestral calling and had personal experience of how an ancestral calling might conflict with one's identity. The person then coincidentally met a healer-therapist. SN explained:

> *I think when it's like obvious cases of someone coming here because they have an ancestral calling and they are in conflict with their identity then THAT would come up. Or if I see a traditional healer and they pick up that I'm also a traditional healer then that would come up*.

Cases of dual nature also existed where the client was consulting with a healer for spiritual issues but a healer was able to see that perhaps the spiritual issues have caused emotional and psychological damage. GN offered an example:

> *I once had a patient which now, she has completed her psychotherapy but she came in- though she had traditional problems but they have caused mental illness because they kept on reoccurring to such an extent that she was feeling depressed and hopeless, and we recommended a psychologist and she said, hell no I'm not doing those white people things. And when she found out that I was a psychologist, the*

way we have treated her and the way we have explained things to her from a traditional perspective she was like, ok let me just try the first session.

There were those clients who consulted with healer-therapists, primarily as healers where they indicated they have consulted with healers beforehand where cleansing was done. The cleansing was done a couple of times by healers where no healer recognised the need for counselling or what the client was going through emotionally. The healer-therapist possess that ability to see the emotional pain and deal with it through counselling. GN explained: *"Others would say, even though I've been cleansed 50 times or 20 times or whatever number, I only- the only thing I need is counselling. I was going through so much emotionally but nobody has ever acknowledged my pain."*

Whereas there were those clients who often concentrated on the psychological and emotional experiences that when they met the healer-therapist, it was almost like fate. It was fate because they had probably avoided going to a healer for a long time that when they met the healer-therapist they realised that it was now unavoidable. GM explained that clients *"usually go for the psychological and the emotional stuff and so when they come here, it's like ah yah neh, yah I've come to the right place even though I've been avoiding this for such a long time"*.

GN noticed in their healer-therapy practice that not all clients with a spiritual imbalance were those with an ancestral calling. Some were experiencing imbalances because of cultural rituals that need to take place but have not taken place. GN gave details:

Not everyone who has a spiritual-mental illness is ah called to be a sangoma. Some are having it because they just need to fix something in the family. Some are experiencing spiritual mental health because they just need to go ko thabeng what you call, circumcision.

A healer-therapist referred to receiving a diagnosis of schizophrenia from western trained doctors. It is assumed that an African healer would have viewed the experience using African wisdom and would have been able to tell that this person has an ancestral calling through divination. GN referred to their own experience of being a healer-therapist as being abnormal to those who did not understand it. GN suggested:

To the person who is experiencing that, they can say it's true but to the person who's not experiencing that which cannot be proven scientifically so within the western medical uhm profession I fall under schizophrenia. Till if somebody can invalidate that what I'm saying is true then I am a patient.

How do healer-therapists negotiate and merge the difference between the two paradigms of healing?

Merging the differences between the two paradigms of healing was dependent on the dominant identity adopted by the healer-therapist. The majority of the healer-therapists viewed themselves as mainly healers who are able to work with both modalities. They did not separate the two identities in practice. Negotiating the differences between the two modalities required the healer to reach a compromise with their client, especially where the client unknowingly consulted with a healer-therapist. Compromise was most often negotiated where the healer-therapist was dressed in a way that resembled the healer or their psychology practice was designed in such a way that resembled dual identity and when the client showed a level of discomfort and/or curiosity about the identity of the healer-therapist consulted. Only in rare cases where the client was also a healer or had an ancestral calling was compromise not necessary.

The differences

Just as the healer-therapist was able to judge the similarities between the two practices, they were also able to judge the differences. MM explained *"I think the differences with the two modalities, is the intensity and the depth in which uhmm this connection happens"*. The differences were identified as the intensity and depth of the connection between a psychologist and their client compared to the connection between the healer and the person who consulted with the healer.

The difference with the practice of a healer and that of a psychologist was that at the psychology practice, the client was the expert who told the psychologist what they were experiencing and what they dealt with. In the healer practice, the healer was the expert who communicated with the client's ancestors and delivered messages to the clients about what is wrong and how to fix it. This is illustrated by the below quotations:

SN: The difference with this practice and the ancestral practice is that when they come to my ancestral practice, they able to, I can- I tell them what's happening and then when they come here, they have to tell me what's happening.

MM: But clinical psychology says keep that distance between you and the patient. No touching, don't sit across the patient. You know? Just sit diagonally and stuff. So they are avoiding that direct contact.

GN referred to a case where a psychologist might have interpreted the client's behaviour as those of someone who had attention deficit hyperactivity disorder where a healer might have interpreted the same behaviour as those of a child who needed a cultural ritual. GN explained further:

In the west a child that is struggling with focus, they are being labelled as ADHD but in the traditional world chances are aba kwenzelanga imbeleko [chances are imbeleko ceremony was not conducted – an imbeleko ceremony is one where a child is introduced to the elders and ancestors], chances are umtwana a bam lobolanga [lobala was probably not paid for the child] or a bam hlaulanga [generally used by the Nguni clan when they want a person to pay a fine – damages].

In judging the two practices, healer-therapists referred to what appeared to be similar between a practice of a healer and a practice of a psychologist. The healer-therapist had the ability to examine the similarities and differences because they practiced from both worldviews. The one similarity identified was that of transference. MM explained further*:*

There are also similarities because if you go at a clinical psychology practice, they talk about transference and stuff. A patient making you feel one, two, three, right? You know what? Isangoma si lawula kanjalo cause when you walk in sit with you. If you suffer from a headache, I will feel the headache. If you thinking one two three, I will think what you thinking.

A healer was sometimes able to experience exactly what a potential client experienced right before the healer met the client. The healer was able to empathise with the client even before meeting with the client. In psychology, that is referred to as transference, but in psychology transference occurred during the counselling process not before the client and the practitioner met. However, in this case, it occurred before the client and the practitioner met. When asked how transference happens for a healer, MM elaborated:

Ah it was just a taste of mental illness where eh just in minutes, let's say a file of a patient is given to you, when a file, when I touched it then I start feeling exactly what the patient is feeling before they even walk into my office. So sometimes you feel like, I'm losing my mind.

The healer-therapist had the ability to fit into the client's shoes unconsciously. Before meeting the client, the healer-therapist could feel what the client was presenting with and when they met the client, all the feelings went away and it sort of made sense. MM further elaborated on transference saying, *"But what was interesting was that, the minute the patient walked in, I would become ok and the patient will present with exactly what I experienced before the patient walked in. And that was very scary for me".* The healer-therapist had the advantage of knowing what type of healing the client they were about to meet needed, once they became aware of this ability. This experience seemed as if it was scary for MM because it was unfamiliar and unconscious but once the practitioner became aware then they got to understand the strange feeling.

Reaching a compromise

Rapport was built by history taking around religion and ancestral beliefs. Following the history taking came the negotiation around how the healer-therapy services might resume, should the client be willing to resume. This often occurred where the client did not have the knowledge of the dual identity of the healer-therapist. At times, clients knew they were consulting with a healer-therapist and reaching a compromise was not necessary in that case. GM and SM elaborated on questions asked during history taking:

GM: Some of the the the assessment questions in the interview, the first sort of two contact times in our sessions, I'll ask you stuff around psychology but then I'll ask you stuff around and kind of generational, ancestral stuff. Uhm then like- then well come up with a plan on how to work together but sometimes other clients come in with an understanding that I'm both and so want both, uhm the psychologist and the gogo.

SN: But what I do is that even when I do history I would ask about, what is your religion?

To GM, clients often demanded a healer-therapist when they came in with the understanding of their dual identity. The healer-therapist did not have to negotiate their identities to those who came with the knowledge of their dual identity.

MM referred to adopting an appropriate approach when a client was consulting with a psychologist and when in a psychology context. MM referred to a practitioner being able to time their reflections to see if the client brought up a particular issue that would help with the healing process. The approach was adopted in order to create a boundary between the different approaches taken by the healer and by the psychologist. MM said the following about this:

> *It's the approach. It's the attitude that I take not giving the client answers when I'm in a clinical psychologist place. This is when I listen to the words, I will time my reflections. If it never comes up, then that's it because otherwise I'll be giving the patient something that they not ready to hear.*

If the client did not bring up the problem, then the psychologist did not discuss the problem. This was the healer stepping back, where the only practitioner needed in this context was the psychologist who was able to give the client space to bring up a certain issue as they became comfortable doing so.

Some psychologists set up their psychology practices in a way that indicated that they were also healers. The psychology practice would reflect as healer-therapy practice although items placed in the psychology practice were often open to interpretation by the clients. These items often seemed meaningless when in actual fact they were a representation of something more, namely a representation of a dual identity, as explained below:

> *PN: And in my practice what I have, it's just a small candle- it's just a fragrance candle. I've had different experiences of people's interpretation of that candle*.

> *PN: I put it as a fragrance uhm because it has a calming effect. Secondly, symbolic of acknowledging the space as sacred. So it has that deeper meaning.*

PN, in their psychology practice, had a fragrance candle that might seem meaningless to the lay person as it might have been common practice for persons to have fragrance candles in their offices.

The moment the healer-therapist recognised a level of discomfort in their client then they disclosed their duality and obtained informed consent from the client to proceed with the therapy session. GM said

> *If I can see there's a level of discomfort or like surprise or whatever. So I'll say ukuthi oh you can- as you can see I'm wearing my beads and my practice is like this, will that be a problem for you?*

The level of discomfort was often noticeable where the healer-therapist was visibly a healer by their clothing and also by certain items (for example, *imphepho*) placed in their practice. This suggests that immediately as the client walked in they were able to recognise that their therapist was also a healer.

Having identified that the psychologist being consulted was also a healer, there was sometimes a request from the client for assistance in understanding their African identity. Upon such a request, the healer-therapist then found a way to incorporate both modalities. However, if the client wished to only focus on psychological phenomena then the focus was most often on emotional and psychological well-being. GM contended:

> *If they coming for psychology, mostly it is- the focus is on uhm emotional and psychological well-being. However if there's a strong pull towards understanding the African identity then it sort of comes in into the conversation and then we find ways to uhm incorporate both modalities*.

Race

SN referred to Black African people knowing more ancestors and African belief systems, on the other hand, acknowledging that not every Black African person believed in ancestors. SN highlights below:

> *SN: No they need to hire more Black people that know about traditional stuff.*

> *SN: One thing that we need to acknowledge is that not every- not every Black person believes in ancestors, isn't it?*

Some healer-therapists alluded to having white clients who embraced *imphepho,* which was used in African healing. GM said *"I've had one- one white client yah. I even gave him imphepho, it was for a while, shame he was embracing".*

MM alluded to the existence of white healers, a healer is not only of Black (African) descent*:*

MM: Right now we need an integrated approach because the people that we are dealing with are integrated people, they are, and it's not only for Black people. This is an interesting thing ukuthi even white people are being called.

MM also indicated that the belief in African healing system was not determined by race because we could assume that Black African people had the knowledge or even wanted to embrace African healing. MM contended that *"even if a person is Black, you can't assume that this person understands e history yakhe. You can't assume that this person knows uhmhm anything about an African understanding or healing approaches in mental health".*

MM further indicated the importance of race in the African spirituality subject matter. It is not only Black Africans who were understanding of African cultures but white people too equipped themselves with this understanding. MM referred to her own experience of having an ancestral calling while studying her masters degree:

…yes, I would have been kicked out but luckily I spoke to someone who knew about this. Who knew about African spirituality more than I did at the time and this is a White guy. So I was saved by him.

What ethical dilemmas come up with dual practice, if any?

Practice ethical dilemmas often came up where the boundaries between the healer and the psychologist were not clearly defined. Ethical dilemmas were also present where the ethics of the psychologist were blurred by the healer. The ethical guidelines for healers were not clearly defined. The ethical dilemma faced by the clients was that the healer cannot be held liable for unethical behaviour by a professional body where the professional body did not exist.

Boundary issues

Creating a boundary in dual practice was pertinent to some healer-therapists. It was sometimes a boundary with one's own ancestors during therapy where the healer-therapist was receiving certain messages but chooses how, when and whether to relay the messages to the client. SN explained:

It's also me establishing boundaries with my own ancestors and myself and the patients because most of them know that I've been through the process so it's also me eh trying to create those boundaries, to say a different context, a different thing but my spirituality doesn't go away. Doesn't mean that when I'm here, I can't see things, it's just that I get to the point where I don't share so much of it.

The healer-therapist explained that they got to a point where they chose not to share much of their visions and received messages from ancestors because the context did not allow for that. Yet, this did not make the healer-therapist ignorant to their spirituality.

Even when creating boundaries between the two practices by only being the psychologist, the healer was always around. The healer was always around because the ancestors were always around. Creating a boundary in this case would be to phrase visions as questions as a result of what clients brought up during the psychotherapeutic process as SN explained:

I don't throw bones here. Uhm but there's stuff that people would come with- like let me give you an example. Like if I see a patient, and maybe a patient eh they- maybe they just lost someone and stuff like that and I start seeing that person in the room. Sometimes I don't know how it happens, I think it's more of a spiritual thing but how it happens is that immediately when the patient starts to mention that person, that person would come into the room. So in order for me to acknowledge that person I would ask the question of, do you feel like this person is always around you?

The healer-therapist would often attempt to phrase visions in a way that fits into the context of dual practice, being the psychology practice. SN said: *"I won't say to the patient, you know I'm seeing this like I would do in my ancestral house but I would ask it as a question to say, you get headaches here, you know that type of thing"*.

There are people who consulted with healer-therapists with the full knowledge of their dual identity even when they might have had contradictory beliefs. The fact that their practitioner was a healer-therapist was not something that bothered them because ultimately they were there to see a psychologist. Regarding this SN said: *"Even though people know that I am a traditional healer, I see different types of also other religions like*

Muslims, the South is filled with a lot of Muslims. Ah there's born again Christians". People consulted with the psychologist and chose not to consult with the healer even when they knew the psychologist was also a healer.

Healer-therapists would sometimes refer to other healers where there were potential boundary issues or where a healer-therapist felt that the healer in them would not have the capacity to assist a particular client. Healer-therapists like GM usually referred people to her *gobela* who was someone known to her and presented a danger of crossing boundaries. GM explained how she dealt with boundary issues:

> *…but then before then- I'd- if eh people came up with eh spiritual issues, I'd usually eh refer to to my gobela. Uhm and even now I still refer to her if there are going to be- usually for boundary issues.*

The referral also took place because the psychologist did not want to bring in the healer in the psychotherapeutic context. PN explained further:

> *PN: I'm not at the position of uku phosa amathambo or whatever I've got to do to guide people. I'm gonna have to give you the number of someone who can help you deeper. Referred and she went, uhm I don't know the follow up but it seems it has worked.*

> *PN: As much you would say to a person who is depressed, go and see a psychiatrist. Uhm what holds me back when I see that this is more of a spiritually inclined and divine case, I would say go to a healer. Uhm someone who would see things that we miss in the process.*

MM was a different healer-therapist, in that, they preferred not to refer clients directly to *isangoma* but led the clients to make that decision for themselves. MM said:

> *I adopt the clinical psychology approach when working with the patient, we will explore whatever their concern is. And if the patient needs to see isangoma then they are free to see a sangoma for themselves. I do not refer to isangoma but I will make the patient be comfortable taking such decisions.*

The healer-therapists also experienced that when their colleagues in psychology learnt of their healing identity, they privately referred or consulted with them regarding clients who bring up cultural, spiritual and ancestral phenomena during their sessions. GM and SN elaborated on this:

> *GM: I work in this perspective and another one came out and other psychologists were like, oh my gosh we didn't even know like there's sangomas in the group. Uhm and kind of the thing that's happened since then is that some of the psychologists will approach me uhm privately with clients who they feel need uhm both ah ah modalities of of healing.*
>
> GM: *If you don't have the the the African healing perspectives, there are limitations when you do psychological stuff and that's why some uhmm doctors or psychologists who don't know much about the space will refer to me because they know ukuthi I'm a gogo*.
>
> *SN: There's a positive outcome even with people that would come to me and say, I have this patient, how do I deal with this patient?*

Healing cannot be governed

A healer-therapist alluded to divination and throwing bones in their clinical practices as something that the HPCSA would frown upon. So the healer-therapist was forced to visibly keep the clinical psychology practice and the healing practice separate. It also seemed that the HPCSA or the clinical community had not reached a point of accepting that a healer-therapist would be throwing bones in their clinical practice. MM explained: *"…they separate and I would love to combine the two (laughs). Especially my clinical psychology practice but we not there yet right? Policy wise we not there yet (laughs)"*

Some healer-therapists were not registered with organisations that went along with the healer identity as much as they were registered with the HPCSA to go along with the psychologist in them. SN, who was described as taking guidance from her ancestors regarding the majority of their decisions, explained how their ancestors have not identified a genuine healer organisation and that is why they did not belong to a healer organisation, as yet. SN explained:

> *SN: My ancestors are very protective and I'm just waiting for them*

SN: I'm waiting for them to show me ukuthi this is an organisation that's safe that you can register with and that's genuine but right now I haven't found that.

The healer-therapist in this case referred to their experiences with genuine and non-genuine healers. Non-genuine and un-registered healers posed a threat to the society because they could not be held responsible for their actions or unethical behaviour should anyone need to do so. SN asked, *"Secondly, the gift itself is not tangible. You can't really know that I'm a traditional healer or not, isn't it?"* SN further referred to the difficulty of proving that someone is a genuine healer and it would, therefore, prove difficult to have a professional body regulating the practice of healers. The first thing would be the identification and providing evidence that someone is a healer in order to register with that professional body.

This sits in opposition to registered psychologists, where the HPCSA has mandate to hold a practitioner liable for unethical behaviour. SN proposed the following:

As much as I would like to refer but I also need to be careful because of traditional healers that are not so genuine. With psychologists I can refer, if something happens then the HPCSA has them. But I think there's a lot that are not registered like me and I don't know if there are traditional healers and they doing genuine work.

At the time of the study, the practice of healing was not regulated by a professional body. There was a Traditional Health Practitioners Act and there were traditional healers associations but that was about it. GN referred to it being easier to have to govern the practice of herbalists but not divination. GN suggested that

probably you could govern the medication side of it but things like ukuhlola which is called divination it's very difficult to govern it. As a result, we have associations as opposed to traditional- ah what you call, professional bodies you know.

There was no professional body whose aim was to protect members of the public by regulating the profession of healing. Only the profession of psychology is governed by the HPCSA. So a healer-therapist was half-governed. GN said *"I'm hoping that ah soon we can be able to have a governing body but how it's gonna be set up I don't know because you can never govern yourself".* Divination was difficult to govern because it could

not be scientifically proven to be true and existing while herbal medication can be scientifically measured and proven to help.

PN was one who was both an academic and a scientist which are professions that are sceptical about African healing, mainly because African healing was founded on methodologies that are non-academic, unscientific and unproven. PN reflected on their journey:

> *I'm at a stage now where again I can uhm I'm still waiting, the academic in me, the scientist always looks for, when is this happening? I'm looking for evidence and trying to make sense and I'm told unfortunately I'm at peace. There's no scientific evidence that can explain what is going on.*

What are the benefits and challenges one can experience with dual practice?

Psychology was helping but not helping

The challenge with going through the process of becoming a healer while going through the process of becoming a psychologist was that some practitioners interpreted their experiences using psychology. It seemed that having knowledge of psychology was somehow a disadvantage and prolonged the acceptance of an ancestral calling. SN admitted this confessing: *"I think what helped me is that when I was trying to find meaning of why this was happening psychology was helping but not helping because there were points where I thought I was becoming psychotic"*

The language, understanding and vocabulary for certain behaviours came from the knowledge of the western psychological framework. Some of the healer-therapists diagnosed themselves according to the psychological framework when going through certain experiences related to being a healer. MM elaborated on this:

> *MM: The only words that you have in your vocabulary to describe your symptoms are the words that pathologises experiences.*
>
> *MM: I even diagnosed myself with converse-conversion at some point. Not because there was then, because on that day I woke up in the morning and I couldn't walk. I was paralysed from my waist down and I sat in in at home and I was supposed to go the (removed), I was supposed to be there at 07h30 I*

think, I couldn't walk. But after a little while, maybe 30 minutes or so, I was ok again. So what do you call that? Is not conversion disorder? Most definitely.

Knowledge of psychology took precedence when going through an ancestral calling experience. The healer-therapist was mostly referred to in psychological terms when explaining their experiences of becoming a healer, as highlighted below:

MM: According to psychology, it is abnormal for me to to to see what I was seeing. It is abnormal. It is crazy. So I became convinced that I was mentally ill and every day I would go to home, look at the DSM-4, look at the symptoms.

MM: When you being called then you will have symptoms that are like anxiety and depression.

The healer-therapists could not dissociate themselves from the psychologist as much as they could dissociate themselves from the healer. This was reflected in the use of language related to psychology in describing those experiences that were not of a psychological nature. MM suggested that *"the minute you say to a person I think I'm having hallucinations. Look, it's a straight forward case, referral to psychiatrist, give anti-psychotics (laughs)."*

The healer-therapists referred to having symptoms like anxiety and depression, which were terms constructed in psychology which could be related to having an ancestral calling. This might add to the confusion of diagnosing someone with a psychological disorder whereas the person had an ancestral calling and needed to go for *ukuthwasa*. SN and GM elaborated on this:

SN: Sometimes Freud doesn't apply to us cause we don't know him. And sometimes I think the closest person that I would say applies to us is Jung with the collective unconscious and the archetypes. But (sigh) it almost feels to me like its more westernised and we get lost in that western way of thinking that now we try to conceptualise our patients there and they end up losing their meaning and even our own languages and tradition. And end up losing their tradition because now there's certain terms that we can't use because they not there in English, isn't it?

GM: Maybe a client will then ask, ok what's going on uhm with my spiritual world? And then I'll say whoa this is what's going on. Have you cleansed your house? Have you cleansed yourself spiritually? Uhm cause sometimes when you haven't done that, then it shows up as depression or anxiety.

GM: You are experiencing like deep anxiety. Uhm and then ask that and so you'll say oh no I haven't met my father, maybe he's died, so doesn't know you. And then it'll be like, so what's happening with you right now is because you haven't met your people, they are heavy on you and so when they are so heavy on you, it might show up as symptoms of anxiety. Uhm and they might be trying to show you particular things but because you don't know how to handle this, then it's just anxiety. You don't know how to understand what it is that's going on with you. However when you get introduced then to your paternal side of the family, you'll find that the anxiety will go away.

MM spoke about challenges associated with being a healer who was also trained in western science. The healer unconsciously used their western science knowledge to explain their experiences instead of using African wisdom. A person most often used language they attained and vocabulary available to them to explain their experiences. MM had the vocabulary and language of Eurocentric psychology and such diagnosed herself with a psychiatric condition. MM explained: *"Otherwise as a western trained young psychologist who was not exposed to eh an understanding of mental health in African- from an African perspective. I myself, had diagnosed myself with a psychiatric condition."*

The advantage of being a healer-therapist

The healer-therapist alluded to the importance of a psychology professional who acknowledged cultural phenomena. In their experience, a client sometimes looked for a psychologist who understood cultural variables, but the clients were not necessarily looking to be divined by that healer-therapist. MM clarified the following:

…even those who know that I am both. They come to… some come because they want to see a clinical psychologist that has an understanding of cultural issues but they still looking for a clinical psychologist and they will go and consult their own inyangas or isangoma.

MM also alluded to their own experience as someone who had an ancestral calling during their studies as a masters student, where they had multiple hospital stays and diagnosed themselves according to the DSM, but a psychology professional recognised that MM might have an ancestral calling instead. This was a psychology professional who acknowledged cultural variables and without them MM would still be going in and out of hospital with multiple diagnoses. MM explained further:

> *So I was saved- you see the importance of having ehh trainers in psychology that are aware of cultural-cultural what? Mental health issues and approach to healing. It's VERY important. So if professor, the professor that ehh at the school of psychology at the time, was not someone who had done a lot of research in this field.*

In the same vein that a client approached a psychologist who could have a conversation with them about cultural phenomena, the healer-therapists also experienced that sometimes clients approached them because they hoped to have a conversation with a healer who also understood that they are emotional and psychological beings. GN further elaborated:

> *GN: I've experienced situations where I've said, no treatment as a sangoma all you need is to go and see a psychiatrist because you not yourself, have burnout, you not thinking or functioning correctly so you need dualistic healing. But uhm touching or, we don't have ah treatment for you, all you need is to do is see a psychiatrist or all you need to do is see a psychologist. We've had so many cases like that to say, you continue to do this, nobody is bewitching you. You continue to beat your wife, you continue to possess (inaudible) your finances, nobody is bewitching you and you don't have a calling to be a spiritual practitioner, all you need to do is to go see a psychologist to find the root of your problem so that you can heal.*

GN happened to be *isangoma* that encourages other *sangomas* to educate themselves about therapy so they were able to advise their clients accordingly, whether the client needed *imbiza* or the client needed counselling. GN postulated that *"you've got izangoma who don't understand mental illness which I understand. And probably it used to be slow but there are traditional practitioners like me who understand it".*

In the African healing space, healers were likely to come across clients diagnosed with Bipolar and Schizophrenia. When the healer consulted with someone with Bipolar or Schizophrenia then the psychological knowledge came in handy. GM explained*:*

> *So it helps- it helps to have the- the psychological uhmm knowledge in terms of ah especially … the extreme cases abo Bipolar. I don't see schizophrenia clients however with the healing space, schizophrenic- in the African healing space schizophrenic patients might come through.*

GM referred to having the psychological knowledge and therefore might have been limited in their consulting. Healers dealt with cases that involved some trauma, therefore a healer who had knowledge of trauma and how to deal with trauma had an advantage because they could actually assist the client. GM further explained more regarding this:

> *…there's things that they can't access which I have uhm access to and there's also things which healers uhm African healers don't have access to which I have an understanding and capacity to understand. Like- cause we deal nakhona with a lot of trauma cases or trauma within the generations and because we are so open, I can start experiencing exactly what it is that you're experiencing or uhmkhulu wakho has experienced and so- then it's like vicarious trauma oh crap, now I have to pull back a bit but I also have an understanding psychologically of what this trauma means and the different ways in which I can take care of myself and what it means also for the client.*

The trauma felt by the client, and the client's ancestors somehow transferred to the healer who was able then to deal with the trauma both for the practitioner and the client because of the understanding of emotions and psychology.

On the other hand, there were those individuals who approached the healer-therapist with an understanding of the dual identity, meaning that the individuals then consulted with a healer-therapist deliberately. GN said:

> *It's just an observation that your needs are not uhm psychological or needs are not visual you have a trauma that you need to deal with. So there's no way that I'm gonna give you treatment because as-*

from a sangoma perspective, I'm not gonna cleanse you, I'm not gonna offer you treatment, I'm not gonna give you imbiza, you just need counselling.

Being a healer-therapist means having to deny the client a service they wanted in exchange of a service they needed. A client who consulted the healer looking for healing service from a healer-therapist ended up being referred for counselling services when the healer-therapist was of the view that these services were most needed.

Being a healer-therapist was presented as an advantage for the practitioner but might have been so for the client, at first. It was an advantage for the practitioner because they were able to pick up on issues the clients were not raising during the psychotherapy session which were the main sources of unrest in a person's life. GN explained that *"so the advantage of being a sangoma/psychologist, you can pick up things that the patient doesn't want to talk about which are the main problem to the behaviour"*.

For the client, the session might have seemed confrontational and therefore, uncomfortable especially if the client was there to see a psychologist and not a healer. The healer-therapist referred to a client being dishonest where it seemed that the client just did not reveal what had happened, yet. GN explained:

Once you go deeper and say no but you are like this because you were once went through rape when you were young and they like, I don't wanna talk about it. Ok you don't want to talk about it but it's coming up, that's is why you are like this because you are very dishonest.

It might have been that the client was not yet ready to disclose what had transpired, for example a sexual assault or the client just did not feel comfortable disclosing because it is not known at what point or after how many psychotherapy sessions the client was viewed as dishonest.

Conclusion and overall impressions

The healer-therapists positioned themselves and their experience from the viewpoint of psychologists who were also healers. However, in their narratives they centre themselves as primarily healers who were also psychologists. The healer was the dominant personality and was always active.

None of the healer-therapists seemed to be able to separate their two identities completely even though they expressed that this was sometimes possible. If the healer was present, there was not much that the psychologist could do besides alter their approach so as to accommodate the healer during the counselling session. Seeing as the separation of the two identities proved to be impossible, the healer-therapists' primarily embraced both identities even though it appeared as if healing was the first considered approach. Where the ancestors were present, the psychological problems were dealt with afterwards.

The presence of ancestors and the cases that presented themselves as cases of a dual nature were the guiding factors to the provision of healer-therapy services. The healer-therapists occasionally had clients who did not embrace healing in their daily lives and had no knowledge thereof, some of which were people of other races, This required the healer-therapists to reach an agreement with these clients in order to continue with counselling services. Where potential boundary issues existed, then referrals to other healers were possible. Interestingly, there was no mention of referrals to other psychologists who might not have been healer-therapists that the client would probably feel more comfortable with.

Ethical dilemmas arose, but these were not easily identifiable as the healer-therapists did not have a set of guiding principles for their work as healer-therapists. They had guiding principles as psychologists and as healers, but not as healer-therapists. Most of the ethical dilemmas would not be dealt with adequately because divination was difficult to govern and, as a result, the healers did not have a professional body that could hold them accountable.

In their work, healer-therapists found that the knowledge of psychology sometimes hindered their acceptance and understanding of experiences associated with that of an ancestral calling. Such experiences were then explained using psychological terms. In the same vain, the healer-therapists often referred to their clients' experiences using psychological concepts like hallucinations or anxiety. The healer-therapists did not name their clients' experiences using healing terms, instead they used the analogy of likening symptoms of a psychological problem with that of a problem to be addressed using healing.

CHAPTER 6: DISCUSSION

Introduction

The concept of transmodernity introduced in the literature review chapter can be used to eliminate the idea of the modern paradigm being an objective reality, which can also be linked to the idea of a non-existent universal truth (Ateljevic, 2013). The underlying message in transmodernity is not novel as it has been part of the postmodern critical turn in the humanities and social science since the 1980s as postulated by Ateljevic (2013). The work of healer-therapists can be referred to as being transmodern because it represents a paradigm shift from traditional psychology to incorporating spirituality or the other way around.

According to Makua (2019, April 24), there are different types of spirits that exist for every healer. For example, Makua (2019, April 24) lists seven spirits in IsiZulu namely; uMlozi, Isithunywa, Amabutho, uMdinki, uMnguni, uMndawe and Amakilimane. Mkhize (2011, October 21) adds that there are two types of spirits mostly prominent in Southern Africa namely: ***IsiNguni*** and ***Isindawe***. IsiNguni consists of two spirits (*imimoya*) namely: Umndiki and Umdawe. Isindawe has its own special herbs called *impande,* and is a type of healing that is rarely found in Africa.

It is thus important to dissect the different spirits belonging to the two types, being *blood spirits* and *water spirits*. Gogo Noklinda Mkhize in Mail & Guardian (2016, July 25) explained the different spirits, *the blood spirits* are those related to a person through blood and consist of uMndiki (named after Mandinka, originating from West Africa, the oldest blood ancestors) and Mnguni (named after Nguni, from Southern Africa, a family ancestor such as a great-grandmother and serves as a protector and guide).

Gogo Noklinda Mkhize in Mail & Guardian (2016, July 25) explained that *water spirits* are a result of relation through commerce and conquest and consist of umNdau (named after Ndau, from Southeast Africa, might be of European traders who interacted with one's ancestors), AmaLozi (named after Lozi, from central and Southern Africa, only *izangoma* have them) and IsiThunywa (prophetic spirit, *umthandazi*/prophet as seen in Zion churches). IsiThunywa do similar work to *izangoma* but are not initiated in any particular way.

Mkhize (2011, October 21) explains that some healers use different types of healing technologies namely: water, candles, bones (*amathambo*), small calabashes while other healers just rely on communicating with ancestors without using any other healing technologies. Four of the healer-therapists who participated in this study were Christian and three of them were discovered in church that they had a calling to become a healer. Similar to Thabiso Siswana who is a *sangoma* and worked in the corporate space exclaimed that she is still Christian as being a *sangoma* was a calling related to her culture which does not impede on her religion (Mail & Guardian, 2013, April 5).

The findings presented in chapter five left more questions than answers, as is reflected in this chapter because there was not much literature related to the existence and practice of healer-therapists. The chapter begins by illustrating the differences that emerged from the data between the two paradigms of healing before delving into the discussion. Table 6.1 refers to the similarities between being a healer and being a psychologist while Table 6.2 refers to the differences between being a healer and being a psychologist.

Table 6.1: Similarities between being a healer and being a psychologist

A healer	**A psychologist**
A healer is trained by *ugobela*: a senior experienced healer	A psychologist is trained by other psychologists, a senior psychologist with experience
Knowledge is passed down from generation to generation	Knowledge is passed down from lecturer generation to student generation
The main focus of the intervention is healing	The main focus of the intervention is healing
There is continuous learning through regular participation in others' *entlombe*	There is continuous professional development (CPD)

Table 6.2: Differences between being a healer and being a psychologist

A healer	**A psychologist**
The process of becoming a healer involves being involuntary called through various experiences, meaning that a healer never chooses to become a healer	The process of becoming a psychologist is voluntary and occurs through applying to study in an academic institution up until a masters level.
When an ancestral calling has been received, a healer-to-be may resist, postpone, delay, or negotiate with ancestors but eventually the process needs to happen otherwise it will catch up with the healer-to-be	There are no consequences for psychologist-to-be should they decide to delay or resist becoming a psychologist. Instead getting into a psychology master's programme is difficult due to limited training spaces and stringent selection requirements and processes and many do not make it
Space is unlimited, as long as one is called, they can become a healer	Space is extremely limited in terms of masters programmes offered by universities for one to become a psychologist

A healer does not always need to be formally trained, healing is innate and a healer can become by himself or herself with the guidance of *ugobela*, when needed	A psychologist needs to receive training through formal education up until a masters level
It is not a requirement for a healer to be registered with a professional body. Healers are sometimes registered with regulatory or advocacy healer organisations	It is a requirement for a psychology graduate to register with the HPCSA in order to refer to themselves a psychologist; this is renewed annually.
A healer is identified either by family members from a young age or by other people, like other healers which can also be prophets	A psychologist-to-be is identified through academic merit, by a panel of experts where the applicant first has to pass grade 12 and have an honours degree with at least 65% average
Healing lies within the spiritual realm	Psychology lies within the academic, scientific realm
A healer tells the client what their problem is by relying on communication with ancestors	The client tells the psychologist what the problem is and the psychologist guides the client to reflect on what they are going through
A healer often practices from *indumba*, using candles or bones for divination	A psychologists practices from an office-like setting and is guided by the DSM for a diagnosis and treatment options

Do healer-therapists practice from a single paradigm and move to the next?

How psychology is viewed

The Australian Psychological Society (2020) defines psychology as both a science and a profession concerned with how people feel, think, behave and learn. Psychology as a science is devoted to better understanding how people, societies and communities function in order to contribute to their betterment (Australian Psychological Society, 2020). Psychology as a profession and a science is dedicated to helping people and communities find solutions to real life problems (Australian Psychological Society, 2020). The healer-therapists are professionals who incorporate elements of spirituality with those of psychology, suggesting that human spirituality cannot be detached from the psyche (Baloyi & Ramoe, 2016). It is thus important to consider the elements that make up a person's psychology in order to understand how healer-therapists are able to incorporate spirituality in their psychotherapeutic work.

The healer-therapists seemed to put the healer identity at the forefront of psychology. The healer-therapists suggested that they became healers before they became psychologists despite some of the healer-therapists completing their psychology training before completing their training to become fully-fledged healers. The healer-therapists suggested that they became healers first mainly because they also mentioned that a calling to become a healer is recognised from childhood. Psychology became a way for the healer-therapists to formalise and put into practice their gift of healing. Some healer-therapists indicated that studying psychology was not a mistake but part of the journey. It is almost like the ancestors directed the healer-therapists to a career in psychology.

There are certain *special* people who are prone to study psychology (South African College of Applied Psychology [SACAP], 2019, February 7). There are also certain character traits that psychologists are suggested to already possess before they pursue their studies or to become successful psychologists (SACAP, 2019, February 7). SACAP (2019, February 7) also points out six character traits that a psychology student needs to have, these are; patience, empathy, ethical integrity, trustworthiness, communication skills, and open-mindedness. It is also important to note that psychology students need to demonstrate strong academic merits alongside prioritising their own development and have a deep sense of self-awareness (SACAP, 2019, February

7). Having certain special people prone to psychology is related to the healer-therapists having viewed their becoming psychologists as not a mistake. The healer-therapists are also special because of them being healers and also because psychology is also a profession of healing.

Access to study psychology

Allly and McLaren (2016, November 17) referenced research which indicates that learners attending fee paying schools are two to four times likely to quality for university studies than learners who attend no-fee schools in South Africa. The majority of psychologists are trained at universities, meaning that the healer-therapists in this study qualified for university studies.

There are five quintiles that schools in South Africa are categorised into based on the wealth of the community surrounding the school (Allly & McLaren, 2016, November 17). Quintile one schools are those who are amongst the poorest communities, and schools in quintile one, two and three are those who are not permitted to charge school fees, normally referred to as no-fee schools (Allly & McLaren, 2016, November 17). There is also a certain amount of funding received by all schools in all quintiles from the provincial education department, the poorer the school, the higher the amount received per learner (Allly & McLaren, 2016, November 17). Persons who studied psychology are usually those who come from quintile four and five schools which suggests that psychology as a profession is an elitist profession. The ability to communicate well in English and being able to modernise one's dual-service as described here might be a product of the type of school that the professional went to that allowed them access to psychology as a profession.

There are many graduate students who were attracted to the profession but are unable to access it; this is why a Bachelor of Psychology professional degree (BPsych) was introduced (SACAP, 2019, February 7). According to SACAP (2019, February 7), a BPsych can help one become a registered psychological professional faster than a Bachelor of Arts degree majoring in psychology. The four year BPsych professional degree leads to one becoming a registered counsellor with the HPCSA with the possibility of enrolling for a masters programme (SACAP, 2019, February 7). The traditional route to becoming a psychologist is to enroll for a Bachelor of Arts degree majoring in psychology, completion of an honours programme and then being selected into a masters programme taking about six to seven years (SACAP, 2019 February 7). The process and the number of years it

takes for one to become a psychologist indicates that only a handful of people have access to psychology and end up becoming registered psychologists.

The psychological paradigm position of power

The healer-therapists' view of psychology determined whether they began with a single paradigm and moved to the next and also determined which paradigm was likely to be in a position of power during consultation. The healer-therapists believed that they became healers before they become psychologists and this was partly because they discovered their calling of being a healer during childhood before deciding to study psychology. This view contributed to the healer-therapists choosing the healing paradigm over the psychological paradigm when they were confronted with what they believed was a spiritual issue. In the absence of a detection of a spiritual issue then the chosen paradigm was the psychological paradigm. The psychological paradigm was also chosen because the healer-therapists primarily practiced in their psychological spaces where the psychology paradigm held a position of power.

The work and narrative of healer-therapists reflected a certain position of power of the westernised psychological paradigm, in that the dominant paradigm and profession in the interviews reflected as psychology. It appeared from the findings that the healer identity constantly had to be negotiated with clients while the psychologist had a clear, defined role. Baloyi and Ramose (2016) referred to different psychologies that cannot claim a universal status, yet the western psychological paradigm has constantly done so. The western psychological paradigm cannot claim to have universal power as it alienates different realities (Baloyi & Ramose, 2016), in this case, it is the realities of Africans who wish to examine their spirituality and ancestral wisdom alongside their psychology.

The healer-therapists referred to the importance of the application of healer-therapy practice where there was shared language, knowledge and values. Baloyi and Romose (2016) posited that in the western psychological paradigm, African experiences are understood with the usage of foreign language leading to Africans being misunderstood and their behaviour being misunderstood and misrepresented. Perhaps here, medically unexplained symptoms could be the result of this misunderstanding. Medically unexplained symptoms (MUS) refer to a social and clinical predicament, it is not the name of a specific disorder but different disorders

(Kirmayer, Groleau, Looper & Dao, 2004). MUS refer to symptoms that have no positive medical diagnosis reflecting the limitations of medical knowledge to determine a clear diagnosis of symptoms that may have no scientific basis (Kirmayer et al., 2004). Symptoms of a spiritual nature such as paternity complications or an ancestral calling may not have a scientific basis and that is the reason for them being considered medically unexplained symptoms.

These MUS are often combined with depression and anxiety according to Nelson, Baldwin and Taylor (2012). Nelson et al. (2012) further suggested the MUS can be exhausting and disabling. Various cultural traditions provide explanations and theories related to different symptoms most of which oppose biomedical notions (Kirmayer et al., 2004). Different cultures have different explanations of medical and psychological problems that are most often related to family and community (Kirmayer et al, 2004). An acknowledgement of these cultural interpretations often gives a window into the client's condition and also validates the client's feelings which might be helpful in reaching out to the client during therapy (Kirmayer et al., 2004). Kirmayer et al. (2004) suggested that only through communication and cultural exchange can clinicians find explanations that seem sensible to clients and their families.

Misunderstanding the behaviour of Africans creates a view that the experiences of Africans is generally insignificant (Baloyi & Ramose, 2016). To curb this, Baloyi and Ramose (2016) suggest that the psychology profession (training and education) requires "a culturally anchored and fairly precise understanding of the concept of psychology" (p. 21).

An African perspective of psychology

The healing paradigm appeared to be a point of departure where a client presented with a problem that may need healing. In dual healing, psychology was the paradigm that followed once problems associated with the spiritual realm were resolved, that is, to deal with the psychological effects thereof. The opposite occurred where the client presented primarily with a psychological problem that the paradigm chosen was that of psychology. Although the healer-therapists primarily positioned themselves as psychologists (who are healers), this presentation could have been because of the study interview questions and interview settings.

The general consensus in this study seemed to be the idea of these modalities not being too far apart to be clearly separated in practice. Furthermore, these healer-therapists themselves could not separate their spiritual beings from the emotional and psychological identities that they embodied. They were adamant that they rather availed their whole selves as healer-therapists and where possible, make available both services where they believed that both services could help resolve or heal the client. Bakker (1999) states that as South Africa goes through social transformation, so too are healer-therapists transforming their profession to be relevant, Africentric and locally informed.

The healer-therapists were neither just psychologists nor just healers: they were able to offer an African perspective of psychology. Baloyi and Ramose (2016) argue for an African-conceived psychology and psychotherapy in their paper titled 'Psychology and psychotherapy redefined from the viewpoint of the African experience'. The healer-therapists offering an African perspective on psychology are redefining psychology and psychotherapy based on the African healing experience. Baloyi and Ramose (2016) argue that this gives rise to a unique epistemology where Africans have the right use their indigenous knowledge that adequately capture their unique ways of knowing and doing. They also argue for a decolonised psychology curriculum in institutions of higher learning to include concepts such as *umoya* which is central to the African perspective of psychology. This concept appears also to be central to the practice of healer-therapists.

In order to decolonise the psychology profession, Ahmed and Suffla (2013) encourage being critical about mainstream psychological approaches. In an era of decolonising psychology, there are other branches of psychology that have emerged. These branches of psychology that have emerged are usually specific to ideologies that have previously been excluded in mainstream psychology. One such branch of psychology is African psychology, which is pertinent to the topic at hand.

In an effort not to see the healer's point of view as being superior to that of psychology, some healer-therapists chose to consult with other psychologists and psychiatrists to establish the progress of their clients. These would be clients who were consulting with healers while they were also undergoing treatment in the western science. The question to be asked here is whether psychologists or psychiatrists would welcome that kind of consultation from a healer? Would psychologists and psychiatrists consult with a healer about one of the clients

they are seeing and share their client files with healers if a client has disclosed that they are also seeing a healer for spiritual healing? The healer-therapists shared that some of their colleagues referred clients or required input regarding some of their cases that required the expertise of the healer, which is a good sign.

It remains to be seen whether psychologists and psychiatrists would share confidential information with healers about the treatment of their clients and whether they would agree with having to wean a client off their medication or therapy treatment should a healer deem it necessary to do so.

Some healer-therapists referred to African-based approaches being holistic in nature, while there were some healer-therapists who considered their fusion of both approaches to be holistic. The healer-therapists could consider the possibility of their practice not being holistic for some of their clients and what it truly meant to provide a holistic healing modality. For example, some healers-therapists referred to having clients who are born again Christians and Muslims, surely these clients would appreciate a practitioner who could incorporate the word of God and Bible verses during psychotherapy, even though this is also a form of spirituality, albeit, a different form of spirituality.

One common question raised within literature is whether African healing modalities can be considered religion or psychotherapy in the face of mental health care (Janse van Rensburg, 2009). In response, the majority of writers who write from a psychological and psychoanalytic perspective saw the African healing modality as more of a psychotherapeutic approach than a religion (Janse van Rensburg, 2009). Contrary to this, representatives of African healers, upon the first draft of the Traditional Health Practitioners Act and upon submitting comments to parliament's Arts and Culture committee, described their practice as a religion (Janse van Rensburg, 2009). Gureje et al. (2015) seconded this by saying that African healing emphasises the spiritual world, supernatural forces or religion.

Race, culture and class

A healer-therapist said "shame" when referring to a White person who they encountered and who accepted *imphepho*. *Imphepho* is Africa's sacred herb with medicinal uses and it is widely used in South Africa as a medicinal plant (Soozi, 2015, March 14). *Imphepho* is used for many reasons namely as a sacred incense used

to call upon the ancestors, to cleanse energy and also used for prayer (Soozi, 2015, March 14). The use of the word 'shame' suggests that *imphepho* is seen as unfamiliar to white people and something that white people do not normally use and so is viewed as an inconvenience. The healer-therapist sounded surprised to encounter a white person who embraced *imphepho,* as if she did not expect a white person to embrace it. Another racialised encounter was offered by a healer-therapist who explained that their white ancestors, being the prominent ancestors, is sensible and educated and as a result, do not go into a trance and do not throw bones. The healer-therapist likened the white ancestors to someone who was educated, someone who was like a psychologist.

The racialised representation of identity can either mean that a non-white ancestor throwing bones and going into a trance exhibits the behaviour of someone who is not educated, and not sensible, that is someone like a healer. An educated, white, sensible person would not do that as they would behave accordingly. This suggests that there is behaviour attributable to a white person and behaviour attributable to a Black person and when a person does not act as 'expected', there is judgment. None of the healer-therapists mentioned experiencing the presence of ancestral spirits and spiritual guidance when consulting with white clients or clients of other races or belief systems.

None of the healer-therapists specifically spoke about having to use the healer for a client who is not Black, as this only related to embracing *imphepho* for a White client. The findings did not specifically point to the concept of *umoya* being relevant to people of other races, although this was specifically the experience of the healer-therapists interviewed for this study, where other healer-therapists might have had different experiences. Suffice to say that there are also white *sangomas* who might be healer-therapists who might have different experiences, as those in Wozniak's (2009) study.

What guides the direction of the dual practice?

Ancestor guidance

Spiritual problems stemming from the clients are a guiding factor to the direction of dual practice. Spiritual problems are most commonly addressed by consulting a diviner who is guided by ancestors in their work. The work of diviners stems from the African ontological framework. Baloyi and Ramose (2016) contend that the concept of life forces (ancestors, *badimo, abaphansi*) cannot be ignored in African ontology. African ontology

holds the view that life is comprised of two life forces, the good and evil, belonging to the reality of invisible beings (Baloyi & Ramose, 2016). These life forces manifest themselves in human behaviour and without the intervention or protection of good life forces, human beings will suffer (Baloyi & Ramose, 2016). Healers are those chosen by ancestors to be agents of these life forces, to be the bridge between the good life forces and the community as postulated by Baloyi and Ramose (2016).

A person turns to their ancestors to understand the why, how, when and where of the problem. The *badimo/abaphansi/*ancestors would be consulted through the healer to find out if they were pleased or displeased about something that transpired in the person's life (Baloyi & Ramose, 2016). This is why healer-therapists were able to communicate with their client's ancestors about something that transpired in their lives so as to determine whether their spiritual problems were as a result of ancestors being pleased or displeased about something or whether it is a psychological problem.

How do healer-therapists negotiate and merge the difference between the two paradigms of healing?

Identity negotiation

The healer-therapists exclaimed that they are able to branch out as either healers, psychologists or healer-therapists. The healer-therapists did not adopt an either or approach. Even in identifying themselves, the healer-therapists made sure to give an identity that captured all that they did, from the psychological space to the healing space.

In their practices, the healer had to be hidden but the psychologist had all the power to be visible. This was also because from the view of healer-therapists, it seemed as if people primarily consulted with a psychologist. Some clients were most often amazed to find out that a practitioner was also a healer. A healer-therapist often had to negotiate with their embodied healer identity depending on the spiritual problems of the client. The healer-therapists also had to reveal their healer identity and negotiate with their clients about their healer identity yet the negotiation did not happen to the psychologist; demonstrating that it was the healer identity that was challenging to navigate around.

Some African healers in a study conducted by Sorsdahl et al. (2010) suggested that allopathic health professionals did not want to work with African healers because they did not view them as effective or valuable

co-workers. Additionally, those allopathic professionals mistrust and were generally reluctant to work with African healers as mentioned by Sorsdahl et al. (2010). The mutual lack of respect and understanding between western and African healing approaches to mental health is sometimes reflected in the ongoing debates in the South African mental health care system as to *whether*, *why* and *how* African healing can form part of the formal mental health system (Sorsdahl et al., 2010).

Potential ethical dilemmas in dual intervention

One of the dilemmas that clearly arise from this approach is if a person intends to consult with a psychologist but ends up consulting a healer-therapist and the healer-therapist suggests an ancestral ritual for the person to get well, what happens when things go wrong and the person does not get well? Does the blame go the psychologist or the healer? Who governs that? Who is accountable? Where does the person lay a complaint because the practitioner is dual?

Healer-therapists pointed out the HPCSA might not be pleased about their duality and that is why they attempted to keep their practices separate. This means that the healer-therapist might not have disclosed their healer identity in their psychology practice profiles. This suggests that some clients may consult with a psychotherapist without the knowledge of the duality of the practitioners they booked a session with. There are two scenarios that could be present here:

> Scenario one: a psychologist does not disclose their healer identity which could seem misleading, deceiving and wrong because they do not give their clients the liberty to choose to consult knowingly with a healer-therapist. So some clients might not be pleased about the hidden identity of the psychologist.
>
> Scenario two: a psychologist discloses their identity in their psychology practitioner profiles which then means that clients might turn away firsthand and the HPCSA might be displeased with the healer-therapists. The HPCSA (2016) general ethical rules which apply to all professionals registered under the HPCSA specify as follows in terms of multiple registrations:

According to the HPCSA (2016) a health practitioner who holds multiple registrations with more than one statutory council or professional board or in one or more categories within the same professional board shall at all times ensure that:

1) No conflict of interest arises from such multiple registration in rendering services
2) Clients have to be clearly informed at the beginning of the session in what capacity the health practitioner is practising from
3) Informed consent is obtained from the client in regards to the previous point
4) Clients are not consulted in more than one capacity and are not charged fees based on more than one such consultation
5) Clients should not be consulted by the same health practitioner in more than one capacity
6) The ethical rules which are applicable to the profession that health practitioner is practising from are strictly adhered to.

The abovementioned ethical rules pose a problem for healer-therapists, specifically point number 5, where healer-therapists feel the need to intervene in a dual manner. The fact is that the healer does exist, so why must their healer identity be debated and hidden. In January 2020, there was a debate on social media, which was started by a healer-therapist advertising their services (Mkhize, 2020). For example, a clinical psychologist who is also a traditional healer has advertised her services in her website saying that she is both a clinical psychologist and a traditional healer (NPK clinical psychologist, 2017). NPK clinical psychologist (2017) mentions offering an infusion of traditional healing and psychology services while adhering to the rules of the HPCSA. Someone made several comments about this advertisement mainly opposing a psychologist who is also a healer. The person kept questioning how a psychologist can be permitted to also become a healer. The person further spoke about contacting the HPCSA about the matter (Mkhize, 2020).

Questions of consent

The healer-therapists often had to reveal their dual identity to their clients. The interactions made it seems as if the clients booked a session with a psychologist. The healer-therapists explained and made it seem like their dual identity was revealed to their clients at the beginning of the session. This made it seem as if the clients

were not informed before the session about the dual identity of the healer-therapists. The clients found out when they were already there for psychotherapy and the clients had already seen the visibility of the healer-therapist.

Clients only finding out about the identity of the healer-therapist at the start of the session raised several questions. Was it not rather late for the healer-therapist to ask the client whether they would be comfortable when client had already arrived for the session? If so, when was the right time to reveal dual identity so that the client has reasonable time to make an informed choice to either opt in or out? If the client opted in, did the client pay the psychologists for reserving that hour for them? If the client had already paid, did they get compensated for wasting their time and approaching someone who is a healer when they would have chosen not to? How much time should be given for consent?

The healer-therapist could choose to be a psychologist and accept bookings where a psychologist was needed even where the psychologist was also a healer. This also raises a concern about whether healer-therapists were only supposed to see clients that would agree to see someone who is also a healer. The problematic identity in this clinical space seemed to be the healer and not the psychologist. This prompts the question: should healer-therapists have two consultation spaces? Some of the healer-therapists in this study do have separate consultation spaces, one for the healer and one for the psychologist but they still manage to intervene dually in both practices.

Some healer-therapists referred to being able to step out of being a psychologist in instances where they needed to do so. The healer-therapists referred to the healer who was always present regardless of the context. In certain cases, the healer was not visible, for example, there were no bones drawn or used in the psychology practice, there was no *imphepho* in the psychology practice, there were no candles, the healer was not in regalia that resembled them being a healer, and no beads. Even when these were not visible, it did not mean that the healer did not receive messages or could not communicate with the ancestors of the person in front of them. Even without all the external elements that represented a healer, the gift of a healer is innate, embodied and is not ‘worn’.

Some healer-therapists explained that they adopted certain approaches to ensure that messages received by the healer were transmitted by the psychologist in a way that sometimes made it seem like it is the psychologist that was picking up those issues. Again, the challenging identity here was that of the healer. The healer was the dominant identity in that if a client presented with a spiritual problem, the psychologist immediately stepped aside so that the spiritual problem could be dealt with first. Then the psychological or emotional ramifications of the spiritual problem were dealt with as a secondary issue. The work of healer-therapists was centered on finding a common ground and devising strategies to not cross any boundaries of the psychologist by involving the healer.

The healer being presented with images and reflection from ancestors may have disturbed the process of psychotherapy. The healer was always aware of what was happening in the client's life and could have been waiting for the client to reveal that, at the same time perhaps not paying attention to the process of getting to a point of comfortability for the client. At the same time, not having to reveal certain reflections by the healer could have been damaging to the healer.

Billing

Based on the above information about the disclosure of dual identity, it can be seen that it is unfair for a client to be billed for a service they did not ask for. At the same time, it is unfair to a healer-therapist to provide two services for the price of one. The healer-therapists in this present study did not mention anything about billing where healer-therapy services are provided. The situation would be different for a client who consulted knowingly with a healer-therapist and a client who did not anticipate consulting a healer-therapist. Is this type of client then obligated to pay for both services when they did not choose to be offered both services? The HPCSA (2004) ethical rules do not permit a client being charged twice where a practitioner holds multiple registrations.

The healer-therapists spoke about clients who made bookings to see them because they are healer-therapists. This also raises several questions; how does one make a booking? To whom does one make a booking: the psychologist, the healer or the healer-therapist? Psychology fees vary per region and per practitioner, typically a

psychologist would charge between R350 and R1200 per hourly session (Arderne, 2019, April 3). Then would a client pay the psychologist fees and also the healer fees?

In Human (2007) a healer who is a nurse indicated that they do not charge a particular amount for healing services, where a simple *thank you* or fifty rand was sufficient. Another participant in Human's study said that some clients are poor and cannot afford to pay for services yet this does not stop services from being provided. Another healer in a News24 article by Khanyile (2018, July 22) reported to charge R300 per session and another charges R100 to R150 for an initial session and R500 up to R1500 depending on the type of treatment required, for example, cleansing.

Would it be ethical for a healer-therapist to charge twice: for the psychologist and for the healer if the person was offered both services? Which profession would determine whether it is ethical for someone to be charged twice? How will medical aids be prepared for dual healing invoicing? Will medical aids have to pay double the price? The HPCSA (2016) ethical rules outlines above do state that clients are not to be billed twice for services rendered so it would be unethical for a healer-therapist to charge a client double the price.

Referral system

There are four types of duality referred to in the present study. Firstly, that which works in isolation where a psychologist acknowledges African knowledge systems and would refer a client to a healer. Secondly, that which takes place in the same working environment with psychologists and healers working together and are able to refer within the same organisation. The third type is that which takes place in the same consultation room where a client can consult with a healer and a psychologist simultaneously and these practitioners can then consult with one another. Finally, that which is the focus of this paper, where a practitioner is able to offer both services as a healer-therapist without referring or consulting with another professional to obtain both worldviews.

Interestingly, some healer-therapists mentioned referring a client to their *gobela*. A *gobela* is a healer's trainer and a healer's healer. This is the same as a psychologist referring their clients to their own psychologist when they felt they cannot consult further with the client. Before discussing whether the practice was ethical because the practitioners knew each other, the researcher discusses the supposed reason behind doing so which may be

the political economy. Money cannot be sent elsewhere when the practitioners knew someone who may need it, so they referred to that person they know instead of money going to a stranger.

Some healer-therapists indicated referring clients who came to see to their own *gobela* for cleansing and divination. This raised questions about whether this type of practice is ethical especially since the healer-therapists referred to bumping into these clients and also cleansing these clients themselves. What then happened to the psychologist and client relationship which discourages formation of dual relationships?

The HPCSA (2004) rules of conduct pertaining specifically to psychology refers to multiple relationships, which occurs when a psychologist is in a professional role and another at the same time with a person or an organisation. A multiple relationship can also occur where a psychologist promises to be enter into another relationship with the client in future (HPCSA, 2004). The HPCSA suggests that a psychologist should refrain from entering into such multiple relationships where the relationship could impair the psychologists' ability to be objective and competent in executing their duties as psychologists or otherwise risk exploiting their clients. A psychologist shall also take reasonable steps in resolving a potential harmful relationship especially where a psychologist may be seen to be exploiting their power over a client (HPCSA, 2004). A psychologist shall not engage in a self-enhancing relationship with a client until after 24 months after the termination of their contract with a client and before terminating, the psychologist is expected to refer the client to another professional to ensure continuation of services (HPCSA, 2004).

Some of the healer-therapists referred to accompanying a client to *ugobela* for a cleansing ritual. This approach also raised several questions since the practitioner is both a healer and a psychologist. A psychologist would refer a client but not accompany them to the referral point because psychologists are meant to keep a distance when it comes to their client's lives and leave their clients to make their own decisions.

A healer on the other hand might be more involved and present in their client's lives and a healer would accompany a client to a referral point until they are healed. Again, where does a healer-therapist draw the line between these two professions they are part of? The boundaries of the psychologist-client are then blurred or non-existent in this case. What happens if the client did not want to do the ritual and feels that they are making

the decision influenced by the healer-therapist's position as a healer? The latter question brings in questions about liability on the part of the healer.

Liability on the part of the healer

Some healer-therapists explained that they did not include their healer practice and ornaments into their psychology practices because of the fear that the HPCSA might not approve and in fact, deregister them as psychologists. Assuming that the HPCSA prohibits the practice of a dual healer, what reason would the HPCSA have to do so? Better yet, how is someone who is a dual practitioner supposed to practice? Does a dual practitioner have to declare to the HPCSA that they are also a healer and that they might unconsciously and unintentionally convey messages to their clients during a psychotherapy session? It was already discovered that a healer-therapist might be unable to separate their identities no matter how much they attempt to do so, the healer is always present.

What happens if the healer-therapists tell the HPCSA that they cannot suspend their healer identity in a psychotherapeutic session? Does this mean that healers should not be psychologists? That healers should not have other professions? According to the rules of the HPCSA (2016) a practitioner can have multiple relationship as long as this relationship is clarified at the start of the session and also the client is to be consulted based on one of the identities of the practitioner and not both at the same time. This presents an ethical conundrum because a healer-therapist sometimes presents both identities during the psychotherapeutic session.

Healers are not obliged to belong to a professional body. It is then worth asking how healers make sure that they are liable for any unethical practice? Especially healer-therapists because then they would most likely be reported to the HPCSA. For example, what if a client has a complaint about a healer taking them to *ugobela* for a cleansing? What if the client feels robbed when their cleansing seems not to have worked? Who then takes responsibility: the psychologist who was initially consulted or the healer? But how then does the public ensure that the healer is liable for their actions?

The role of healers in South Africa and other African countries has continued to evolve over time. This has resulted in recognition from government departments that healers have an important role to play in the world of

healing (Thornton, 2009). This means that the work of healers can now be removed from the 'othered' population. This recognition has led to the establishment of the Traditional Health Practitioners Act, the recent Act being number 22 of 2007 which was assented to on the 7th of January 2008 (Traditional Health Practitioners Act, 2007). The aim of the act was to establish an interim Traditional Health Practitioners Council and to provide a framework for the regulating the delivering of African health care services (Traditional Health Practitioners Act, 2007). The establishment of such a policy demonstrates a positive move in the South African legislation.

The aim of the Traditional Health Practitioners Act is to ensure quality services are being provided and to manage amongst others, registration and training of students and professionals (Traditional Health Practitioners Act, 2007). The practice of traditional healing (referred to as African healing in this study) refers to "the performance of a function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practice" (Traditional Health Practitioners Act, 2007, p. 3). The different categories of African healers listed and defined under the act include diviners, herbalists, traditional birth attendants and traditional surgeons (Traditional Health Practitioners Act, 2007).

The practice of African healing includes the following:

- To maintain or restore physical and/or mental health functioning
- Diagnosis, treatment and prevention of physical or mental illness
- To rehabilitate individuals to enable them to return to normal functioning with their families and communities
- To physically and mentally prepare an individual for various stages of development, including puberty, adulthood, pregnancy, childbirth and death (Traditional Health Practitioners Act, 2007).

The act and the above-mentioned practices of African healers bring change to the face of mental health in South Africa. Although this change remains on official papers with little practical application observed. The Act signifies the importance of a multi-cultural and inclusive approach to mental health care in South Africa by emphasising mental health where African healing modalities are concerned (Janse van Rensburg, 2009). The above-mentioned different practices exclude professional practices of an individual also practicing under the Pharmacy Act, Health Professions Act, Nursing Act, Allied Health Professions Act or Dental Technicians Act or

any activity that is not related to traditional philosophy (Traditional Health Practitioners Act, 2007). The exclusion of different practices is problematic because it might mean that dual practitioners cannot be included under the Traditional Health Practitioners Act, as they would be included under the Health Professions Act.

Healers do not have official oversight into their work or medicines provided to their clients in South Africa despite parliament passing the Traditional Health Practitioners Act in 2007 according to Khan (2012, November 15). The national organiser for the Traditional Healers Organisations (THO) said there were about 183 000 practitioners in South Africa, of which, only 72 000 are registered under THO (Khan, 2012, November 15). The national organiser proceeded to call for a statutory body in order to deal with malpractice complaints (Khan, 2012, November 15).

In 2014 the Traditional Health Practitioners Act was passed to prepare for the regulation of healers, additional regulations were published in late 2015 (Street & Rautenbach, 2016, January 21). Street and Rautenbach (2016, January 21) further postulated that some healers have been criticising the regulations as they are seen as unrealistic and unworkable. Street and Rautenbach (2016, January 21) postulated that South Africa wants to regulate healers but this will not be easy mainly because of the requirements placed on healers for them to be registered. The requirements are that healers will have to apply to the council to be registered and pay a R200 fee for a practice certificate before they can practice but the registration of an applicant will only happen if the registrar appointed by the minister of health is satisfied that all requirements have been met (Street & Rautenbach, 2016, January 21). The requirements according to Street and Rautenbach (2016, January 21) include;

1) Must be a South African citizen
2) Provide character references from persons unrelated to the healer
3) Proof of qualifications.

The greatest advantage for healers being registered is that the public can be protected from non-genuine healers. Street and Rautenbach (2016, January 21) outline additional requirements from the proposed regulations that make it difficult for healers to be regulated, which are:

1) Healers will need to undergo training at an accredited training institution to comply with universally accepted health care norms. This is a challenge as there are currently no accredited training institutions for healers and

training to be a healer is not under formal post-school education

2) The trainer will have to register at a cost of R500 and provide a list of their qualifications, details of course modules, skills to be acquired and duration of the course. The minimum qualifications and skills needed are not defined
3) Trainers will have to produce copies of their teaching or learning materials keeping in mind that different categories of healers will have different training needs
4) Students need to have at least an Adult Basic Education Training Certificate level 1 to attain basic literacy and numeracy skills
5) Age restriction of 18 years for student diviners and herbalists
6) A minimum of one year for training for diviners, herbalists and traditional birth attendants and five years for traditional surgeons
7) At the end of their training, students need to submit log books to the council providing details of their training and also be registered as students before registration as professionals.

What are the difficulties and challenges one can experience with dual practice?

Naming African experiences

All the healer-therapists used concepts such as anxiety, depression or schizophrenia to refer to conditions that are spiritual in nature. A question that is pertinent here is where does a healer-therapist draw the line with use of such clinical terms? Why does the healer use clinical language to refer to something that has not been proven to be clinical in nature? How does a healer who has psychology knowledge not use language used in psychology when psychology is not used as a healing modality? For example, depression and anxiety are clinical, diagnostic terms from the DSM; are they presenting in the same way in the spiritual realm? How does it work in spirituality? Is there language that a healer can use that is related to spirituality without using clinical terms? Does the healer-therapist have access to language that is used by healers? This kind of approach or practice can affect the worldview of the client. Baldwin (1986) recognises this as a dependency by Black scholars and Black people in general on the western type of education received.

If a person is showing signs and symptoms of depression, they cannot then be said that they are experiencing spiritual illness based on those signs and symptoms; or can they? Is there a language that can be used to capture

these in healing? Depression is a product of the DSM and a psychologist is meant to use the DSM to diagnose a client of such a clinical case. If the psychologist did not use the DSM then they cannot possibly suggest that a person has depression or any of the approximately 297 conditions across the five axis in DSM-4 (Sadock & Sadock, 2007). A healer-therapist cannot use their spiritual gifts to diagnose someone with an illness that is supposedly scientific and evidence-based. Similar to the healer-therapists, Dussel (n.d.) saw himself as belonging to a generation whose intellectual beginnings arise from the 1950s automatically belonging to the western culture. For this reason, Dussel believes that some of the categorical judgments made by this generation are done so in the opposition of themselves.

The healer-therapists seemed to foreground the clinical terms. The were putting more weight on the clinical terms than those words associated with healing, such as anxiety and depression. If the healer-therapists continued using these terms to explain spiritual illness, then the healer would forever be seen as a last resort. But then who can blame the healer-therapists because they do have a working knowledge of psychology, and that includes the DSM. The healer-therapist knew what psychosis is, they knew what hallucinations are, they could identify and name these experiences when they present in a client. So instead of saying a client is '*seeing things*', a healer-therapists would name the experience as hallucinating before associating the experience with psychology or an ancestral message.

Naming African experiences required the recognition of cultural diversity which refers to the differences found in a community, a nation and the world (Nyathi-Saleshando, 2016). Co-existence occurs where it is nurtured and respected for its difference and diversity (Nyathi-Saleshando, 2016). If diversity is seen as a threat then co-existence will cease to exist making it difficult for cultures that are not favoured to rise (Nyathi-Saleshando, 2016). There are forces which seem to draw attention to uniformity rather than diversity, in that, the forces seek to suppress diversity as it is a threat to businesses, trade and international communication hence the need for one language and a common culture (Nyathi-Saleshando, 2016).

Healer-therapists referred to a moment where one says they are experiencing hallucinations, then it is a straight forward case and one is then referred to a psychiatrist. But how do we then blame western science when healers borrow words used in western science to explain experiences supposed to be of the African worldview? Nyathi-

Saleshando (2016) asserts that Africa is served through colonial languages instead of African languages and yet Africa is seen as a diverse nation. It is important to also note, according to Nyathi-Saleshando (2016), that even in countries where diversity is valued, English is still the dominant and preferred language of choice globally. The dominance of English as a language discourages the use of multiple languages in education and also the use of other languages in the workplace. African languages often have no role to play at an international and global level, only at a community level or at home (Nyathi-Saleshando, 2016).

This study suggests that healers need to own their own experiences. This ownership starts with naming their own healing experiences. Africans need to start naming their own experiences as well. For example, a person will have to say that they are seeing things that are not there instead of saying they have hallucinations. Africans would need to devise a word that refers to seeing things but a word that would reflect that things that are being seen of a spiritual ancestral message rather than of a clinical, diagnostic nature.

A person, at some point in time, saw something that was unfamiliar to them and that then deemed that behaviour abnormal and proceeded to construct the behaviour in their own worldview which led them to label the behaviour an illness. Traditional psychology is mostly concerned with abnormality although there are other branches of psychology that are not entirely focused on abnormality, for example, community psychology.

When a person is due to receive a message from their ancestors, but in the meantime is experiencing misfortunes because a certain ritual has to be performed, the effects of those misfortunes sometimes comes in the form of medically unexplained symptoms. Is the person ill? Is this person in need of healing? The person is in need of a diviner who can communicate with their ancestors in order to find what it is they have to do in order for the misfortunes to go away. Does this person fit the description of a person who is ill? Or these just historically medically unexplained symptoms? These medically unexplained symptoms have led to a number of people being admitted and treated for sickness they do not have (Kirmayer et al., 2004; Nelson et al., 2012).

That is exactly why African experiences need to be named in a way that differentiates them from clinical terms. Baloyi and Ramose (2016) note that African psychological literature and the majority of Africans continue to use words belonging to the western psychological paradigm, noting the difficulty in moving away from the western paradigm. Baloyi and Ramose (2016) suggest replacing the word psychology with *umoya* viewed as

the metaphysical being in African ingenious knowledge, in the road to cultural pluriversality. Perhaps as a starting point, African should not make use of English to advance African indigenous knowledge. The use of English represents a particular problem, which is not devoid in this paper and the healer-therapists' interviews, that African experiences are continually being understood by using non-African tools (Baloyi & Ramose, 2016).

The majority of African countries have language policies that stipulate the use of a local and international, official language (Nyathi-Saleshando, 2016). African people then become bilingual in these languages and over time, they tend to lose their home languages to the national and official languages (Nyathi-Saleshando, 2016). In South Africa, the different languages are most commonly recognised by the state through greetings only during speeches being made. According to Nyathi-Saleshando (2016) African leaders have been convinced that there is no development without the use of colonial languages and thus become the most fluent speakers of these languages.

Language as a cultural tool

Healer-therapists spoke about attracting young people as clients as a result of speaking mostly English and practising in a modern way. Speaking mostly English is not only a reflection of the kind of school one went to but also a reflection of age, spaces one occupies, the school one went to, and the neighbourhood one is part of. The younger the participant, the more likely it is that they speak English. The more educated the participant, the more like it is that they speak English because academics require a higher level of English proficiency.

Speaking English is sometimes a sign of status, the status that being a psychologist comes with. Nyathi-Saleshando (2016) notes that when a person rejects their own language and culture, they reject the total individual. Furthermore, the status of a language reflects the status of its speakers (Nyathi-Saleshando, 2016). Nyathi-Saleshando (2016) went on to further state that cultural discrimination translates to economic discrimination. A psychologist is required to work in spaces that requires one to know English well in order to engage with colleagues and psychology material.

The healer-therapists in this study referred to shared language as strengthening the connection and understanding between the professional and the client. "Language is the DNA of culture and its vehicle of

expression" (Nyathi-Saleshando, 2016, p. 160). Language refers to the method of combining words used and understood by a community (Merriam-Webster, 2020). Language is culturally transmitted and language is learned. Crystal and Robins (2019) refer to language as a system of written or spoken symbols that human beings, as members of social groups and culture, use in their expressions. Dialect refers to the habits of expression by a single person (Crystal & Robins, 2019). Everett in Weitzman (2013) considered language as a system of signs. Language can be seen as a tool, a tool that aids human beings in being able to carry their various tasks (Weitzman, 2013).

Language can also serve as a cultural tool. Everett in Weitzman (2013) refers to language as a cultural tool that arises out of a social need for meaning. Everett presents the following formula in understanding language and its important elements: cognition + culture + communication = language (Weitzman, 2013). These are not pre-requisites for languages but rather they symbolise the need to use language (Weitzman, 2013). The functions of language according to Crystal and Robins (2019) are communication, play, emotional expression, expression identity and play.

Implications for collaboration and integration

Some healer-therapists were of the perception that ancestors are now targeting those who are employed because they are able to spread knowledge related to African based healing in spaces where this knowledge is not readily available. Whereas, historically, it was either healers were not being educated or those who were educated resisted becoming healers or those who were educated did not want to make it known in prominent spaces that they are healers. There are many scenarios one came up with regarding the implication of healers who are now occupying prominent spaces and the implication this would have on those healers who are not in prominent spaces.

There are a group of practicing healers who could not pass grade 12, those who did not qualify for higher educational studies. Then there are healer-therapists who made it into Master's degree programmes at universities in order to become psychologists. The existence of healer-therapists could have negative implications for those healers who are not educated and cannot occupy prominent spaces. One of the negative implications could be that the majority of healers might be required to be educated in order for them to practice

with credibility. It could be an expectation that a healer would only occupy certain spaces if they have a secondary qualification or skill that sort of 'fits' in.

The healer-therapy identity offers the healer-therapists the ability to be able to compare and contrast traditional psychology as well as healing. This means that the healer-therapists might have the ability to add to the growing calls and body of knowledge regarding integration and collaboration of traditional psychology and healing. This brings a new research conversation around duality with regards to the impact and evaluation of duality which future studies should look at. Is duality the way to go? Is society directed towards dual therapies?

Healers who are well organised and trained could be a viable referral and treatment source for South Africans presenting with symptoms of a mental illness that could be explained using African indigenous knowledge (Sorsdahl et al., 2010). The challenge is that many activities related to modern and African philosophies reflect a division when looking at South Africa (Mokgobi, 2015). According to Hall et al. (2010) it is imperative that a working relationship is created between the two paradigms of healing. This highlights the need for a strengthened working relationship or integration between the two healing modalities. An integrated approach would ideally start by health practitioners accepting, understanding and respecting the different interpretations of a mental illness (Sorsdahl et al., 2010).

It is important to recognise the strengths and weaknesses of the bio-psychosocial modality to illness and healing as it cannot explain other symptoms experienced by Black people (Nwoye, 2015). The challenge is that because African healing is mostly rooted in the cultural practices of Black people, it is a practice that is mostly frowned upon, criticised, denounced and surrounded by controversial views.

There is literature that is referenced in this thesis that highlights the possibilities of integrating of African healers into the general health care system, mental health included. The difficulty, however, seems to lie with the implementation of such an integrated service. The importance of the implementation of collaborative services can be brought about by the proven impact of integrated services on the clients. Healer-therapists are in an ideal position to be able to highlight the impact of such services on clients.

CHAPTER 7: CONCLUSIONS

This study sought to investigate experiences of Black healer-therapists in Johannesburg, South Africa. The study found that one can be a healer and a psychologist simultaneously and the controversy that is deliberately created and resourced to surround healing can be challenging to the healer-therapist. It is possible that healers experience a bit of conflict with practising both these modalities in mental health care because African beliefs have been marginalised, hedonised, demonised and rendered illegitimate within the context of a western health care provision for centuries.

Owing to this exclusion, it has taken healers too long to be incorporated into the formal health care space, and there are still challenges that illustrate that there is still a long way to go. Meanwhile, there are healers who have entered the formal health care sector in another capacity: the healer-therapists. These are healers who were able to recognise discrepancies in their own work as psychologists that the healer was able to work around. From the findings, it is clear that a healer-therapist cannot detach a specific identity when in a certain context and both their skills are useful in either a therapy room or *indumba*. It was also clear, even though no service users were interviewed that there is a need for healer-therapy services or dual services, especially where cultural variables are considered to be important.

Study limitations and recommendations for future studies

- The study only looked at Black South African healer-therapists which limited the study to only Black healer-therapy perspectives, leaving out perspectives from practitioners who are White, Indian and Coloured. A future study might want to look at experiences across the races.

- The study interviewed healers who were in private practice which limits the findings of the study as having specific reference to the affluent minority who have access to private services. A future research study could look at interviewing healers in the public health care sector to ensure the voices of the majority are reflected.

- Future studies could also focus on the ethical dilemmas and ethical considerations of healer-therapy and attempt to explore possible ethical rules that could apply to such a service.

- Future studies could explore the significance of dreams in the cultural African psychological worldview of healing and illness which was not explored in this research study, especially exploring how dreams (and visions) are significant in the journey to becoming and being a healer.

- The study could have adopted a narrative account of the lived experiences of the healers in order to attempt to get the full picture of these experiences.

- Another study related to dual healing could approach the study from a discourse analytic viewpoint to in order to explore the power dynamic between the two modalities of healing.

- The study looked at dual healing from the viewpoint of a single person providing healer-therapy services. It will not always be possible to see a healer-therapist when presented with an illness. Future research could also look at dual healing as provided in a single facility because ultimately that it is a universal healing system that South Africa should strive for.

- Further studies may also look at healer-therapy services from the perspective of service users because in this case, it was the perspective of the practitioners only.

- Further studies could explore other forms of cultural or spiritual psychologies and types of healing from other parts of the world as well as humanistic-existential psychologies and religion or Christianity in the context of decolonisation.

According to Robertson (2006) the public generally lacks knowledge of African healing systems because of the negative portrayal of adverse consequences that have previously been publicly noted about African healing systems. Robertson suggests that there has to be mutual understanding of the practice and knowledge base of the two approaches in order for collaboration to take place. This highlights the usefulness of both modalities in mental health care. This paper is not trying to criticise either of the modalities but rather illustrate that the one needs the other.

Research outputs:

🎧 Kamogelo Sefanyetso's SA FM radio interview on dual healer-therapy modalities in South Africa https://iono.fm/e/806097, 24 January 2020.

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APPENDICES

APPENDIX A: ORGANISATIONAL LETTER

Good day

My name is Kamogelo Sefanyetso and I am a student at the University of the Witwatersrand completing my Master of Arts in Social and Psychological Research Degree. As part of my research component, I would like to obtain personal contact details of practitioners who form part of your association/council and reside in Johannesburg. I would like to conduct research on dual healing modalities in mental health care in the South African context.

This will involve conducting interviews with dual practitioners (who are both a traditional healer and a mental health professional). With your permission, I would like to invite the practitioners to participate in my study. I would like to approach practitioners by contacting them directly, preferably, through email. Participation is completely voluntary and participation carries no foreseen repercussions for those involved.

All information that is collected from the interviews will remain confidential, with only the researcher, her supervisor and co-investigators will have access to the transcriptions. All responses used in the research will have a pseudonym and will be kept as anonymous as possible given that this is a small, unique group of participants and can easily be identified.

On completion of the project, a summary of the general end results will be made accessible to the organisation as well as the participants upon request.

I, _____, in my capacity as the _____ _____ of the organisation/council give Kamogelo Sefanyetso permission to access practitioner's contact details for the purposes of her research, as indicated above.

Signed: _____

Date: _____

Should you have any further questions or concerns please feel free to contact us.

Kind regards,

Kamogelo Sefanyetso

Telephone: 071 626 9529

Email: 1893142@students.wits.ac.za

Mzikazi Nduna (supervisor)

Telephone: (011) 7174525

Email: Mzikazi.Nduna@wits.ac.za

APPENDIX B: POSSIBLE QUESTIONS FOR THE DUALPRACTITIONERS

Good day, I am Kamogelo Sefanyetso and I am a masters student in social and psychological research. I am currently conducting research looking at the experiences of a dual practitioner. Please introduce yourself (you do not have to mention your name), you can just start by telling me more about your work?

- Under which category of mental health professionals do you fall under? Or are registered under?
- Can you tell me more about your journey of becoming an African healer?
- How long have you been a dual practitioner?
- What is the likelihood of a case that requires the use of dual intervention (African healing and westernised approaches to mental health care)?
- In your experience, is it often the specialist or the client that requires or recommends that use of both approaches for their mental health care?
- What is the usual attitude of clients towards using both healing modalities simultaneously?
- In your experience, how would you define traditional approaches to mental health care?
- In your experience, how would you define westernised approaches to mental health care?
- What would you say have been positive outcomes that came out of dual intervention involving both traditional and westernised approaches to mental health care?
- What would you say have been negative outcomes that came out of dual intervention involving both traditional and westernised approaches to mental health care?
- Have you had to choose between either one of the approaches? If so, which one did you choose and why? Please give a description of circumstances that lead to making such a decision.
- What are the limitations of each approach to mental health care?
- How do you see these two approaches complimenting each other?

APPENDIX C: PARTICIPANT INFORMATION SHEET

Title: Dual healing modalities in mental health care in the South African context

Good day

My name is Kamogelo Sefanyetso. I am a Master of Social and Psychological Research (MASPR) student at the University of the Witwatersrand. I am conducting research looking at **the experience of being a dual mental health specialist aimed at professionals practising both African healing and psychological approaches to mental health.**

I would like to invite you to partake in this research study in your professional capacity as a dual practitioner of both healing modalities.

If you choose to partake in this study, you will be asked to take time out of your busy schedules to assist by becoming an interviewee for approximately an hour. With your permission, the interview will be audio recorded and transcribed verbatim for the purposes of data analysis. The data obtained for the research will only be seen by the researcher and supervisor (in which case anonymity cannot be guaranteed) and will not be destroyed in case of publication at a later stage by the researcher or supervisor. Where direct quotations are used, pseudonyms will be used to assure confidentiality.

There are no direct benefits for participation (for example, monetary compensation) and participation will bear no negative consequences. As a participant, you will contribute to growing literature related to African healing and the provision of mental health services.

The researcher and supervisor's contact details will be provided to you below. Should you have any concerns, you are more than welcome to contact the researcher or supervisor. Should you wish to withdraw your participation, you

can do so at any point with no explanation necessary. Should you be asked any questions you feel uncomfortable with/unable to respond to, you can choose to not provide a response to the specific question/s.

The researcher and supervisor will be glad to answer any questions you have about this study at any time. The researchers contact details are 1893142@student.wits.ac.za, 071 626 9529. The research supervisor's contact details are Mzikazi.Nduna@wits.ac.za or 011 717 4525.

Should you have any residual feelings following participation; you are advised to utilise the contact details below for counseling/debriefing purposes.

Johannesburg parent and child counseling centre: 011 484 1734, gabby@jpccc.org.za

Lifeline counseling number: 0861 322 322, 011 728 1347

Signature (researcher): K. Sefanyetso Date: _____

Signature (research supervisor): _____ Date: _____

APPENDIX D: INFORMED CONSENT FORM

Title: Dual healing modalities in mental health care in the South African context

I _____ hereby give my consent to being a participant in an interview conducted by **Kamogelo Sefanyetso**. Looking at **the experience of being a dual mental health specialist aimed at professionals practising both African healing and psychological approaches to mental health.**

I, the participant, understand that:

- Participation is voluntary
- I can refuse to answer questions that I do not wish to discuss with the researcher
- I have the right to withdraw my participation at any point, should I wish not to proceed
- No information that could identify me will be included anywhere in the research procedure including the final journal article write up
- Participation in this study has no direct benefits or negative consequences
- I give consent for the researcher to use direct quotations with the understanding that pseudonyms will be used to assure confidentiality
- If, for some reason, negative consequences arise from participation in the research, the researcher and her supervisor's contact details are made available to me in order to address any questions or concerns.

Signed: _____

Date: _____

APPENDIX E: PERMISSION TO AUDIO RECORD

I _____ give permission for my interview responses to be audio recorded.

I, the participant, understand that:

- The audio recording will only be heard by the researcher, supervisor and co-investigator
- Transcriptions will only be accessible to and seen by the researcher, supervisor and co-investigator
- The information transcribed will only be analysed by the researcher, supervisor and co-investigator
- Transcriptions will not be destroyed in case of publication at a later stage by the researcher or supervisor
- There will be no identifying information used in the process of transcribing
- Where direct quotations are used, pseudonyms will be used to protect the confidentiality of the participants

Signed: _____

Date: _____