AFRICAN WORLDVIEWS – THEIR IMPACT ON PSYCHOPATHOLOGY AND PSYCHOLOGICAL COUNSELLING.

By

REV. FR. JAMES ONYANGO JUMA MHM

Submitted in fulfilment of the requirements for

the degree of

MASTER OF ARTS

in the subject

PSYCHOLOGY

at

THE UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF. M.C MATOANE

OCTOBER 2011

DECLARATION

I REV. FR. JAMES ONYANGO JUMA MHM DECLARE THAT THE TOPIC- ***AFRICAN WORLDVIEWS-THEIR IMPACT ON PSYCHOPATHOLOGY AND PSYCHOLOGICAL COUNSELLING-*** **IS MY OWN WORK AND THAT ALL SOURCES OR QUOTATIONS ARE INDICATED OR ACKNOWLEDGED AND A LIST OF REFERENCES PROVIDED.**

---------- **……..**

SIGNATURE **DATE**

ABSTRACT

This study investigates the role that African traditional beliefs and practices play in defining psychological problems, determines how these beliefs and practices manifest in a counselling relationship and explores how Western based forms of counselling manage these manifestations in counselling. This investigation is in the context of the on-going debate on the relevance of Western Psychological counselling in South Africa and the rest of Africa, including my experience during my internship to register as a Counsellor. It explores the impact of conducting counselling with clients whose worldviews are different from those of the counsellor and focuses on the impact of the client's worldviews on psychological well-being, psychological ill health and the resolution of psychological problems. Psychological well-being, ill health and counselling were discussed from a Western perspective.

The study found that the client participants defined their psychological problems in terms of their African traditional beliefs and practices. They communicated their presenting psychological problems in ways that created possibility of miscommunication between themselves and their counsellors, for example by using figurative language. There was also a clear distinction between how psychological problems are managed from an African traditional perspective (*ritualistic*) and a Western perspective (*talking therapy*). The study recommended the creation of specific departments in Universities to embark on research aimed

at establishing foundational structures on which to build an African Indigenous Psychology as an alternative to Western Psychology.

More comprehensive research on African people's attitudes is, suggested, on what traditional Africans think of psychological counselling. Another recommendation accruing from the limitation on sampling in this study is that future studies should be conducted with larger and more diverse samples; moreover, data should be gathered on a wider variety of demographics and cultural belief systems and practices.

To counter prejudice and ignorance, the counsellor 'to be' should study African culture and customs during their BA Honours studies. On-going training and workshops on cross-cultural issues from various cultures should be part of the counselling profession. More emphasis should be placed on prevention and therefore more mental health clinics in the rural areas need to be opened and general education on psychological issues and cultural integration be initiated.

KEY TERMS

African worldviews, Indigenous psychology, Western perspective, Depth psychology, Ecosystemic, Behavioural and Learning approaches.

ACKNOWLEDGEMENTS

My sincere gratitude to the following, for without their help this study would not have been possible. Glory is to God Almighty for giving me strength, determination and perseverance. To Jacque Vermeulen who supervised my internship and Dr Karen van der Merwe (N.W. University, Vaal Triangle Campus) who had a one-to-one counselling with me during the internship. This study was born from my internship experience, you both made it possible.

Thanks and appreciation to Talana Erasmus for her guidance and assistance in the Library. Last but not least, to my supervisor, Prof. M.C. Matoane (Chair of Dept. of Psychology, UNISA) for her guidance, interest, experience, support and patience. Prof. Matshepo, thank you! Working on your feedbacks was challenging and taught me a lot.

TABLE OF CONTENTS

1.	**BACKGROUND TO THE STUDY**	**1**
1.1	Introduction	1
1.2	Psychological Counselling in South Africa	3
1.2.1	Psychology from a global perspective	3
1.2.2	Importing psychology to non-Western context	5
1.3	Research Problem	10
1.4	Outline of the Study	12
2.	**LITERATURE REVIEW**	**14**
2.1	Introduction	14
2.2	Psychological well-being a Western perspective	17
2.3	Psychopathology from a Western perspective	25
2.4	Counselling from a Western Perspective	31
2.5	Psychopathology and Counselling within the (South) African context	39
2.5.1	Indigenous Psychology	40
2.5.2	African Worldviews	42
2.5.2.1	Psychopathology viewed from the traditional African perspective	46
2.5.2.2	Traditional African approaches to healing	49
2.6	Conclusion	56
3.	**RESEARCH METHODOLOGY**	**58**
3.1	Introduction	58
3.2	Research Approach	59

3.3	Research Design	61
3.3.1	Population sample	63
3.3.2	Sampling and selection	63
3.3.3	Data gathering	65
3.3.4	Data analysis	70
3.3.4.1	Data analysis process	71
3.4	Ethical Issues	80
3.5	Conclusion	84
4.	**RESEARCH RESULTS**	**85**
4.1	Introduction	85
4.2	Result	86
4.2.1	Biographical information	86
4.2.2	Psychological problems	87
4.2.2.1	Physical complaints	87
4.2.2.2	Emotional complaints	89
4.2.2.3	Hallucinations	91
4.2.2.4	Misfortunes	93
4.2.2.5	Behavioural symptoms	94
4.2.3	Belief systems and psychological problem96	
4.2.3.1	Psychological Problems defined	96
4.2.3.2	Causes of Psychological Problems	100
4.2.3.2.1	Traditional beliefs	101
4.2.3.2.2	External misfortune (death and rape)	103

4.2.4	Managing psychological problems and African Traditional beliefs	105
4.2.4.1	The Healer	105
4.2.4.2	Method of healing/intervention	108
4.2.4.3	Target of healing/intervention	113
4.3	Conclusion	117
5.	**CONCLUSIONS OF THE STUDY**	**119**
5.1	Introduction	119
5.2	Implications of the study's findings	121
5.2.1	The role played by African traditional beliefs and practices in defining psychological problems	121
5.2.2	Manifestations of African beliefs and practices within a counselling relationship	123
5.2.3	Management of the beliefs and practices within the African worldviews	128
5.3	Limitations of the current study	133
5.4	Suggestions for future research	134
5.5	Concluding remarks	137
REFERENCES		**140**
APPENDICES		**155**

CHAPTER 1: BACKGROUND TO THE STUDY

1.1 INTRODUCTION

Psychologists, Spiritual Directors and Pastoral Counsellors provide perspectives on approaching people with mental health problems. The true, genuine and honest care of a person who is mentally ill, does not make distinctions between dimensions of persons; body, soul and spirit are seen as aspects of one totality with mutual and reciprocal influence, as Benner (1998) has eloquently stated.

Theological, philosophical and spiritual studies prepared me for my work as a priest offering pastoral care and spiritual direction to Christians in the Church to which I belong, which is, the Roman Catholic Church. Working with and listening to people for over ten years in Kenya, Cameroon and now South Africa, inspired me to acquire more knowledge besides theology, philosophy, missiology and spirituality that would help me care for people holistically (body, soul and spirit).

In pursuit of acquiring more knowledge and also out of my curiosity and suspicion arising from the way psychology was used in my training to become a priest, I chose to study psychology in order to know what psychology is all about and how best it should be understood and applied in real life. Another reason I chose it was to help me know others and myself better and move closer to caring for people, especially those under my care as a priest.

I selected psychology as a major subject, was admitted to an Honours course and graduated with BA Honours in Psychology. In order to register with the Health Professional Council of South Africa (HPCSA), I completed a six-month internship at a Mental Health Institution working in health centres under the Institution in an area in the Gauteng Province of South Africa.

The internship covered psychological assessment, psychological intervention, collaboration and referral, training, research, abiding by policy, basic practice management and ethical and legal issues in practicing.

A registered psychologist and counsellor supervised my work. Every Friday we had a staff meeting, inputs and feedbacks involving medical doctors, psychologists, psychiatrists, nurses and administrators. Doctors and nurses referred clients to me for counselling. Counselling covered bereavement, family and relationship issues, drug abuse, depression, anxiety and HIV/AIDS related issues.

Sessions lasted forty-five minutes and I had eight sessions with some clients and visited some homes with social workers. In one of the township's community health centre, I formed a support group for women clients who had been rape victims and had meetings with them weekly.

As an African, the clients felt free to share with me their cultural and traditional issues. Confronted with these issues in a counselling situation, I realised how my BA Honours Course had not prepared me for these encounters. The studies

prepared me to look at people's sufferings and problems from within scientific parameters.

What I studied did not, as a rule, address the belief systems and cultural issues of the people I encountered in counselling situations during the internship.

I also noticed that most people who attended the clinics were mainly collecting medication for stress, depression and anxiety. From their medical files, I noticed that every time the medical doctor prescribed medication, the patients were also advised to consult counsellors or psychologists, yet most had failed to do so. This led me to try and understand the reasons for this lack of consultation, hence the current study.

1.2 PSYCHOLOGICAL COUNSELLING IN SOUTH AFRICA

1.2.1 Psychology from a global perspective

Psychology began and developed as an independent discipline in Western cultural context. Western psychology is predominantly used in most parts of the world and there is a risk of assuming that psychological theories and constructs can be applied equally all over the world. (Allwood & Berry, 2006).

According to Ngaujah (2003), the predominant approach within Western psychology studies the biological, cognitive, emotional, behavioural and interactive aspects of human conditions from a rational, logical and intellectual

perspective. Its teaching and practice is largely based on models that emphasize American and Europe's civilising mission.

In discussing the origins and development of scientific psychology in Africa, Nsamenang (2007) noted that psychology was 'transplanted' in Africa that had its own approaches of dealing with matters pertaining to psychological issues that have not been examined completely in order to find more about them.

The development of psychology as is studied and practised today in Africa is very recent and is slowly developing into a professional discipline. Serpell (1984) pointed out that by mid 1980s less than 20 African universities had a department of psychology.

It is possible that a number of universities in Africa today have fully fledged departments of psychology, like those present in South Africa. Nevertheless, the teaching of psychology, as can be seen in Psychodynamic, Cognitive, Adlerian, Behavioural, Humanistic, Existentialist and Ecosystemic theories I covered in my Honours studies, demonstrate that the teaching and practice of psychology in South Africa is still largely based on Western models of understanding and managing mental health issues.

My internship experience indicates that most counsellors use Western paradigms indiscriminately, posing a serious challenge to the quality of services offered to African clients. It is; nevertheless, fair to point out that multicultural adaptation of

psychological assessments is a positive development. This study will explore the impact of a Western based psychology as it is applied to clients originating from the (South) African context.

1.2.2 Importing psychology to non-Western context

The practice of psychology in South Africa cannot be complete without its multicultural nature and historical background. The apartheid system introduced in the Republic of South Africa in 1948 created a society with four distinct races namely Whites, Indians, Coloureds and Blacks.

In the past, psychology and counselling approaches have operated in line with the political system. The Mental Disorders Act of 1916 declared Whites to be superior to the blacks in line with the Eurocentric view of mental health (Whittaker, 1990). This declaration of the apartheid system created a psychology that politically and socially favoured the Whites at the expense of the Black majority.

The four races in South Africa have their own cultural and religious beliefs that affect their lives in many ways including psychological well-being, as can be seen within the black culture among the Zulus, Basotho, Xhosas and others. According to Beuster (1997), the practice of psychology based on the Euro-American perspective has largely ignored the social-cultural and religious belief contexts of the African people.

Some people seeking counselling have issues of personal and external forces to deal with and sometimes do not find opportunities to address them in a counselling situation that is rigidly from a Euro-American perspective.

Failure to take into consideration the socio-cultural and beliefs contexts of a client in a counselling situation may not only lead to misunderstanding but can also be anti-healing (Buhrman, 1987).

In the past African patients have been misdiagnosed as psychotic and ended up in psychiatric institutions. Cheetham and Griffiths (1981, p. 72) found that close to sixty percent of Blacks were misdiagnosed as schizophrenic in South Africa.

Counselling from a Western perspective faces challenges of cultural expressions. Men from Sotho, Maasai and Luo cultures, besides other African cultures, do consider where and to whom certain feelings can be expressed.

Traditional men in these cultures will hardly express emotions portraying pain or anguish, for example crying, in front of women counsellors or younger men. This is seen as a sign of weakness and vulnerability that is not expected from men. Talking about issues of sex is another difficult area in these cultures depending on who is talking to whom. For example, married women would rather discuss sexual issues with fellow married women than with younger women or men. Elderly men would hardly talk about such issues with men or women younger than themselves. Younger people would not ask older people how they feel. Women would not ask or talk about sexual issues in the presence of men. In a

counselling relationship, this difference can present a serious challenge for a younger woman counselling an older man who is bereaved and presenting a different picture emotionally to her due to his cultural background. This situation may not result in an appropriate assessment and intervention.

The use of specific concepts and meanings attached to the words also presents a challenge in counselling situations. In Sotho, *ho utlwa* means *to hear* and to *feel.* The distinction is based on the context but the meaning attached to the word matters a lot. The response to a question like, *"how do you feel"* is, therefore, not as straightforward as it would be for someone from a European or American background. In the above-mentioned cultures, the place where the question is asked or the person who asks the question, for example, has to be considered prior to answering the question, especially when it has an emotional connotation attached to it.

Younger people would not ask older people how they feel. Women would not ask or talk about sexual issues in the presence of men. In a counselling relationship, this difference can present a serious challenge for a younger woman counselling an older man who is bereaved and presenting a different picture emotionally to her due to his cultural background. This situation may not result in an appropriate assessment and intervention.

Other cultural bodily gestures can also present challenges among and between different cultural groups and races. In my culture, among the Luo people of Kenya, looking someone in the eyes when conversing, especially with an elderly person, is a sign of lack of respect. In some Western cultures, especially among the English people it is a sign of shyness or dishonesty. This can also present a challenge to a Western counsellor in a counselling relationship with, for example, a Luo client who is younger. The client runs the risk of being assessed inappropriately.

Most traditional Africans do not draw a line between matters pertaining to religious beliefs and empirical reality. Western psychology practitioners tend to operate within the scientific parameters even though they might have their own beliefs. It seems, therefore, that Western Psychology practitioners do not in principle, prescribe to religious or mystical explanations for a person's state of fragmentation and disintegration according to Hammond-Tooke (1989). This seems to imply that Western-healing techniques may not adequately address psychological problems within the (South) African context given its multicultural diversity.

Given the above implication, addressing psychological problems within the African context raises a number of questions that need answers. With the African Worldview adopting a holistic approach to healing and the West adopting a

fragmented approach, how can the two be utilised to effectively assist the African client?

The second question in relation to the above mentioned question is: How does teaching and practicing psychology address the socio-cultural contexts, traditional belief systems, customs and religious belief systems of African people? The third question in relation to addressing psychological problems within the African context is: Do the traditional healers, faith based carers and counsellors have anything in common and do they need to share anything about their activities for the good of the African client?

Tisdale, Doehring and Lorraine-Poirier (2003), suggest the need for a well – articulated applied or clinical model(s) that effectively captures an approach to care of the mentally wounded people with a multifaceted focus in practice. The kind of healing or counselling that most South Africans are inclined to embrace is one that relates to their Ubuntu worldview, a collective existence as opposed to the imported European ethos on the principle of individual survival. Most South Africans in their cultural and religious beliefs would embrace a counselling approach that makes their family members (extended relations, deceased or alive), their belief systems and nature around them part and parcel of the healing process and solution to their problems.

1.3 RESEARCH PROBLEM

The current status of practising psychological counselling is largely western based. In the South African context, it seems to lack integration of socio-cultural and religious beliefs of the African people into its practice. Beuster (1997) notes that the traditional African view of mental disorders goes beyond inter- and intra-psychic dimensions and defines abnormal behaviour in terms of disharmonious and fractured social relationships.

Behaviours like animosity, aggressiveness, jealousy and selfishness that disrupt the social system' cohesiveness, are therefore considered pathological. Abnormal behaviour according to the African worldview can also result when disharmony exists between a person, family or community and ancestors. In traditional African cosmology, the causes of abnormal behaviour are mostly assigned to external and personalized forces that transcend the Western inter- and intra- psychic dimensions.

According to Beuster (1997) the person, family or community can get afflictions from God, the ancestors or witches and sorcerers. In traditional African communities, abnormal behaviours like alcoholism, drug-abuse and addictions, constant and unresolved conflicts in relationships, women's barrenness, to name a few, are attributed to external forces.

Buhrman (1987) points out that diagnosis and healing of mental disorders is much more intuitive, experiential and symbolic. Healing is more nonverbal, takes place through and in symbolic acts like chanting and dancing. The Western approach of healing includes more explanation from the healer, deals more with natural world and rarely prescribes rituals.

As pointed out earlier, some patients were reluctant to consult counsellors/psychologists. The reasons given for not consulting counsellors vary from financial problems, language communication problems, to not believing that counsellors who are non-Africans or not conversant with African beliefs and traditions would understand their African worldviews that are part and parcel of their mental health issues.

From what I saw on their files, most of the clients had relied on medications for the symptoms of stress, depression and anxiety for some time. According to the nurses who have been administering the medication to them for some time, the conditions of some clients had worsened and others simply remained the same.
Given the explanations on the causes of mental illness from an African perspective, it is essential for counsellors to ask themselves whether cultural contexts and traditional belief systems play any role in counselling as a healing process to the African patient.

Therefore the aim of this study is to investigate the relationship between African Worldviews and psychological counselling. The specific objectives for the study are:

- To investigate the role that African traditional beliefs and practices play in defining psychological problems.
- To determine how these beliefs and practices manifest in a counselling relationship.
- To explore how Western based forms of counselling manage these beliefs during counselling.

1.4 OUTLINE OF THE STUDY

The next Chapter deals with the literature review for the study. It covers a few findings by research papers on indigenous psychology, teaching and practicing psychology in South Africa, Western conceptualisation of well being, ill health and the healing process as viewed by Depth Psychology, Behavioural and Learning and Ecosystem Approaches. African worldviews on the three cosmic orders namely, macro-cosmos, meso-cosmos and micro-cosmos are discussed.

Chapter Three explains the research methodology – research problem, research design, research setting, data collection and analysis of methods used in the study.

Chapter Four presents the results of the study while Chapter Five presents the conclusions, discussions and recommendations from the study's research findings.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

The challenges discussed earlier as a result of importing psychology to a non-Western context (South Africa) exist to date, but it is fair to point out that there has been development in the right direction to some extent. There have been discussions focussing on healing models based on an African worldview, for example *Ubuntu-Oriented Therapy* (Van Dyk & Matoane, 2010) beside other discussions on indigenous psychology (Mpofu, 2002). Another development has been the adaptation of measures and the detection and elimination of bias from measures in the context of a multicultural South African society according to Kanjee (2001, p. 101).

Mpofu (2002) and Serpell (1993), nonetheless, indicate that psychology-training programs on the African continent have generally remained ossified in the past, that is, they still aim to faithfully reproduce the content and research questions of interest to Western rather than African communities. Similar issues have continued to be debated in South Africa.

For instance, authors like Seedat (1997) write about the quest for liberating psychology while De la Rey and Ipser (2004, p. 550) argue for the research and curricula agendas within the South African context to be revisited.

This implies that, at this point of Africa's history, training in psychology that genuinely mirrors African precepts and accurately reflects a native-born African psychologist's own theory of the universe and cultural knowledge (African worldview) is at best in its nascent stage or rather only beginning to exist according to Nsamenang (2007). What I experienced during my internship period working in various mental health centres is that not enough local people who speak the languages of the majority of South Africans and understand their cultures have been trained to practice counselling.

As far as matters pertaining to counselling approaches and techniques are concerned, I felt that the use of Western models of counselling I was trained in and expected to use, needed to be examined in terms of their *accessibility*, *suitability, and efficacy* (Leung & Lee, 1996). In other words, there is a need to examine how many counselling facilities are available in townships, how these models are relevant to multicultural South Africans (Africans in the continent) and to what extent these models produce results for the majority of the black South African population and traditional Africans to a larger extent.

Some of the current psychological theories and tools practiced in South Africa and Africa at large could be insensitive to Africans' social thought and indigenous knowledge. This is because they are based on researches done with people from the West who have different cultural backgrounds from Africans.

The need to invest in traditional knowledge of herbs and ways of healing that indigenous people like San people of Southern Sahara have possessed and used for years cannot be emphasised enough.

Holdstock (1981) and others have continued to point out that the current state of academic psychology and its development in Africa is determined more by colonial and imported forces than by endogenous African factors. As counselling psychology is transported from the West to other cultures, we need to address the fundamental issues of counselling *by whom*, counselling *for whom*, and counselling *for what* (Cheung, 2000). In other words, counsellors with knowledge of how cultural issues affect their clients and how these issues manifest themselves in counselling relationships. Counselling should be for all who require and need it, irrespective of their cultural background and it should be for the psychological well-being of the individuals in all aspects of their lives.

It is clear from this introductory discussion that despite the adaptations of measures and the detection and elimination of bias discussed by Kanjee (2001), counselling still remains an imported commodity in South Africa and Africa as a continent. It is therefore important to understand how health, ill health and processes of healing are understood from both Western and African perspectives.

2.2 PSYCHOLOGICAL WELL BEING FROM A WESTERN PERSPECTIVE

This section presents what is considered good health as seen from a Western perspective. This study acknowledges the vast number of theoretical approaches in the study of human behaviour as reflected in the number of existing theories within the discipline of psychology.

For the purpose of this study, only three main approaches will be referred to, namely *Depth Psychological* approaches, *Behavioural and Learning* approaches and *Ecosystemic* approaches (Meyer, Moore & Viljoen, 2003).

Depth Psychological approaches and Behavioural and Learning approaches have been chosen for this study because they form part of the classical theories explaining human personality. In addition, these approaches provide an understanding of how personality is conceptualised from a Western perspective, with emphasis on biological determinism.

Including the Ecosystemic approach, the three approaches reflect a shift from a pure deterministic approach (Depth Psychology), to consideration of the environment (Behavioural approach) through to consideration of the entire system (Ecosystemic approach) in the development of personality (Corey, 2005). Within these three approaches, what is considered good health or psychological well-being is now discussed beginning with Depth Psychology as the earliest theory practiced and has influenced the recent theories in various ways.

Depth Psychological approaches.

There are a number of theorists that fall within the broad framework of Depth Psychology namely; the Orthodox Freudians, the Neo-Freudians, the Ego Psychologists, Socially-oriented Psychoanalysts and Post-modern developments (Meyer et al., 2003).

The approaches' views on what constitutes a healthy Personality differ even within the same groupings. Carl Jung for example views optimal development to occur when the distinction between the conscious and unconscious is less clear or rather blurred while Freud deals with the distinctions extensively. Jung's view allows some adaptation of the individual to externally oriented adjustment while Freud focuses mainly on the *explanation* and *treatment* of intra-psychic disturbances. His views on human nature are deterministic.

For Alfred Adler, a mentally healthy person is one that has developed social interests and lives for other people as well. This differs from Freud who views the way we behave and act, as determined by unconscious, irrational forces and motivations, and also by biological and instinctual drives as they evolve in our psychosexual development stages in the early years of life (oral stage, anal stage, phallic stage, latency stage, and genital stage (Louw, Van Ede & Louw, 1998). More precisely, our motivation and the determinants of why we act as we

do, derives from the sexual energy (libido) and life and death instincts (Goldenberg & Goldenberg, 2004).

For the purpose of this study, only the Psychoanalytic theory of Sigmund Freud will be dealt with. Freud discussed the individual's personality from the view of the conscious (all that people are aware of), the pre-conscious (all that is accessible to consciousness but not present at the moment, for example, my student number which becomes conscious when I need it) and the unconscious (which stores all people's wishes and memories that have been repressed).

Meyer et al. (2003) discusses that as time went, Freud created three further concepts: the Id (the biological component), the Ego (psychological component) and the Super-ego (social and moral component). This was because he realised that the three levels of consciousness did not fully explain a person's complex psychic functioning. The Id functions on the level of unconsciousness whereas the Ego and the Super-ego function on the level of consciousness though not to the same extent.

Freud sees humans as energy systems. This discussion will therefore focus on the structure of personality according to the Id, Ego and Super-ego. Personality functioning flows from the way this energy is distributed into various parts of the psyche (the Id, the Ego and the Super-ego).

For a healthy personality, these three energy systems must be well controlled and balanced in the way they are distributed. The Id, operating according to pleasure principle, must be restrained; the Ego, which operates according to the principle of reality must manage the demands of the Id and the realities of the external world; and the Super-ego must inhibit immoral impulses, and persuade the Ego to substitute moralistic goals for realistic ones, for example by creating guilt and inferiority feelings.

Behavioural and Learning approaches

The radical Behaviourism of BF Skinner and the Social Cognitive Learning approaches are discussed under Behavioural and Learning approaches in this study. In Behaviourism there are three complimentary learning processes namely; classical conditioning, operant/instrumental conditioning and observational/vicarious learning process. Classical conditioning is the unconditional stimulus and the unconditional response (Meyer et al., 2003).

Operant/instrumental conditioning based on the Law of Effect/Reinforcement formulated by Skinner is that if a behaviour results in positive consequences, then that behaviour will be reinforced. For example, give a child sweeties for breaking a water glass and she/he will break another one shortly afterwards whereas a negative reinforcement (punishing the child) will weaken the behaviour (breaking another glass).

Observational/vicarious learning on the other hand, is others performing the behaviour or how to do things by simply observing them regularly when being acted out by others. A healthy personality, therefore, adopts positive behaviours from observing them being performed.

In a nutshell, in the Behaviourist approach, behaviour is the product of learning through conditioning, reinforcement or imitation. The Behaviourists adopt the same elementalists and associonists forms of thinking, and hold that behaviour consists of small parts, namely stimuli and responses, which become associated with each other on the basis of certain laws of learning (Corey, 2005).

Cognitive Behaviour theory differs from Behaviourism in that it brings the focus on to internal mental events (cognitions) while still emphasising the importance of learning. According to the Cognitive approach, what determines behaviour is not the event itself but our interpretations (cognitions) of that event (For example if my boss shouts at me and I become depressed, the cause of my depression is what I told myself about the shouting, i.e. I am an absolute failure).

Given that humans are seen as largely responsible for creating their problems and as having the ability to think more rationally, a healthy personality therefore, is one that disputes and challenges irrational beliefs and substitutes them with rational ones resulting in more appropriate behaviours and feelings

The Ecosystemic approach

The Ecosystemic approach's main assumptions are explored. The discussion covers the three shifts in viewing human nature and the implications they have for a healthy personality. It begins with Newtonian-Cartesian epistemology, first and second order cybernetics and social constructionism.

Newtonian epistemology is a mechanistic linear causality approach to human life. It is about cause and effect and understands reality as an objective. For example, malaria parasites cause fever and headaches in humans, irrespective of where or who the individual is. From isolated, independent units of Newtonian epistemology the shift moves to interconnectedness (orders of feedback), which are the First-order cybernetic view of human life.

Second-order cybernetic refers to a shift higher that includes the observer as being part of the context (Becvar & Becvar, 2000). In a nutshell, First-order cybernetics looks at the connections between everything in the world without including the observer and the observed. Second-order, on the one hand makes the connection between the observer and the observed.

Cybernetics being the science of pattern and organisation, focus in the Ecosystemic approach is how the 'system' is structured and the patterns involved in the system. A system is a network made up of parts that are in mutual interaction in which every part is affected by all other parts (Goldenberg & Goldenberg, 2004).

The discussion will therefore focus on the broader theoretical approach, moving continually between the first and the second order (between doing/first order and reflection/second order) rather than on the three separately.

Families understood as systems, exchange information with the environment. They are ‘self-correcting’ cybernetic networks that process information (the input) and govern themselves through rules according to Goldenberg and Goldenberg (2004). Rules in this context do not mean morals or principles; they refer to repetitive matters of relationality in families.

It could be, for example, that in a family, for generations, children have always greeted adults with both hands or not called parents by their names. These repetitive behaviours are referred to as rules.

The families are characterised by openness (continuous flow of information from outside, for example, other families), relationship (mutual interactions of family members), non-summativity (no member of the family is bigger than the rest of the other members) and equifinality (the outcome is always the same due to interrelatedness of the members of the family).

The interrelations are through feedback loops (if a child breaks a window, and is punished, the punishment is fed back into the child, causing him/her to be more careful next time he/she is playing around the window). Families like systems strive to maintain themselves, thus striking a balance/homeostasis (staying the same).

The feedback loops help maintain the balance by creating boundaries or parameters controlled by the rules. The degree, to which these limits allow information to be let in to the system/family from outside/other families, will characterise the system as either open or closed. An open family allows more interactions from outside the family as opposed to a closed family.

These feedback loops do effect changes into the families/systems. The birth of a new child in a family may require positive feedback loops, which have the potential to reset the parameters of the family to cope with a new young member of the family. For example, playing music softer may be required in the family for the sake of the new young member, hence resetting boundaries in the family. In resetting boundaries, it has to be noted that an epistemological and methodological challenge remains given that an African worldview may focus more on family while a Western perspective focusing more on matters pertaining to the individual.

According to Becvar and Becvar, (2000), there is always an on-going tension between the need of a family to maintain itself (morphostasis) and to change (morphogensis). This tension calls for circular patterns of interactions where a symptom is involved. A family that is ‘healthy’ or well-functioning is one that is able to encourage each individual member to realise his/her potential (to develop personal identities), while at the same time allowing them to feel attached to the family group.

Realisation of the potential of an individual in an African worldview is restricted within a collectivistic approach as opposed to the Western individualistic approach, which poses an epistemological and methodological challenge. For example a girl who is interested in boxing may not be allowed in cultures where the sport is meant for boys while from a Western perspective it may not be an issue.

A healthy family, therefore, is one that is open and succeeds at balancing the needs of the system with the needs of the individual member and a healthy personality is one that succeeds in balancing his/her needs with those of the family (Goldenberg & Goldenberg, 2004).

2.3 PSYCHOPATHOLOGY FROM A WESTERN PERSPECTIVE

This section now presents a discussion on ill health from a Western perspective as viewed by the three approaches namely Depth Psychology, Behavioural and Learning and Ecosystem.

Sue, Sue and Sue (2003) notes that it remains a concern for health practitioners, that there is still not an established definition of the construct of mental disorder or what pertains to psychopathology.

Western conceptualization of psychopathology seems to rest on normal versus abnormal functioning.

Explicit within the definition of a mental disorder provided in the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA 1994) is that the condition ''*must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual*'' (APA 1994:xxi–xxii).

Mental disorders, by large, involve impairments in psychological or behavioural functioning, whereas physical disorders (general medical conditions) involve disorders of physiological functioning. The distinction is primarily with respect to phenomenology. Disorders in psychological or behavioural functioning can be the result of a neuropsychological etiology and pathology, but the phenomenology of the disorder is more psychological than physical (Sue et al. 2003).

Depth Psychological theory and Behavioural and Learning theories conceptualise psychopathology based on the psycho behavioural modalities such as individuality, uniqueness and differences. The ethos of this worldview rests on survival of the fittest and control over nature of the person. Human life is controlled by a series of physical and biochemical processes that can be studied and manipulated by scientific activities. A *mechanistic* perspective is typically held by those Western cultures that adopted a scientific approach to life.

According to this perspective a machine is a metaphor for the human body and human functioning. Human psychopathology is viewed in terms of human

physiology and behaviour, as reflected in the conceptualizations of the field of psychology as a behavioural science (Naidoo, Sehoto & De Villiers, 2006).
Psychological problems are explained in terms of human behaviour or responses that are the result of chemical disturbances in the body, peoples' past experiences, or dysfunctional transition through human development stages (Scott, 1997).

Depth Psychological approaches

Depth Psychology generally considers unconscious processes to be the root of all forms of neurotic symptoms. Psychopathology according to Freud is caused by an imbalance in the structure of personality. As discussed earlier, a healthy personality has the three energy systems (id, ego and super-ego) under control and well distributed.

The imbalance in the structure that results in ill health (psychopathology) is created when the Ego is too weak to manage conflict between the Id and the Super-ego more effectively according to Meyer et al. (2003).
When an Id impulse threatens to break through in consciousness, it results in anxiety for example; moralistic anxiety (resulting from conflict between Ego and Super-ego) and neurotic anxiety (resulting from conflict between Ego and Id) according to Stern (1985). For Freud these conflicts have historical causes, for example, a fixation and parental over-protection can create a weak Ego with

insufficient rational skills or with ineffective defence mechanisms. An overly strict Super-ego as a result of parental discipline that is too strict will create a moralistic anxiety when it conflicts with the Ego.

In a nutshell, in situations where the Ego fails to cope with the anxiety coming from the conflicts between the Id and the Super-ego using defence mechanisms, the result is pathological behaviours. Pathology or ill health arises when the conscious becomes unconscious and the ego is so weakened that the behaviour is based more on instinctual cravings (id) or irrational guilt (superego) than on reality, in other words, what is actually happening in the life of the individual.

The Behavioural and Learning approaches

Skinner, a behavioural and learning theorist, does not attribute psychopathology to internal conflicts or guilt feelings as in Depth theory. He attributes psychopathology to lack of *effective* behaviours or rather behaviours that do not help the individual in coping with his/her environmental circumstances (Corey, 2005).

Abnormal behaviours (such as phobia) are seen as the product of unfortunate early learning or conditioning in the three processes namely; classical conditioning, operant/instrumental conditioning and observational/vicarious learning processes. Unhealthy personality adopts behaviours like smoking drugs, robberies, etc, from observing others performing them.

In classical conditioning, for example, if a child is conditioned to get whatever he/she wants (unfortunate conditioning), the unconditional response is an expectation to simply get things without working for them regardless of whether they are really needed or not.

Such a child may grow up to be a person not equipped to cope with his/her environment and may not be able to differentiate between needs and wants or even to work for a living, hence an unhealthy personality.

In Operant/instrumental conditioning, abnormal behaviours are positively reinforced for example rewarding a child for breaking a glass, whereas other abnormal behaviours are simply observed as they are done and then learnt. Living in a violent environment may be reinforcement for one to become violent and therefore lacking an effective behaviour. In other words the person lacks a behaviour that may help him/her live at peace and unity with relations and neighbours thus an unhealthy personality.

The Social Cognitive Learning's perspective on psychopathology is that the abnormal behaviour is learnt. Bandura, a Social Cognitive Learning theorist explains that *lack of self-efficacy* is essential in the development of abnormal behaviours (Meyer et al., 2003).

The Ecosystemic approach

Within the Ecosystemic perspective, pathology is present in a system that reveals a *lack of balance and/or complexity* according to Meyer et al. (2003, p. 478). For example, in a family where there is abuse of some sort, sexual or physical, the family tends to be closed from the wider community or other extended family members.

Closed systems are unable to interact with external environment, and they become isolated and resist necessary changes. They have ineffective responses to demands for change, becoming disorganised and disordered (entropy) according to Becvar and Becvar (2000).

Psychopathological families/systems are less able to adapt to changes and become ‘stuck’, in the sense that they are unable to re-establish equilibrium once they have been knocked off by an event or they respond to change with increased rigidity (as they attempt to maintain the familiar but outdated rules).
Such inflexible families/systems are limited to negative feedback (for example, parents may continue to treat their adolescent as a child, refusing to adjust to the adolescent’s developmental phase), or they may be unable to use positive feedback mechanisms appropriately to restore homeostasis at a new level as Becvar and Becvar (2000) puts it.

How then do these three approaches, *psychoanalytic, behaviourist* and *Ecosysytemic* deal with psychopathology in a counselling situation?

2.4 COUNSELLING FROM A WESTERN PERSPECTIVE

Psychological counseling from a Western perspective has been encapsulated in ethnocentric assumptions that are taken to be universal. The theories, research and practice of psychological counseling as a specialized profession, originate in the United States but are assumed to be universally applicable by Western counsellors (Corey, 2005).

Researchers like Highlen (1996); Myers (1999); Sue and Sue (1999); and Utsey, Adams & Bolden (2000) have pointed out that Western conceptualisations of counselling focus primarily on independence and individuality in relationships, direct verbal communication styles, emotional expressiveness, clear distinctions between the mind and the body, and intrapsychic processes in the context of psychological problems.

Following the discussion on psychological well being and psychopathology from a Western perspective in Depth Psychology, Behaviourism and the Ecosystemic theories, the sections below now discuss counselling as viewed from these theoretical approaches.

Depth Psychological approaches

Analysis of transference is central to psychoanalytic approaches because it allows clients to relive their past in counselling. The '*fundamental rule'* of psychoanalysis involves clients saying whatever comes to mind without censoring (Corey, 2005).

The counselling aims and objectives of these approaches are to make the unconscious conscious and to strengthen the ego so that behaviour can be based more on reality rather than on instinctual cravings (id) or irrational guilt (superego). The aim is to achieve a basic transformation of the personality. The general objectives are to help the client to gain freedom to love, work and play, to achieve self-awareness, more effective personal relationships as well as to deal with unconscious anxiety in more realistic ways (Meyer et al. 2003).

According Corey (2005), the counsellor's function is to reveal nothing of himself/herself in order to facilitate the establishment of a transference reaction (the client projecting his/her feelings and behaviours of the past onto the counsellor), which is the key to the analysis. The counsellor's (analyst's) main tool is interpretation in order to accelerate the uncovering of the unconscious material (through analysis of dreams, free-associations and resistance) and also handle his/her own counter-transference reactions to the client.

The relationship between the client and the counsellor is very essential and crucial. The client's reaction in the transference process has to be 'worked through' and it takes a long time.

The Depth Psychology counselling perspective could be appropriate for culturally diverse clients if one takes into account the socio-cultural aspects of the clients as well as developmental aspects. As much as clients develop a general overall ego identity, they also develop a cultural identity. It follows therefore, that a culturally sensitive counsellor will explore the meanings and effects of events and issues at various critical turning points in the lives of clients from both a personal and a socio cultural perspective.

Given the fact that counselling from a Depth Psychology perspective focuses on intrapsychic, individual functioning, this may conflict with the African traditional values which emphasize environmental and interpersonal social variables (collectiveness). Traditional African clients would rather prefer to focus on external sources of their problems, for example, environments that are oppressive and discriminatory to them.

The Behavioural and Social Cognitive approach

The primary objective of this approach is to improve clients' functioning in the particular situation they find problematic. Behavioural and social cognitive

approach to counselling specifies treatment goals in concrete and objective terms, focuses on the client's current problems, the factors influencing them and emphasises observing overt behaviour.

The goals are to change the current factors in the client's environment that are influencing his/her behaviours and to create new conditions for learning, to eliminate maladaptive behaviours and to learn more effective behaviours. The concept of goals is at the centre of Behaviourism, and these are formulated, together with the client, in specific and measurable terms that can be empirically tested.

In counselling, operant conditioning would be used to bring change and healing by rewarding positive consequences. For example, in trying to control smoking, drinking or over-eating, staying away from these behaviours for a duration would be rewarded to bring change eventually. Self-management as part of conditioning to produce positive consequences (staying away from smoking/drinking for two weeks, etc.) would be used too. A client is made to observe a model and is encouraged to reproduce the behaviour and is rewarded (operant conditioning). To bring change and healing, one with a problem of anger would be encouraged to watch anger management videos regularly, for example, and perform steps shown from time to time when the situation arises.

The counsellor may also arrange with someone to intentionally induce a reaction from the client to see whether he/she performs what has been observed, hence observational learning.

Corey (2005) points out that the counsellor is highly active in this approach. He/she is a teacher or trainer, providing an educational role, helping clients to learn new skills and transferring these skills to real life situations.

The counsellor has a well-defined and empirically validated set of techniques and also models appropriate behaviours and attitudes for the client, which gives the counsellor a high degree of power and thus responsibility not to abuse this power. The client is expected to be active, to engage in specific actions in order to deal with his/her problems, and to experiment with new responses to situations, rather than simply talking about them.

Counselling in this perspective therefore depends on a collaborative partnership between the counsellor and the client. A good working relationship is crucial for implementing the behavioural procedures, and the relationship (including the counsellor's warmth and empathy) is seen as necessary for this purpose.

Corey (2005) notes that this relationship is not seen as sufficient and therefore specific techniques/procedures are still needed. These techniques/procedures have to be acted on in real life situations if change is to occur or be achieved.

This approach could be useful for African clients who do not value the expression of feelings and sharing of personal information. Traditional African clients look for

practical action plans and behavioural change (rituals) that can be immediately applied to solving their problems.

Focussing on changing specific behaviours and developing problem-solving skills would appeal more to them. Having said this, it is important to note that this theory focuses on increasing social skills and assertiveness in a member of a family. Traditional African clients who subscribe to cultural values of submissiveness may find more problems than solutions in this approach.

According to Corey (2005), the goal of counselling in the Social Cognitive Learning approach is to teach the client how to dispute and challenge his/her irrational beliefs and substitute them with more rational statements, which ultimately results in a philosophy of change that gives rise to a new set of behaviours and feelings. The counsellor in this approach is highly active, providing structure and direction to the client and functioning as a catalyst and a guide. The client is a student to the counsellor (teacher) and also plays an active role by demonstrating learning through homework assignments and ultimately challenging his/her own beliefs outside of the counselling room. The relationship between the counsellor and the client is important and the counsellor adopts an attitude of full acceptance or tolerance of the client. He/she refuses to judge or evaluate him/her while actively challenging his/her ideas, often through the use of humour.

This approach aims to understand the core values/beliefs of the client. This is important where there is a conflict of cultures in situations where one culture may be dominant. Behaviourism attributes behaviour to an external agent.
In this regard their view corresponds more with the African perspective, which attributes behaviour wholly to external agents outside the person (Meyer et al. 2003).

The Ecosystemic approach

In the Ecosystemic approach, the main focus of healing is the family and the interrelationships of the members of the family. Counselling in this approach holds that an individual is best understood by assessing the interactions between and among family/community members.
An individual's symptoms are best understood within the context of a dysfunctional system and it is essential that the counsellor includes an examination of how one's culture has influenced each person in the family. The approach does not use standardised techniques as if they were 'magic pills' that are intrinsically powerful, with predictable effects (Goldenberg & Goldenberg, 2004).

The counsellor structurally couples with the structure in such a way as to perturb the system and to co-construct different realities. The counsellor does not change or treat the client; instead s/he 'co-drifts' with members of the family with

the goal of achieving more functional behaviours for the system through perturbation. According to Becvar and Becvar (2000), perturbation is achieved through introduction of ‘meaningful noise’ into the system. That is, new information that will allow members to see things differently and to become unstuck from their rigid frames of reference about their behaviour.

The new information must fit the client’s worldviews and acknowledges both stability and change in the system.

Facilitating change, as a healing process in this approach, requires the use of an organised map that demonstrates the way family members/or members of a system interact and identify how closed the family is. Change is then facilitated to help the family to interact more with the external environment and accept change rather than resist it.

In short, in this approach, each member’s reality meshes to form ‘family reality’ that describes the situation as problematic. The counsellor’s role here is to assist in perturbing the reality, and to structurally co-drift with members in a new direction in which the situation is no longer referred to as a problem.

Ecosystemic thinking has already had profound influence on psychology and related helping professions in South Africa according to Corey (2005). Given the diversity of the South African community, the counsellor in this approach accommodates different realities in a family and helps a closed family to open up to external realities for change and healing to occur.

The Ecosystemic approach to counselling is valuable today, in an age where the needs of so many cannot be attended to fully on an individual basis, for example, in the expensive one-on-one relationship which is common with either Depth Psychology approaches or Behaviourism. What follows is counselling seen from a South African context.

2.5 PSYCHOPATHOLOGY AND COUNSELLING WITHIN THE (SOUTH) AFRICAN CONTEXT

From my experience of working as a missionary in West Africa, East Africa and now in South Africa, it seems as if there are two distinct ways in which people deal with illness. One class, mainly the educated and middle class, emphasises pharmacology or Western medically oriented approaches, while the vast majority of traditional Africans predominantly use traditional healing.

Although South Africa is comprised of individuals from various cultural backgrounds, mental health services in South Africa focus primarily on Western approaches. This phenomenon may create conflict between the needs of these individuals and the mental health services that are available to them (Macias & Morales, 2000).

The individuals from more collectivistic cultures such as most traditional Africans in the continent including South Africa may feel that Western approaches to healing are culturally incongruent with their African worldviews. From their

perspective, familial and social interdependence and having a spiritual worldview are considered to be of paramount importance (Highlen, 1996).

Due to the fact that some traditional Africans may be uncomfortable with these fundamental values and goals of Western counselling, there is need to identify and highlight indigenous forms of healing that some of these individuals may use in the face of personal distress. The next section therefore, focuses on the role and importance of local cultural understandings of health, illness and healing.

2.5.1. Indigenous Psychology

Indigenous psychology can be defined as a psychological approach with concepts that originate within a culture or society (Sue & Sue, 1999; Lee, 1996). Allwood and Berry (2006) present conceptions of Indigenous Psychology by 15 leading researchers in the field of Indigenous Psychology in various parts of the world.

From their research, Allwood and Berry found that Indigenous Psychology arose as a reaction to the mainstream version of psychology and its aim is to reflect on the social, political, economical and cultural character of people around the world. The themes of the post-colonial reactions to mainstream psychology seem to echo the dominant reasons advanced by some Africans who choose not to go for counselling.

In my pastoral activities in South African townships, I hear many South Africans arguing that counselling is meant for White people. “Telling someone you hardly know all about your life, is like ‘stripping oneself naked in front of a stranger”, some argued. During my internship at mental health clinics, I noticed that most black South Africans simply took prescribed medication as it may be regarded as less intrusive.

Mainstream psychology seems to treat aspects of counselling as universal and can be applied to all people. In other words, issues of stress for example, in China or America are dealt with in the same way in South Africa, Kenya and everywhere across the globe.

This objectivity and globalisation of mainstream psychology is one of the main criticism put forward by advocates of Indigenous Psychology (Stam, 2007).

Within the on-going debate on Indigenous Psychology, some researchers and authors place emphasis on understanding relationships in culture and recognizing that cultures are neither static nor independent variables. They argue that Indigenous Psychologies make very valuable contributions to Psychology as a discipline both in their local and global environments when they confront the differences in various cultural groups (Stead, 2004). The differences in cultural groups make it difficult to apply theories researched in one particular community to be generalised and applied to other cultural groups.

According to Nsamenang (2007), some of the research results deemed valid for most societies have led to misdiagnoses, for example in some cases of schizophrenics which then became very expensive to deal with in deprived countries, thus rendering the economic argument for a universal application of theories that it is cheap, invalid.

The ‘relevance’ debate (the debate on how the practice of psychology impacts on a South African multicultural society and its usefulness today) points out that a psychology that is imported cannot successfully be indigenised and flourish to serve Africa’s multiple needs without anchor in the local reality and context.

As increasing numbers of African psychologists and counsellors capture and bring indigenous phenomena and processes to the field of counselling, they slowly but surely inject African precepts and praxes into the literature (de la Rey & Ipser, 2004).

2.5.2 African Worldviews

This section presents African worldviews (traditional cultural and belief systems), which highlight indigenous forms of understanding human nature and healing methods.

In African people’s worldviews of societal and cosmological relationships, there is a strong understanding of respect for self, other people, and all of nature,

especially the land, trees and the water (Mbiti, 1969). This explains why land remains such a thorny issue in the continent of Africa.

The African worldviews look at existence from the point of view of cultures and social structures which make up communities. A communal ideology and unique worldview exists between and among African people. This common thread is inherent in most African cultures and customs despite the impact of Westernisation (Mpofu, 2006). From these worldviews, knowledge is not necessarily based on what is researched and verified. The experience of the individual acquired from others and passed down from elder members of the community is more valued.

As Ivey and Meyer (2008) point out, this acquired and passed on knowledge and experience is treated as norms and adhered to irrespective of whether they are scientifically validated. How a traditional circumciser and a medical doctor qualify and practice can be seen here as an area of a clear conflict between Western and African worldviews.

Makwe (1985, p. 4) defines these African worldviews as '*an abstraction which encompasses the total way of life of the African society. It is a psychological reality referring to shared constructs, shared patterns of belief, feeling and knowledge which members of the group that subscribe to this reality carry in their minds as a guide for conduct and the definition of reality*'.

The philosophy of these worldviews is *'holism'.* It has an approach that focuses on the whole living organism. This is evident in the traditional life styles of African tribes that still keep their traditional way of life; this can be seen in the San people of Southern Africa and the Maasai people of Kenya.

For these traditional African tribes, God is seen in all their spheres of life. For example, God is invoked in times of drought, good harvests and outbreak of diseases. Matters pertaining to their life are interconnected to God, nature and other relations (living or dead).

Sow (1980) explains that this indivisible cosmic whole can be theoretically distinguished, namely *macro-, meso-,* and *micro-cosmos* though blending together in everyday lives of people.

According to Sow (1980) the ***macro-cosmos*** is the area of activity and existence where God is experienced. This is the area where most traditional African people interact and experience God in their human functioning. Traditional African people experience and communicate with God in the fields when growing crops, when looking after their animals and in times of happiness and sadness. God is not limited to Sunday services in churches, though there are sacred places for various communities where God is invoked through some special rituals.

For example, in times of drought when cows are dying, a Maasai leader will go to this sacred place to offer sacrifices to God for the drought to end.

Meso-cosmos is the sphere where ancestors, malignant spirits and sorcerers are encountered and experienced (Sow, 1980). It is the world of animals and human beings, forests, bushes, trees, rivers, wind, rain, darkness and light.

From an African perspective, this is an African worldview in which conflicts; events such as accidents, sicknesses, deaths, failures as well as successes of various kinds are explained. Certain aspects of human behaviours, if not all, are explained and understood from these African worldviews. External agents tend to determine human behaviours in these worldviews.

According to Hammond-Tooke (1989), spirits of the departed ancestors are believed to look after the best interest of their descendants and at the same time can also send them illness and misfortune when they are moved to wrath. Today people communicate and relate to ancestors through anniversary celebrations of their deceased members, tomb stone services and other activities like "*mpho ya badimo" among* Sotho speaking people.

The ***Micro-cosmos*** is regarded by Sow (1980) as the level where the individual is seen to exist within the context of the collective. This individual existence nevertheless, does not rest on the principle of individual survival enshrined in the theory of evolution of Western perspective. Every human being has relatives, living or dead. Every human being encounters and experiences nature in some way; rain, trees, and the like.

No one is an island of himself or herself. As the Basotho say '*motho ke motho ka batho*' (I am because we are). A person exists because others exist.

The collective existence of the individual gives room for individuality. This individuality is manifested in the use of names unique to the individual in the family and not collective family names as Mbiti (1969) points out. Among the Sotho people, surnames or family names are not normally used to address the individuals; instead they are used when collective existence of the individual in a particular tribe, clan or extended family is referred to.

This collective existence does not necessarily make the individual lose his/her individuality. It is evident that psycho behavioural modalities from an African view of the person and the worldview emphasises groupness, sameness and commonality. Values and customs are reinforced by cooperation, collective responsibility, co-operation and interdependence (Viljoen, 2003).

2.5.2.1 Psychopathology viewed from the traditional African perspective

Psychopathology from the African worldviews is defined in terms of disharmonious and fractured social relationships. Disharmonious relationship with God (**macro-cosmos)** leads one to suffer from ill health. In an African

worldview, psychopathology results when disharmony exists between people and the ancestors. An individual member of a family may suffer as a result of disharmony between the family or community and the ancestors. This disharmonious relationship falls within the level of **meso-cosmos.**

In contrast to the Western concept of psychological well-being, which focuses on the individual, well-being from an African perspective encompasses the *physical, spiritual* and *social* dimensions of the individual (Meyer et al., 2003).

The natural and supernatural elements are inextricably interwoven. Health and well-being is not seen merely as a biological matter, but one bonding the human body and the soul in total harmony. The absence of harmonious relationship with the members of the supernatural world, and the resolution of interpersonal, family and community conflicts and tensions results in ill health.

Disharmonious interpersonal relationships leading to ill health is seen within the level of **micro-cosmos.** In most traditional African cultures, disturbed social relations that create disequilibria expressed in the form of physical or mental problems cause illness. A disturbed relationship with one's God (*macro-cosmos*), conflict with one's relations, nucleus and extended family members (*micro-cosmos*) and problems with ancestors (*meso-cosmos*) contribute to the individual's unhealthy status (physical or mental). From an African perspective, conflicts in interrelationships, killing animals that the community consider sacred

or cutting sacred trees may cause an individual, family or community some health problems.

A psychologically unhealthy person therefore is the individual who lives in disharmony with the forces of nature. From a traditional African perspective, ill health is manifested in physical diseases (microbiological infection) or psychological-mental illnesses, as well as a breakdown in social and spiritual mechanisms of the individual and the community.

The interconnectedness of the phenomenal world and spirituality are two major aspects of the traditional African worldviews that deal with ill health, causes of ill health and healing.

Ill health from an African perspective accrues from multiple causes that are mostly external. These external causes have *humans*, *supernatural* and *ancestral spirits* as agents of diseases of various kinds.

According to Sogolo (1993), if an African is involved in an adulterous act with his brother's wife, whether or not this act is detected, he undergoes stress, having disturbed his social harmony. If he cheats his neighbour, has been cruel to his family or has offended his community, the anxiety that follows may take the form of phobias, either of bewitchment or the affliction of disease.

According to Sotho people, a widow who fails to carry out the cultural prescriptions like not wearing the same clothes *(thapo)* for a period of time, not

avoiding contact with men during a prescribed period and coming home late after sunset before a prescribed mourning period has elapsed (*ho bula thapo)* is bound to suffer from a physical condition called *mashwa.*

Mashwa is also a general label used for any disorder with bodily manifestations. These bodily manifestations are assumed to have at least a partial cognitive and emotional aetiology, that is, bodily manifestations that are to some extent psychological in Western terminology. For example, the guilt and worries of not adhering to these cultural norms will make the individual sick mentally, physically or both.

In a nutshell, the interconnectedness of the phenomenal and spiritual worlds discussed above conceptualises psychopathology from the perspective of the psycho behavioural modalities such as collectiveness, sameness and commonality. The ethos of this view rests on survival for the tribe and the individual being one with nature.

2.5.2.2 Traditional African approaches to healing

Restoration of health, whether mental or physical from an African perspective, lies within the social, cultural and historical contexts. Mpofu (2006) discusses that healing from African worldviews, is knowledge and practices used in the diagnosis, prevention and elimination of physical, mental and social imbalance. These practices are based on the knowledge derived exclusively from practical

experiences and observations handed down from generation to generation, mostly verbally.

Approaches to healing from an African perspective therefore include practical and open relationships. The approach is directive, deals with supernatural and natural world, focuses on *who caused the problem* and is aimed at social cohesion. The healer in this approach tells the client why he has come for healing, in most case prescribed rituals, the main tools of treatment are materials such as bones, stones and herbs.

Given that from African worldviews, the root cause of wellness or ill health is explained in metaphysical terms, healers and their patients prefer directive treatments or mostly externally oriented methods (e.g., ritual cleaning, enactment, sacrifices). However, internally oriented healing methods such as scarification or making bodily incisions, aromatherapy, vomiting and purging are also used but mostly in their perceived function to keep evil spirits, witches and bad luck far away from daily lives of the individuals and community (Meyer et al., 2003).

The African worldviews emphasize holistic healing, that is, healing approaches that encompass spiritual, psychological and physical aspects of the illness. These approaches are also grounded on the conception that no one is an island to him/herself. Community collectiveness (*micro*-cosmos) therefore, becomes a

major resource for the individual's well-being. The healing methods are now broadly discussed under physical activities, rituals, herbal extracts, cleansing, naming and dreams.

Physical activities

Traditional healing in the African worldviews includes physical activities. The disequilibria created as far as matters pertaining to *macro-cosmos, meso-cosmos* and *micro-cosmos* are expressed in either physical or mental problems. When expressed physically, it follows that healing involves physical activities. In these activities there are interpersonal interactions like dancing around the fire at night with beatings of drums together with the patient.

The patient may or not join in the dance depending on his/her condition. The activities normally involve only close members of the family.

According to Comaroff (1980), these group activities help in reconstruction of the client's physical, social and spiritual environments. In African traditional healing ceremonies, the dynamics of human relationships in collaboration with the significant others of the client is crucial for the healing.

Impressive regalia including garments from animal products such as skins, body parts or droppings, head gear made from brightly coloured clothing (pure white or blood red) bedecked with charm objects and dressing with at least the skin from major cats (e.g., leopard, lion) or bird (eagle) is a healing approach that helps

healers achieve high expectation of being healed from their clients (Lesolang-Pitje, 2000). These kinds of donning of impressive regalia make clients hold the belief that the healer or his/her agents must have killed a major cat, which in itself, is a powerful accomplishment. Moreover, the attire also points to the healer's association with spiritual beings or supernatural endowment.

Rituals

Another approach to healing within the African worldviews is the use of rituals. According to Mpofu (2006), ritual enactment is one approach of traditional healers to cast away malevolent spirits. African worldviews maintain that traditional healers preside over traditional rituals (healing and thanksgiving). The traditional healers are men and women set apart by a special calling and training to conduct the rituals.

In the Africa worldviews, a ritual is more than just doing something in the same way. It is connecting the concrete with the symbolic. It serves to connect fundamental abstract principles of a culture and its sociological relations to physiological and psychological realities (Turner, 1967).

Healing in the African worldviews does not just take place in any place. There are designated places for healing where the rituals are performed. Spending some time with some San people in Botswana, I was shown some particular trees under which particular healing rituals would be performed.

Herbal extracts

Traditional healers also use herbal extracts mixed with other liquids. These are given to clients to drink, wash with or sprinkle around and in the house. These herbs and ways to mix them are passed on through years of training to become healers. The healers make body incisions to directly administer herbal treatments into the blood streams according to Peltzer (1989).

Some healers use scarification as a healing approach to treating children brought to them with '*puana,' 'phogwana,' and 'sihoho'* among the Sotho, Tswana and Luo people respectively. These are children's condition caused by jealous neighbours among the Sotho people and having contacts with other children from other tribes before a weaning period among the Tswana. Among the Luo of Kenya, some women cause this condition by simply looking at the children. This is in line with the African worldview of *collective existence* (micro-cosmos) whereby the cause of psychopathology is not only biological but also involving external agents like the use of *muti,* a traditional medicine.

Cleansing

Cleansing or fumigation is a typical treatment strategy in the traditional African perspective. Cleansing treatment is performed to remove the causes of presenting problems or ill health either from the inside or outside of the body of

the patient and from the environment of the patient. The participating healers in this study described the use of *mukubetso* (incense burnt and used to drive away evil spirits from houses and homes especially houses and homes of sick people).

Naming

Healers sometimes do name a variety of different problems and observe the client's reaction to each specific precision. In contrast to the Western approach to healing where the client tells the healer/therapist why he/she has come, it is the healer who names the problem and provides the steps to be taken for the healing process in the African traditional healing approach.

Patients expect healers to name their problems and to provide them with steps to take for the healing process. Through naming, the healer provides the patient with a language in which unexpressed states can be directly expressed. Through naming, negative events are explained and personifications are provided, the patient is initiated to enter the treatment process.

In the naming process ancestors of the patient and the healer become part of the healing intervention in the world of living. Patients may experience a reduction in symptoms following a naming procedure. Therefore, the act of naming can be considered as therapeutic (Torrey, 1986).

Dreams

Dream description and interpretation is another traditional African approach to healing. Traditional Africans believe that dreams affect people's daily lives in various ways and do cause illness, misfortunes at home, work or in relationships. The healers interpret the dreams and prescribe the treatment or rituals to be performed for the appeasement of the angry ancestors or cure of the sickness caused by the evil spirits.

Dream interpretation is not particularly unique to the African approach to healing. In the Bible, Joseph interpreted Pharaoh's dream of seven cattle and seven ears of corn as a prophecy of seven years of abundance and famine. Plato called dreaming '*the between state',* an actual place where the soul went to meet with the gods. Aristotle suggested that malfunctioning of the senses in the body that allowed dreams to occur, formed dreams.

Freud, the 'father of psychoanalysis' used dreams to uncover hidden thoughts and desires. Carl Jung, a psychotherapist, a philosopher and a mythology scholar looked to the purpose of dreams as opposed to Freud who was interested in the cause of dreams (Inserra, 2002).

In a nutshell, approaches to healing from the African perspectives or worldviews, vary depending on the 'state of debilitation' or symptom presentation. The healing approaches deal with presenting problems varying from acute health,

social, economic problems, chronic health, to troubled spirits and spate of unusual negative events like death, accidents and illnesses.

Interventions too, depend on the presenting problem and vary from medication, advice to spiritual screening by *Obanayo* (one who spiritually diagnoses states of debilitation and sees beyond 'our world'). Helping agents consulted also vary depending on the treatment required. These include herbalists, *inyanga, clan leader and Isangoma* (Naidoo et al., 2006).

2.6 CONCLUSION

Teaching and practicing psychology in Africa has come of age through developmental stages. Significant reforms and transformations have taken place to some extent in some universities though a lot still needs to be done. The chapter has outlined Western and African conceptualisations of psychological well-being, illness and healing. It has also revealed how Western psychology differs from non-Western forms of healing by distinguishing individualism from collectivism.

Secondly, the dualism of mind-body that exists in Western conceptualisation of healing in contrast to the integration of mind-body-spirit in indigenous psychology and its forms of healing were discussed. Western perspectives place values on cause and effect laws, linearity, rational thought, objectivity, the belief in a *universal truth,* and the constancy of measurements (Sue et al., 1998) while in

the African perspective humans form an indivisible whole with God, other human beings and nature with the ethos based on the survival of the community and being one with nature (Meyer et al., 2003).

The implications of these differences are that some traditional Africans may avoid traditional counselling services because of cultural biases that exist within many mental health systems. The challenge therefore, is how this integration can be attained for the good of a disadvantaged African client who finds him/herself in a highly Western system of healing. The next chapter deals with the method used in the study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The purpose of this Chapter is to describe and justify a research design aimed at exploring African Worldviews and counselling issues, that is:

- To investigate the role that African traditional beliefs and practices play in defining psychological problems.
- To determine how these beliefs and practices manifest in a counselling relationship.
- To explore how Western based forms of counselling manage these beliefs during counselling.

Determining the appropriate design for research requires a process of decision making, data collection, data analysis and sampling. These are referred to collectively as research design. Finally, ethical considerations for the study are also presented.

3.2 RESEARCH APPROACH

The research approach adopted for this study is qualitative in nature. Mouton and Marais (1989, p. 157) define a qualitative approach as *one in which the procedures are formalised and explicated in a not so strict manner, but in which the scope is less defined in nature and in which the researcher does his or her investigation in a more philosophical manner* (Translation).

Maso (1994) points out that qualitative researchers are interested in the world as explained, experienced, and constituted by the subjects as long as that world forms part of the research that they want to conduct. This means that the researchers who conduct their research qualitatively try to explain, to experience and to constitute the world of the subjects as the subjects define, experience and constitute it.

At the end of the day it is all about the subjects and how they view their world around them. In this study, it is all about the clients and how they view their psychological problems and to what they attribute their symptoms. It is all about the traditional healers and how they view their clients, causes of their problems and healing methods they apply (interventions).

The aim with this approach is to understand the social and cultural contexts of people's behaviours and explore the '*why*' questions rather than the '*how*'. The

emphasis, therefore, is on the quality and depth of information rather than on the scope or breadth of information. The approach helps the researcher to gain new insights about a particular phenomenon, develop theoretical perspectives about the phenomenon and discover the problem that exists within a phenomenon (Leedy & Ormrod, 2005).

The phenomenon in this study is the psychological problems from the African perspective. The problem is the impact of the traditional beliefs and practices on psychological problems and their treatments within a counselling situation.

The qualitative research approach applies to the study, as my concern is to understand the social and cultural worldviews of the clients, their psychological problems and what they attribute their problems to. The focus is on describing, understanding and analysing and constructing the individuals' African worldviews and their impact on psychopathology and psychological counselling in a naturalistic context of counselling.

The approach deals with human activities in a more holistic way, that is, considering the religious, cultural, philosophical, psychological and biological aspects of the activity of the individual (Maree, 2007). The study locates the clients' views, opinions and feelings in their cultural, religious and social contexts.

3.3 RESEARCH DESIGN

According to Maree (2007, p. 70), a research design is a strategy that moves from the underlying philosophical assumptions to specifying the selection of respondents, the data gathering techniques and the data analysis. The underlying philosophical assumptions in this study are phenomenological assumptions. According to Reber and Reber (2001), phenomenology is a philosophical doctrine, which advocates that the science of immediate experience be the basis of Psychology.

The focus of the phenomenological doctrine is on events, occurrences, happenings, etc, as the individual experiences them. Leedy and Ormrod (2005) notes that phenomenological study attempts to understand people's perceptions, perspectives, and understandings of a particular situation.

The study therefore, attempts to understand the participants' perceptions, perspectives and understandings of their psychological problems. For example, what is it like to suffer from psychological problems in the Sedibeng area of the Gauteng Province in South Africa? During my internship to register as a counsellor, I had a counselling relationship with the participants and I intended to gain a better understanding of the role played by African traditional beliefs and practices in defining psychological problems, how these beliefs and practices manifest in counselling, and how Western based counselling manage these beliefs during counselling.

The design chosen for this study therefore is Phenomenological. According to Creswell (1998), phenomenological researchers depend exclusively on interviews. The sample size varied from 5-25 individuals, all of whom had direct experience with the phenomenon being studied according to Leedy and Ormrod (2005).

The phenomenological study design is very relevant to this study as the participants were carefully selected from the clients I interacted with during my counselling internship. The participants were those who raised issues of traditional beliefs and practices during counselling sessions. The sample size for this study (which consisted of 7 participants) fell within the phenomenological study sample size.

According to Leedy and Ormrod (2005), from multiple perspectives on the same situation, the researcher can make generalisations on or about the phenomena studied.

Maree (2007) holds that phenomenological study as an interpretive perspective is based on assumptions like:

- human life can only be understood from within
- social life is a distinctly human product
- the human mind is the purposive source or origin of meaning
- human behaviour is affected by knowledge of the social world
- the social world does not ‘exist’ independently of human knowledge.

3.3.1 Population sample

I interacted with 20 black South African clients during the internship. 12 out of 20 raised issues of external and personalised forces from African worldview perspectives during counselling sessions. I also interacted with elderly Sotho speaking people to understand more about the traditional belief systems including traditional healers. I have had casual talks with four traditional healers who live in the area where I have been working for the last four years. The population for this study was adults who were referred to me for counselling and traditional healers I talked with.

This population was accessible to me during my internship period in the clinics of Levai Mbatha, Johan Heyns, Bophelong and Boiphatong in the Sedibeng area of Gauteng Province. The location of the population is Sotho speaking people with specific Sotho culture and belief systems.

3.3.2 Sampling and selection

A *sample* refers to the subject of units or elements that combine together to form the population. In this research the units are referred to as *clients* and *healers.* Research participants were selected through the use of purposive sampling. Neumann (1997), states that this type of sampling is usually used for specific

cases. The advantage of using purposive sampling is that the researcher decides who will be more relevant and informative for the research.

For the purpose of this study, 5 clients were selected from the 12 for interviews on the basis of the issues that are fundamental to understanding African worldviews and their impact on psychopathology and psychological counselling. I also selected two traditional healers in order to get a fuller picture of the research topic. In selecting the five clients for interviews and the counselling documents, interviews recorded during counselling sessions at the time of internship were revisited in order to draw out issues for further study that are fundamental in answering the research questions.

In a nutshell, the process used in selecting the 5 clients from the 12 clients was a non-probability sampling design. For the sake of confidentiality, I used codes for the participants' names. A pre-selected set of criteria relevant to the research topic and questions was used, for example, whether the clients raised issues of external and personalised forces during counselling and other matters pertaining to African worldviews.

The main criterion of the selection was that the client was to be prepared to voluntarily and willingly do the interview based on some of the issues raised during previous sessions and talks about her/his traditional belief system in relation to his/her illness. The request for participation in the research was

formulated around whether the client is willing to share his/her personal views, opinions, feelings, and experiences on traditional cultural beliefs and practices on his/her psychopathology or mental illness. The client was informed of the significance of the research and how it could greatly contribute to the present knowledge of counselling processes and the variables of change that influence counselling. An agreement was then signed.

3.3.3 Data gathering

The primary data gathering technique was largely the *interview*. The interviews were in-depth, semi-structured and interactive. According to Maree (2007, p. 87), an interview is a two-way conversation in which the interviewer asks the participant questions to collect data to learn about the ideas, beliefs, views, opinions and behaviours of the participant. Questions were open-ended (*Can you tell me about your traditional practices and the impact they have in your life?).* I used a voice recorder small enough to be in a pocket to avoid distraction during the conversation in recording the data. Participants were informed of the recording.

Interview schedules as shown in the appendix were used for interviewing the individual clients and the two traditional healers. The traditional healers were interviewed on 15/05/2009 and17/05/2009 at their respective homes. The five

clients were interviewed between 19/05/2009 and 20/06/2009 at the local clinics at various times that suited the individuals.

Research Interview: Although Kvale (1996) regards the research interview as a way of obtaining scientific knowledge about the social world, he depicts it as just another way of having a conversation in everyday life whereby the participants formulate conceptions of their lived world in a dialogue. It is a structured conversation and it involves human beings interacting interdependently and producing knowledge while they interact, with the aim of obtaining statements that are meaningfully based on how the events are interpreted.

The interaction between the researcher and the participant goes beyond spontaneous exchange of views. It involves a process of careful listening and continuous clarification in order to obtain constructive and scientific knowledge. The interview is sensitive and close to the participant's lived world, and this, according to Kvale (1996), reflects its value. It also provides the understanding of the participants' world from their point of view as it unfolds the meaning of their experiences and uncovers their lived world prior to scientific explanation.
Through this, knowledge about participants and their conditions may develop effectively without manipulating their behaviour. The strength of the interview lies in the fact that it helps capture the multitude of participants' views on an issue and provides a multifaceted picture of the human world.

The semi-structured Interview: The interview was semi-structured. I had an interview schedule prepared, which was meant to guide my discussion with the participants by asking them open ended questions to allow them space to express their views. This was done so that I could obtain detailed information from participants' stories about their psychological problems. A semi-structured interview is an appropriate and powerful way of collecting and analysing empirical material. It provides a useful balance to the strengths and weaknesses of research such as this study. It serves as a window into people's lives (Denzin & Lincoln, 1998).

For the purpose of this study, the interviews were conducted face-to-face based on my personal experience of dialoguing with clients during counselling sessions and was guided to the research question. I realised that despite being advised many times to consult counsellors, the participants had failed to do so for various reasons, such as believing that white counsellors do not understand their traditional beliefs that defined their problems.

This failure to consult counsellors and the reasons advanced got me interested to find out more about the issues they were referring to. This impact of traditional beliefs and cultures on psychological counselling and psychopathology informed the specific questions asked in the study. The questions were then constructed to address African traditional beliefs and psychological problems, traditional beliefs within counselling relationship and traditional beliefs and western-based counselling. The language used was mainly Sesotho. Sesotho not being my first

language, I had to use a native speaker to explain to me certain terms and expressions when translating the interviews into English.

Semi-structured interviews gather more information as compared to structured ones and other types as it deals with both verbal and non-verbal information. Its objective is to understand the subject matter without pre-conceived ideas or perceptions. Semi-structured and open-ended interviews make it easier for the participant to express himself/herself in the way he/she normally speaks and thinks.

This type of interview does not mould or remodel the participant's natural jokes and stories into a predetermined format; the objective is to maintain the participant's experiences and way of seeing things. In this study, in order to maintain the participants' experiences and perceptions, the questions were asked in relation to what was actually happening in their lives as far as matters pertaining to their health conditions were concerned.

Qualitative and In-depth Interviews: The interview was in-depth and of a qualitative nature. Qualitative interviewing is based on the dialogue or conversation between the researcher and the participant. The researcher asks questions and listens to what the participant says.

The participants are viewed as people who create meaning through the interviews. Most of the time qualitative interviewing serves to interpret what the participant is saying and not just focus on the facts of the participant's situation and condition.

In an in-depth interview participant and researcher communicate with each other from different viewpoints given their backgrounds but the emphasis is on the participant's viewpoints. It is crucial that the researcher understands fully the process and meanings of communication from the participants during the interview and therefore there have to be no distractions during this exercise of interview, according to Kvale (1996).

Qualitative interviewing builds on the conversational skills (communication skills) that the researcher already has. It differs from everyday conversations, as it requires empathic listening skills. This type of interviewing can be between total strangers or those who know each other very well.

Qualitative and in-depth interviewing was essential and useful to this study as my objective was to capture the participants' lived experiences in their communities with specific cultural traditions and customs as far as matters pertaining to their psychological problems or health conditions and how these matters manifest themselves in counselling situations.

Interview schedule: One of the advantages of open-ended questions is that they allow respondents to say what is on their minds without being influenced in any way by the researcher, thereby expressing themselves in their own words.
The respondents are able to reveal their level of information and strength of their feelings towards certain issues freely according to Foddy (1993).
In an interview schedule, questions are usually pre-determined. The interviews can be conducted face-to-face or they can be conducted telephonically, through emails or other modern communication technologies as long as they meet the ethical requirements of the study. During the interactions between the participants and I, notes were also taken.

Field notes are essential in data collection and form the core of data from ethnographic research. They help in keeping the records of ethnographer's observations, conversations, interpretations and suggestions of future gathering of information according to Agar (1993).

3.3.4 Data analysis

The method used for analysing data for this study was *content analysis.* According to Maree (2007, p. 101), content analysis is a systemic approach to qualitative data analysis that identifies and summarises *message content.* It refers to the analysis of things such as books, written documents, transcripts etc. Content analysis is found in a wide variety of disciplines, including psychology.

Content analysis involves quite a great amount of planning at the front end of the study. The researcher typically defines a specific research problem or question at the very beginning as has been done in this study in an earlier chapter (chapter one). Content analysis is typically performed on *forms of human communication,* including videotapes of human interactions, and transcripts of conversations. *Sometimes content analysis is used when working on narratives such as diaries or journals, or to analyse qualitative responses to open-ended questions or surveys, interviews or focus groups* (Maree, 2007, p. 101).

For this study, it has been used on transcripts of conversations from interviewing seven participants selected through the use of purposive sampling as discussed earlier in the previous section.

3.3.4.1 Data analysis process

The process reflects on how the perceptions and experiences of the clients have been constructed against a background of socially shared understandings and how these socially shared understandings have become the normal way of how things are done and have gained a status considered to be factual.

The central task to this process of data analysis is to identify common contents in the participants' descriptions of their psychological problems. The transcriptions were made from the voice recorder to a written text. I, along with a Sotho native

speaker, listened to the voice recorder many times and then wrote the text in English. It is possible that even with the use of a Sotho native translator there was still a possible challenge of misrepresentations of the participants' life stories as expressed and accounted. I used a second translator just to minimise the possible errors in order to arrive at the most effective translation that I could. The data was rendered into English after identifying statements that related to the research topic.

After this was done, the transcriptions were then analysed. Through this process, relevant themes were identified on the basis of the three study objectives outlined in the earlier section. The themes were grouped into meaningful and relevant categories based on commonalities among them. I interpreted the information gained by looking at the interviews with the aim of verifying whether the research objectives were met or not.

As a narrative investigation, the objective is to interpret the psychological problems of the participants from an African perspective. Neuman (1997) points out that a qualitative researcher analyses data by organizing it into categories on the basis of themes, concepts, or similar features. He/she develops new concepts, formulates conceptual definitions and examines the relationships among concepts.

When coding the data, a researcher organises the raw data into conceptual categories and creates themes or concepts, which she/he then uses to analyse data. Qualitative coding is an integral part of data analysis. Coding data is the hard work of reducing mountains of raw data into manageable units. Content analysis is, therefore, concerned with the study and analysis of themes of perceptions and experiences to reveal the discursive sources of psychopathologies and how these sources are initiated, maintained, reproduced and transformed within specific social, economic, political and historical contexts (Maree, 2007).

The analysis tries to illuminate ways in which African traditional beliefs and practices in societies construct versions of reality that dictates their way of life and to uncover the ideological assumptions that are hidden in the traditional practices of healing. Reflexivity in this analysis is to produce meanings by showing how the experiences, conceptions and stories are ingrained in the belief systems of the communities. I engaged with clients' discourses during internship in this holistic approach.

The product of the study, therefore, is an understanding from the clients' perspective that creates a richer and deeper meaning of psychopathology and psychological counselling from an African worldview perspective. Phenomenological perspective is, therefore, more relevant to the study, than

interpretive, critical theory, post-modern and post-positivist perspectives on qualitative research.

My interest in understanding the lived experience of the participants and the meaning they make derived from that experience exposed my values as playing a significant role in my inquiry. Interacting with the participants was inherent in the interviewing structure as I was part of the interviewing process. As I collected data and analysed data from the interviews, I found issues to explore, for example, how the participants defined their presenting problems. Throughout this study I have constantly checked my expectations and values as a continuing reminder of the role these values play in a study like this one I have undertaken. On-going discussions with my supervisor on data collected and their analysis helped me a lot to identify and account for my biases and assumptions in the study. For example, my negative experience of the use of psychology in my training to become a priest in London sometimes clouded my assessments of views and contexts and differentiating my role in counselling and as a researcher.

Kvale (1996) points out that interviewer are also part of the process of interviewing. My interaction with the participants was inherent in the structure of interviewing. Throughout the study, I was wary of the risk of overriding the participants' accounts of their life stories but also acknowledged that understanding implies summarising the participants' accounts of their life stories.

As much as the participants identified with me as an African and one who could also understand their language and culture, I needed to accept that my Western education background and Christian faith (a priest) does not fully allow me identify with them. During this research, at times I needed the process of '*distanciation'* as explained by Ricoeur (1979). No matter how thoroughly we understand a context from within; there are certain things that are only clearer when we look at them from the outside.

In analysing the data (beliefs, ideas, views, behaviours):

Step One was to listen to the recorded interview again and again;

S*tep Two* was to search and identify explicit and implicit meanings attributed to the phenomenon of the African worldview in the interview (striking a critical distance from the text in order to identify discourses). Thus, statements could be identified that relate to the topic of the study namely:

- African traditional beliefs and psychological problems
- Traditional beliefs within a counselling relationship
- Traditional beliefs and Western-based counselling

Step two further involved re-articulating what was stated openly as well as what was implied from a psychological perspective (linking accounts to actions, examining texts for their effects rather than their veracity (Terre Blanche, 1999, p. 160). Here segments of statements are grouped into the themes within the

above-mentioned statements of objectives namely: definition of psychological problems and the causes of psychological problems.

Step Three looks at and considers the various ways in which the participants experienced the problems (phenomenon). Traditional beliefs within a counselling relationship are considered including my personal experiences (specific cases) with the clients in a counselling process. Divergent perspectives are sought also in this step.

Step Four is the construction of a composite. Here I use the various meanings identified to develop an overall description of the psychological problems of the participants as expressed and experienced. How the cases in Step Three were managed in contrast to western counselling is also dealt with in this step.

As for the reliability and validity, in the qualitative approach the phenomenon manifests itself as it is and registered by the researcher as opposed to the quantitative approach where a specific structure is imposed on the phenomenon. The use of an open-ended questionnaire as an instrument posed no threat to the validity or reliability of the approach as the instrument neither improved nor deteriorated.

The approach's focus on fostering a relationship of trust and empathy between the researcher and the subjects makes it more reliable in achieving an intended

goal as it reduces chances of manipulations of the measuring scale in any way. This is therefore, the strength of the approach as far as matters pertaining to reliability and validity.

Validity is the extent to which the instrument measures what it is supposed to measure (Leedy & Ormrod, 2005). According to Maxwell (1996), descriptive validity is the extent to which a researcher's account is factually accurate. In this study, the participants' accounts of their life stories were recorded and therefore not distorted or made up. Given that the accounts were recorded in Sesotho and later translated in English, the challenges of translation, for example, omitting some of the expressions of the participants could be considered a threat to this descriptive validity. Another form of validity considered in this study was interpretive validity. According to Maxwell (1992), interpretive validity is the extent to which the research accounts are grounded in the language of the people studied and rely as much as possible on their own words and concepts. This study relied heavily in the Sotho language and the concepts of the participants.

More generally, reliability is the degree to which a measuring instrument consistently measures whatever it measures (Leedy & Ormrod, 2005). The participants described their conditions within African worldviews in the same way and this indicated the reliability of the data collected. I had two native Sotho translators and compared the transcripts to achieve more reliable data. This "double checking" of translation was crucial as far as matters pertaining to

interpretative validity. What was at stake here was the accuracy of the accounts as applied to the perspectives of the participants given that interpretative validity is inherently a matter of inference from the words of the participants as recorded during the interview.

In quantitative research, methods of measuring are identified, developed, and standardized with validity and reliability of measuring instruments in mind. Qualitative researchers on the other hand, operate on the assumption that reality is not easily divided into discrete, measurable variables (Leedy & Ormrod (2005). It could therefore be argued that there is no such concept as reliability in qualitative research.

Generalizability is the extent to which one can extend the account of a particular situation or population to other persons, times or settings than those directly studied (Becker, 1990). The conclusions arrived at in this study may be useful in making sense of counselling situations of traditional Africans who ascribe to African worldviews. It is nevertheless, necessary to point out that qualitative studies are usually not designed to allow systematic generalization to some wider population.

Guba (1981) discusses four criteria that he believes should be considered by qualitative researchers in pursuit of a trustworthy study, trustworthiness being the

extent to which these four criteria are demonstrated. These are credibility, transferability, dependability and confirmabiltity.

Credibility, according to Guba (1981), is the extent to which a true picture of the phenomenon under scrutiny is presented. The qualitative research methods I adopted are well recognised. I also developed an early familiarity with the culture of the participants having worked among the Sotho speaking people. Some participants were my former clients, my supervisor provided scrutiny of the project as it progressed and I examined previous researches to frame findings. All these addressed credibility as a criterion for trustworthiness.

Transferability is used in preference to external validity/ generalizability according to Lincoln and Guba (1985) and Creswell (1998). It is the degree to which the results of the work at hand can be applied to a wider population. Since the findings of a qualitative project are specific to a small number of particular environments and individuals, it is impossible to demonstrate that the findings and conclusions are applicable to other situations and populations. In this study, I provided the relevant contextual information about the participants and the fieldwork sites.

Dependability is used in preference to reliability. It is extent to which a study demonstrates that if the work were repeated, in the same context, with the same methods and with the same participants, similar results would be obtained

(Lincoln & Guba, 1985). The research design and its implementation, the operational detail of data gathering, for example, correspondence letters and evaluation of the effectiveness of the process of the study provided by regular correspondence with the supervisor demonstrated the level of dependability of the study.

Confirmability is the extent to which study findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher. Miles and Huberman (1994) discuss that the most important criterion for confirmability is the extent to which the researcher admits his or her own predispositions. In demonstration of confirmability, the accounts of the participants were recorded and effort made to keep their accounts intact as much as possible even after the transcription process took place. My predispositions of the Christian faith and values as priest and educational background were constantly kept on check.

3.4 ETHICAL ISSUES

Ethical issues were taken into consideration when the study was conducted. Participants were assured that their identities would be kept confidential. They were told that pseudonyms or numbers would be used to protect their identities. The participants were given all the information that they required to know concerning the study. They were also informed that they could withdraw at any

stage during the study if they felt uncomfortable with the process of the study. They were given the opportunity to comment on what was written about them before it was published. They were informed that a voice recorder would be used to record the interviews and be deleted after the information had been retrieved.

Neuman (1997) points out that researchers protect privacy by not disclosing a subject's identity after information is gathered. This takes two forms, both of which require separating the individual's identity from his/her responses. Anonymity means that the subjects remain anonymous or nameless, thus the individual is unknown to the reader of the published material. If anonymity is not possible, researchers should protect confidentiality.

Confidentiality means that information may have names attached to it, but the researcher holds it in confidence or keeps it secret from the public. It means that what has been said will remain a secret and will not be repeated to someone else.

The researcher is very aware of the fact that confidentiality is a debatable and controversial issue. There are a number of practical implications involved, for example, when other people like family members are mentioned or need to know some information from the interview or conversation. The principle in such situations is that if breaking confidence is in the interest of the client, it may be appropriate to do so. The client has the key to the dilemmas. The researcher or

facilitator has to decide together with the participant or client according to du Toit, Grobler and Schenck, (2001, pp. 99-100).

This argument is mainly applicable within a counselling set-up but in an open-ended questionnaire, subjects may mention names of others as responsible for their problems. In this particular study, two members of the families of the respondents were curious to know the contents of the interviews. The husband of one of the respondents thought I was his wife's attorney as they were in the process of getting divorced. Extreme care regarding confidentiality was therefore not underestimated.

In this study codes are used and the real names of the participants will remain anonymous. Anonymity still needs to be guaranteed like avoiding publishing of names even though I conducted individual interviews. Some clients undergoing traditional healings did not want to be exposed as receiving medical or mental health services at the same time.

Other clients' traditional healers discouraged this too. I am bound to guarantee their anonymity but more of their confidentiality than their anonymity given that I conducted individual interviews with them at the clinics.

An ethical principle is that a researcher should not cause harm to the participant. Physical harm, psychological harm, legal and economic harms were all guarded

during the process. I was very aware of the fact that some participants were my clients. In turn I was constantly conscious of possible therapeutic misconceptions that could arise and the impact it might have on informed consent. I explained my role as researcher to be only concerned with trying to understand their lived experience and the meaning they derived from that experience. I pointed out that I was not their counsellor anymore and there was no client/counsellor relationship that was binding. My objective was simply to have them reconstruct their experiences within the topic under study (Kvale, 1996). The research proposal was submitted and approved by the University research ethics committee prior to commencing the research study.

If it were to be perceived that the participants' conditions were aggravated by misrepresentation of responses in any way, I would take the appropriate ethical and professional steps. I would address the issue with the participant, seek professional advice and refer the client to a more professional and relevant practitioner for more help if needed.

Four universal fundamental principles namely *respect for people's dignity and rights, responsible caring, integrity in relationships, and responsibility* was fully adhered to during the study.

3.5 CONCLUSION

The Chapter dealt with the methodology applied in the study following the stages in research namely: defining the problem, obtaining the information, analysing and interpreting the information and communicating the results. The qualitative research method was described in detail including phases of the research process, design, sampling and data collection method. Ethical considerations were dealt with in relation to human rights, different research approaches and to me as a researcher. The next Chapter presents the results of the study. It presents the results of the individual interviews and that of the Traditional Healers.

CHAPTER 4: RESEARCH RESULTS

4.1 INTRODUCTION

This chapter presents the results of the seven research participants that took part in the study. The participants' responses are classified according to themes that are used as elaborative tools to give detailed descriptions of each participant's experiences of their psychological problems.

This study undertook to investigate the relationship between African Worldviews and Western ways of conceptualising and treating psychological problems.
The specific objectives for the study to be discussed in the thesis are:

- Investigating the role that African traditional beliefs and practices play in defining psychological problems,
- Determining how these beliefs and practices manifest in a counselling relationship,
- Exploring how these beliefs and practices are managed and their implications for Western based counselling.

4.2 RESULTS

4.2.1 Biographical information

A total of seven participants took part in this study. Five of whom manifested some form of psychological problem that was based on African traditional beliefs and two of whom are traditional healers that deal with and treat these kinds of problems from an African traditional perspective. Of the five female client participants, the youngest was 27 years old, the oldest 57 years and others 32, 44 and 48 years old respectively. Three of these participants are married, one is separated and one in the process of divorce.

Two of the five participants passed grade 10 and the other three passed standard 5, 6 and 10 respectively. All five participants are Christians – two of whom belong to the Ethiopian Church, one to the AME church, another one to the Zion Christian Church while the other one is a born again Christian.

Of the two traditional healers who were interviewed for this study, one was a 60 year old female and the other one a 50 year old male.

The female traditional healer passed grade 3 while the male traditional healer passed grade 10. Both of them are Christians who are members of the Roman Catholic Church.

4.2.2 Psychological problems

The five client participants were requested to name the problems that led them to seek psychological counselling. The two traditional healers who also formed part of this study were requested to indicate the kind of problems their clients would present them with when consulting them. The responses are categorized into five main themes – physical complaints, emotional problems, hallucinations, misfortunes and behavioural symptoms. These are discussed in detail below.

4.2.2.1 Physical complaints

The participants presented various physical complaints ranging from headaches and neck pains to pain all over the body. One participant who complained of experiencing headaches, described them as follows: "*the headaches move around my head, in the morning it sits on my forehead, during the day it stands on top of my head and the movement goes on to the right, left and the back of my head"* **(MG-C3).**

From this description, it is clear that the headache was not specific to any particular area of the participant's head. The participant further provided the analogy of the feeling of being "*knocked with a hammer*" all over the body to explain the intensity of the pain. These headaches described by **MG-C3** are not very different from the Western perspective of DSM-IV-TR classification of

psychological factors affecting medical conditions. Sue et al. (2003, pp. 219-221) discusses headaches as among the most common psycho-physiological complaints categorised as migraine, tension and cluster headaches.

Other participants complained of experiencing pain in different parts of their body such as pain in the neck, in the joints (specifically the knees) and pain all over the body. Some reported fainting and falling. **PM-C1** reported: "*I just fainted and fell down. I felt pain nowhere."*

One participant explained physical pains as follows: "*I used to be a very active girl; I could hardly sit idle doing nothing but now I feel tired and weak all the time, can hardly do anything and just gain weight day and night. I have terrible pain on my knees and can hardly walk"* **(LIS-C2).**

MAT-H one of the traditional healers who took part in this study and is specialised in treating children's conditions reported "*running stomach"* as one of the physical complaints presented by some of her patients. Diarrhoea, according to the healer is a very common complaint of the children with the condition known as Anterior Fontelle-*puana.* **DIT-H,** another traditional healer reported *ho khathala*-physical tiredness/weakness as some of the complaints he receives from clients consulting him. These physical complaints form a general label for any disorder with bodily manifestations that are to some extent psychological according to Sue et al. (2003). For example, a physical condition known as

mashwa (rushes all over the body believed to be caused by having sex with a partner still in a mourning period among the Basotho).

In the literature review it was discussed that there is not a clear boundary between psychological and physiological functioning even though according to APA (1994), there are *pain disorders associated with psychological factors, and pain disorders associated with both psychological factors and a general medical condition*. For example, pain disorder is diagnosed when psychological factors are judged to have an important role in the experience of/or difficulty tolerating pain.

4.2.2.2 Emotional complaints

Apart from physical complaints, participants also presented some emotional problems that varied from anger, sadness, suicidal ideation, and emotional outbursts (like crying). Naidoo et al. (2006, p. 90) discuss states of debilitation amongst the AbaNguni stating that there are a variety of states of debilitation. From a Western perspective, such states may be construed, at least phenomenologically, as disorders of the body or the mind. Those that are socio-emotional are amongst others; social withdrawal, fatigue, lack of motivation and anxiety.

This is confirmed by the emotional complaints presented by participants' responses below. One participant, after the death of her son, reported

experiencing feelings of sadness. Another one, whose child had also died and who had, in addition, been sexually and physically abused, reported experiencing feelings of intense pain to the point of being suicidal.

She had this to say: "*Every time I had a knife in my hand, I felt like pushing it through my heart and every time I had medication to take, I felt like taking the whole lot at one-go"* **(AT-C4).**

Other participants experienced a combination of emotional feelings to the point where they found it difficult to contain their emotions. This is illustrated in the following response: "*I do not know what is happening, one moment I am so angry with everybody for no apparent reason and another moment I find myself crying and want to be on my own all the time. I fear for my anger. The other day I shouted at my grandmother for nothing and I hated myself afterwards"* **(EM-C5).** When asked how she knew that she was not well, **LIS-C2** reported, "*she knew she was in tears most of the time".* **MG-C3** also reported that she "*felt sad and cried most of the time and she knew something was wrong with her".*

These emotional complaints of the participants are very similar to Western perspective's classification of mood disorders. Sue et al. (2003, p. 349) discusses affective symptoms (feelings of sadness) and cognitive symptoms (thoughts of suicide) that are not very different from the complaints presented in this study by the participants.

4.2.2.3 Hallucinations

Another theme that emerged from participants' presenting problems included experiences, which were outside of an individual's normal mental status. Hearing voices, seeing images of animals and people in their rooms and on the streets and reporting flashbacks and nightmares formed part of these experiences.

It appears as if what starts off as intense pain is followed by or experienced as a form of physical sensation in the body as illustrated by this response: **"***the pain all over my body sometimes turned into a strange feeling of insects crawling all over my body but nothing physical could be seen. I would scream terribly and no one would see why I am screaming"* **(EM-C5).**

Another participant's experience is described as follows: "*I just fainted and fell down one day*. *Medical diagnosis revealed nothing*. She said: *from there I started seeing images and hearing voices. There is an Aunt of mine I never met but have only seen her photo. She died even before I was born but I keep on seeing her image at particular places in the house and the compound"* **(PM-C1).**

Dreams of all sorts were also reported by one of the traditional healers as comprising some of the complaints they receive from clients. **DIT-H** reported *ditoro (dreams)* as some of the complaints he receives from clients consulting him. The response of one participant that relates to experiencing flashbacks and nightmares is seen in this response: "*I wake up in the middle of the night*

shouting and crying. Images of people who raped me keep on appearing to me even during the day when I am alone. Any noise at night wakes me up. I check the door many times even in the middle of the night; I wake up to check if the door is closed. During the day I lock the door when in the house alone and sometimes I hear all kinds of voices and noises "**(LIS-C2).**

In African worldviews, hallucination without psychotropic substance puts one in a special category of persons in the community (one with unique powers). Presenting problems at the beginning may be a sign for one being called to be a healer. The traditional healers confirmed some of the problems reported by the participants, for example, **DIT-H** reported clients hearing voices, clients feeling insects walking on their bodies and invisible people touching them. Some clients would report a combination of these complaints. **MAT-H** also reported most clients complaining of hearing voices known in Sotho as *mukutu.*

The Western perspective discusses the presenting problems mentioned in this section under *perceptual distortion.* According to Sue et al. (2003, pp. 417-418), *'hallucinations may involve a single sensory modality or a combination of modalities: hearing (auditory hallucinations), seeing (visual hallucinations), smelling (olfactory hallucinations), feeling (tactile hallucinations) and tasting (gustatory hallucinations).'*

The participants in the study presented mainly olfactory, tactile and visual hallucinations and like in the case of **LIS-C2** described earlier, a combination of these hallucinations.

4.2.2.4 Misfortunes

Participants also presented problems that included misfortunes such as death; rape and the disappearance of loved ones. **AT-C4** presented the problem of the death of her husband who sexually abused her and only a few months after her husband's death, her child also died (*I felt like killing myself, angry all the time because of sexual and physical abuse by my late husband. My child also died).* She also had this to say: "*my child died from Anterior Fontelle or Puana in Sotho. Someone caused it through 'muti' in Sotho".* The child was bewitched, so to say. Another external misfortune presented was rape. **LIS-C2** reported: "*I was raped because ancestors were not happy. My parents did not perform some cultural customs & traditions".* The participant presented physical and sexual abuse as external misfortunes as these are not experiences that people anticipate and experience as pleasant.

MG-3 presented the misfortune of the disappearance of her son, who was the sole breadwinner. The loss of the son caused her other complaints as discussed earlier and she had this to say: "*my son disappeared because ancestors are not happy with my family or someone is jealous with me. But I have no idea what wrong I have done."*

Bojuwoye (2005) discusses harmony with the forces of nature impinging upon the person for a psychologically healthy person. Misfortunes, on the contrary, are viewed as disharmony between the person and nature or ancestral spirits.

Naidoo et al. (2006, p. 70) also demonstrates the above results of the study on external misfortunes as follows; *people may wish to know why s/he is experiencing misfortune. Generally clients have experiences of misfortunes or there is a series of incidents, which have a negative impact making them ponder as to why they are having such experiences.*

One may however suspect that the incidents have their origin in the ancestral spirits' action or inaction but may not know why they are taking place. Such incidents may involve family misfortunes such as recurrence of accidents, illnesses, and loss of valuables, to list a few.

4.2.2.5 Behavioural symptoms

Some participants reported experiencing sleeplessness and loss of appetite. **LIS-C2** reported lack of sleep and loss of appetite after her rape ordeal (*I could not sleep and eat. I was afraid to be alone anywhere*). **EM-C5** and **MG-C3** reported: "*When I could not eat, sleep and started losing weight, I knew that I was not well"*.

"I was tired all time and could not do anything", **PM-C1** reported when she was asked about how she knew that she was not well. **AT-C4** reported that after

losing her child, she avoided people. These behavioural symptoms are not very different from Western perspective classifications of mood disorders.

According to Sue et al. (2003, p. 350), *a person with depression often shows social withdrawal and lowered work productivity* and discusses somatic and related symptoms such as *loss of appetite, weight* and *sleep disturbances.* Both traditional healers **DIT-H** and **MAT-H** confirmed complaints of the participants as some of the complaints they receive from clients. Lack of appetite- *takatso ya dijo,* (Sotho) and lack of sleep-*ho hlabaela,* (Sotho).

The problems discussed above are psychological problems because the participants consulted medical services and medications provided failed to bring relief to the participants, leaving no option of an alternative explanation but to attribute even the physical complaints to psychological problems.

The above-mentioned categories of the problems reported were recurrent but other symptoms like decreased concentration, indecisiveness, social withdrawal (all the participants felt they wanted to be on their own most of the time), were also mentioned in a number of circumstances. The participants experienced these symptoms for months before seeking help resulting in their social and occupational functioning being seriously impaired.

All of the conditions presented by the participants for this study were not as a result of a medical condition. While all of them initially consulted with a medical

doctor, although they were given medication, the problems did not respond to the medication and that is why their doctors referred them for psychological counselling.

One case illustration is of a participant who had fainted and fallen down as a result and subsequently started hearing voices and seeing images of animals and people. Seeing that she was not responding to medical treatment she sought the assistance of a traditional healer who could offer her some explanation from an African traditional perspective.

4.2.3 Belief systems and psychological problems

In this section the study sought to understand the role of the participants' belief systems on the problems they experienced. Emphasis in this section is on understanding how belief systems influence the definition of psychological problems, their causes and subsequent management.

4.2.3.1 Psychological Problems defined

In reporting their conditions as presented above, participants had difficulties finding words in Sotho that draws a clear line between what is physical and mental, for example the participant (**MG-C3**) described her headache as if her

head was being "*knocked with a hammer"* all over. Sometimes the knock was focussed on specific parts of the head.

The Western description of the above participant's condition would be simply *cluster headaches* that could be the result of a stressful situation. The participants also described their problems in long sentences and gestures. The problems were hardly described in one word as it is done in English (fatigue, fever, exhaustion or nausea). **MG-C3**'s description of her cluster headaches quoted above illustrates this point. Thus when stress is encountered, the mental health professional is likely to hear complaints involving physical complaints such as headaches, fatigue, restlessness, and disturbances of sleep and loss of appetite.

In most traditional African cultures, illness is understood and defined in the context of psychological conflicts or disturbed social relations that create disequilibria expressed in the form of physical or mental problems. In some instances, participants in their definitions tended to be generally non-specific as to the part of the body afflicted by disease except when prompted to explain further by the health practitioner. An example of this was pointed out earlier by a participant who described her cluster headaches as pain moving around her head at various times of the day. Another participant confirmed this by referring to pains all over the body turning into feelings of insects crawling all over her body.

African health depends on *physical, spiritual* and *social* well-being of the individual. The natural and supernatural elements are inextricably interwoven. Health is not seen merely as a biological matter, but one of bonding the human body and the soul in total harmony. From a traditional African perspective, disease is not only viewed as evidence of microbiological infection, but also as a breakdown in the physical, social and spiritual mechanisms of the individual and the community.

Religious and mystical beliefs are incorporated in an African worldview and these give disordered persons existential explanations for their afflictions as explained by Beuster (1997). Pathology from an African worldview is more inclusive than from a Western perspective approach. There is never a clear line drawn between consciousness and dreams from the traditional African perspective. The manner in which participants reported their psychological problems is in line with African worldviews on health and well-being where no distinction is made between body and mind.

From an African perspective, body and mind is one in the same thing. The mind is never considered to be a separate entity from the body. Mental illness or psychological problems are not completely lacking in physical symptoms.

Tension and stress, sleep disturbances, negative self-concept, distrust of other people and loneliness, insecurity, thoughts of family murders and actual family murder, major psychoses, suicide and neurosis are complaints that mental health

workers are familiar with and hear almost every day at work places or in the field. Medically, psychosomatic cases like panic attacks now show that attitudes and emotional states can have an impact on physical well-being. Mental health professionals now recognize, however, that almost any physical disorder can have a strong psychological component (Sue et al. 2003).

The classification of physical disorders into Axis III by **DSM-IV-TR** acknowledges the belief that both physical and psychological factors are in involved in all human processes according to White and Moorey (1997).

A stressor is an external event or situation that places a physical or psychological demand on a person. Various external events placed physical and psychological demands on the participants. Their coping behaviours failed and the results were psycho-physiological symptoms: apathy, anxiety and panic. Not all the problems presented by the participants were of a medical nature. The participants expressed disequilibria in the form of physical, emotional and hallucination complaints.

From a Western perspective, mental disorders by large, involve impairments in psychological or behavioural functioning, whereas physical disorders (general medical conditions) involve disorders of physiological functioning (**DSM-IV**).

In reality, in an African traditional healing context, healers consider (including the two participants of this study) mental and physical disorders to be complex -

necessitating the approach of body, mind and soul as one entity (Naidoo et al., 2006).

4.2.3.2 Causes of Psychological Problems

By understanding illness to be caused by physical and/or social and spiritual conflicts, the African traditional perspective provides a clear justification for the causes of psychological problems (Lee, 1996).

In addition to mentioning psychological problems that led them to seek psychological counselling, participants were asked to indicate whether, in their culture and tradition, there were some explanations as to the causes of these problems.

Traditional healers typically treat a variety of mental, physical and psychological disorders. For example, they treat mental health conditions including hysteria, anxiety and functional psychotic disorders. They also treat psychosomatic disorders/conditions, or psychological conditions believed to manifest as physical conditions as demonstrated by the results of this study (Peltzer, 1989). Participants' responses to the causes of psychological problems were classified into the following themes: *traditional beliefs* and *external misfortunes* such as death and rape. These are discussed in detail below.

4.2.3.2.1 Traditional beliefs

One possible explanation as to why participants experienced the problems as presented in the previous section had to do with their traditional beliefs. In the cultural and traditional explanation of their mental health conditions, the participants seemed to embrace communal beliefs as opposed to individual beliefs. This is reflected in their responses as follows:

In telling me about these traditional and cultural practices, **PM-C1** said: "*traditional beliefs are very strong and if you do not follow them, there is always some fear of bad consequences".* **LIS-C2** said: "*it is part of our life. You cannot avoid it. It has its place in our life",* **MG-C3** said: "*I grew up in the traditional practices. One cannot question many things in the traditions. It has its value"* and **AT-C4** said, "*The practices are part of us. You cannot avoid it. The* beliefs *are all around us".*

To justify these beliefs, one participant attributed her symptoms of fainting and falling to witchcraft. These participants' responses attest to their earlier explanations as to what in their views caused their problems: "*the neighbours caused it out of jealousy. In Sotho it is referred to as* ***boloi- motho o lowe.*** *I was bewitched. I do not know whether I can forgive who did this to me. Some bad spirits were sent to me to make me sick"* **(PM-C1).**

"My son disappeared because ancestors are not happy with my family or someone is jealous with me. But I have no idea what wrong I have done" **(MG-C3). MG-C3** was not sure of whether the cause was jealousy or ancestral unhappiness and attributed the cause to either of the two.

Another participant attributed her depressive symptoms and experiences of flashbacks and nightmares to ancestral spirits. "*I was raped because ancestors were not happy. My parents did not perform some cultural customs & traditions. I am sacrificed on behalf of the family's failure. Why me, I have no idea"* **(LIS-C2). "***In Sotho it said that I have spirits- ke na le moya. I have a calling to be a traditional healer"* **(EM-C5).**

Exploring **LIS-C2's** symptoms in detail reveals that, according to her belief system, her parents did not perform some cultural customs and traditions when she was born and that is why she was raped. As to why she was singled out to be raped, there is no answer because she is not the only girl in the family. What is clear to her is that the ancestors were not happy and needed to be appeased.
In some instances, like in the case of **EM-C5**, the symptoms are a manifestation of possession by ancestral spirits where there is a calling to become a traditional healer (Sangoma). The traditional healers who participated in this study also confirmed the above-mentioned causes of the problems by the participants. **DIT-H** reported: "*The causes are boloyi (bewitchment) or a calling to be a healer or Bolanya (natural madness). Going against cultural norms also cause these*

problems". **MAT-H** also attributed the causes of the problems to traditional beliefs and external agents by saying: "*Other people out of jealousy are the cause (ho etsa ka bomo). These symptoms can be contracted on the streets where things used for treatment have been poured or disposed".*

Jahoda, (1961); Mpofu, (2003); Simwaka, Peltzer and Banda, (2007); Teuton, Bentall and Dowrick (2007) explain that disharmony with ancestors results in a wide variety of states of debilitation at each significant milestone in a person's development or more appropriately, passage through life. The states of debilitation range from physical and social problems to general misfortunes in life.

As it has been observed in this section, health-related beliefs held by traditionalist Africans encompass the family or community collective as a major resource for well-being. According to Staugard (1986) problems and illness are not individualized but interpreted within the social system, kinship, and traditional cultural norms.

4.2.3.2.2 External misfortune (death and rape)

A second theme under causes of psychological problems includes causes that relate to misfortune such as death or rape as illustrated in the following response:

"*I felt like killing myself, angry all the time because of sexual and physical abuse by my late husband. My child also died*" **(AT-C4).**

"I was raped, and after that I was sleepless, lost my appetite and had nightmares. From the rape I was never the same person I was before". **(LIS-C2).**

These causes of psychological problems as explained by the participants are not very different from the Western perspectives of the causes of psychological problems of a similar nature. For example, **LIS-C2's** symptoms of sleeplessness, loss of appetite and nightmares as a result of her rape ordeal are typical of symptoms related to post-traumatic stress disorder as discussed by Sue et al. (2003, pp.156-160) under anxiety disorders.

AT-C4 was physically abused and sexually abused. The physical illness from these abuses caused terrible emotional and physical complaints. Physical and sexual abuse acted as a biological stressor and made her coping behaviours fail.

LIS-C2 who was raped, suffered from sleeplessness, loss of appetite, flashbacks, excessive checking and securing, depressive moods and nightmares. These post-traumatic symptoms experienced for months significantly impaired her social and occupational functioning.

Straker (1994) points out three main external causes of illness, namely *mystical, animistic* and *magical.* These causes come about through means other than sensory inputs and cognitive processes, through spirits with specific powers and roles to play in the nature of things and persons and through supernatural

powers. These external causes have *humans*, *supernatural* and *ancestral spirits* as agents of diseases of various kinds. Through the communication with the ancestral spirits, messages received from the other world may explain sometimes why people are sick or what they need to do to get cured.

4.2.4 Managing psychological problems and African Traditional beliefs

The results of this study have indicated the crucial role played by traditional beliefs and practices in defining psychological problems from the perspective of the participants. Participants indicated that they usually consult traditional healers at the first appearance of symptoms and when these symptoms do not respond to traditional medication or treatment, they then seek the assistance of medical doctors.

In this section, participants' responses to how these problems are managed from an African traditional perspective are presented. The responses of both the participants who manifested some psychological problems (out of the five participants) and the traditional healers (two participants) are presented.

4.2.4.1 The Healer

The two healers in this study **DIT-H** and **MAT-H** fall under the category of the *healing practitioners of influence.* They are very influential people in their

communities for they fight against illnesses and evil spirits affecting their patients and communities.

Naidoo et al. (2006) mentions *inyanga*, *isangoma* and *umthandazi* as practitioners of influence with specific specializations. Other categories of practitioners are *non-healing* and others who are enigmatic in nature. The category of those who are enigmatic in nature is characterized by an extra-ordinary possession of powers. These powers are like magic but they are not.

Healers fall into the category that Mbiti (1969) refers to as ‘African Specialists’. In this category you have medicine men, mediums and diviners, rainmakers and priests. Mediums and diviners, who in their profession deal with the spirits and the ‘living-dead’, undertake the duty of linking human beings with the ‘living-dead’ and the spirits. These specialists belong to a ‘special’ category of its own; they have a language, symbolism, knowledge and skills acquired after a long period of training. They play an important role in the life of African villages and communities.

To be effective in his or her practice, the healer must have a comprehensive knowledge of his or her culture, tradition, and the environment in general. His or her task is to convey cultural ideals on the basis of mythological structures to the clients, given that most healers serve their own communities.

The age, gender and marital status of these ‘specialists’ vary, and may be men and women, married and unmarried, middle-aged and elderly. Among the Sotho people in the area where I carried out my research, the vast majority of these ‘specialists’ are elderly people in their late fifties and sixties. Participants prefer to consult a traditional healer who is older in age and who often takes the role of a medium or diviner. This means he/she is able to communicate with the ancestors and spirits.

My age and gender were issues in a counselling relationship to some clients during my internship. Elderly men and women found it difficult at the beginning to talk about issues of sexuality to me, whom they considered younger than themselves. They would use figurative language when it came to sexual issues; avoid eye contact and use long phrases, which took me, time to comprehend. **LIS-C2** and **EM-C5** did not refer to sex directly when talking about their rape and abuse respectively. **LIS-C2** said: “*After my rape I would refuse my husband blanket sometimes”.* They referred to sexual issues as “ditaba *tsa dikobo”* (issues of the bedroom or blanket) and refusing to have sex as “*ho hanela monna* dikobo” (refusing a man blanket) I also noticed that some women never looked me in the eye when talking to me.

The implications of the use of these figurative languages around sexuality for Western therapy is that, failure to understand the use of such figurative language around sexuality and what they entail besides matters pertaining to age and

gender issues in a particular culture, may lead to a counsellor pathologizing or misdiagnosing a client.

Furthermore, the use of verbal communication in counselling assumes that there are universal meanings to the words that constitute language and clients like the participants in this study who may not use standard English, may be viewed by some counsellors as deficient or abnormal (Highlen, 1996; Myers, 1999).

The categories of traditional practitioners of influence are based on their specialisations with various problems. This categorisation is similar to the Western perspective's categorisation of psychologists, psychiatrics, counsellors and psychometricians.

4.2.4.2 Method of healing/intervention

The common methods that are used by traditional healers to deal with the above-discussed symptoms include the prescription of herbs and the performance of certain rituals.

Mpofu (2003) classifies treatment methods used by traditional healers as follows: (1) physical activity with management of interpersonal relationships; 2) use of expectation; 3) use of symbolism and enactment; 4) use of naming; 5) dream interpretation; and 6) cleansing, libation and scarification as demonstrated by the healers interviewed in this research.

Traditional healer **(DIT-H)** for instance had this to say: **"***I use various herbs, rituals; give sick people instructions to carry out for example abstaining from certain activities and foods. All these I have learnt from other healers. I also train future healers. Some treatments or rituals are confidential; you can never reveal them to anyone".* Peltzer (1989) confirms the use of herbal extracts mixed with other liquids, which healers administer directly into the blood streams by making bodily incisions.

Other methods concerning interpretations of dreams involved visiting grave yards and performing some rituals on the grave yard as demonstrated by the following report from

DIT-H, "*For a client who has bad dreams about a deceased member of the family, I send him/her to the grave with specific herbs and powder from animal bones dissolved in water to pour on the grave while saying some specific words and performing rituals".*

MAT-H also reported the use of herbs as an intervention method by saying this: "*I use incense (mukubetso) and traditional herbs (meriana) and rituals. Other techniques you cannot tell anyone".* Traditional healers use, as medicine, various things like 'plants, herbs, powders bones, seeds, leaves, liquids and the like; and dealing with a patient, the healer may apply massages, needles or thorns, and he/she may bleed the patient; he/she may jump of over the patient, and he/she may ask the patient to perform various things like sacrificing a chicken or a goat,

observing some taboos or avoiding certain foods, acts or person- all these in addition to giving the patient physical medicines' (Mbiti, 1969, p.169).

The client participants were familiar with a process where the healer did everything for the client and prescribed the treatment. During my internship training I had to ask questions in order to get more information from them. The clients were not familiar with the counselling process that entailed asking questions or engaging in a dialogue. There was an expectation that I needed to know who or what caused their conditions automatically. They were not familiar with just talking as a healing process. They needed herbs and rituals as a process of healing.

LIS-C2 asked: "*Reverend, what can you do to help me stop having these nightmares? What can you give me to stop these nightmares and flashbacks?"*

It became very clear to me that the participants expected a healing process that included material medicine and rituals. Talking alone was not going to be enough.

Contrary to the African perspective, the counsellor in the Western approach expects the client to describe his/her problem, rarely prescribes rituals and the main tools of interventions are verbal (Mpofu, 2006). The traditional healer tells the client what his/her problem is. The process followed by the traditional healer in dealing with illness and misfortune is to discover the cause of the sickness, find out who the source of the problem is, diagnose the nature of the disease,

apply the right intervention and supply means of preventing the misfortune from reoccurring.

This process of healing is partly psychological (invoking of ancestral spirits and how these beliefs affect the client) to help in diagnosis and partly physical (use of herbs on the body, drinking the herbal mixture and burning of incense) in the actual physical healing activity.

African traditional healing clearly reflects a holistic approach to understanding and explaining health and illness. A holistic model of healthcare has several advantages among which is the recognition that an illnesses does manifest across various levels of the community, and physical problems can also cause psychological problems (Marks, 2006).

Healers tend to achieve their treatment effects through a secondary process. Healing by secondary process is primarily directed to the reactions of the illness by significant others rather than to the primary symptoms by the patient (Prince, 1974).

The client is abrogated of any responsibility for the illness and assumes the role of a neutral observer of a social healing process (Chavunduka, 1978). The healer achieves secondary process treatment effects in part by validating the implicit theories held by the patient and significant others about the illness and appropriate treatment as by his or her active therapeutic procedures (Mpofu, 2003).

The following questions from the participants demonstrated that talking alone in counselling was not going to be enough; *what can I do to stop these nightmares, what can I take to stop sleeplessness, what can stop me from being angry all the time? What can I take to stop these headaches?*

As discussed earlier, **LIS-C2's** rape ordeal was attributed to failure to keep cultural norms and customs. Part of the intervention strategy was to perform the customs that were never performed. As far as matters pertaining to prevention are concerned, the healers had this to say, "*some symptoms you cannot prevent e.g. the calling to be a healer. The ancestors decide whom to call".*

"For some sicknesses, we give people charms to put on their bodies, houses or offices for protection. I use rituals for prevention of other sicknesses. Keeping cultural norms and customs are also ways of prevention. The problem is that young people these days do not know these cultural norms especially about funerals, giving births, sexual relationships" ***(DIT-H).***

MAT-H confirmed and re-emphasised the point of keeping and respecting the customs and traditions as a way of prevention by saying*, "Keeping to traditions is an important prevention method. To prevent mukutu (hearing voices), rituals are performed in the compound and houses. I put medicine, muti, at the corners of the homes and houses".*

"For Puana, (Anterior Fontenelle) a medical condition affecting children - specific rituals are done on the child and medicine given to prevent Anterior Fontenelle.

Keeping the tradition prevents Mashwa, a condition caused by engaging in a love affair involving a widower or widow still in a mourning period. Symptoms of calling to be healers cannot be prevented; the solution is to follow the ancestors' instructions completely".

The traditional healer combats witchcraft and magic by preventing their actions and sometime by sending them back to their authors. They are concerned with sickness, disease and misfortune. From an African perspective the ill-will or ill-action of one person against another, causes the sickness, disease and misfortune, normally through the agency of witchcraft and magic according to Mbiti (1969).

4.2.4.3 Target of healing/intervention

Since the causes of psychological problems are attributed to traditional beliefs, the person being treated may often be more than one person who presents the symptoms. Their ancestors and other family members may form part of the treatment. The scope of practice for the African traditional healer is not just the sick person(s) but also the sick person's primary and associational groups and the community in general.

The participants attributed their problems to neighbours, parents and ancestors. As discussed earlier, **MG-C3** attributed her problems to either jealousy of

neighbours or ancestral unhappiness *(my son disappeared because ancestors are not happy with my family or someone is jealous with me. But I have no idea what wrong I have done) and* **LIS-C2** attributed her rape to the failure of parents to perform some cultural rituals when she was born (*I was raped because ancestors were not happy. My parents did not perform some cultural customs & tradition).*

In responding to the question as to what causes the problems presented to them by the clients, the healers had this to say: "*the causes are boloyi (bewitchment) or a calling to be a healer or Bolanya (natural madness) or going against cultural norms" (**DIT-H**).*

MAT-H on her part had this to say: "*other people out of jealousy are the cause (ho etsa ka bomo). These symptoms can be contracted on the streets where things used for treatment have been poured or disposed".*

This clearly shows that intervention targets these other people who are considered to be the cause of the problems. In cases where events or places are involved like streets where *muti (medicine)* has been poured, then intervention has to address these specific places.

In responding to the question as to how he goes about treating illnesses, **DIT-H** said that he uses various herbs, rituals and gives sick people instructions to carry out. These instructions and rituals could involve other members of the family and

community especially those seen to have a direct link to the sickness of the patient.

Family members or community members would also be involved, for example, in performing a ritual or ceremony like *mpho ya badimo* (a traditional ceremony offered to ancestors as a result of a misfortune or fortune among the Sotho people). This is a clear indication that the healer's focus was not just the participants but also their neighbours, parents (alive or deceased) ancestors and other external forces.

The above discussion on collective existence meant that the counselling relationship with the participants had to include and involve others; relatives, deceased members and perceived enemies. The focus was on *'who caused this*' rather than '*what is happening*'. The discussion on collective existence is seen in the light of *Family systems* and *Ecosystemic* approaches in this study as follow: **MG-C3** was unable to define her problems separately from neighbours or ancestral spirits. At the same time, **LIS-C2** also could not define her rape ordeal separately from her parents (her parents' failure to perform customs). This inability to define oneself separately from one's significant others or events is referred to as *acculturation* in family systems therapy.

The collective existence from an African perspective implies, as in Family systems, therapy that an individual is best understood by assessing the

interactions between and among family members; an individual's symptoms are best understood within the context of a dysfunctional system- **LIS-C2** suffered because the ancestors were unhappy with the family, not her as an individual.

In light of the *Ecosystemic* approach, a human being is seen as a *subsystem* within a hierarchy of larger systems, such as family and the community. This nature of the person viewed from an *E*cosystemic perspective seems to be relevant to the collective existence from an African perspective (Meyer et al., 2003, p. 470). The individual client participant had issues within family and to a larger extent within their communities.

This focus manifested itself on the participants wanting to know who, rather than what, caused their problems. Given that from visiting traditional healers earlier, they have been told who the enemies were and the feelings of anger and hurt were evident.

The participants had this to say, "*who is doing this to me and why, what have I done?"* **(PM-C1)** attributing her health condition to bewitchment, "*why me of all the people Reverend, there are other girls in the family. Who did this to me?"* **(LIS-C2)** said; "*could you help me find my son? Can you tell me where he is or what happened to him?"* **(MG-C3)** asked referring to her son who disappeared.

According to Mbiti (1969), the African perspective does not focus primarily on the individual but on the community to which the individual belongs. To be human is

to belong to the whole community, and to do so involves participating in the beliefs, ceremonies, rituals and festivals of the community.

In comparison, this African perspective is not very different from the Western healing from an *Ecosystemic* approach where the *idea or optimal functioning is seen as a relationship between the individual and a system in which the functioning of both is maximised.* The actualisation of the individual is acknowledged but not at the expense of the environment or of others.

The Ecosytemic approach views pathology to be present in a system that reveals a *lack of balance*. Western healing from an *Ecosytemic approach* is therefore based on the *principles of second-order cybernetic and constructivism, in terms of which there continues to be a focus on interactional patterns within and between systems, on complexity and on context, but the therapist now participates actively as an observer of the interactional processes* (Meyer et al., 2003, pp.484-485). From an African perspective, the traditional healer actively participates in the process of healing. The healer actively observes and supervises the prescriptions for the healing, be it ceremonies, rituals or festivals.

4.3 CONCLUSION

This chapter presented the results of the study, starting with presenting participants' brief biographical information. The results demonstrated that the belief systems and practices of Africans in South Africa play a crucial role in

defining psychological problems. These problems manifested themselves in a variety of ways, namely physically, emotionally and behaviourally. Some of the causes of these psychological problems were accounted for by African traditional beliefs while others could be explained from Western perspectives. The management of the problems presented did not only focus on the individual but also on the family and community members besides external agents. The interventions included physical activities, performance of rituals like cleansing, libation and enactment and were not only limited to verbal techniques. The next chapter will discuss the conclusions that can be drawn from the study and the implications of the study.

CHAPTER 5: CONCLUSIONS OF THE STUDY

5.1 INTRODUCTION

This study sought to explore the African worldviews and their influence on psychopathology and counselling. This was done through interviewing 5 client participants and 2 traditional healers who embrace African worldviews, in order to obtain in-depth information into the subject.

The study's results revealed that traditional African beliefs play a significant role in the definition of psychological problems. Furthermore, the study presented a number of examples of ways in which psychological problems are treated from the African worldviews perspective.

In line with the objectives of the study, the following conclusions can be drawn from this study's results:

- African traditional beliefs and practises play a significant role in defining psychological problems. The physical complaints, emotional problems, hallucinations, misfortunes and behavioural symptoms that participants reported as characterising their psychological problems reflected a connection with the African worldviews on health and well-being where no distinction is made between body, mind and soul (holistic approach).

- Clients whose psychological problems are rooted in African traditional beliefs and practices often use language that may not adequately communicate their psychological problems (in a Western perspective) and thus create the possibility of miscommunication between themselves and their counsellors. Clients would use figurative language, avoid eye contact and use long phrases in expressing themselves with the possibility of a Western based counsellor struggling to comprehend the language and gestures (body language).

- There seems to be a clear distinction between how psychological problems are managed from an African traditional perspective and a Western perspective. Whereas the Western perspective relies heavily on “talking therapy” with the aim of empowering the client, the African traditional perspective takes the responsibility for resolving the problem away from the client by performing (supernatural) rituals and by sometimes including others in treatment (extended family members, alive and deceased).

5.2 IMPLICATIONS OF THE STUDY 'S FINDINGS

5.2.1 The role played by African traditional beliefs and practices in defining psychological problems

One of the conclusions of this study is that participants' presenting problems reflected their African traditional beliefs and practices. From these beliefs and practices, participants understood and defined their conditions in the context of psychological conflicts or disturbed social relations that created a discomfort expressed in the form of physical or mental problems.

The implication of this conclusion is that a Western based counsellor in a counselling relationship with a client whose psychological problems are informed by their traditional beliefs and practices may misunderstand the client's worldviews and unduly struggle to come up with a relevant diagnosis and intervention for the client.

In the African worldviews, the natural and supernatural elements are inextricably interwoven and health is not seen merely as a biological matter, but one bonding the human body and the soul in total harmony. Pearce (1989) argued, "It is too simplistic to see disease as only something physical, which attacks the body". According to him, disease causation can be due to "things we see and things we don't see". Many of the things we don't see are included in the African belief systems, their cultural and social values, philosophies and expressions.

The Cartesian dualism of mind-body that exists in Western conceptualisations of mental health treatment is in contrast to the African worldviews of an integrated mind-body-soul (holism), which is related to African concepts of sickness and illness and in a wider sense, indigenous definitions of psychological problems (Lewis-Fernandez & Kleinman, 1994; Markus & Kitayama, 1991).

A Western based counsellor without a conception of this 'holistic' description of mental health problems may unduly pathologize or misdiagnose clients who believe in African worldviews. To an African, biology alone does not explain all about disease causation, because it is seen as a social phenomenon, and as such has significance for the whole ethnic group and immediate community members.

Also Africans believe that diseases can be transmitted from one generation to another as long as the stains of a fault have not been cleared. Many collective rites exist, for example *'mpho ya badimo'* (offertory to the ancestors) among the Sotho people, whose aim could be to stop transmission of some diseases that run in the family.

In addition, Western counselling places value on cause and effect laws, linearity, rational thought, objectivity, the belief in a 'universal truth', and the constancy of measurements (Sue, Carter, Casa, Fouad, Ivey & Jensen, 1998). In light of these kinds of structures, which are presumed to be "standard" and "normal," clients who embrace African worldviews may not feel comfortable with the potential

rigidity of the constraints imposed by Western counsellors and as a result not benefiting from the interventions.

5.2.2 Manifestations of African beliefs and practices within a counselling relationship

The second conclusion of this study referred to the possible miscommunication that can occur between a client whose psychological problems are rooted in African traditional beliefs and practices and a counsellor who operates from an exclusively Western based perspective to counselling. This can be attributed to the differing roles that are played by language in Western based counselling and in African traditional perspectives.

According to Maiello (1990), words do not have the same value in African cultures as in verbal communication in Western cultures. African people act and represent a lot of communication in singing, dancing, rituals and ceremonies. Western people on the other hand would mostly think and talk in communication. The vocabulary that is used in the English language, which is one of the mediums used in counselling, cannot be easily and directly translated into the same vocabulary in the African languages. A word such as sadness, which is commonly used and easily understood in English and therefore within Western counselling does not have a simple African language word. Instead one needs to explain the word in a sentence or phrase to communicate its full meaning.

Participants in this study indeed used long sentences to describe their symptoms.

The results of this study revealed that at times, clients, especially when consulting with a counsellor of a different gender and age, might use figurative language as a way of communicating their problems. An example cited in the results was the use of specific figurative expressions to refer to sexual relationships and activities as the explicit use of the English terminology (for these conditions) would be interpreted as disrespect or taboo in their indigenous African language. Older clients have reservations talking about their private lives with younger people. Men, too, have difficulties talking about their private issues with women and vice versa and as a result resort to using figurative language during counselling relationship that involves these gender and age differences.
When a client uses such figurative language with a Western based counsellor, chances are high for the counsellor not to fully understand what they mean. There is also the potential that the client's freedom of speech and expression in narrating the events surrounding their problem becomes limited out of fear and shyness.

One of the implications of all this is a possible breakdown in communication between the counsellor and his/her client, with the result that the establishment of rapport, which is the first crucial step in building a counselling relationship, is greatly affected. Rogers points out that *'the organism reacts to the field as it is*

*experienced and perceived. "This perceptual field is, for the individual, reality" (*Rogers, 1987, p. 484).

Counselling skills such as attentiveness, listening and empathy are crucial for any counsellor working with a client with a different worldview. The counsellor must attend to the client, both verbally and non-verbally. To fully understand the client's experiential world, listening to symbolised experiences of a client cannot be emphasised enough if a necessary rapport is to be struck in the counselling relationship. Another skill that would be crucial in this situation is empathic communication. According to Egan (1994), empathy involves both listening to and understanding both the symbolised and unsymbolised experiences of the client. It requires the counsellor to put aside his/her pre-conceived ideas or prejudice and hear, understand the client and communicate to him/her the understanding verbally and non-verbally.

Another implication of this conclusion is that, because of the lack of proper understanding of the client's use of language, the counsellor may unduly regard certain behaviours or experiences as pathological and end up misdiagnosing their clients' conditions. The use of verbal communication in counselling assumes that there are universal meanings to the words that constitute language according to Highlen (1996). Psycho-physiological complaints are often formulated as subjective bodily sensations, including heat in the head and body, a sensation of worms crawling all over the body, a sensation of heaviness in the

brain, the sense that the heart is melting and wants to fly away and a lump in the throat (Ebigbo & Ihezue, 1982).

The implication of lack of concise words used in defining problems and not using Standard English is that these clients may be viewed by Western counsellors as deficient or abnormal or even be misunderstood and misdiagnosed. Miscommunication can happen at the level of basic communication (language) and at the level of content (what is being communicated). In South Africa, due to the multicultural nature of the society and the barrier that is often posed by language in a counselling relationship, a common solution is sought in the use of interpreters. Although this can facilitate communication between a client and his/her counsellor, it also has its problems. The use of interpreters has the potential to interfere with the establishment of rapport between a client and his/her counsellor and interpreters also run the risk of using their own frame of reference in translations.

According to du Toit et al., (2001, p. 204) "t*ranslators also translate according to their own personal frame of reference; translators may add their own experiences, interpretations, prejudices and comments"*. It is clear from this that while the use of translators is meant to alleviate miscommunication; it can result in more harm for the client as the client's problems may become misrepresented.

Another ethical challenge that the use of translators poses is the violation of clients' confidentiality. At the same time, difficulty in using language or not knowing the language perfectly well can be an asset in the sense that it stretches counsellors, according to du Toit et al., (2001, p. 205), to:

- *Use very clear and simple language.*
- *Check continuously with participants whether they understand him/her correctly and thus work from his/her frame of reference.*
- *Be creative in the use of alternative communication media.*

A third implication of this conclusion is that when clients are not able to freely and fully express themselves with a Western based counsellor, there is potential for these clients to develop mistrust in the interventions and services provided. From the results of this study, some of the clients discontinued their counselling sessions due to difficulties in communication. Some of them did not know English well while others could not understand Afrikaans - the two main languages that are used by Western based counsellors to facilitate communication.

Others stated that they discontinued the sessions because they felt that they were not being fully understood by the Western based counsellors as far as matters pertaining to cultural issues were concerned. In some cases, they did not even talk about their cultural issues, as they believed that the counsellors would not understand what they were talking about. Eventually clients may not benefit

from the intervention and the whole healing process will not be effective and beneficial.

5.2.3 Management of the beliefs and practices within the African worldviews

The third conclusion of this study relates to the contrast that exists in the management of mental health issues between the Western perspective and the traditional African perspective. Given this contrast many traditional Africans may continue to use the means of healing provided by the African worldviews, which they seem satisfied with (Mbiti, 1988). This shows that the Africans prefer to use treatments that recognize their ways of thinking and their value system.

As I experienced during my internship, some Western counsellors have mixed feelings about advocating the use of traditional healers and healing approaches to address psychological problems. Despite these mixed feelings, traditional healers and healing approaches are often the only available options for most people in rural traditional African areas (Torrey, 1986). Clients who embrace African worldviews, too, have their own difficulties and reservations and therefore gaps to be filled still do exist.

The main tool that is used for healing in Western counselling is verbal communication, as opposed to the use of symbolism and enactment, cleansing,

libation and scarification in the African worldviews. The African traditional approach to healing is aimed at social cohesion and therefore the focus on ‘who caused the problem’ should be aimed at bringing about reconciliation rather than revenge in order to deal with the element of *cycle of enmity.*

This is to say that traditional healers in some cases reveal to the clients the perceived contributors to their problems and take steps to punish them. In turn, the perceived enemy consults another healer who might reveal the punisher and the process continues causing more and more conflicts and enmity in the families and communities. A client rooted in this approach and seeking the services of a Western based counsellor is likely to be dissatisfied when such a counsellor does not meet his/her expectation by focussing on him/her as a target of intervention instead of focussing on the “system”. Western counselling focuses on the *self* as an autonomous entity that is unique in its internal mechanisms. This construct reflects individualism (Stewart & Bennett, 1991), a value that may not be part of the African collectivistic cultures. In contrast, *allocentric* or *interdependent* views of self (Markus & Kitayama, 1991), in which individuals are often defined in relation to significant others, are the African traditional ways, ‘*we are, therefore, you are.’ ‘Healing in the traditional African context is grounded in the collective existence of the microscopic order whereby the individual is always seen as an integral part of the community’* (Meyer et al., 2003, p. 545).

One interdependent way of managing traditional healing and addressing health problems of traditional Africans is through social support resources in the form of relationships with significant others, such as family members and close friends.

Inviting a client's significant others into the counselling relationship might cater for the social support and healing of the "system" as opposed to the individual.
A client who embraces collectivism as an aspect of the African worldviews may be at ease with the Ecosystemic approach to counselling that is embraced by the Western perspective as opposed to other approaches like Psychoanalysis that focuses more on the person (Meyer et al., 2004).

One of the implications of the above conclusion is that Western based counselling may not necessarily be effective when used with African traditional clients. But it has to be mentioned that focusing on '*who caused the problem*' as a way of resolving the problem in the African perspective, may lead to the participants not taking some responsibilities for the resolution of their own problems, thus resulting in lack of *individual empowerment*. For example, participants who had marriage or relationship problems simply attributed their problems to bewitchment, attributing the cause of the problems to other people or events. This did not give them the opportunity to look into what role they might have played in their marital problems.

Another implication of this conclusion is the need for a counselling approach that caters for African traditional clients who prefer to use healing methods that recognize their value systems as people bound by a culture (collectivism).
It is also true that the same individuals as a result of Western influences may at times seek Western-healing methods on an individual basis (individualism).

Nefale and Van Dyk (2003) point out that both dimensions in this kind of cultural dualism are experienced in various levels among diverse groups of people in different places. One way of addressing the gap that exists in providing Western based counselling to clients with an African traditional background is for Western counsellors to become acquainted with African views of psychopathology (Beuster, 1997).

It is important for Western trained counsellors to examine their own worldviews and cultural biases and identify ways that may either consciously or unconsciously interfere with their effectiveness with traditional Africans seeking counselling in respect of unique experiences and perceptions of people (du Toit, Grobler & Schenck, 2001). This examination and identification will help counsellor's stereotypes about clients who are different from them given that in an African worldview, ill health affect mind, body and soul and healing is deeply rooted in the physical, emotional and spiritual aspects of the individual (Mpofu, 2002; Moodley, 2005).

Another way of addressing the above-mentioned gap is for Western counsellors to seek healing methods that seek to provide for African families and community values in the healing process. Van Dyk and Matoane (2010) advance the notion of Ubuntu therapy as a healing method that can contribute to healing families with HIV/AIDS within the African perspective. They further assert that *ubuntu is a worldview that* emphasizes collectiveness and interdependence. Western counsellors may also be unaware of values and customs within a culture that would help in understanding and treating certain behaviours.

Therefore, to be more effective and avoid early termination of treatment by traditional African clients, counsellors may need to develop greater cultural understanding and knowledge. They need to become more culturally at ease and to be able to listen to clients' stories irrespective of how their own worldview differs with that of their clients.

There may also be a need for collaborative relationships to be developed between Western based counsellors and traditional healers in an attempt to provide clients with the best services (Nefale & van Dyk, 2003).

Collectivistic values of the African worldview are not very different from the Western Ecosystemic approaches to healing. Both approaches seek assistance of family members and significant others within clients' communities to help in the healing process. This is an area where both Western counsellors and traditional

healers can co-operate to develop support and self-help groups as a healing process for the clients.

Within this co-operation, the African worldview and its traditional healers may also have to look at the 'self' as *an autonomous entity that is unique in its internal mechanisms* (Stewart & Bennett, 1991). Some focus on the individual may help the individual to take some responsibility about his/her health condition.

5.3 LIMITATIONS OF THE CURRENT STUDY

The study is limited in presenting objective conclusions given that finding what could be termed strictly African in a uniform way is almost impossible. South Africa, like many other countries in the continent, has many tribes and therefore many cultures, traditions and customs. Even within one tribe, uniformity is not always possible as in the case of Basotho, whose people were the participants of this study; there still exists northern and southern Sotho's or Luhya tribe in Kenya with many sub-Luhya's with different cultural and customary beliefs and practices.

The study dealt with the issues of one culture only, the Sotho culture. However, this being a qualitative study, the participants raised the issues under study in this research naturally and the purpose was to study the issues without manipulation and as interrelated wholes. The sample was therefore chosen in line with the qualitative approach.

Purposive sampling (also called judgemental sampling) employs a principle to select cases with a specific purpose in mind. The purposive sampling means of selecting the participants could not rule out all the threats to internal validity. For example, the participants in this study were determined by their issues of traditional African worldviews raised in the counselling process rather than by random selections. The purposive sampling of the seven participants of this study was therefore limited in being representative enough.

Another limitation of the study was the homogenous and small sample size of the participants that limits any objective generalisation of the results. Notably, the small number also included mainly women with only one male participant.
This also limits the perspective of males in the results found in the study.

5.4 SUGGESTIONS FOR FUTURE RESEARCH

One of the above mentioned limitations of this study is the many cultures of many tribes in Africa even in a country like South Africa, thus making it almost impossible to be objective when talking about cultural issues. Indigenous healing systems are those locally developed, recognized and used by most of the inhabitants of a historical community, which they believe to incorporate their health concepts and needs (Mpofu, 2006).
Information on these systems is mainly from anthropological researches and is very localised. Have the curricula in most African universities covered issues at

the cutting-edge of African traditional beliefs and practices and its impact on Psychological health as de la Rey and Ipser (2004) alluded to in the call for a relevance debate? The answer is probably “NO”.

There is, therefore, a serious need to obtain comprehensive information about the African worldviews theories and forms of healing (Grills & Rowe, 1998; Lee & Armstrong, 1995). Bate (1995) advocated for a connection between enculturation and healing. His basic argument was that an analysis of culture is the key to understanding the sickness and its healing process.

The focus of future research therefore, given the results of this study, should be to create specific departments in African institutions/universities to embark on comprehensive field research studies within Psychology departments. These studies can be carried out by Masters Students on various themes in African worldviews with a view of creating a concrete foundational structure on which African Indigenous Psychology can be built and established as an alternative to Western Psychology.

This study revealed that the participants despite being advised by medical health carers to consult counsellors hardly did so. As much as there were other reasons for them not to follow the advice like, lack of affordability of treatment and language barriers, there were also elements of pre-conceived ideas and stigmatisation of mental illness thus a general negative attitude towards seeking psychological help. Ruane (2010) also pointed out these issues from a particular community in South Africa.

More comprehensive research on African people's attitudes is, suggested, on what traditional Africans think of psychological counselling. One cannot underestimate the impacts of political colonialism and assimilation systems that existed in the African continent for years and not forgetting apartheid in South Africa.

In the West, given my experience of living and studying in London for five years, counselling seems to be a normal consultation like any other medical consultation for many. People may even consult counsellors on how to cope with a promotion at work place, something that is very rare in Africa.
In Africa counselling seems to be not always out of free will and seems to be viewed as a sign of weakness, or not being able to weather family difficulties.

Another recommendation for future research based on the above mentioned limitation on sampling is that future studies should be conducted with larger and more diverse samples; moreover, data should be gathered on a wider variety of demographics and cultural belief systems and practices. This could be the way forward for coming up with 'innovative and uniquely South African alternative theories and methodologies' that de la Rey and Ipser (2004, p. 549) discusses.
It is to be noted though, that this kind of research could be localised but focus should not be lost on the fact that African countries have a lot in common as far as matters pertaining to traditional belief systems and practices concerned.

These researches should be carried out in the global socio-political context, but taking into consideration the historical backgrounds of African countries.

5.5 CONCLUDING REMARKS

In the final analysis, it is the researcher's view that counselling from an African perspective can play a role in bridging the gap between modern counselling and traditional healing. The above-mentioned recommendations could go a long way in integrating the mental health care services and thus contributing to the transformation process in South Africa and the rest of Africa.

The awareness of and need for counselling as a mental healthcare service to the people of South Africa has increased tremendously. In the midst of the pandemic of HIV/AIDS, more African people are consulting counsellors or are advised to do so. There is, therefore, a great need to improve the counselling service and from this study, a number of suggestions for the future are recommended in this chapter.

To counter prejudice and ignorance, the counsellor 'to be' should study African culture and customs during BA Honours studies. On-going training and workshop on cross-cultural issues from various cultures should be part of the counselling profession. More emphasis should be placed on prevention and therefore more

mental health clinics in the rural areas need to be opened and general education on psychological issues and cultural integration be initiated.

Traditional healers need on-going training and workshops on modern mental health issues so as to compare with their own issues and diagnoses and integrate their own understanding or contribute to Western healing perspectives. Workshops on modern health issues may help traditional healers to see and acknowledge their felt limitations and be able to refer their clients to Western health practitioners in some cases like getting blood transfusions.

This study contributes to the on-going debate on provision of counselling services in a multicultural country like South Africa and similar countries elsewhere even outside Africa with people holding views different from Western views in Psychology.

The counselling practice as it is now and with very few trained and registered counsellors does not accommodate traditional African worldviews given that ‘the cultural upbringing of many Africans dictates different patterns of communication that may place them at a disadvantage’ (Sue & Sue, 1990). However, many questions remain, concerning how such integration might occur. One area of concern is how these belief systems can be measured and whether such methods would be subject to adequate empirical testing and outcome researches before they become widely used (de la Rey & Ipser, 2004).

Ruane (2010) pointed out impersonal service and lack of cultural sensitivity as one of the obstacles to the utilisation of psychological resources in a South African township community. This can be said of the whole continent where at least these resources exist noting that most African countries hardly have these resources. Most important therefore, is the need to understand the vocabulary, belief system and the perceptions of the traditional African patients, which hopefully should be the objective of all counsellors concerned with providing effective counselling services. In a nutshell, while the sample size for this study was such that its results cannot be generalized, the results have nonetheless provided valuable information in reflecting the role played by African traditional beliefs and practises in understanding psychological problems.

REFERENCES

Agar, M. H. (1993). *The Professional Stranger (2nd ed.).* San Diego: Academia Press.

Allwood, C.M. (2005). Psychology in a global world: Locally relevant… but globally ignored? *The Psychologist*, 18 (2): 84-86.

Allwood, C.M. & Berry, J.W. (2006). Origins and development of indigenous psychologies: An international analysis. *International Journal of Psychology*, 41(4): 243-268.

American Psychiatric Assoc. (1994). *Diagnostic and Statistical Manual of Mental Disorders*. Washington, DC: Am. Psychiatric Assoc. 4th ed. P. 886.

Bate, S. C. 1995. *Inculturation and healing. Coping-healing in South African christianity.* Pietermaritzburg: Cluster Publications.

Becker, H.S. (1990). *Generalizing from case studies.* In E.W. Eisner & A. Peshkin (Eds), Qualitative research in education: The continuing debate(pp.233-242). New York: Teachers College Press.

Becvar, D.S., & Becvar, R.J. (2000). *Family therapy: A systemec integration.* Boston: Allyn & Bacon.

Benner, D.G. (1998). *Care of souls: Revisioning Christian nurture and counsel*. Grand Rapids, MI: Baker Books.

Beuster, J.R. (1997). Psychopathology from a traditional South African perspective, *Vista Occasional Papers*, 5 (1): 13-22.

Bojuwoye, O. (2005). *Integrating traditional healing practices into counselling and psychotherapy*. Thousands Oaks, Calif.: Sage Publications.

Buhrman, M.V. (1987). The feminine in witchcraft (II). *Journal of Analytical Psychology*, 32: 257-277.

Chavunduka, G.L. (1978). *Traditional healers and the Shona patient*. Gwelo, Zimbabwe: Mambo Press.

Cheetham, R.W.C. & Griffiths, J.A. (1981). Errors in the diagnosis of Schizophrenia in Black and Indian patients. *South Africa Medical Journal*, 49:71-75.

Cheung, F.M. (2000). Deconstructing Counseling in a Cultural Context. *The Counselling Psychologist*; 28:123.

Comaroff, J. (1980). Healing and the cultural order. The case of Baralong Boo Ratshidi of Southern Africa. *American Ethnologist*, 7: 637-657.

Corey, G. (2005). *Theory and Practice of Counselling and Psychotherapy* (7th ed). Belomont, CA: Brooks/Cole.

Creswell, J. W. (1998). *Qualitative inquiry and research design: choosing among five traditions*. Thousands Oaks, CA: Sage.

De la Rey, & Ipser, J. (2004). The call for relevance: South African Psychology ten years into democracy. *South African Journal of Psychology*, 34(4): 544-552.

Denzin, N.K. & Lincoln, Y.S. (1998). (Eds), *Collecting and interpreting qualitative materials.* Thousand Oaks, CA: Sage.

Du Toit, A.S., Grobler, H.D. & Schenck, C.J. (2001). *Person- Centred Communication: Theory and Practice*. Cape Town: Oxford University Press.

Duncun, N., Bowman, B., Naidoo, N., Pillay, J. & Roos, V. (2007). *Community Psychology: Analysis, context and action*. Cape Town: UCT Press.

Ebigbo, P.O. & Ihezue, U.H. (1982). Uncertainty in the use of western diagnostic illness categories for labelling mental illnesses in Nigeria. *Psychosomatic Africaine*. 3 XVIII (1): 59-74.

Ebigbo, P.O. (1989). The mind, the body and Society: African perspective. L.K. Peltzer & P.E. Ebigbo (Eds), *Clinical psychology in Africa* (pp. 482-484): Enugu, Nigeria: WGAP.

Egan, G. 1994. *The skilled helper: a systematic approach to effective helping*. (5th edition). Monterey, CA: Brooks/Cole.

Feierman, S. & Janzen, J.M. (1992). *Therapeutic Traditions of Africa: A Historical Perspective.* In The Social Basis of Health and Healing in Africa. Steven Feierman and John M. Janzen, (Eds), pp. 163-174. Berkeley: University of California Press.

Foddy, W. (1993). *Constructing Questions for Interviews and Questionnaires: Theory and Practice in Social Research*. Cambridge: Cambridge University Press.

Gobodo, P. (1990). Notions about culture in understanding black psychopathology: Are we trying to raise the dead? *South African Journal of Psychology*, 20 (2): 93-97.

Goldenberg, I. & Goldenberg, H. (2004). *Family therapy: An overview*. (6th ed.), CA: Los Angeles: Thomson, Brooks/Cole.

Grills, C. & Rowe, D.M. (1998). *African traditional medicine: Implications for African-centred approaches to healing*. In R.L. Jones (Ed), African American mental health (pp. 71-102). Hampton, VA: Cobb & Henry.

Guba, E.G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology Journal, 29:75-91.*

Gumede, M.V. (1990). *Traditional healers: A medical doctor's perspective*. Braamfontein: Slotaville Publishers.

Hammond-Tooke, W.D. 1989. *Rituals and medicines*. Johannesburg: A.D. Donker.

Highlen, P. (1996). MCT theory and implications for organizations/systems. In Hill, G.W. (2000). Incorporating a Cross-cultural Perspective in the undergraduate psychology curriculum: an interview with David Matsumoto. *Teaching of Psychology*, 27(1): 71-75.

Holdstock, T. (1981). Psychology in South Africa belongs to the colonial era: Arrogance or ignorance. *South African Journal of Psychology* 11: 123-129.

Inserra, R. (2002). *Dictionary of Dreams: Understanding dreams & their messages.* Australia: Hinkler Books Pty Ltd.

Ivey, G. & Meyers, T. (2008). The psychology of bewitchment (Part I): A phenomenological study of the experience of bewitchment. *South African Journal of Psychology*, 38(1): 54-74.

Jahoda, G. (1961). Traditional healers and other institutions concerned with mental illness in Ghana. *International Journal of Social Psychiatry*, 7: 245-268.

Kanjee, A. (2001). *Cross-cultural test adaptation and translation.* In C. Foxcroft & G. Roodt (Eds), An introduction to psychological assessment in the South African context, pp. 86-101. Cape Town: Oxford University Press.

Kim, U. (2000). Indigenous, cultural, and cross-cultural psychology: A theoretical, conceptual, and epistemological analysis. *Asian Journal of Social Psychology*, 3:265-287.

Kvale, S. (1996). A place for Place-Identity. *Journal of Environmental Psychology*, 3: 343-344.

Kvale, S. (1996). *Inter Views: An introduction to qualitative research interviewing.* Thousand Oaks, CA: Sage.

Lee, C.C. (1996). *MTC theory and implications for indigenous healing*. In D. W. Sue, A. E. Ivey, & P. B. Pedersen (Eds), A theory of multicultural counselling and therapy (pp. 86-98). Pacific Grove, CA: Brooks/Cole.

Lee, C.C. & Armstrong, K.L. (1995). *Indigenous models of mental health intervention.* In J.G. Ponterotto, J. M. Casa, L. A. Suzuki, & C. M. Alexander (Eds), Handbook of multicultural counselling (pp. 441-456). Thousand Oaks, CA: Sage.

Leedy, P.D. & Ormrod, J.E. (2005). *Practical Research: Planning and Design*, 8th Edition. New Jersey: Pearson Merrill Prentice Hall.

Lesolang-Pitje, N. (2000). *Initiation into traditional healing: A personal experience.* In S.N. Madu, P.K. Baguma and A. Pritz (Eds), Psychotherapy and African reality. (pp. 120-135). Sovenga: University of the North Press

Leung, P.W.L. & Lee, P.W.H. (1996). *Psychotherapy with the Chinese*. In M. H. Bond (Ed). The handbook of Chinese psychology (pp. 441-456). Hong Kong: Oxford University Press.

Lewis-Fernandez, R., & Kleinman, A. (1994). Culture, personality, and psychopathology. *Journal of Abnormal Psychology*, 103: 67-71.

Levers, L.L. (2006). Traditional healing as indigenous knowledge: Its relevance to HIV/AIDS in Southern Africa and implications for counsellors. *Journal of Psychology in Africa*, 16: 87-100.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry.* Thousand Oaks, CA: Sage.

Louw, D.A., Van Ede, D.M. & Louw, A.E. (1998). *Human Development (2nd ed.),* Cape Town: Kagiso Tertiary.

Macais, C.L. & Morales, L. S. (2000). Utilization of heath care services among adults attending a health fair in South Los Angeles County. *Journal of Community Health*, 25: 35-46.

Maiello, S. (1990). Encounter with an African healer: Thinking about the possibilities and limits of cross-cultural psychotherapy. *Journal of Child Psychotherapy*, 25(2): 217-238.

Makwe, E.R. (1985). *Western and indigenous psychiatric help- seeking in an urban African population.* Unpublished master's dissertation, University of the Witwatersrand, Johannesburg, South Africa.

Maree, K. (2007). *First Steps in Research*. Pretoria: Van Schaik.

Marks, L. (2006). *Global health crisis:* Can indigenous healing practices offer a valuable resource. *International Journal of Disability, Development and Education*, 53: 453-470.

Markus, H.R. & Kitayama, S. (1991). Culture and self: Implications for cognition, emotion, and motivation. *Psychological Review*, 98: 224-253.

Maso, I. 1994. *The Phenomenology Chameleon:* A paper presented at the Science and Vision Conference. Pretoria: HSRC.

Matoane, M. (2008). *The impact of the UNISA HIV/AIDS programme on learners and their community*. Thesis (D. Litt et Phil. (psychology)) – University of South Africa.

Maxwell, J.A. (1992). Understanding and Validity in Qualitative Research. *Harvard Educational Review, 6: 3.*

Maxwell, J.A. (1996). Qualitative research design: An interactive approach. Sage Publications, Beverley Hill, CA.

Mbiti, J.S. 1969. *African religions and philosophy*. London: Heinemann.

Mbiti, J.S. 1988. *African religions and philosophy*. London: Heinemann.

Mbiti, J.S. 1990. *African religion and philosophy*. Oxford; Portsmouth, N.H.: Heinemann.

McLeod, J. (2001). *An Introduction to Counselling*. Buckingham, UK: Open University Press.

Meyer, W.F. Moore, C. & Viljoen, H.G. (2003). *Personology: From individual to ecosystem.* 3rd ed. Johannesburg: Heinemann.

Miles, M.B., & Huberman, A.M. (1984). *Qualitative data analysis: A Sourcebook of new methods.* Newbury Park, CA: Sage.

Miles, M.B., & Huberman, A.M. (1994). *Qualitative data analysis: an expanded Sourcebook. 2nd ed.* California: Sage.

Moll, I. (2002). African psychology: Myth and reality. *South African Journal of Psychology*, 32 (1): 9-16.

Moodley, R. (2005). *Integrating traditional healing into counselling and psychotherapy*. Thousands Oaks, Calif.: Sage Publications.

Mouton, J. & Marais, H.C. (1989). *Methodologie van die geesteswetenskappe: basiese begrippe.* Pretoria: Raad vir Geesteswetenskaplike Navorsing.

Mouton, J. (2001). *How to succeed in your master's and doctoral studies*. Pretoria: Van Schaik Publishers.

Mpofu, E. (2002). *Indigenization of the psychology of human intelligence in Sub-Saharan Africa.* In W. J. Lonner, D. L. Dinnel, S. A. Hayes, & D. N. Mpofu, E. (2003). *Conduct disorder in children: Presentation, treatment options and cultural efficacy in an African setting.* International Journal of Disability, Community and Rehabilitation, 2(1), http:/www.ijdcr.ca/Vol.02 01 CAN/articles/mpofu.shtm1.

Mpofu, E. (2006). *Majority world health care traditions intersect indigenous and complementary and alternative medicine*. International Journal of Disability, Development and Education, 53: 375-380.

Myers, L. J. (1999). *Therapeutic processes for health and wholeness in the 21st century: Belief systems analysis and the paradigm shift*. In R. L. Jones (Ed.), Advances in African American psychology (pp. 313-358). Hampton, VA: Cobb & Henry.

Naidoo, L R, Sehoto, S & De Villiers, L. (2006). Towards Culture-Sensitive Healthcare : The case of AbaNguni. Available at: http://www.ukzn.ac.za/scc

Narikiyo, T.A. & Kameoka, V.A. (1992). Attributions of mental illness and judgements about help seeking among Japanese-American and White American students. *Journal of Counselling Psychology*, 39: 363-369.

Nefale, M. C & Van Dyk, G.A.J. (2003). *Ubuntu Therapy- A Psychotherapeutic model for the African client.* In S.N. Madu (Ed). Contributions to psychotherapy in Africa (pp. 7-21). Polokwane, South Africa: University Press.

Neuman, W.L. (1997). *Social Research Methods* 3rd ed. Qualitative and Quantative Approaches. Boston: Allyn and Bacon.

Ngaujah, D. E. (2003). *An eco-cultural and social paradigm for understanding human development: A (West African) context*. Graduate Seminar Paper (supervised by Dr. Dennis H. Dirks), Biola University, CA.

Nsamenang, A.B. (1992). *Human development in cultural context: A Third World perspective*. Newbury Park, CA: Sage.

Nsamenang, A.B. (1993). Psychology in sub-Saharan Africa*. Psychology and Developing Societies*, 5: 171-184.

Nsamenang, A.B. (1995). Factors influencing the development of psychology in Sub-Saharan Africa*. International Journal of Psychology*, 30(6): 729-739.

Nsamenang, A.B. (2006). Origins and development of indigenous psychologies in Cameroon. In C.M. Allwood & J.W. Berry (Eds), Origins and development of indigenous psychologies: An international analysis. *International Journal of Psychology*, *41*: 258-259.

Nsamenang, A.B. (2007). *Origins and development of scientific psychology in Afrique Noire.* In M.J. Stevens and D. Wedding (Eds), under the supervision of John G. Adair. Psychology: IUPsyS Global Resource (Edition 2007). London: Psychology Press. http://www.psypress.com/iupsys/contents.asp

Pearce, T.O. (1989). Social Organization and Psychosocial Health (Peter. K and Ebigbo, P. (Eds), *Clinical Psychology in Africa*, (pp. 47-55).

Peltzer, K. (1989). *Traditional healing and psychosocial health care in Malawi*. Heidelberg: Asanger

Peltzer, K. & Bless, C. (1989). History and present status of professional psychology in Zambia. *Psychology and Developing Societies*, 1: 51-64.

Peltzer, K. (1995). *Psychology and health in African cultures: examples of ethno psychotherapeutic practice*. Frankfurt/M.: IKO Verlag.

Prince, R.H. (1974). *Indigenous Yoruba psychiatry*. In: A. Kiev (Ed.) Magic, faith and healing (pp. 155-192. New York: Free Press.

Queener, J. E. & Martin, J. K. (2001). Providing culturally relevant mental health services: Collaboration between psychology and the African American church. *Journal of Counselling Psychology*, 32: 711-719.

Reber, A.S. & Reber, E.S. (2001). *The Penguin Dictionary of Psychology* 3rd ed. UK: Penguin Books.

Ricoeur, P. (1974). *The Model of the text: meaningful action considered as a text.* In P. Rabinow & W.M. Sullivan (Eds), Interpretive Social Science: a reader. Berkeley: University of California Press.

Rogers, C.R. 1987. *Client centred therapy: Its current practice, implications, and theory.* London: Constable.

Ruane, I. (2010). Obstacles to the utilization of Psychological resources in a South African township community. *South African Journal of Psychology*, 40(2): 214-225.

Scott, P. (1997). *The road less travelled and beyond*. *Spiritual growth in an age of anxiety.* New York: Simon & Schuster.

Seedat, M. (1997). The quest for liberatory psychology. *South African Journal of Psychology*, 27 (4): 261-270.

Seedat, M. (1998). A characterisation of South African Psychology (1948-1988): The impact of exclusionary ideology*. South African Journal of Psychology*, 28(2): 74-85.

Serpell, R. (1984). Research on cognitive development in sub-Saharan Africa. *International Journal of Behavioural Development*, 7: 111-127.

Serpell, R. (1993). *The significance of schooling: Life-journeys into an African society*. Cambridge: Cambridge University Press.

Shams, M. (2002). Issues in the study of indigenous psychologies: Historical perspectives, cultural interdependence and institutional regulations. *Asian Journal of Social Psychology*, 5 (2): 79-91.

Simwaka, A., Peltzer, K. & Banda, D. (2007). Indigenous healing in Malawi. *Journal of Psychology in Africa*, 17(1/2): 155-162.

Sogolo, G. (1993). *Foundations of Africa Philosophy: A definitive analysis of conceptual issues in Africa thought*. Ibadan: Ibadan University Press.

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

Stam, H. J. (2007). 'Image of a global village': Global theorizing and local knowledge. *Journal of Theoretical and Philosophical Psychology*. 27 (1): 1-18.

Staugard, F. (1986). *Traditional healthcare in Botswana*. In M. Last & G. Chavunduka (Eds), The professionalization of African medicine (pp.51-86). Manchester, UK: Manchester University Press.

Stern, D.N. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.

Stewart, E.C. & Bennett, M.J. (1991). *American cultural patterns: A cross-cultural perspective*. Yarmouth, ME: Intercultural Press.

Straker, G. (1994). Integrating African and Western healing practices in South Africa. *American Journal of Psychotherapy*, 48: 455-467.

Sue, D.W. (1978). Eliminating cultural oppression in counseling: Toward a general theory. *Journal of Counseling Psychology*, 25: 419-428.

Sue, D. W. & Sue, D. (1990). *Counselling the culturally different: Theory and practice* 2nd ed. New York: Wiley.

Sue, D.W., Carter, R.T., Casa, J.M., Fouard, N.A., Ivey, A.E., Jensen, M., LaFromboise, T., Manese, J.E., Ponterotto, J.G., & Vasquez-Nuttall, E. (1998). *Multicultural counselling competencies*: Individual and organizational development. Thousand Oaks, CA: Sage.

Sue, D. W. & Sue, D. (1999). *Counselling the culturally different*: 3rd ed. New York: Wiley.

Sue, D., Sue, D.W. & Sue, S. (2003). *Understanding Abnormal Behaviour*. 7th ed. Boston: Houghton Mifflin.

Terre Blanche, M. & Durrheim, K. (1999). *Research in Practise: Applied methods for Social Sciences.* Cape Town: UCT Press.

Teuton, J., Bentall, R. & Dowrick, C. (2007). Conceptualizing psychosis in Uganda: the perspective of indigenous and religious healers. *Transcultural Psychiatry*, 44(1): 79-114.

Tisdale, T. C., Doehring, C. E. & Lorraine-Poirier, V. (2003). Three Voices, One Song: A Psychologist, Spiritual Director, and Pastoral Counsellor Share Perspectives on Providing Care. Journal of Psychology and Theology, 31(1): 52-68.

Torrey, E. F. (1986). *Witchdoctors and psychiatrists: The common roots of psychotherapy and its future*. Northvale, NJ: Emerson Hall Publishers.

Tracey, T.J., Leong, F.T.L., & Glidden, C. (1986). Help-seeking and problem perception among Asian-Americans. *Journal of Counselling Psychology*, 33: 331-336.

Turner, V. W. (1967). *The forest of Symbols: Aspects of Ndembu ritual*. Ithaca, NY: Cornell University Press.

Tutorial Letter 102, PSY474-V. (2006). Department of Psychology, University of South Africa, Pretoria.

Utsey, S. O., Adams, E. P., & Bolden, M. (2000). Development and initial validation of the Africultural Coping Systems Inventory. *Journal of Black Psychology*, 26: 194-215.

Uys, J. (ed.), (1992). *Psychological counselling in the South Africa context.* Maskew Miller Longman (pty) Ltd. Cape Town.

Van der Post, L. (1955). *The dark eye of Africa.* Braamfontein: Lowry.

Van Dyk, G.A.J & Matoane, M.C. (2010). Ubuntu –Oriented Therapy: Prospects for Counselling Families Affected with HIV/AIDS in sub-Saharan Africa. *Journal of Psychology in Africa*, 20(2): 327-334.

Viljoen, H. (2003). *African Perspective*. In W. Meyer, C. Moore & H. Viljoen. Personology: From individual to ecosystem (pp.529-549). London: Heinemann.

Vontress, C.E. (1991). *Traditional healing in Africa: Implications for cross-cultural counselling.* Journal of Counselling & Development, 70: 242-249.

Vontress, C.E. (1999). Interview with a traditional African healer*. Journal of Mental Health Counselling*, 21: 326 –336.

Wakefield, JC. (1997). Diagnosing DSM-IV—Part I: DSM-IV and the concept of disorder. *Behav. Res. Ther.* 35:633–49.

West, W. (1997). *Integrating counseling, psychotherapy and healing: An inquiry into counselors and psychotherapists whose work includes healing.* British *Journal of Guidance and Counselling*, 25: 191-311.

White, P. D., & Moorey, S. (1997). Psychosomatic illnesses are not 'all in the mind.' *Journal of Psychosomatic Research*, 42: 329-333.

Whittaker, S.R. (1990). Education for oppression: The case of psychology in Azania/South Africa. *Psychology Quarterly*, 1(2):5-14.

Wing, D.M. (1998). A comparison of traditional folk healing concepts with contemporary healing concepts. *Journal of Community Health Nursing*, 15: 143-154.

Zhang, A.Y., Snowden, L.R., & Sue, S. (1998). Differences between Asian and White American help-seeking and utilization patterns in the Los Angeles area. *Journal of Community Psychology*, 26: 317-326.

APPENDICES

Appendix 1: Letter to Clinics

Rev J.O. Juma,

P. O. Box 752, Parys 9585.

056 8176153 or 0721035211.

Johan Heyns Mental Health Centre

Vanderbeijlpark

Gauteng Province

Request to use some of your facilities

Dear Sir or Madam:

I worked at the clinic for the first six months in 2007 as an intern to become a registered counsellor. I am currently conducting research in order to meet requirements for an MA dissertation with UNISA. The participants of my research are some of the clients I worked with during the internship.

The reason for my letter is to request the use of your facilities (a room that may perhaps be available) for my use to interview these clients.

Once I receive a favourable response from you we can then arrange the date and time for the interviews. I hope my request will meet a very kind consideration and look forward to hearing from you.

Yours truly,

Rev. J.O.Juma

Appendix 2: Letter to Respondents

Dear Respondent,

I am conducting research as part of my requirements for an MA degree in Psychology with UNISA. The topic of my research is ***"African Worldviews- Their impact on Psychopathology and Psychological Counselling***".

During my internship to become a registered counsellor, I learnt that some clients have been advised a number of times by their medical doctors to consult counsellors or psychologists but have not done so for various reasons. The aim of my research is to try and understand the reasons for this lack of consultation. Another aim of my research is to understand how problems such as the one you consulted me for are explained from your cultural perspective. You are therefore, one of the people identified to assist me with this research.

The interviews will be done at Johan Heyns and Levai Mbatha Clinics at dates and times agreed upon with you. Confidentiality will be kept and you will only talk about what you choose and want to talk about. If you are willing to accept the invitation to take part in the interview, please let me know as soon as you can and you can contact me through any of the contacts below. If I do not hear from you I will try to contact you.

I hope my request will meet very kind consideration and I look forward to hearing from you.

Yours truly,

Rev. Fr. James Juma mhm.

Appendix 3: Contract Agreement

I … on this … day of … 2009, hereby consent to:

1. Being interviewed by Rev. J.O.Juma on the topic: ***African Worldviews- Their impact on psychopathology and psychological counselling.***
2. Follow up interview, if necessary
3. The interviews being audio-taped
4. The use of data from these interviews by the interviewer to the Research Report as he deems appropriate.

I also understand that:

1. I am free to terminate my involvement or to cancel my consent to participate in this Research at any time I feel like doing so.
2. I grant the Researcher permission to still use the information given unto the point of termination of the interview by me.
3. The Researcher will maintain anonymity and that will under no circumstances be reported in such away as to reveal my identity.
4. The Researcher will make no reimbursement for information given or participation in this project.
5. I may refrain from answering questions should I feel the questions are an invasion of my privacy.
6. By signing this agreement I undertake to give honest answers to reasonable questions and not to mislead the Researcher and shall be given the original copy of this agreement on signing it.

Client…….. Researcher……. Date……..

Appendix 4: Interview Schedule for the Individual Clients

Gender……

Age……

Marriage status……

Level of Education……

Religion……

Date……..

Introduction

Thanks for accepting this interview. It has been quite some time since we had sessions and how have you been since then? During the counselling sessions you raised issues of your traditional beliefs and that is what this interview will focus on as I mentioned in my letter to you. Please note that there are no right or wrong answers. What is important for me is your belief and views on the questions I am going to ask you.

1. You consulted with me regarding your state of health during (2007) and you mentioned your condition to me. By the way what was your condition at that time?
2. Does your culture and tradition have a way of explaining your illness? And if so, how does it explain it?
3. Do you believe in this traditional way of explaining your illness?
4. I am interested in your views, feelings and opinions about your traditional and cultural practices?

5. How did you know that you were not well?
6. When you realised that you were not well, where and how did you first seek help or treatment?
7. Did this treatment help you?
8. What made you consult with the medical doctor regarding this condition?
9. Your medical doctor referred you to me. Given your experiences of our interaction last year, what would you say are your views, feelings and opinions on the treatment you have received in this clinic?
10. Given your experiences of how you initially dealt with the illness, what would you say are your views, feelings and opinions on the traditional approach that was used to treat your illness?
11. Given that you belong to a particular Church, has your faith, Church or religion played any role in your illness? If so, how?
12. If you were to choose between the traditional way of treating your illness and the western way of treating it (as was done with me), which one would be your first choice? And why?

Appendix 5: Interview Schedule for Individual healers

I would also like to gather some information from one who deals with mental illnesses from an African worldview perspective in the form of treatment. I intend to interview a traditional healer.

Place……Date……

Gender……Age……

Level of Education……

1. Sometimes people complain of symptoms like lack of sleep, feeling down all the time, avoiding being with other people, seeing visions, hearing voices, lack of appetite, not interested in doing anything etc. Are you familiar with these symptoms? If so, how do you refer to them in Sotho?
2. What normally causes these illnesses from your culture and tradition?
3. How do you go about treating these illnesses?
4. How do you know if you have been successful in treating the illness?
5. Is it possible that some of your clients may not heal through your prescriptions?
6. Do you advise clients to see medical doctors if not healed?

7. Do you have a way of preventing these kinds of illnesses according to your culture?
8. Do you have a way of preventing these kinds of illnesses according to your culture and tradition? How do you do that?
9. Does your faith, Church or religion play any role in your work?
10. What would you say is your success rate in treating people with these kinds of illnesses?