An Exploratory Study Of Trainee And Registered Psychologists' Perceptions Of Indigenous Healing And The Role of Indigenous Healers In The Mental Health Care System

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ABSTRACT

This study was undertaken to explore trainee and registered psychologists' perceptions of indigenous healing, its recognition, its inclusion in the formal mental health care system, and its role in the mental health care system. A qualitative, exploratory, and descriptive study was conducted in Durban. Unstructured interviews and focus group interviews were conducted with registered and trainee psychologists respectively. Data was analyzed using thematic content analysis. Based on the findings the following conclusions were drawn: In comparison to student psychologists, intern and registered psychologists held more positive views about indigenous healing, its recognition, its role, and its inclusion into the formal health care sector. Most participants reported that they would not refer to indigenous healers unless a client made an explicit request; registered psychologists were more confident about their ability to collaborate with indigenous healers; and most participants reported a need for more knowledge on indigenous healing. The implications of these findings are discussed.

Chapter One: Introduction

One of the challenges facing the health care system in South Africa is the integration of indigenous and western health care systems, which have previously been viewed as quite different and incompatible (Pretorius, 1999). Indigenous models of healing are based on the assumption that there is an all-powerful Supreme Being, known by different names in different religions. This Supreme Being communicates with human beings through divinities, prophets, and the ancestors (Edwards et al. 1983). Indigenous models usually attribute causes of illness to micro-social and supernatural forces and powers. Further, indigenous healers are believed to get their healing powers from supernatural forces and their treatment of illness focuses on biological, spiritual, social, and psychological aspects of the patient (Freeman and Motsei, 1992).

In contrast, western healing models are dominated by the biomedical approach. This approach is based on the belief that there are some illnesses which are purely biological and others which are psychological in nature (Swartz, 1998). Traditional psychological theories of psychopathology identify causes of mental disorders within the individual psyche, with the self viewed as a unitary social actor (Mkhize, 2004; White and Marsella, 1982).

During the apartheid regime the western model of healing, being based within the biomedical paradigm, was formally recognised by the government as it was seen as rational and scientific (Hopa, Simbayi, and du Toit, 1998). In contrast the indigenous model was marginalized and seen as unhelpful and unproven in efficiency (Swartz, 1998). According to Korber (1990), the term 'traditional' or 'indigenous' has been used

to refer to people's behaviour that has been seen as irrational, old-fashioned, and backwards and therefore could not fundamentally compete with the 'western' which was seen as modern, civilised, and progressive. The same principle applied to indigenous and western healing systems.

With the process of political transformation taking place in South Africa, the interest in indigenous healing practices is steadily increasing. This is in line with the World Health Organization's 1977 resolution to promote traditional medicine (Swartz, 1998). Prior to the 1994 elections, the African National Congress proposed the integration of indigenous healing into the formal health care system. Efforts have since been and are being made towards this integration (Hopa et al., 1998).

In September 2004 the South African national assembly passed the Traditional Health Practitioners Bill and in May 2005 the Traditional Health Practitioners Act no. 35 of 2004 was gazetted to govern the practices of traditional healers (Department of Health, 2005). However this Act has since been declared invalid by the Constitutional Court in August 2006 on the basis that the government failed to comply with its obligation to facilitate public participation before passing the legislation. The Constitutional Court has however suspended its order of invalidity for eighteen months and ordered the government to rectify this failure and invite public participation on this issue (Department of Health, 2006).

According to the South African Minister of Health, Ms Tshabalala-Msimang, (cited from BBC News 2004) this legislation aimed to create a framework for cooperation between mainstream health practice and indigenous healing. The legislation also aimed to provide for the establishment of the Interim Traditional Health Practitioners Council of

South Africa; make provision for control of the registration, training and practices of indigenous health practitioners; and to serve and protect the interests of members of the public who use the services of indigenous health practitioners (Department of Health, 2004).

While the legislation aims to address some of the concerns about indigenous healing practices and indicates a significant step towards the formal recognition and inclusion of indigenous healers in the formal health care sector, the fierce opposition facing this legislation suggests the extent to which views on indigenous healing vary. This raises a need for exploration of views on this subject among different stakeholders, particularly health care practitioners.

It is important to explore how psychologists view indigenous healing and its role in the formal health care system as mental health problems cannot be understood apart from its cultural context in South Africa. The role of culture and traditional explanatory models in causation and treatment of mental illnesses have been well documented in the literature (Helman, 2001; Mkhize, 2004; Pedersen, 2002; Swartz, 1998; Tyson, 1987). According to Mkhize (2004) etiologies of mental disorders and its manifestations are largely informed by the cultural context and the rules that different cultural systems have for regulating emotional expression and interpersonal relationships. Thus the symptoms experienced by people and the beliefs they hold about mental illness differ remarkably from one culture to another. Therefore mental health practitioners need to take culture into consideration when dealing with mental disorders (Mkhize, 2004).

Statement of the Research Problem and Purpose of the Study

Considering the progress made towards recognition of indigenous healers in the formal

health care system, working in collaboration with indigenous healers may thus become a

reality for many psychologists in South Africa who have traditionally functioned

primarily within a biomedical paradigm.

This study thus aims to examine training and registered psychologists' perceptions of

indigenous healing, and its role in the South African mental health care system. In order

to achieve this aim, the study explores trainee and registered psychologists' perceptions

of:

- Indigenous healing practices in general.

- Their personal and professional experience with indigenous healers, if

  any.

- Formal recognition of indigenous healers by the South African

  government.

- Integration of indigenous healers into the formal mental health care

  system.

- Role of indigenous healers in mental health care.

- Referrals to and from indigenous healers.

- Their need for knowledge and skills to enable a beneficial working

  relationship with indigenous healers.

Significance of the Study

This study is the first part of a larger investigation into psychologists' perceptions of indigenous healing and its relevance in mental health care. A qualitative approach has been adopted so as to establish emerging themes that will form the basis for a larger quantitative study. This approach also allows for in-depth exploration of these perceptions. It is hoped that the research findings will inform this larger study and add to the body of knowledge in psychology as the understanding of trainee and registered psychologists' perceptions of indigenous healing gives some indication of how they are likely to work with indigenous healers. In addition, the findings will also have implications for the training of psychologists with regard to their future collaboration with indigenous healers.

Operational Definitions

For the purpose of this study the following definitions will apply:

- Indigenous healers – refers to diviners, herbalists, and faith healers.
- Trainee psychologists – refers to trainees registered as student and intern (counselling and clinical) psychologists.
- Registered psychologists – refers to practitioners registered as (counselling and clinical) psychologists.

Chapter Two: Literature Review

2.1 Western Healing Systems

Historical background

The field of psychology has traditionally been largely dominated by the principles of the biomedical model (Sam and Moreira, 2002). This model is based on the assumption of the existence of commonality in human experience. Human beings are viewed as intrinsically the same across all cultures and mental disorders are also seen as the same irrespective of where it is observed (Sam and Moreira, 2002). This approach locates psychological distress within the individual, thereby overlooking the impact of the environment on the individual's state of mind. In doing so, this perspective assumes culture to have no influence in the meaning and expression of human behaviour (Mkhize, 2004).

Diagnostic practices

The training and practice of psychologists require that they use diagnostic systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV-TR (American Psychiatric Association, [APA] 2000). They are required to make use of psychodiagnostic tools such as the clinical interview and psychometric testing to reach a diagnosis. The DSM and these psychometric assessments are based on universalist assumptions of mental illness (Ahmed and Pillay, 2004).

Universalism in psychology is based on the assumption that mental illness is the same in all human beings across cultures (Sam and Moreira, 2002; Swartz, 1998). However the fact that we label and express the conditions differently in different cultures obscures the universal nature of illnesses. Within this model, the role of clinicians when working with

culturally diverse persons is to uncover these obscuring factors and find commonalities with respect to symptoms (Mkhize, 2004; Sam and Moreira, 2002). Although this principle is beneficial in that it allows for epidemiological studies and a common code of communication for professionals across different contexts, it has also been criticized for not giving equal value to all ways of seeing the world and for considering the western diagnostic system to be standard and normative for people all around the world (Swartz, 1998).

Earlier versions of the DSM, DSM III (APA, 1980) and DSM III-R (APA, 1987), were widely criticized for ignoring the influence of cultural factors in the development and maintenance of illness (Kleinman, 1996). Commenting on this, Hughes (1985) and Fabrega (1996) criticize western psychodiagnostic systems as being ethnocentric both in the layout and content of these diagnostic systems. According to them these systems are influenced by values and beliefs of the specific society where they evolved.

In an attempt to address this criticism, the DSM IV (APA, 1994) has provided for cultural and ethnic factors in the multi-axial diagnosis (Lewis-Fernandez and Diaz, 2002; Petersen, 1998). This has included a glossary of culture bound syndromes as well as a cultural formulation (CF) model. The CF model requires the clinician to consider the patient's cultural picture and how it affects all five axes as well as psychosocial factors such as help seeking behaviour and expectations, family and community views on the illness and its outcome, and institutional pressures on the clinical encounter, which are not considered by the multi-axial structure (Lewis-Fernandez and Diaz, 2002). These give the clinician a broader understanding of the client's background and context.

Communication of this understanding during therapy is likely to strengthen therapeutic alliance and effectiveness of therapy in return.

Petersen (1998) is of the view that although these changes have created an awareness of a biopsychosocial model of illness, they do not ensure that the users of the manual consider psychosocial factors in the etiology of illnesses. According to Kleinman (1996) mental health workers often do not regard psychosocial issues to be core issues in the mental health of the patient even when they do consider them. According to Albee (1998) the reason for this is that psychologists in hospital settings are under pressure to provide a diagnosis before treating a patient. This places emphasis on symptom groupings rather than meanings of the illness. In addition, medical aid insurance funds also require practitioners to provide a DSM or ICD-10 based diagnosis before treating patients, before these funds validate their financial claims. For these reasons, Axis IV and V of the multiaxial diagnostic system are viewed as just 'window dressing' by those who advocate for the meaning centred model of illness (Petersen, 1998).

<u>Theories of etiology and treatment</u>

van Niekerk (1992) outlined four theoretical approaches that have been prominent in traditional western psychology. These are psychoanalytic, existential, humanistic, and cognitive behavioural theories. Sigmund Freud's psychoanalytic theory marked the beginning of scientific study of counselling and psychotherapy. From this perspective, psychological and physiological symptoms are largely caused by unconscious experiences, thoughts, and feelings. In therapy this model focuses on analyzing and interpreting childhood events and transferences. One of the major criticisms against this approach is that it is based on upper and middle class, Eurocentric values and therefore is

irrelevant for many South Africans who are in need of psychological assistance (van Niekerk, 1992). Corey (2005) criticized this approach's ambiguous stance on the therapist role as potentially problematic for clients from cultures that expect direction from the therapist.

Existential theory in Europe and humanistic theory in the United States were developed with the basic assumption that the individual's perception of himself and the world is the key determinant of behaviour (van Niekerk, 1992). These theories also hold a positive view of human nature. They place emphasis on the relationship between the therapist and the client as an essential factor in the therapeutic process. They also emphasize authenticity, warmth and acceptance as factors that promote positive growth in therapy. One of the criticisms levelled against these approaches is their limited applicability to clients who are not psychologically minded. They may perceive lack of direction from the therapist as frustrating and unhelpful (van Niekerk, 1992). Corey (2005) contends that use of this approach with collectivistic societies and people who have been oppressed can be problematic, as their values may contradict the individualistic concept of the clients' right to self-determination.

Cognitive behavioural theories are based on the assumption that an individual's assessment of life situations is influenced by his or her expectations, beliefs, attitudes, assumptions, internal standards, images, interpretations, and attributions (van Niekerk, 1992). These cognitive processes are considered as important in understanding behaviour and planning treatment. The process of therapy typically aims to bring about changes in overt behaviour, self regulatory activity, and cognitive structures (van Niekerk, 1992). Corey (2005) asserts that cognitive behavioural therapists usually consider the

sociocultural context in which the problem occurs and therefore they are able to work in multicultural environments. However van Niekerk (1992) cautions that the exploration of cognitions (which are embedded in belief systems) is a central task of cognitive behavioural therapy and may be a very sensitive issue for clients. Thus he advises that the therapist should have understanding of the client's sociocultural background before engaging in this process.

Traditional psychological theories have largely been criticized for neglecting and underestimating the power of cultural values (Mkhize, 2004; Pedersen, 1999). According to White and Marsella (1982) the basic principles which inform psychotherapy are based on western values and culture. The authors contend that the use of 'talk therapy' in which behaviour is altered through the individual gaining insight into his or her personality is embedded in the western conception of a person as a distinct and independent individual. These criticisms have led to a range of developments within the field of psychology, including the development of interpretive models, meaning centred approaches, and multicultural counselling theories.

2.2.Indigenous Healing

Human beings have used indigenous knowledge and religious methods to cure their ailments long before the existence of scientifically tested treatment (Coleman, 1985). With the lack of knowledge of medical explanations of illnesses it is not surprising that early man turned to supernatural forces to explain illness. The combination of herbal remedies, observation of rituals, and the power given to diviners have been key elements

in the promotion of well-being and treatment and prevention of illnesses in Africa (Coleman, 1985).

Pretorius (1999) defines an indigenous healer as a local healer whom the community regards as competent in providing health care using natural resources, such as water, plants and animal products like skin and bones. This person needs to have extensive knowledge on physical, mental, and social well-being. According to Courtright, Chirambo, Lewallen, Chana, and Kanjaloti (2000), these healers are respected in their communities because of their work, experience, age, and role in the community.

<u>Categories of indigenous healers</u>

The literature outlines three broad categories of indigenous healers namely, diviners, herbalists, and faith healers (Courtright et al., 2000; Freeman and Motsei, 1992; Pretorius, 1999). However there appears to be no clear distinction between these categories as they tend to overlap. For example, one can find a diviner who engages in some of the practices traditionally used by herbalists and there are faith healers who experience a calling to become a diviner but opt for faith healing (Freeman and Motsei, 1992). According to Pretorius (1999) in order to be a diviner one needs to experience a "divine calling" through dreams and unusual illnesses. Once they have accepted the calling, an experienced diviner trains them. Their work mostly involves mediation between ancestors and their patients.

Courtright et al. (2000) and Pretorius (1999) concur that herbalists do not need to have a calling, but they are assumed to have profound knowledge on the indications and effects of medicinal herbs and use them whilst acknowledging the role of supernatural forces. They are commonly known as *"amaxhwele"* in Xhosa. This can be someone who

has worked closely with a herbalist, perhaps as an assistant (*isigogo*), and once the herbalist feels that he is competent enough, he is allowed to practice on his own (Courtright et al.,2000; Pretorius, 1999).

Another category of indigenous healers consists of faith healers. In order to become a faith healer the person needs to first have a calling and then undergo purification rites and training under a qualified healer. These persons integrate traditional practices and religious rituals in healing. Different religions in South Africa refer to faith healers by different names. African faith healers (*Umthandazi*) divine and heal within the framework of African Independent Churches. Their healing is in accordance with the traditional African world view that healing must be holistic and thus focuses on body, spirit, and soul (Pretorius, 1999).

Mahomed (1997) provides the following comparisons of faith healers and diviners: they have a shared theory of illness and health, treat various diseases including culture bound syndromes, and have similar means of divination but faith healers differ in that they believe that they are assisted by God or the Holy Spirit rather than ancestors. In their diagnosis and treatment they use prayer, ashes, salt, seawater, candlelight, holy water, and other religious rituals. They believe that their healing power comes directly from God through a trance contact with either ancestral spirits, Holy Spirit possession, or a combination of both (Mahomed, 1997).

Indigenous views about illness and health

According to Zungu (1992) people consult indigenous healers not only for their health problems but for problems in other areas of their lives as well, such as relational problems, misfortune, need for improved sexual or work performance and productivity,

and protection from evil spirits and sorcery. The indigenous healing models are considered to be holistic and thus promote mind-body unity (Teh, 1998). The author asserts that in the traditional African view, good health implies a balanced relationship between a person and his environment, the people around him and his spiritual world. Pillay (1996) describes the traditional African view of being healthy as feeling good and comfortable in body and mind and involves a feeling of contentment with life. In contrast, disease is seen as a state of disharmony in the body as a whole and sometimes the society. This view of being healthy is consistent with the World Health Organization's (1978) definition of health as more than an absence of disease but a state of complete physical, mental, and social well-being (Pillay, 1996).

Indigenous diagnosis

Indigenous models of healing use a combination of patient self-diagnosis, divination such as casting of bones and dream interpretation, and observation by the healer when diagnosing illness (Bodibe, 1992; Swartz, 1998). The diviner typically asks the patient about his or her different areas of functioning in the form of statements, which the patient is free to agree or disagree with. The healer usually asks about the following areas: ancestral influences, dreams, marital relationship, sexual functioning, overall physiological functioning, interpersonal relations, financial and work matters, and relationships with superiors (Bodibe, 1992).

According to Straker (1994) and Swartz (1998) the diagnosis is concerned with answering the questions: what illness is this?; who or what caused it?; why has the person been chosen for the affliction at this particular point in time? Unlike western healers, indigenous healers are more concerned about the etiology of the disease rather than

symptom groupings when providing a diagnosis. It is therefore possible for people presenting with completely different symptoms to be given the same diagnosis of bewitchment or disharmony with ancestors (Swartz, 1998).

Edwards et al. (1983) and Straker (1994) outline three main causes of illness in indigenous models namely, mystical, animistic, and magical causation. In mystical causation illness develops naturally when one is in a state of pollution, for example persons who are recently bereaved, women who are menstruating or have recently given birth, and men who have just had sex are considered to be polluted and therefore vulnerable to illness. These persons are required to perform a variety of rituals or observe certain taboos in order to protect themselves or others from the effects of their pollution (Straker, 1994).

In contrast, magical and animistic causations refer to illnesses inflicted on the person by outside forces. Magical causations ascribe the disorder to human use of sorcery and witchcraft. Animistic theories attribute the illness to the behaviour of some personalized supernatural agent such as anger or dissatisfaction of gods or ancestors (Edwards et al., 1983; Straker, 1994). Bodibe (1992) explains that in African thought, ancestors serve to protect the individual against afflictions, so going against the former's will leads to their wrath and dissatisfaction. Consequently the individual will lose their protection and become vulnerable to sorcery or illness.

Indigenous healing treatment

Indigenous healers use various forms of treatment ranging from mediation with ancestors, to prayer and prescription of rituals and herbal remedies, depending on the healer's knowledge and skill (Swartz, 1998). Their treatment is also holistic and satisfactory

healing is regarded as one in which spiritual, social, and psychological reintegration of the patient into their community has taken place (Bodibe, 1992; Freeman and Motsei, 1992). These authors go on to say that many practices of indigenous healers are designed to maintain cultural institutions and to help the patients live in peace with their inner-selves, families, and communities. This is in contrast with traditional western models which are more individualistic in their approach, focusing solely on the patient.

Kellerman and Thindisa (1998) question this view that indigenous healers are holistic in their approach to understanding and treatment of illnesses. According to them the argument that traditional healers provide holistic care has weak evidence. This is consistent with Swartz's (1998) comment that some authors feel that in indigenous healing there is little more than naming of the disease and prescription of the treatment, and that there is no further support provided to the patients. In addition, Bodibe (1992) remains critical of some of the indigenous healing practices which he describes as harmful. He cites examples where indigenous healers have claimed to have a cure for AIDS; families have been broken down because of accusations of witchcraft made by indigenous healers; as well as ritual and *muti* related murders as practices that must be addressed before traditional healers find themselves a place within the field of counselling and psychotherapy.

2.3 Culture Bound Syndromes

Ngubane (1977) outlined two broad categories of illness within the Zulu world view, namely *umkhuhlane* and *ukufa kwabantu*. *Umkhuhlane* attributes illnesses to natural causation; on the other hand, *ukufa kwabantu* refers to explanation of illness by

supernatural causation. Whilst natural causes of illnesses are recognized by biomedicine, supernatural causes become problematic for western based practitioners to recognize as *ukufa kwabantu* (traditional ailments) usually do not respond to western healing (Pretorius, 1999).

Ukufa kwabantu is congruent with the concept of culture bound syndromes. According to Sadock and Sadock (2003) the term culture bound syndromes is "generally accepted to refer to culturally based signs and symptoms of mental distress or maladaptive behaviour that are prominent in folk belief and practice. Such patterns are informed by native cultural assumptions, sorcery, breach of taboo, intrusion of disease object, intrusion of a disease-causing spirit, or loss of soul" (p. 529).

The most commonly identified and extensively examined categories of culture bound syndromes in South African literature are *amafufunyane* (spirit possession) and *ukuthwasa* (calling to be a healer) (Swartz, 1998). Ngubane (1977) describes *amafufunyane* as a form of spirit possession that is mainly caused by sorcery. It is believed that the sorcerer mixes soil and ants from a cemetery to make a harmful mixture which is then placed in the path of the victim to make him or her sick. The common behavioural symptoms observed in *amafufunyane* are: the person becomes hysterical, throws herself/himself on the ground, and cries loudly and uncontrollably; he or she also reacts aggressively to people who try to calm him/her down and may try to commit suicide. The person may also speak in a voice of the opposite sex and/or in foreign languages (Ngubane, 1977).

The person may also report hearing voices from his/her stomach which give him commands. The different language and tone of voice is often attributed to the view that it

is not the patient who is talking but rather that the spirits are communicating through the patient's vocal cords. The patient usually has amnesia and cannot remember what happened during the episode. This disorder can also occur as a mass phenomenon affecting large groups of people in the community (Tyson, 1987).

In contrast to *amafufunyane*, which is viewed as a negative state of possession and associated with mental disorder, *ukuthwasa* refers to a more positive state (Swartz, 1998). The author defines *ukuthwasa* as a positive state of spirit possession emanating from emotional turmoil that follows the calling by the ancestors to become an indigenous healer. Once this process is completed the person is believed to have fulfilled the ancestors' wishes and therefore no misfortune will befall him/her. However if the person refuses the calling an incurable state of *ukuphambana* (madness) may develop.

Meaning centred approaches to mental illness challenge the concept and existence of culture bound syndromes (Hughes, 1985, 1996). Hughes (1985) asserts that the concept of culture bound syndromes is based on the use of western diagnostic systems as the norm, hence deviation from this norm is considered to be culture bound. In his view all illnesses are influenced by culture, including 'western disorders' and based on this view, western diagnostic systems are also culture bound.

Fabrega (1996) uses the examples of narcissistic and schizotypal personality disorders to argue that disorders mostly prevalent in western societies can also be viewed as culture bound. The author argues that the narcissistic traits and abnormalities in social relations, which are symptomatic of narcissistic personality disorder, are directly created by customs that western societies and culture create. As such, its features are unlikely to be depicted similarly across cultures because other societies have different principles about

interpersonal power, intimacy, emotions, self, and objects. The author argues further that schizotypal disorder cannot exist in societies where magical thinking and magical beliefs are considered normal because these are consistent with the way ordinary citizens think about themselves and their world. He therefore questions the validity of the term 'culture bound' and calls for a move to a stage where the influence of culture will be acknowledged in all disorders. Hughes (1996) thus contends that there are no compelling reasons for labelling only some conditions as culture bound and for keeping this term. He therefore calls for the abandonment of the term 'culture-bound' and advocates for the search of an acceptable general classificatory term.

2.4. Culture and mental health

Relativism and meaning centred approaches in the fields of medical anthropology and psychology have emerged as an attempt to address the criticisms levelled against the universal approach to understanding illness (Sam and Moreira, 2002). The relativist approach is based on the assumption that all human behaviour is culturally patterned. Its goal is to understand people within their own cultural narratives. From this view it is not enough to diagnose the physical symptoms of a person. The clinician needs to examine the person's experience of the illness as this experience determines the person's behaviour, treatment seeking, and response to treatment (Sam and Moreira, 2002; Swartz, 1998).

Swartz (1998) and Helman (2001) assert that the clinician also needs to understand the patient's explanatory model and if it differs from his own, he needs to negotiate between the two and find common ground. This is likely to increase patients' compliance and

participation (Helman, 2001). Criticism levelled against relativists is that their desire to be as true to the context as possible may cause them to lose the bigger picture (Sam and Moreira, 2002). Further, they may end up with a lot of fragmented information that is difficult to organize and may also overlook symptoms which indicate the need for psychotropic treatment (Swartz, 1998).

Sam and Moreira (2002) describe multiculturalism as a middle ground between the universalist and relativist approaches. According to Pedersen (1999) multicultural counselling theory has been developed to "provide a conceptual framework that recognizes the complex diversity of a plural society while suggesting bridges of shared concern which bind culturally different persons to one another" (p6-7). In line with this approach the clinician recognizes that there are common as well as unique aspects about human beings across various cultures.

Some of the competencies for multicultural counselling outlined by Sue, Arredondo, and Mc Davis (1992) are therapist's cultural self-awareness; understanding the worldview of the culturally different client; and developing appropriate counsellor interventions, strategies, and techniques. Cultural self-awareness refers to awareness of own assumptions, values, biases, and their influence as well as awareness of personal limitations and comfort with the client's beliefs and cultural differences. In understanding the worldview of the culturally different client, the therapist contrasts his own belief systems with those of the client in a non-judgemental fashion. Developing appropriate counsellor interventions includes respecting client's religious or spiritual beliefs and respecting indigenous helping practices and networks (Sue et al., 1992). Pedersen (1999, 2002) advocates for a culture-centred approach to counselling as a means to complement

traditional psychological theories by making culture a central rather than a marginal issue in understanding human behaviour.

2.5. The Move Toward Recognition Of Indigenous Healing

As far back as 1977, the World Health Organization called for the recognition of indigenous healers. The 30th World Health Assembly adopted a resolution to promote traditional medicine world wide (Swartz, 1998). Discussions and debates on the recognition of indigenous healers were started by the South African government even before the first democratically elected government came into power (Freeman, 1992).

After the acceptance of the National Health Plan in 1994, the Medical Association of South Africa provided guidelines for cooperation, especially referrals between western and indigenous health practitioners (Pretorius, 1999). However, in the latter's view, referrals are still one-way from indigenous to western health practitioners. This pattern, which can be attributed to possible scepticism among western healers towards indigenous healing practices, was also observed by Freeman and Motsei (1992).

Public hearings on traditional healers were held in 1997 to examine the practicality of traditional health care in South Africa. The reports indicated that all the provinces were in favour of a statutory council for traditional healers, consisting of local representatives (Public Hearings on Traditional Healers, 1997). Many national role players that submitted their proposals, except for Doctors for Life, were in favour of the incorporation of traditional healers into the formal health care system (Pretorius, 1999).

In 2004 the South African government passed the Traditional Health Practitioners Bill of 2003 and in May 2005 Traditional Health Practitioners Act no. 35 of 2004, was gazetted by the government. The Act provided for the establishment of the Traditional

Health Practitioners Council of the Republic of South Africa. This council will oversee the registration and practices of traditional healers (Department of Health, 2005). The Act faced fierce opposition from Doctors For Life who challenged it in the Constitutional Court. The Act has since been declared invalid on the basis that public consultation done by the government before passing of the Act was inadequate (Department of Health, 2006).

2.6. Theoretical Framework

Social representations theory

Data from the research participants will be understood within Moscovici's (1984) social representations theory, which is a theory of knowledge. According to this theory different social groups have their unique social representations of aspects in their worlds. A social representation is defined as a system of beliefs, values, ideas, and practices shared with other members of a group about one aspect of the world. In other words this refers to the meaning that the particular society attaches to particular aspects such as illness, healing, motherhood, or democracy. These social representations are not constructed by the individual but they are collectively created and collectively maintained. As members of a society, people gradually learn that particular events or situations are understood in certain ways within their culture as they become socialized (Smith and Bond, 1998).

Social representations serve to establish an order which will enable individuals to orientate themselves in their material and social world and to master it. They transform the unfamiliar and complex into the familiar and straight forward and thus provide a common sense framework for interpreting experiences. This facilitates communication

amongst members of a community as a particular society will have a common code for social exchange, in that the meaning they attach to things will be the same (Smith and Bond, 1998).

Social representations theory maintains that people's beliefs are socially constructed, that is, their opinions and ideas are moulded by what other people believe and say. People's reactions to events and their responses to stimuli are influenced and defined by a given value system common to all the members of the community to which they belong. From an attitudinal perspective, this theory emphasises that attitudes are socially constructed and tend to reflect the society or groups in which people live their lives - (Hogg and Vaughan, 2002).

In accounting for individual differences in attitudes within the social groups this theory differentiates between consensual beliefs and individual beliefs. Consensual beliefs are those that are generally shared by members of a group. Although individual beliefs are influenced by consensual beliefs, as individuals people evaluate consensual beliefs from the perspective of their own experience. Furthermore, social representations theory posits that individuals tend to be more strongly affected by consensual beliefs of in-groups, particularly those with which they identify strongly (Hogg and Vaughan, 2002). Ideologic strain can result when an established social representation is challenged. Typically people respond to ideologic strain by identifying more closely with the in-group with whom they share a social representation and rejecting the representation of the out-group (Moscovici, 1984).

Applying this theory to the current study, the researcher will explore the social representations that psychologists have about indigenous healing. The participants in this

study will be at different levels of training and qualification which means that their level of socialization into the profession of psychologists, is also at different levels. Therefore the researcher will explore if there are any differences in the social representations held by participants at the different levels of training. Also the researcher acknowledges that in addition to their professional grouping the participants also belong to other social and cultural groups, one of which is their racial groups. Participants' prior socializations in their cultural and racial groups may thus affect their views of indigenous healing. Prior socialization may either be congruent or be in conflict with the socialization they receive during their training. Based on this, some participants may have ambivalent views about indigenous healing. The study will thus also explore if there are any differences in responses given by participants of different race groups.

Summary

This chapter has provided an understanding of the basic assumptions, diagnostic and treatment practices of both indigenous and western healing models, and a review of perspectives on culture and mental health. The progress made in the recognition of indigenous healers in South Africa has also been discussed. Further review of literature on previous research will be covered in the discussion of research findings (chapter four).

Chapter Three: Research Methodology

This study aims to develop an understanding of trainee and registered psychologists' perceptions of indigenous healing and its role in the mental health care system. In order to achieve this aim the former's perceptions of the following areas were explored:

i.   Indigenous healing in general.

ii.   Professional or personal experience with indigenous healers.

iii.   Formal recognition of indigenous healers.

iv.   Inclusion of indigenous healers in the mental healthcare system.

v.   Referrals between psychologists and indigenous healers.

vi.   Cases appropriate for collaboration with indigenous healers.

vii.   Skills they require to enable them to work in collaboration with indigenous healers.

These areas were identified in accordance with the calls made by Swartz (1998; 1999) that western practitioners need to critically analyse the usefulness of indigenous healing and be able to make rational and informed decisions about when to and when not to refer to indigenous healers.

3.1 Research Design

This study is exploratory and descriptive in nature. It focuses on exploring and describing the perceptions and opinions of training and registered psychologists. According to Durrheim (1999) exploratory research uses an open, flexible, and inductive approach to research and is commonly used to gain new insights into the phenomena being studied. Although a fair amount of research has been done on attitudes towards indigenous healers

(Hopa et al., 1998; Peltzer, 2001; Peu, Troskie, and Hattingh., 2001), an exploratory approach is adopted because of the limited literature which focuses on the perceptions of mental health care professionals, particularly psychologists. The insights obtained from this study will form the basis for a larger study in the future. This study is descriptive on account that it describes the perceptions of training and registered psychologists.

The study adopted a qualitative design because of the need for participant openness and to facilitate in-depth exploration of the research issues. Qualitative research is more commonly used to inductively explore and provide detailed description of the phenomena and it is distinguished by its reliance on inductive reasoning to interpret and structure the meanings that can be derived from data (Durrheim, 1999; Pope, Ziebland, and Mays, 2000; Smith, 2003).

3.2 Sampling Procedure

Non-probability sampling, specifically purposive sampling, was used in this study. Non-probability sampling refers to the case where the probability of including each element of the population is unknown (Bless and Higson-Smith, 1995). Purposive sampling is a type of sampling based on the judgement of the researcher regarding the characteristics of a representative sample (Smith, 2003; Strydom and Delport, 2002). Attention was paid to ensuring representativity of the sample by including individuals from different racial and cultural backgrounds.

The researcher made several attempts to include at least three race groups in the sample (from each level of training) but was unsuccessful. Black student psychologists

could not be included in the sample because they declined to participate. However four of them had participated in the pilot group and their views are included in the analysis.

3.3 Participants

The study was conducted in Durban. The sample consisted of four student psychologists (SP), six intern psychologists (IP), and eight registered psychologists (RP). In total the sample was made up of eighteen psychologists. In terms of sex, there were seventeen females and one male. The description of the sample in terms of race, level, and category is illustrated in the tables one and two below.

Table 1: List of participants according to race and level of training

	Student (SP)	Intern (IP)	Registered (RP)	Total
Black	0	3	3	6
White	2	2	2	6
Indian	2	1	3	6
Total	4	6	8	18

Table 2: List of participants according to level of training and category of registration

	Clinical	Counselling	Total
Student	2	2	4
Intern	3	3	6
Registered	5	3	8
Total	10	8	18

3.4 Pilot Study of the Interview Schedule

The interview schedule was piloted using six participants. For the pilot study, one focus group comprising of four student psychologists (Black) as well as individual interviews with an intern psychologist (White) and a registered psychologist (Indian) were conducted. The questions were clear to all participants in the pilot study. After the pilot study, changes were made in the order of questions so as to make them flow better. Data from the pilot study has been incorporated into the data analysis and interpretation, which is presented in the results and discussion chapter.

3.5 Method of Data Collection

Focus groups were held with student psychologists and intern psychologists, and individual semi-structured interviews were conducted with registered psychologists using the same interview schedule. Greeff (2002) defined a focus group as a research interview conducted with a group of people who share a similar type of experience but are not naturally constituted as an existing social group. This method is differentiated by its focus on interaction and communication between research participants. Semi-structured interviews are defined by Greef (2002) as interviews organized around particular areas of interest while still allowing considerable flexibility in scope and depth. These data collection methods were used because they allow for in-depth understanding and probing of data that emerges.

Focus groups and semi-structured interviews are useful for exploring people's knowledge, perceptions, and attitudes toward an issue as well as factors that influence

opinions (Gibbs, 1997; Greef, 2002). Some of the advantages of using focus groups as a data collection method are that it allows for sharing of insights that may not be readily available in individual interviews, has high face validity, and it is flexible in its application. The disadvantages include the fact that it gives the researcher less control compared to individual interviews, may produce data that is difficult to analyse, and may also be intimidating for shy members (Gibbs, 1997; Smith, 2003). It may also be difficult to clearly identify individual messages because the participants in focus groups are in a specific context and culture, therefore it cannot be assumed that they are expressing their own definitive individual view (Gibbs, 1997).

3.6 Data Collection Procedure

The focus groups for student psychologists and intern psychologists were conducted separately. This helped to address the potential limitations, such as inhibition of some participants, which could be brought about by the presence of individuals considered to be more or less qualified than the others. According to Smith (2003) most researchers aim for homogeneity within each group in order to capitalise on shared experiences.

The researcher aimed to get a minimum of six participants for each focus group but was unable to reach this target in the student psychologist sample. The focus group was postponed several times because of poor turn-out of participants and eventually proceeded with those who were available. Whilst some authors (Greeff 2002; Green and Thorogood, 2004; Terre Blanche and Durrheim, 1999) advocate that focus groups should ideally be made up of six to twelve participants, others such as Smith (2003) advise that

they can be made up of four to eight participants. Hence, this focus group proceeded with the minimum number of four participants and this may have compromised the findings.

The researcher used the interview schedule (Appendix A) as a guideline for both focus groups and individual interviews. The role of the researcher was to provide explanation of the purpose of the study, introduce some of the key issues by asking open ended questions, encourage participants to engage with one another, and keep discussions focused on the topic. Each focus group session lasted about 45 to 60 minutes.

Semi-structured interviews were used to collect data from registered psychologists. The researcher had initially aimed to conduct focus groups with all the participants but semi-structured interviewing was chosen for its convenience because the researcher could not get all the participants to participate in a focus group at the same time because of work constraints. Although this method allows the researcher more control over the sessions, focus group interviews could have produced richer data in terms of collective experience and group dynamics. The individual interviews lasted about 30 to 45 minutes. All the interviews were conducted in English.

3.7 Data Analysis Procedures

The interviews were audio recorded and transcribed. The researcher used thematic content analysis to analyse the data. Green and Thorogood (2004) describe thematic content analysis as the most basic type of qualitative analysis which aims to report key elements of responses given by participants. According to Terre Blanche and Kelly (1999) qualitative data analysis starts during the data collection process. When gathering

data the researcher starts developing ideas and theories about the phenomenon being studied. The authors outlined five stages involved in qualitative data analysis, however they cautioned that these steps do not necessarily occur in a neat linear form and that the process may involve going back and forth through these steps. These stages are:

1. *Familiarization and immersion* involves reading transcripts repeatedly so as to have an understanding of what information can be found in the data as well as what sorts of interpretations are likely to be supported by the data.

2. When *inducing themes* the researcher identifies all key issues and themes that emerge from the data. It is important for the researcher not to lose focus of the study when looking at the themes. The researcher can look at the aims of the study to ensure this. Emergent issues raised by the participants and analytical themes arising from recurrence of particular views should also be noted.

3. *Coding* is often done concurrently with the process of inducing themes. The process involves breaking down the data into labelled meaningful pieces.

4. *Elaboration* requires the researcher to ensure thorough analysis through fine exploration of themes. Data is then further refined and grouped together.

5. *Interpretation and checking* involves the researcher doing a written account of the phenomenon being studied. During this stage the researcher reviews research notes, compares and contrasts the perceptions and accounts, searches for patterns and connections and seeks explanations for these within the data.

According to Smith (2003) one of the advantages of using thematic content analysis is that it allows for quantification of data which in turn increases the credibility of the research. In this study the researcher broke down the data into underlying themes and

frequencies of occurrences of themes are noted. Although the data is quantified in this manner, the researcher maintains a purely qualitative approach for analysis of data. Information from all interviews is considered as important regardless of the overall frequency of occurrence. The researcher also provides a comparison of themes from different focus groups.

3.8. Ethical Considerations

- Ethical clearance was obtained from the research office of the University of KwaZulu-Natal.

- Informed consent - the researcher sought informed consent of the participants. Participants were informed of the aim and procedure for the research. They were also advised that their participation was voluntary and that they could withdraw their participation from the study at any stage.

- Confidentiality – the researcher guaranteed anonymity of information obtained from the participants. Identities of research participants are not disclosed and data is reported on collectively. The research participants were required to give their commitment to keep information discussed in the group confidential.

Chapter Four: Results and Discussion

The participants' transcripts formed the database for the analysis that follows. An example of a transcript is contained in Appendix C. Themes from participants' responses are listed according to the objectives of the study, that is, to develop an understanding of trainee and registered psychologists' perceptions of:

  i.   Indigenous healing in general.

  ii.   Their professional or personal experience with indigenous healers.

  iii. Formal recognition of indigenous healers.

  iv.   Inclusion of indigenous healers in the mental health care system.

  v.   Referrals between psychologists and indigenous healers.

  vi.   Cases appropriate for collaboration with indigenous healers.

  vii. Skills they require to enable them to work in collaboration with indigenous healers.

In this chapter the following coding applies:

- SP – student psychologists

- IP – intern psychologists

- RP – registered psychologists

In addition to the level of qualification the following codes represent race of the participants:

- B – Black

- W – White

- I – Indian

4. 1.   <u>Perceptions of Indigenous Healing In General</u>

Participants were asked about their general perceptions of indigenous healing. The perceptions of participants in all race groups, all levels of training and categories of registration varied from positive, to neutral, to negative. The following themes emerged in relation to the first objective, which was to develop an understanding of training and registered psychologists' general perceptions of indigenous healing.

<u>Use and Efficiency Linked To Belief Systems About Indigenous Healing</u>

All the participants (N =18) as well as those in the pilot study (n = 6) felt that indigenous healing services are used by people who believe in them and perceived the efficiency of this healing as being closely linked to the client's belief in it. The following excerpts illustrate this:

> RP-B1 *"...Most people....they go to indigenous healers when they think whatever problem they are experiencing is because of amadlozi (ancestors). So they think that those problems can be solved by inyangas (traditional healers)..."*
>
> IP-W1 *"I also think they are useful to people who believe in them. Apparently their healing power lies in the belief. If you do not believe in them then healing does not work."*
>
> RP-B2 *".....well maybe they are useful to people who believe in them....."*
>
> RP-I2 *"If you strongly believe you've been bewitched and whether it's true or not, the mere act of that process of consulting and believing that when you do those rituals then you will cease the symptoms. I think that on its own can clear the illness"*

This view could be related to the fact that indigenous healing is largely informed by traditional African beliefs and cosmology. This world view attributes illness to natural, supernatural and spiritual forces which cannot be subjected to scientific examinations (Bodibe, 1992). This is in contrast to the western healing approach which is based on principles of objectivity, neutrality, and empiricism. Swartz (1998) also acknowledges that indigenous healing models are mostly spiritual in nature. Indigenous healers are believed to get their healing powers from supernatural forces. Their process of healing usually involves performance of rituals, mediation with ancestors, prayer, or prescription of herbal remedies depending on the healer's skills (Swartz, 1998).

Alcock (2001) asserts that belief in the ability of the type of treatment to provide relief for the ailment is an important part of any kind of treatment. According to him belief in the type of treatment is an important determinant in choosing the type of treatment to be consulted and individuals need to believe in the treatment provided to them in order for it to be effective. He cites the well known concept of 'placebo effects' in western medicine as evidence that importance of belief does not only apply to alternative therapies. The author explains that beliefs in the efficacy of treatment can be learned in a number of ways, including observation, direct experience, and information from authority figures such as media and researchers.

Indigenous Healing Provides Culture Sensitive Services

Three participants (RP = 1; SP = 2) were of the view that indigenous healers provide a culture sensitive intervention because they share the same cultural background as their

clients. This was perceived to have a positive effect on compliance. The following excerpts illustrate:

> SP-I1 *"I think it's important because so often we have problems like lack of cultural sensitivity. And like faith healers and sangomas and that, they are sensitive to cultural issues and belief systems within those cultures."*

This is consistent with the Public Hearings on Traditional Healers (1997) report and Pretorius' (1999) view that indigenous healers are an important health resource because they share cultural values and beliefs with their clients. They are used by a large number of African people regardless of their educational status or location and people who do not typically consult them sometimes make use of this service when they feel that their afflictions are related to traditional causes (Freeman and Motsei, 1992). These authors attributed this to the belief in the explanation and treatment provided by these healers. Indigenous healing services include ritual cleansing, facilitation of communication with the supernatural beings, good luck charms, and treatment for physical ailments (Zungu, 1992). All of these healing methods are based on cultural understandings of ailments and afflictions. Therefore this form of healing involves activation of cultural belief systems to provide relief from symptoms.

White and Marsella (1982) highlighted the significance of shared cultural understandings in therapy. These authors contend that for therapy to be effective the repertoire of messages must be embedded in the culture of the client. Further, they assert that by tapping into and making use of familiar cultural themes, the healer may be able to produce cathartic effects which in turn give therapeutic leverage.

Swartz (1998) and Helman (2001) however caution against assuming that indigenous healers are automatically more in touch with their clients because of the common cultural background. According to them it is possible for clients, families, and healers, who have the same cultural background to hold different explanatory models and therefore it should not be assumed that they always hold the same views. Thus there can be individual differences within cultural groups, which need to be taken into consideration. In fact, Freeman and Motsei (1992) expressed the view that because indigenous healers are seen as being the mouth-pieces of the ancestors and give voice to the latter's directives, this often limits the choices for clients during treatment.

Suspicion about Questionable Healing Practices

Lack of scientific research on indigenous healing methods

A few participants (SP = 4) as well one registered psychologist in the pilot study, expressed concern about the lack of research on indigenous healing methods and felt that indigenous healing has questionable validity and poor consistency. They also expressed the view that because the herbs and remedies used by indigenous healers have not been researched medically, they can be harmful and toxic. The following extracts illustrate:

> SP-W1 *"For me......first comes the medical model and that's where*
>
> *research......there's scientific evidence, studies, and years and years of studies.*
>
> *You can't compare that with somebody that's......you know, not studied at all.*
>
> *And even no matter what religion be it Muslim, be it Christianity there's never*
>
> *gonna be every single time where there's healing that occurs and there's....so you*
>
> *can't rely on that."*

SP-I1 *"Exactly how consistent and how reliable are these alternative practices...like sangomas and stuff? How do you know that they are right on the mark when they give you a diagnosis?*

SP-I2 *"I think there can be complications when the client is taking say treatment for HIV/AIDS...is on ARVs and then take treatment from a traditional healer as well. There can be negative reactions from the chemicals or medicines."*

SP-W1 *"What is so sad is that so many people who go to people like these are naïve, they are ignorant, and they don't understand that them being cut or fed these things is actually so unhealthy for them....it's more detrimental than useful."*

These views may be related to media exposure about patients who are treated for complications that result from toxic use of herbs dispensed by indigenous healers. According to Pretorius (1999) it is estimated that 15% of the patients admitted to a hospital near Pretoria for poisonous intoxication have complications attributed to traditional medicines.

Kellerman and Thindisa (1998) criticise the lack of scientific research on indigenous healing methods whilst western healing methods are subjected to high levels of scientific research before they can be accepted. They use the example of western practitioners not being allowed to mix two cough mixtures although they have known chemical compositions and question the fact that indigenous healers just mix their herbs without any research on the chemical composition, indications, and contraindications of those herbs. They are therefore of the view that indigenous healing practices should be also subjected to rigorous scientific research before they can be accepted.

This critique about lack of scientific evidence is consistent with the observation by Gaines and Davis-Floyd (2003) that western healers often feel that traditional healing must be subjected to scientific research before it can be considered acceptable. However, Korber (1990), drawing from Schweitzer (1980), argues that it is difficult to assess efficiency of indigenous healing methods because the goals and objectives of these methods are not defined within a biomedical idiom. She therefore argues that they cannot be meaningfully assessed in terms of the usual procedures employed in clinical practice.

Yeh, Hunter, Madan-Bahel, Chiang, and Arora (2004) argue that western methods of studying human beings and their behaviour are based on cause-and-effect relationships and therefore cannot get beyond the physical and cognitive realms of existence. In their view, the typical quantitative and experimental research designs cannot capture the essence of spiritual, cosmic, and metaphysical aspects that indigenous healing methods incorporate. They suggest that alternative research methods which are mainly of a qualitative nature would be more effective in capturing the gist of the subjective experiences relating to different indigenous healing methods.

Concern about harmful indigenous healing practices

Most participants (N = 13) (SP = 4; IP = 5; RP = 4), as well as four participants in the pilot study, expressed concern about harmful indigenous healing methods. The following excerpts illustrate:

SP-I2 *"...you sometimes hear of traditional healers who cut many people using the same blade...."*

SP-W2 *"...there are some very negative things about them, I've also heard that people are sometimes killed to make the medicine..."*

Concerns about harmful indigenous healing practices are well documented in the literature (Helman, 2001; Kellerman and Thindisa, 1998; Korber, 1990; Pretorius, 1999). Helman (2001) acknowledges that some of the methods used by indigenous healers, such as use of unsterilized needles and blades which may lead to severe skin abscesses and the spread of Hepatitis and HIV, are dangerous. He also cautions that in some cases the views of traditional healers on disease and their treatments are so detrimental to health that they themselves form part of the problem. Kellerman and Thindisa (1998) give examples of cases where dirt from people's genital areas and vomit has been used to make medicine to be consumed. Further, these authors cite cases where people have been murdered in order to make traditional medicine as the killing of a human being and use of human parts apparently makes the healers and their medicine more powerful.

Insufficient training to enable physical intervention

Student psychologists (n = 4) expressed concern about the lack of training of indigenous healers on human physiology. These participants also expressed concern about the previous two points. They felt that indigenous healing has questionable efficiency in diagnosing and treating physical conditions. The following excerpts illustrate:

> SP-I1 "...somebody with the medical model, they know the biology, parts of your body, and how they work. And for someone who hasn't studied how do they know exactly how this chemical affects this movement or whatever, this part of the brain affects that?.... So how do they know exactly what they are treating........you know?"

> SP-I2 "...but if you have a life threatening disease you can lose out on necessary treatment"

SP-W1 *"When you have no medical knowledge of chemical composition of medicines you should not be allowed to give medicine"*

This view is linked to the two views discussed earlier, which relate to indigenous healing methods not having been adequately researched and harmful indigenous healing methods. According to these participants these healing methods have the potential to do more harm than good on the physical level. This view is consistent with the report by Hopa et al. (1998) on the views of medical doctors about indigenous healing.

<u>Indigenous healing is susceptible to fraudulent healers</u>

The issue of fraudulent healers and healers who misrepresent their competencies was of concern to all the participants (N =18), as well as those in the pilot study (n = 6), in all levels of training and categories of registration. Participants viewed the lack of standardized training and the mystery surrounding training of indigenous healers as making this form of healing susceptible to fraudulent healers. The following extracts illustrate:

RP-I3 *"...I think that the reputation of indigenous healers has been hurt by people who pretend to be indigenous healers when they do not have the skills..."*

IP-B3 *"It's unlike professionals you see...they [psychologists] undergo training and learn from a qualified psychologist. So here it's difficult to say...people say they go under the water for training for a month. Who is sure that the person really went under the water?"*

RP-I3 *"There is potential for a lot of harm if traditional healers are recognized just because they say they are traditional healers. If they are allowed to practice,*

I mean the mumbo-jumbo traditional healers that say they can cure AIDS....and

that if you have sex with a virgin you will be cured of AIDS"

RP-12 *"But I still have some concerns with regards to the whole HIV/AIDS*

issue....traditional healers who claim they can cure it and discourage use of

ARVs..."

Concerns about fraudulent indigenous healers are well documented in the literature by

various authors (Bodibe, 1992; Courtright et al., 2000; Helman, 2001; Pretorius, 1999;

Swartz, 1999). According to Pretorius (1999) it is estimated that only ten percent of the

indigenous healers practicing in Gauteng are true healers. The author attributed this high

level of fraud within indigenous healing systems to the fact that there is no single

regulatory board for the indigenous healers and also that the existing organizations do not

have mechanisms to enforce the code of ethics. They also view high levels of

unemployment as motivating people into regarding indigenous healing as a means to

make a living when they do not actually have the skills to perform what they claim to.

Furthermore, unlike in the past where indigenous healers practiced in their

communities (where they were known to be true healers), the migration of people has led

to more and more indigenous healers in search of work practicing in the urban areas

where they can make a living (Pretorius, 1999). In South Africa it is not uncommon to

see advertisements for indigenous healers from other countries that practice in South

Africa, often bringing with them new healing practices. This further complicates the

process of determining who is a "real" healer and who is not. Bodibe (1992) also

criticized indigenous healers for sometimes making claims in excess of their abilities

such as the claim that they can cure AIDS. This can lead to delays in the commencement

of antiretroviral treatment and also withdrawal from antiretroviral programmes in favour of indigenous healing.

Interestingly, although the Traditional Health Practitioner's Bill (2003) and the Act (2004) state that it will be unlawful to practice as a traditional health practitioner unless the practitioner is registered in terms of the Act and that the Minister of Health together with the Traditional Health Practitioners Council may regulate on these issues (Department of Health, 2005), these legislations do not provide details on what training criteria or minimum requirements will have to be fulfilled for a person to be deemed qualified.

The finding of no major differences in the responses of participants across racial groups suggests that race does not have much effect on their perceptions towards indigenous healing. This is in contrast to the suggestion by Freeman (1992) that Black professionals within the biomedical professions are more negative towards indigenous healing. However differences were noted in responses by participants at the different levels of training. In comparison to registered and intern psychologists, student psychologists appeared to be more negative about indigenous healing. They appeared to be the most concerned about lack of scientific research on indigenous healing methods and opposed physical intervention by indigenous healers more strongly. No major differences were found in the general perceptions of intern psychologists and registered psychologists.

4. 2. <u>Experiences with Indigenous Healers</u>

Participants were asked about their personal and professional experience with indigenous

healers in order to explore the relationship between their experiences and their general

perceptions of this healing. The following themes emerged from the data.

<u>Personal Experience</u>

Seven participants (RP = 4; IP = 2; SP = 1) reported personal experience with indigenous

healers. This experience was in the form of personal consultation with the healer. Among

these participants, one had a positive experience, two had neutral experiences, and four

had negative experiences. None of the participants in the pilot study reported personal

experiences with indigenous healing.

<u>Positive experiences</u>

The participant (SP) who had a positive experience with a faith healer reported as

follows:

> SP-I1 *"For us the minute we have something bad or get sick or start to wheeze we*
>
> *go to a Moulana and he says read this from the Koran and I take tablets*
>
> *anyway... I believe that if the tablets are gonna work anyway it's God that makes*
>
> *it to work and everything happens for a reason. When we go to a traditional*
>
> *healer or a Moulana it's because he knows the Koran probably better than you,*
>
> *he knows certain prayers. He'll give you things to do he will pray for you or do*
>
> *spiritual counselling because he is closer to God."*

This participant was more positive about faith healing as compared to other categories of

indigenous healing. This is indicated in the section on recognition of indigenous healers.

Neutral experiences

Two participants (RP = 1; IP = 1) had neutral experiences. These participants together with their families consulted with indigenous healers for guidance about rituals. They were unsure about whether the rituals worked. The following excerpt illustrates:

> IP-B1 *"Well it's difficult to say whether that worked, I don't know if they [ancestors] found us but my father believes our ancestors are with us now and we are protected."*

Negative experiences

Four participants (RP = 3; IP = 1) reported negative experiences related to dissatisfaction about indigenous healing services offered to them. The following excerpts illustrate:

> IP-B3 *"....So my parents took me to traditional healers and they said no we have to slaughter chickens or perform rituals ....and nothing helped."*
>
> RP-B2 *"it did not work....Maybe I did not believe in them...."*
>
> RP-B3 *"It was complicated to understand because there was a lot of things and when you try to understand and get answers, you don't get answers and you are not supposed to ask....Most of their practices remain a mystery...."*

Their dissatisfaction arose from issues such as:

- Ineffective practices by indigenous healers and which led to their failure to meet participants' expectations.

- Confusion surrounding mystery around indigenous healing practices, and not being allowed to ask about indigenous healing.

Interestingly these participants were not those who indicated concern about lack of scientific research on indigenous healing practices.

This point aimed to explore the relationship between the participants' personal experiences with indigenous healers and their general perceptions of indigenous healing. Most participants did not have first hand personal experience with indigenous healers. Those who did were mostly African participants and they mostly had negative experiences. However they did not generalize their negative experiences to all indigenous healers and were hopeful about the merit of indigenous healing to those who believe in it. There were no major differences in responses given by participants who have had first hand personal experience and those who had no personal experience. All the participants (N = 18) and those in the pilot study, expressed concerns about harmful indigenous practices regardless of whether they had personal experience or not. Therefore it can be concluded that participants' perceptions of indigenous healing are not related to personal experience.

Secondary Experience

Two participants (SP) reported that they had friends and family friends who had experiences with indigenous healers. Two participants reported that their friends had negative experiences, which were mostly related to unhygienic and harmful practices which resulted in worsening of the situation or death. The following extracts illustrate:

> SP-I2 *"....it was a very good friend of mine....She ended up going to a traditional healer...she came back with these weird weird things that she had to eat....things that from a medical perspectives could make it worse because they are not good*

for you or probably toxic and her immune system was weak. She ended up dying a week later. So I don't know, it was a very negative experience. "

SP-I1 *"We had a domestic worker who had an abscess and we booked her an appointment in a hospital. But even before going there she had gone to a sangoma who had cut it and drained it and he had caused more damage to it.... "*

Notably these two participants are amongst those who expressed concern about insufficient training of indigenous healers and lack of scientific research (discussed earlier) more strongly.

In addition one participant (SP) in the pilot study reported a positive experience with a family member who consulted an indigenous healer and reported as follows:

B1 *"There is also this thing.....it's called speed trap (umeqo). I don't believe in traditional healers but I've seen it. My husband had it, the foot was swollen and he had consulted a number of doctors who did not help him. He consulted with a traditional healer; he poked his foot with needles until the swelling came down. But then when he told me before I did not believe it's a speed trap. So I believe that helped and they charged him a very low fee as compared to doctors.... "*

Although this participant explicitly stated that she did not believe in indigenous healing for her own personal use, she maintained an open mind and held more positive perceptions about this healing and its use by other people.

Professional Experience with Indigenous Healers

Eight participants (RP = 7; SP = 1) had professional experiences of consulting with clients who were consulting with indigenous healers concurrently. Three of these

participants (RP) had telephonic or personal contact with the indigenous healers who were treating the same patients as them. The lack of professional experience with indigenous healers amongst trainee psychologists may be related to their limited exposure to clients in comparison to registered psychologists.

<u>Positive</u>

Seven participants (RP) reported their experiences with indigenous healers as positive. Among these participants the three who had contact with indigenous healers described the experience as beneficial and positive. They were surprised by the openness of the indigenous healers towards western healing and by the level of interest shown by the former in collaborating with them. The following excerpts illustrate:

> RP-W2 *"Certainly it was an eye opening experience....It was more than positive... I was stunned with how spot on the sangoma was....I was also surprised at the extent at which the sangoma had respect for western medicine."*
>
> RP-I1 *"....the traditional healer that she was attending was a very accessible person so for me that was useful. She was willing to understand about my concerns and where I was coming from in terms of treating the patient."*

All seven participants reported that they had to align their therapy with the client's belief system. They reported that eliciting clients' explanatory models and belief systems made them more sensitive to their clients' needs. The participants described their experience of working with these clients as positive and did not experience contradictions as they were able to negotiate the differences between their explanatory models and those of their clients. The following excerpts illustrate:

RP-I3 *"It was useful and very interesting; it's not something that you learn in your training..."*

RP-I2 *"I found it to be a positive experience because ultimately that person felt that he could trust me more because I wasn't dismissing his beliefs....So he found in me a person that he could trust and rapport was deeply established so that means our therapeutic relationship was stronger..."*

RP-B3 *"And I found out that after she went to Zion the anxiety got better because she believed...her home was protected..."*

RP-B1 *"I never find it difficult to combine the two because my intention is not to contradict. I think I've always looked for collaboration in my own way....I've always made sure and understood that people that I work with find value in this type of healing from traditional healers and I respect their point of view..."*

The exploration of clients' explanatory models described by this sample of registered psychologists is consistent with interpretive approaches to understanding mental health. This approach aims to understand people in their own terms and requires the clinician to consider the person's individual experience of illness and distress (Swartz, 1998). The therapist needs to explore and understand the patient's explanatory model and if it differs from his own, he needs to negotiate between the two and find common ground which will form the basis for treatment.

Eliciting client's cultural explanations is one of the important factors in the Cultural Formulation model outlined in the DSM IV-TR (APA, 2000). According to this model the clinician should analyze the patient's presenting problem using the following factors: cultural identity, cultural explanations of the illness, cultural factors related to

psychosocial environment and levels of functioning, cultural elements of the clinician, and overall impact of culture on the diagnosis and care. This would help the therapists provide an accurate diagnosis and formulate treatment plans which are acceptable to the client. Clients are more likely to comply with treatment if their cultural explanations are accepted, validated and understood by the therapist (Lewis-Fernandez and Diaz, 2002)

Negative

One participant (SP) had a negative experience, in her role as a counsellor, with a client who was consulting a traditional healer. She described her experience as confusing partly because she was not familiar with the client's belief system. She reported as follows:

> SP-I2 *"...I remember during consultations instead of discussing the problem he continued talking about the traditional healer, the ancestors that are not happy and all those things. Very confusing, very confusing more especially because I haven't consulted...If you don't have any experience for you it's like this person is talking another language that you really don't understand."*

This description suggests that the cultural differences between the practitioner and the client as well as the practitioner's lack of knowledge about the client's cultural beliefs were perceived as an obstruction in therapy. While this confusion may often be genuine, Swartz (1998) cautions against what he terms 'cultural camouflage', which he described as an attempt to block access on the part of the practitioner by claiming cultural difference as a basis for misunderstanding.

The literature suggests that cultural differences should no longer be a barrier in therapy as different approaches to multicultural assessment and diagnosis have been

formulated to enhance cross cultural counselling (Sue et. al, 1992; Swartz, 1998). Sue et al. (1992) outline the following key competencies for multicultural counselling:

- Therapist's cultural self awareness – awareness of own assumptions, values, biases, and their influence as well as being comfortable with client's beliefs and cultural differences.

- Understanding the worldview of the culturally different client – Swartz (1998) suggests that the best way to learn about the client's belief system is by asking the client directly and respectfully. According to him although some practitioners may be embarrassed about their lack of knowledge, pretending to understand when one does not, may actually be more detrimental to the therapeutic relationship. Sue et al. (1992) recommends that the therapist should contrast his own views with the views of the client in a non-judgemental fashion in order to gain an understanding.

- Developing appropriate counsellor interventions, strategies, and techniques – respecting client's religious or spiritual beliefs and respecting indigenous healing practices and networks.

In summary there were no major differences in the general perceptions of indigenous healing among participants who had professional experience with indigenous healing and those who did not. However differences were noted in the views of these participants on collaborating with indigenous healers. This will be discussed in the sections that follow.

4.3. Views on Formal Recognition of Indigenous Healing Systems by the Government

Participants were asked about their views on formal recognition of indigenous healers by the South African government. The objective of this question was to explore how the participants viewed the government's impending recognition of indigenous healers.

Indigenous Healing Systems Should Be Recognized

Notwithstanding their concerns about harmful indigenous healing practices and fraudulent indigenous healers, most respondents (N = 12) (RP = 6; IP = 5, SP = 1) in all categories of registration were positive towards the formal recognition of indigenous healers by the South African government. In addition two student psychologists in the pilot study shared this view. These participants had the general view that government cannot regulate indigenous healing unless they formally recognize it. Thus they were of the view that once it is recognized it can be regulated thereby making it safer and improving the quality of the practices involved. This excerpt illustrates:

> SP-W2 *"Now with traditional healers perhaps it's a way to regulate it. In the past when you don't regulate it, you tried to pretend as if it's not happening. It happens a lot so you can save a lot of people if you regulate it ... if you recognize it"*

The following benefits of formally recognising indigenous healers were cited by the participants:

- Will allow for quality control and exclusion of fake and harmful healers.
- Will allow for recognition of training provided by indigenous healers.

- Will encourage indigenous healers to refer to western healers because they will see themselves as working in a team.

- Will make indigenous healing services more accessible.

- Will deal with the stigma associated with consulting indigenous healers and allow people to consult with indigenous healers more freely.

- Will acknowledge indigenous healers for their work and give them an opportunity to work with the western healers.

- Will facilitate communication between indigenous healers and western trained healers.

- Will encourage clients to use western healing as well because when they are discouraged from using indigenous healing they stop coming for western healing as well.

In relation to this last point, Korber (1990) and Pillay (1996) noted that clients often make use of both indigenous and biomedical services. This often happens when they are not satisfied with the explanation or treatment provided by either model.

These participants view the recognition of indigenous healing as an opportunity to address concerns such as harmful practices and fraudulent healers. These views are consistent with the aims of the Traditional Health Practitioners Bill which allows for formal recognition of indigenous healers and the establishment of the Interim Traditional Health Practitioners Council which will regulate and monitor indigenous healing practices (Department of Health, 2004). However Doctors For Life remains skeptical about the governments' ability to regulate indigenous healers. In their view the Bill is a

mechanism that cannot regulate the spirit world, which indigenous healers operate from (Umoniyi, n.d.)

Indigenous Healers Will Continue To Exist Regardless Of Whether They Are Recognized or Not

Some participants (N = 3) (RP = 2; IP = 1) were of the view that, since people make use of indigenous healing and that they will continue using this service, it is necessary for indigenous healers to be recognized. The following excerpts illustrate:

> RP-B1 *".....they are used by most black people....So I think they play a major role in our society. We should just accept that they are there and we should try to work with them."*

> RP-I1 *"It exists in the mind and lives of many people who subscribe to indigenous healing beliefs and that because it exists it needs to be taken into consideration"*

This view is also consistent with Mkhize's (2004) call for recognition of indigenous knowledge systems. In his view, indigenous worldview will not cease to function just because it is marginalized. Rather "people continue to rely on it, sometimes secretly" (p. 38).

Bodibe (1992) and Pretorius (1999) estimate that indigenous healers are used by about 60 to 80% of the South African population. This view concurs with that expressed by Korber (1990) and Freeman and Motsei (1992) that traditional healing is considered an important health resource by its users and therefore cannot be ignored.

<u>Ambivalence about Recognition of Indigenous Healing Systems</u>

Three participants (SP) were ambivalent about the recognition of indigenous healers. While they viewed the recognition as beneficial in that it will allow for regulation of indigenous healers, they also felt that this recognition should not be given to all categories of indigenous healers. In their view indigenous healers should not in any way be allowed to intervene on a physical level, that is to prescribe medication or cut people, and therefore they opposed recognition of indigenous healers who intervene in this way. They felt that recognition should be given to faith healers and those who only make use of rituals.

Notably the participants who expressed this view were also those who expressed concern about insufficient training for indigenous healers and lack of scientific research on indigenous healing methods. According to Courtright et al. (2000) western healers are often wary of indigenous healing methods because their exposure to indigenous healing is often limited to the cases where this kind of healing has resulted in mishaps; and remain unaware of the cases where this healing has been successful. This therefore leads to the perception that their recognition will legalise their harmful practices. This is consistent with the findings of this study; the participants who reported negative secondary experiences with indigenous healers had limited knowledge of indigenous healing, with their exposure being limited to negative media reports on indigenous healing. As such, they also felt that they did not have enough information to comment on the role of indigenous healers in the mental health care system. This point will be discussed further on the role of indigenous healers in the mental healthcare system.

In addition three student psychologists in the pilot study were also ambivalent about the formal recognition of indigenous healers as they felt that they lacked enough information to express an informed opinion.

In summary, participants had various views about the formal recognition of indigenous healers. Most registered psychologists and intern psychologists were positive towards this recognition. There was a predominant view that formal recognition of indigenous healers will allow for regulation of indigenous healing practices. This view stems mostly from the concern about harmful indigenous healing practices and the fact that this form of healing will continue to exist regardless of whether it is acknowledged or not; thus necessitating its recognition and formalization. However some participants, notably student psychologists, were ambivalent; although they acknowledged the benefit of regulating indigenous healing they were concerned about recognition being given to all categories of indigenous healers and harmful practices by indigenous healers. They therefore felt that recognition should be given only to participants who make use of prayer and rituals. Others cited lack of knowledge and uncertainty about the benefit of indigenous healing as the reason for their ambivalence about its recognition.

4.4 Views on Inclusion of Indigenous Healers in the Formal Mental Health Care System

Participants were asked for their views on whether indigenous healers should be included in the mental health care system and if affirmative, how they should be included.

Participants' responses were varied; they ranged from fully agreeing to inclusion, ambivalence, to totally rejecting their inclusion.

Indigenous Healers Should Be Included

Six participants (RP = 4; IP = 2) felt that indigenous healers should be included in the formal mental health care system. These participants held the view that indigenous healers should be included in the mental health care sector without losing their autonomy and as equal partners to western healers. Two of these participants (RP) expressed concerns that unless the former was done, indigenous healing may end up being treated as an alternative rather than a main approach to treating illness. These participants were also concerned that inclusion of indigenous healing may just be window dressing, when in fact they are still viewed as 'quackery', 'weird', and 'not the real healing' by the western practitioners. Consistent with this concern, Wreford (2005) cites examples where attempts at collaboration between indigenous healers and western healers have been characterized by one-way dissemination of information where western practitioners educate indigenous healers, instead of engaging in a dialogue between the two paradigms. This has led indigenous healers to feel that their input is not appreciated by western practitioners, as they were not given the opportunity to share their knowledge. This type of interaction which infers the hegemony of western healing systems is problematic (Wreford, 2005). Gaines and Davis-Floyd (2003) and Wreford (2005) thus call for collaborative efforts where both knowledge systems are valued.

These participants also expressed the view that the two systems should work together in a collaborative form such as a multidisciplinary approach to treatment. Further, they felt

that such an approach should allow for considered and appropriate referrals between the two systems, rather than referring because one doesn't know what else to do with the client. The inclusion was seen as an opportunity for holistic patient care and the two systems to learn from each other.

The following excerpts illustrate:

> RP-B3 "...*I think that working closer to them we can learn a lot from them and they can learn a lot from us. We all have the common goal of saving and helping the society. We should not be competing, the society sees us all as people who can help them. Traditional healers are there, people are consulting with them and they are in demand. If they were not in demand there wouldn't be so many of them. We could share ideas perhaps do research on combining our treatments. We could work together.*"

> RP-W2 "*When a person comes into the health system they should be referred to a traditional healer as a rational decision and in terms of where the person is coming from, it shouldn't really matter if they are black.*"

Collaboration would require the two systems to have fairly good knowledge about each other in order to know who and when to refer to the other system. Participants had different views about the level at which this sharing of information should take place. Three participants (IP = 2; RP = 1) were of the view that information should be shared at the psychological board level so that psychologists can first acquire information about indigenous healing practices. The other three participants (RP = 2; IP = 1) were of the view that information sharing should start at grassroots level in the form of case reviews and discussions then move up to other levels.

This support for collaboration is consistent with the views expressed by Korber (1990) and Bodibe (1992) that collaboration is the preferred method for inclusion of indigenous healers into the formal health care system. In collaboration or cooperation the two systems keep to their methods of operation and recognise the importance of the other. The practitioners from the two systems would have to decide which disorders should be referred to whom or alternatively decide that each approach is not sufficient on its own and let the client consult with both systems concurrently. The practitioners will then be required to refer to each other as needed. As Korber (1990) and Bodibe (1992) anticipate difficulties in trying to merge the two approaches in a manner that would require the one or the other to lose its autonomy, they suggest a collaborative approach which allows for each healing system to retain its autonomy and strengths. However, the history of a one-way referral pattern in which western practitioners fail to reciprocate referrals from indigenous healers (Freeman and Motsei, 1992; Pretorius, 1999) suggests reluctance or resistance among western practitioners towards collaboration with indigenous healers.

Ambivalence about Whether They Should Be Included

Although some participants (N = 5) (RP = 3; IP = 2) felt that indigenous healing should not be marginalized; they were ambivalent about its formal inclusion into the mental health care system. Two student psychologists in the pilot study also shared this view. They voiced the opinion that western healers do not know enough about indigenous healing for it to be included in formal health care. The following excerpts illustrate:

RP-I1 *"For me it's like a double edge sword...Isolating them is the worst case scenario because you make it interesting to people who are gonna go*

there ... That's difficult to answer unless we know we have an understanding of what is traditional healing and all about them ...one cannot work alongside an unknown entity."

RP-12 *"To be very honest I think it should be in some kind of manner in which we can be able to monitor and control it ...So maybe not into the heath care system but functioning within it where you can monitor the treatment that they give. Maybe some kind of specialty can be developed where the doctor can say I'm referring this particular person. So you can come in there not to just any healer, somebody with some kind of qualification and background.....then we can work with those who are professional and their treatment is monitored."*

It is noteworthy that most of the registered psychologists and intern psychologists were either agreeable or ambivalent towards inclusion of indigenous healers into the mental health care system. This is in contrast with student psychologists who were mostly opposed to this inclusion. This indicates a pattern of more negative views towards indigenous healing among student psychologists as compared to registered psychologists. Student psychologists' exposure to clients is often limited to the clients that they consult with in their respective university clinics. Ahmed and Pillay (2004) note that with the training of psychologists in South Africa being very much located within a biomedical paradigm, this does not adequately prepare students for working in a diverse society like South Africa. The implication of this finding is that with more experience and exposure to clients outside of a university setting, psychologists are likely to become more open to alternative ways of healing.

<u>Opposition to Inclusion into Formal Mental Health Care System</u>

Seven participants (SP = 4; IP = 2; RP = 1) were opposed to inclusion of indigenous

healers in the formal mental health care system. In addition two student psychologists in

the pilot study also shared this view. Reasons cited for opposition of this inclusion

included:

- Lack of knowledge about indigenous healing.

- Lack of research on indigenous healing methods.

- Lack of regulation for indigenous healers.

- Harmful indigenous healing practices.

- Inclusion of indigenous healers would take way the autonomy of indigenous

  healers.

- Inclusion would limit clients' choices.

- Lack of common ground between indigenous healing and western healing

  therefore the two systems would clash.

- Indigenous healers are good in specific areas, so if integrated one healer may have

  to perform healing in areas he is not gifted in.

The following excerpts illustrate:

RP-B2 *"No I don't think they should be brought into the mental health system,*

they are okay where they are and they should provide alternative treatment... We

would be limiting patient's choices....Besides we do not know much about

traditional healers. There is still a lot of work that needs to be done in terms of

researching on their therapeutic methods"

SP-W2 *"...you cannot marry an approach if you remain ignorant about it... "*

SP-I1 *"...Otherwise we're going to take the medical approach down by marrying it with this healing..."*

Lack of information was cited by participants as the reason for ambivalence and total rejection of inclusion of indigenous healers into the mental healthcare system. This is consistent with the Freeman (1992) and Hopa et al. (1998) reports that western practitioners do not have adequate information on indigenous healing. The finding suggests that training institutions are still not doing enough to expose students to alternate ways of understanding mental health and illness. Mkhize (2004) also laments the insufficient integration of indigenous knowledge systems into the training of psychologists. According to him the criticism that such integration reifies culture is invalid as this criticism is not levelled against western knowledge systems which are also influenced by western culture.

The view that the two healing systems would clash because they have no common ground is related to the fact that the two systems hold different basic assumptions about illness, its causation and treatment (Yeh et al., 2004). Indigenous healers are believed to get their healing powers from supernatural forces and tend to be mysterious about their training and healing methods, while western healing places emphasis on standardized training of healers and scientific research of healing methods (Bodibe, 1992; Swartz, 1998).

Although the two healing systems are different, literature suggests that they can be compatible (Helman, 2001). The author asserts that a hermeneutic approach can enable therapists to link indigenous healing to psychotherapy. The hermeneutic approach moves

primary focus from the individual to other cultural, social, and religious factors which will lead to an integrated meaningful view of the person and his environment. This approach has been discussed in more detail earlier in this chapter.

Notwithstanding concerns about harmful indigenous healing methods related to regulatory problems, authors such as Freeman (1992); Freeman and Motsei (1992); Korber (1990) suggest that there are power struggles between the two systems which are an eminent part of the debate on inclusion of indigenous healers into the formal healthcare system. These authors assert that indigenous healers pose an economic threat to western healers in terms of competition for patients and state resources. If indigenous healers are subsidized by the government this would mean that the health budget has to be divided further, thus reducing the slice that western healing has always enjoyed. Korber (1990) notes that apart from the issue of economic power, inclusion of indigenous healers may also be perceived as threatening the hegemony and power vested in western medicine. Given the historical acceptance of biomedicine as superior to other knowledge systems and forms of treatment, acknowledging the benefits of the other system implies inherently affirming their equal status (Gaines and Davis-Floyd, 2003).

4.5. Role of Indigenous Healers in Mental Health

Participants were asked their views on whether there is a role for indigenous healers in the mental health care system. The following themes emerged from their responses.

There Is a Role for Them

Most participants (N = 13) (RP = 6, IP = 6, SP = 1) agreed that there is a role for indigenous healers. They outlined the following as the role of indigenous healers:

- Allay people's fears from a cultural perspective.

- Explain people's problems from a cultural point of view and give meaning to illness.

- Encourage a positive outlook towards illnesses such as HIV.

- Emotional support to patients and their families.

- Spiritual healing.

- Supplementary role to make up for the shortage of professional mental health practitioners.

Some participants felt that indigenous healing has more of a role to play in mental health than in physical health because of the mind-body dualism and the fact that mental health is about the individual's unique beliefs and perceptions about the illness. Helman (2001) expressed a similar view that medical authorities have come to recognize that indigenous healers play a beneficial role especially when dealing with psychological problems. This view is consistent with the view expressed by Heyl (1992) and the study by Hopa et al., (1998) that services provided by indigenous healers are useful for emotional support in a way similar to counselling services. In the latter's view indigenous healers should collaborate more with psychologists because while the medicines they use are often harmful, their services are useful for emotional support.

In support for this Bodibe (1992) identified the following therapeutic benefits of indigenous healing rituals in dealing with mental health problems:

- The unquestioning manner in which dreams are related has a healing and integrating effect.

- The singing and dancing ritual allows for expression of emotions which also has a healing effect.

- Anxiety might be overcome by the dramatization involved in the singing, drumming, and dancing.

- Indigenous healing also mobilises social support for the patient because the patient is accompanied by his or her family when consulting with the indigenous healer and also when doing the rituals. The client therefore feels supported during his time of distress as he receives support, understanding, and acceptance of his or her family.

The benefit of these factors in dealing with psychological disorders is also documented in psychological theories, for example, the humanistic approach.

Role Should Be Defined By Clients of Indigenous Healers

Two participants (RP) were reluctant to clearly define what they think the role of indigenous healers should be. The following excerpts illustrate:

> RP-I1 *"I wouldn't want to be presumptuous and say they can only work with us....I think to be available to people that seek out their help and fulfill that role in an ethically good manner so that nobody has been hurt or violated."*
>
> RP-W1 *"The role would be what people seeking indigenous healing define it to be."*

<u>Uncertainty About Their Role</u>

In contrast to most registered psychologists and intern psychologists who felt that indigenous healing has a role to play in the mental health care system, three participants (SP) were unsure what role indigenous healing can play because they felt that they did not have enough knowledge to voice an informed opinion about this. The following excerpt illustrates:

RP-W2 *"I don't know a lot about this healing so I don't know what their role is."* Notably these participants also cited lack of information as one of the reasons for opposing the inclusion of indigenous healers into the mental health care system. This affirms the implication made earlier, that with more exposure and experience comes more openness to alternative ways of healing.

4.6. <u>Referrals Between Psychologists And Indigenous Healers</u>

Participants were asked about their views of referrals between psychologists and indigenous healers. This question was posed to explore how they are likely to work with indigenous healers, considering that they will be required to work with them at some point in their career lives. The following themes emerged from the participants' responses.

<u>Referrals from Indigenous Healers to Psychologists</u>

<u>Would accept referrals from indigenous healers</u>

All participants (N = 18) reported that they would accept referrals from indigenous healers. However one participant (RP) engaged in private practice reported that medical aid funds would not process claims of cases referred from other practitioners other than

medical doctors. So although they are willing to accept these referrals, they would not be able to accept referrals from indigenous healers unless medical aid policies change.

Referrals from Psychologists to Indigenous Healers

Would not refer unless the client makes an explicit request

Most participants (N = 14) (SP = 4; IP = 6; RP = 4) reported that they would not refer to an indigenous healer unless the client makes an explicit request for a referral. Reasons given were:

- The client may not believe in indigenous healing.

- Psychologist would not know how to recognize clients that need to be referred to indigenous healers.

- Lack of knowledge of indigenous healer referral base.

- Lack of knowledge of indigenous healing code of conduct and practice.

- Reluctance to take responsibility involved with referring a client to an indigenous healer as one would have to ensure that the client is not harmed.

- Lack of knowledge of indigenous healing and how it would help therefore it would be unprofessional to refer to an unknown resource.

- Lack of regulation for indigenous healers.

- Indigenous healers would not be able to understand referrals from psychologists because they use different professional languages.

While some of these reasons were valid, some were based on participants' valorising of western systems and invalidation of alternate healing practices, for example:

- It would be wrong to refer to an indigenous healer.

- It's not the role of a psychologist to refer to an indigenous healer. Psychologists should refer to other western healers.

It is interesting that some of these participants reported positive experiences of consulting with clients who were consulting with indigenous healers and one of them had positive interaction with the indigenous healer who was treating the same patient as she did, and yet that was not sufficient to remove doubt about referring to indigenous healers. It is also noteworthy that some of these participants cited collaboration as the preferred form of inclusion of indigenous healers into the mental healthcare system. Thus the formal recognition and the subsequent regulation of indigenous healers, creation of clear referral procedures, and increased knowledge on indigenous healing among western healers may bring about a shift from the one-way referral patterns noted by Freeman and Motsei (1992) and Pretorius (1999).

Recommendation versus referral

Two participants (RP) reported that they would not make a referral but would recommend that a patient consults an indigenous healer. Their reasons included:

- Indigenous healers would not be able to understand referrals from psychologists.

- Reluctance to take responsibility if harm is done by the indigenous healer.

- No knowledge about indigenous healing and their referral base.

Would refer

Two participants (RP) reported that they would refer patients to indigenous healers. Notably, these participants also reported positive experiences of having had contact with indigenous healers with whom they collaboratively treated a patient. They cited the following reasons for referrals to indigenous healers:

- Psychologists need to realize that there are disorders and problems that western healers cannot treat.

- Referrals would make life easier for both indigenous and western healers.

- If as a psychologist he/she is convinced that the client is presenting with a culture bound condition.

The fact that most participants reported that they would not refer unless the client made an explicit request mirrors the one-way pattern of referrals where western healers fail to reciprocate referrals from indigenous healers (Freeman and Motsei, 1992; Pretorius, 1999). Pretorius (1999) attributed this to skepticism and suspicion about indigenous healing amongst western healers. Helman (2001) expresses the view that western practitioners still tend to view indigenous healing methods as quackery, and the healers as charlatans and witchdoctors who pose a threat to patients' health, hence they do not refer to them. Some of the concerns raised by participants about referring to indigenous healers are consistent with the regulatory problems that these participants expressed earlier.

Courtright et al. (2000) assert that western practitioners often have an incorrect perception that indigenous healing is illegal and view referrals to indigenous healers as legitimising the improper and harmful indigenous healing practices. This is consistent with the last two reasons cited by participants, such as the view that referring to indigenous healers is wrong.

4.7. Collaboration with Indigenous Healers

Views on Collaboration

Participants were asked if there are any cases they think would benefit from collaboration between psychologists and indigenous healers. Although most participants agreed that there are cases that would benefit from indigenous healing, their views on collaboration differed. Most trainee psychologists (n = 9) expressed anxiety about consulting with clients who were consulting with indigenous healers concurrently. In their view the two approaches would either contradict or lead to confusion in both the therapist and the client and hinder the treatment process. They therefore recommended that clients consult one of the approaches at a time. Registered psychologists were however confident about their ability to conduct therapy with clients using both healing systems. This could be related to the fact that registered psychologists have had positive experiences with such clients and more exposure within the field of psychology. It can also be inferred that the difference between registered and training psychologists is related to registered psychologists' greater confidence about being exposed to alternate ways of viewing illness.

Cases for Collaboration with Indigenous Healers

Participants cited the following psychological and social problems and scenarios as cases that would benefit from collaboration between indigenous healers and psychologists:

- Bereavement

- Trauma

- Marital problems

- Cases of adolescents

- Depression

- Hysterical phenomena

- HIV/AIDS patients

- Child abuse

- When a client believes that the problem or disorder is caused by supernatural forces, i.e. cultural explanatory models.

- Cases where the psychologists feel that clients are not making progress in therapy and therefore feel that there is a culture bound problem.

- Clients who feel suicidal or homicidal after being told by an indigenous healer that they are bewitched or their problems are caused by supernatural forces.

All of these psychosocial problems and scenarios were identified on the basis that the clients had cultural explanations for their causation. The participants felt that they would refer clients with these conditions only after they have found that clients believed in indigenous healing and understood these problems within this framework. Indigenous healing was identified as a possible resource to help these patients make meaning in their lives. Notably these participants did not limit the cases to the so called 'culture bound' conditions. This suggests a broader view of the role of indigenous healers and emphasis on the context of the client, which is consistent with the hermeneutic approach.

According to Zungu (1992) indigenous healers are consulted for a variety of physical and psychosocial problems which are not only limited to physical health. The benefit of indigenous approaches in dealing with mental health problems has already been

discussed above in the section on inclusion of indigenous healing into mental health care system.

According to Swartz (1998), if healthy interaction is to be achieved between the two health care systems it is essential that they both have mutual respect for each other. He asserts that mutual respect does not mean simply admitting that the other system is helpful without criticizing it, but that both systems need to critically analyze the usefulness and limitations of the other. Each practitioner has a responsibility and moral obligation to inform their client when they think that consulting the other system will harm them, without infringing on their client's right to self determination (Swartz, 1998). The views of the participants in this study were in accordance with this recommendation by Swartz because although they acknowledged the benefits of indigenous healing they also maintained a degree of criticism about harmful indigenous healing practices.

4.8.   Skills and Knowledge Needed To Enable Collaboration with Indigenous Healers

Participants were asked what skills and knowledge they need in order to be able to work in collaboration with indigenous healers. They listed the following:

- More exposure to community psychology modules at training level.

- More exposure to multicultural counselling modules at training level.

- More exposure to cultural formulations of mental illness.

- Awareness and understanding of different healing and belief systems.

- Understanding of culture and interaction between western and indigenous approaches with illustration of case studies.

- Workshops, conferences, and modules to encourage in-depth awareness of indigenous healing, its basic assumptions, healing practices, and which conditions or disorders they deal with.

- Workshops conducted by indigenous healers to get more information about indigenous healing.

- Clear definition of roles of different indigenous healers and their competencies and areas of specialty so as to inform referrals to indigenous healers.

- Thorough assessment skills so that 'real psychopathology' is not overlooked in the interest of being culture sensitive.

- Openness to indigenous healing approaches and sensitivity to other world views.

- Education of communities and indigenous healers on the role of psychologists.

The need for information about indigenous healers and the need to incorporate this into the training of psychologists was raised by almost all participants (N = 17). This lack of information on indigenous healers is consistent with the findings by Hopa et al. (1998) and Korber (1990). Their findings indicate that there is a level of ignorance amongst western practitioners about indigenous healing. Thus these authors argue that there is a need for training of practitioners and students to be adapted appropriately as this ignorance is often a barrier to effective collaboration. This lack of information reported by the participants can be related to Swartz's (1999) point about the way literature on indigenous healing is presented. According to him this "literature is presented, to a large

extent, as unexplained and mysterious to a predominantly white audience" (p106). This manner of presentation in literature makes it more likely for information contained in them to be dismissed.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

The South African government has taken significant steps towards the formal recognition of indigenous healing. The gazetting of the Traditional Health Practitioners Act No 35 of 2004, by the South African National Parliament in May 2005 was the most significant step in this direction. However, fierce opposition by the Doctors For Life organization and subsequent suspension of this Act suggests the extent to which health practitioners' views on formal recognition of indigenous healing may differ. This study therefore undertook to explore training and registered psychologists' perceptions of indigenous healing. The findings and implications for training of psychologists are discussed below.

Major Findings

Student psychologists, in this study, held more negative views about indigenous healing and its inclusion in the formal health care sector than other participants. They expressed more concern about lack of scientific research and insufficient training of indigenous healers to enable them to render physical intervention. Consistent with these two concerns most of these participants (n = 3) felt that recognition should not be given to all categories of indigenous healers. They felt that recognition should be given only to those who do not intervene on the physical level.

All student psychologists were opposed to inclusion of indigenous healers into the formal mental health care system. Along with the concerns discussed earlier they cited lack of information as another reason for this opposition and their uncertainty about the role of indigenous healers in mental health. Notwithstanding their negative views about indigenous healing, these participants maintained that indigenous healing is useful to

those who believe in it and thus they all reported that they would only refer clients who make explicit requests for referrals to indigenous healers.

No major differences were noted in the perceptions of intern psychologists and registered psychologists towards indigenous healing. These participants were more open to indigenous healing, its formal recognition, and its inclusion in the formal mental health care system. Notwithstanding their concerns about harmful indigenous healing practices and fraudulent healers, most of these participants (N = 11) felt that indigenous healing should be formally recognized so that its practices can be regulated. Some participants held the view that people will continue making use of indigenous healing regardless of its formal status and it should therefore be officially recognized.

Most registered and intern psychologists (N = 11) were open to the inclusion of indigenous healers in that they were agreeable or ambivalent towards the inclusion. All registered and intern psychologists felt that indigenous healing has a role to play in mental health care. They cited spiritual support and assistance with psychosocial problems as the areas where indigenous healers can be of help. Most of these participants reported that they would not refer to indigenous healers unless the client made an explicit request. In addition to their earlier concerns related to poor regulation they cited lack of information on indigenous healing as another factor which makes them reluctant to initiate referrals to indigenous healers. The implication of this is that if western practitioners can be educated more about indigenous healing and if the latter can be appropriately regulated, the problem of one-way referrals between the two systems reported by Freeman and Motsei (1992) and Pretorius (1999) can be overcome.

No differences were noted in the general perceptions of indigenous healing between participants who had personal or professional experience and those who did not. Thus there appears to be no relationship between personal or professional experience and the general perceptions towards indigenous healing. However the participants who had professional experiences with indigenous healing, that is, registered psychologists were more confident about their ability to collaborate with indigenous healers.

Although all these participants have been exposed to training that is predominantly located within the biomedical paradigm, intern and registered psychologists by virtue of their longer period of exposure to the field of psychology, have more exposure in terms of both consultation with clients outside of the university setting and engagement with critical debates within the field of psychology. Thus they are exposed to various dialogues on critical psychology, the need for the move away from exclusive use of traditional psychological theories to a more contextualized understanding of clients, and the importance of culture in the causation and treatment of illness. The findings thus suggest that as psychologists become more socialized into the profession they develop more positive views about indigenous healing.

Limitations of the Study

The lack of black student psychologists in the sample could have compromised the findings. However, it is hoped that the inclusion of data from the pilot study which included four black student psychologists has reduced the impact of this limitation. Secondly, based on the qualitative nature of this study and the fact that participants were

only from Durban, the researcher wishes to express that findings of this study cannot be directly generalized to the entire population of psychologists.

Greeff (2002) notes that although qualitative research can provide rich data which cannot be accessed through quantitative research, there is a possibility that participants may express socially desirable views. The researcher however assured participants that they would not be judged for their responses and encouraged them to share their honest views.

Recommendations

With the widespread use of indigenous healing alluded to by authors such as Bodibe (1992) and Pretorius (1999) and progress made towards the formal recognition of indigenous healing it is imperative that trainee psychologists in South Africa be prepared for working with indigenous healers. In order to achieve this, it is recommended that training institutions incorporate knowledge on indigenous healing into their training programmes (Yeh et al., 2004). However these indigenous knowledge systems should be presented as having equal status as western knowledge systems, rather than with one having hegemonic status. This information can also be integrated into continuing professional development programmes and seminars of registered psychologists.

It is also recommended that training institutions expose students more to community psychology modules and cultural formulations of mental illnesses. This can be done by encouraging use of such formulations in case conferences and case presentations. This will help psychologists move away from the individualistic approaches which have been

criticised as being irrelevant for the South African context (Pillay and Ahmed, 2004), towards a more contextualised understanding of clients and their illness representations.

More pronounced interaction between indigenous healers and psychologists in the form of seminars, conferences, and case reviews is also recommended. This can provide space for a dialogue between the two systems and facilitate formation of formal links between the two systems of healing. This will also address the issue raised by participants about acquiring knowledge directly from indigenous healers. This is likely to address the criticism that literature on indigenous healing presented as mysterious (Swartz, 1999).

A scientific study of this nature needs to be replicated and qualified with further research and thus a larger study combining qualitative and quantitative research designs is envisaged. The differences observed in the perceptions of psychologists at different levels of qualification needs to be researched further. It would also be noteworthy to find out psychologists' views on how the process of recognition and integration of indigenous healers into the formal health care system should be done.

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APPENDIX A

<u>Focus group guide</u>

Everything that will be discussed here today will be treated as confidential and no names will be disclosed. I will audio record the session in order to transcribe the data later. You can listen to the tape after the interview and decide if I can use it.

There has been some controversy about the South African government's decision to pass the Traditional Health Practitioners Act no 35 of 2004, which allowed for formal recognition of indigenous healers and the establishment of the Interim Traditional Health Practitioners Council which will regulate and monitor indigenous healing practices. For the purpose of this study indigenous healers refer to diviners, herbalists, and faith healers.

1. What do you think about indigenous healing in general?

2. Have you ever had any experience, personally or professionally, with indigenous healers?

    • If yes, how did you find the experience?

3. What are your thoughts about the formal recognition of indigenous healers by the government?

4. Is there a role for indigenous healers in the mental health care system?

    • If no, why?

    • If yes, what do you think is that role?

5. Do you think they should be included into the mental health system? If yes, how do you think they should be included (incorporation, total integration, or collaboration)?

6. What are your views about referrals from psychologists to indigenous healers and visa versa?

    • Are there any cases where you think cooperation/collaboration with indigenous healers will be helpful?

If yes, what skills or knowledge do you think you need to obtain to enable you to work more efficiently in cooperation/collaboration with indigenous healers?

APPENDIX B

<u>Informed consent</u>

I am a masters student undertaking research on the perceptions of registered and training psychologists towards indigenous healing and the role of indigenous healers in the mental health care system. I request your participation in an individual interview or as a member of a focus group on the research topic, which will take approximately one hour. The discussion will be audio recorded and transcribed after the discussion. Your identity as a research participant will not be disclosed and data will be reported on collectively. As a focus group participant you are also required to maintain the confidentiality of other participants. Your participation is voluntary and you will be free to withdraw from the research at any point without being disadvantaged in any way.

_____

N.Q. DALASILE

Researcher

_____

S. RAMGOON

Research supervisor/ Counselling psychologist

(031) 260 7615

<u>Declaration</u>

I hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

_____   _____

Participant   Date

APPENDIX C

Example of a Transcript

TRANSCRIPT OF AN INTERVIEW WITH REGISTERED PSYCHOLOGIST – C

Q: **Everything that will be discussed here today will be treated as confidential and no names will be disclosed. I will audio record the session in order to transcribe the data later. You can listen to the tape after the interview and decide if I can use it. There has been some controversy about the South African government's decision to gazzettte the Traditional Health Practitioners Act no 35 of 2004, which allowed for formal recognition of indigenous healers and the establishment of the Interim Traditional Health Practitioners Council which will regulate and monitor indigenous healing practices. For the purpose of this study indigenous healers refer to diviners, herbalists, and faith healers.**

Q **: What are your thoughts about indigenous healing in general?**

A : I think that this particular discipline can be quite useful certainly in terms of allaying people's fears about from a cultural perspective. I think that it can be quite useful although I think that the reputation of indigenous healers has been hurt by people who pretend to be indigenous healers when they do not have the skills to be indigenous healers. But I think that it's a useful tool, I have positive attitude towards indigenous healing.

Q **: Have you ever had any personal or professional experience with traditional healers?**

A : I have had professional experience with indigenous healers not on a one to one basis but I've had clients who consulted with me and with traditional healers as well. And

I have found that I had to let my therapy be congruent with what they are doing and take it into account because it influenced the client. So in that respect I've had professional experience.

Q   : How did you find that experience?

A   : Interesting, certainly it opens your mind because when you ask the client why do you think this particular problem is afflicting you their explanations can be very vary and in that particular case the child was bedwetting and said it was because a particular ritual had not been performed, the *sangoma* told him the ritual had to be done. So being a young psychologist at the time it took a little bit of a mind shift to incorporate that into what I was doing and to allow for that because I needed to help the person as well as the *sangoma* put in his effort to solve the problem.

Q   : So it was interesting?

A   : It was useful and very interesting, it's not something that you learn in your training it's not part of it and they don't adequately train you on how to integrate indigenous healing into what you do. And I think that's perhaps something that is lacking in the training and I think with the new legislation I think that training will be modified and find some way to incorporate indigenous healing.

Q   : What are your thoughts about the formal recognition of indigenous healers by the government?

A   : I think again like I said in the first question it is useful but I think that it needs to be regulated properly. There's potential for a lot of harm if traditional healers are recognized just because they say they are traditional healers. If they are allowed to practice I mean if you think about the mumbo traditional healers that say they can cure

AIDS and people have the perception that I can go and have unprotected sex because there's a cure for it I think that that can be very dangerous. And that if you have sex with a virgin you will be cured of AIDS...But I think it's an idea that has merit but needs to be regulated and they need to look into how they are going to decide who becomes a registered indigenous healer and who does not.

Q   : Can you see that happening?

A   : Them registering indigenous healers? Yes honestly I think yes, if you look at the department of health now there is a very strong focus on cultural issues. So I think our current government and its take I think they are going to regulate indigenous healing.

Q   : What do you think is the role of indigenous healers in the mental health care system?

A   : I think that it's a complementary role to what psychology is doing. Not all mental illnesses require medication from psychiatrists, I do think that indigenous healers have a role to play in keeping people positive and making them have a positive outlook towards the problems particularly diseases like HIV. I think that there is a role to play in that because some people are more likely to take into account what is said by the indigenous healer because they feel that indigenous healers, they understand them better than western doctors. If you look at right now our training programme it's still largely from a very western perception of diseases both physical and mental. I do think that indigenous healers have positive effect in explaining from a cultural perspective and people are more likely to listen. It certainly is something that people are looking into if you look at the popularity of indigenous healers.

Q : Do you think that they should be formally included into mental health care system?

A : They should be included but that should go back to what I said earlier that they should be monitored to control for harmful practices. Even though we do not share similar background we are interested in what they do. They can help us understand problems in the societies and communities. They can advise us about cultural factors in the society or community.

Q : How do you think they should be included in health care system?

A : I haven't given it much thought because now it's been a far fetched idea, including them. I am unsure how they should be included because when I think about it they would probably work like in a hospital system maybe as one part of a multidisciplinary team where people could either go to a social worker, doctor, or physiotherapist. I don't think that would be easy but it's possible.

Q : What are your views about accepting referrals from indigenous healers?

A : I ...I would accept a referral from an indigenous healer as I would with any other health professional whether it's a GP or another psychologist. I think that there's a whole lot more, there's a kind of background history that the referral service would give. That idea interests me. Yes I wouldn't have a problem accepting a referral from an indigenous healer I would treat the referral as I would with other referrals. The same way I would consult with professionals without allowing the indigenous healer to overpower the treatment or dictate to me or influence the clinical work that I do.

Q : What are your thoughts about referring to indigenous healers?

A : I think that largely depends on the client. Generally when I see a client I would ask them why they think the problem is occurring to them and if it is something that has traditional basis, as in the case I told you, I wouldn't have a problem if a person wants to consult an indigenous healer. Any means to try and sort out the problem so whatever would be best for the client I would allow.

Q : **Would you make a formal referral?**

A : Like I would refer to anybody else I maybe contact them telephonically and let them know that this is the person I will refer to them. I would discuss the case, I would be able to give them background information but I have a sense that indigenous healers are more likely to not want too much background information, they would want to gather it themselves because they work in a particular modality.

Q : **How did you refer the client you talked about earlier?**

A : I did not make the referral to the indigenous healer; the person was already consulting with the indigenous healer he had already gone to one. I don't know of an indigenous healer referral base.

Q : **What skills or knowledge do you think you or other psychologists need in order to work efficiently in collaboration with indigenous healers?**

A : Certainly an openness to working with them. I think that is an essential skill, that's where mind shift comes in and this particular skill should be taught. I think people need to... it's a paradigm shift people need to have an open mind. If we kind of learn that what we've learnt in DSM IV and DSM IV-TR is the only way to diagnose and treat people, it's going to be difficult to be open to traditional healing. If you have openness and realize that we're all here for the best interest of the client. That's something that can

be taught at varsity level. In particular with use of case studies, like this was the manifestation of the problem, this is how it was treated, these are the things involved in the treatment process, this is why it wouldn't have worked from only the western approach. I think that people who are sceptical of it would be able to see the value of it. But I suppose it's largely the individual choice you can't force people to accept help from any professional. There are psychologists who think psychiatrists do not benefit patients and would not refer to psychiatrists on principle and there isn't much you can do about it. But I do think that an openness to seeing that we can work together in multidisciplinary approach is the main thing.

Q   : Is there any knowledge or skills that you think you need to get?

A   : As a psychologist? I do think that there's extensive literature on indigenous healing. There's Swartz and module on community psychology and there's a lot of research done on traditional healers and the role they have to play, looking at psychological disorders things like *amafufunyane*, there's a lot of research but perhaps as students at varsity level you learn a small part of it then you know it exists. From a counselling psychologist view in my internship I had a lot of experience and information in community work and that kind of literature probably because I was doing counselling. If they [indigenous healers] are going to be registered everybody needs to get this kind of information whether you are clinical or counselling you do need to know what is being done out there.

Q   : Do you have any other comments?

A   : No except that I think it's an interesting area of research. But it's something that has been long overdue it's been out there and until there's regulatory body it is open to abuse and harm.

APPENDIX D

RESEARCH OFFICE (GOVAN MBEKI CENTRE) · ·
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL : ximbap@ukzn.ac.za

27 OCTOBER 2006
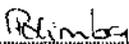
MS. NQ DALASILE (204000166)
PSYCHOLOGY

Dear Ms. Dalasile

ETHICAL CLEARANCE APPROVAL NUMBER: HSS/06596A

I wish to confirm that ethical clearance has been granted for the following project:

"An exploration study of trainee and registered psychologists' perceptions of indigenous and its role in the mental health care sector"

Yours faithfully

MS. PHUMELELE XIMBA
RESEARCH OFFICE

cc. Faculty Office (Post-Graduate Studies)
cc. Supervisor (Sarojini Ramgoon)