An Integration of African Traditional Healing Rituals with Psychological Therapeutic Practices: Insights of Psychologists

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A mini dissertation submitted in partial fulfilment of the requirements for the degree of

Master of Arts in Clinical Psychology

Faculty of Humanities

Department of Psychology

Rhodes University

December 2025

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ABSTRACT

African traditional healing practices have been used by the majority of South African Black populations for various health reasons, including mental illnesses, which are often understood as punishment or a gift from ancestors and sometimes as witchcraft. However, in South Africa, traditional healing is not readily accepted into the formal healthcare system and biomedical practices are more dominant and even considered safer. The Traditional Health Practitioners Act 22 established the Interim Traditional Health Practitioners Council of South Africa, which sets out regulations to ensure quality, safety, and other matters related to traditional health care services. Despite this, the inclusion of such practices into the formal healthcare system is relatively limited. This becomes an important consideration within the South African healthcare system, given that cultural beliefs direct the understanding and expression of mental illness. This study examined psychologists' insights into African traditional healing rituals alongside psychological therapeutic practices. Understanding their experiences is important for the discipline, as South African belief systems often extend beyond traditional Western interpretations and understandings of mental illness. The research methodology for the study was qualitative in nature, using purposive sampling and Interpretative Phenomenological Analysis, and was guided by Decolonisation Theory as its theoretical framework. Four psychologists from the Makana Municipality and Nelson Mandela Bay participated in the study. Through in-depth semi-structured interviews, the research reveals integration as a complex engagement with identity, culture, and knowledge systems in post-apartheid South Africa. The research highlights integration as a culturally situated practice and calls for urgent curriculum transformation and structural policies that enable meaningful, non-tokenistic collaboration.

DECLARATION

I declare that An Integration of African Traditional Healing Rituals with Psychological Therapeutic Practices: Insights of Psychologists (Mini dissertation) hereby submitted to Rhodes University, for the degree of Master of Arts in Clinical Psychology, has not been previously submitted by me for a degree at this or any other university or any platform for examination. The research is a result of my work, except where otherwise stated, and sources have been acknowledged, and a list of references has been provided.

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Buhle Buthelezi (December 2025)

DEDICATION PAGE

This study is dedicated to my late grandmother, Florencia Nomfazwe Bokia Buthelezi. Ndiyabulela Khuma! Your wisdom, resilience, and belief in education continue to be a lasting source of motivation in my academic journey. I also honour the memory of my late father, uncle, and cousin.

ACKNOWLEDGEMENT PAGE

I would like to express my sincere gratitude to my supervisor, Mrs Sandisiwe Nabo-Bazana. This thesis would not have been possible without her guidance, patience, availability, and encouragement throughout this journey. Your support, especially during times when I went quiet and felt demotivated, helped me preserve and complete this work.

I am deeply thankful to the participants who generously shared their time and experiences, without whom this study would not have been possible.

To my mother, Nomonde Buthelezi, thank you for love, understanding and unwavering belief in me. It has been quite a journey.

Above all, I give thanks to God for his grace and strength that sustained me through it all.

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CHAPTER 1: INTRODUCTION

1.1 Background and Rationale

South Africa's mental health landscape is marked by a legislative paradox that directly informs this study. The Mental Health Care Act 17 of 2002 defines mental health practitioners exclusively as psychiatrists, psychologists, and allied professionals, excluding traditional healers from its framework (Mental Health Care Act 17 of 2002, 2002). While the Traditional Health Practitioners Act 22 of 2007 explicitly recognises traditional healers as legitimate providers whose scope includes the "diagnosis, treatment or prevention of a mental illness" (Traditional Health Practitioners Act 22 of 2007, 2008). These Acts operate in parallel with no formal mechanism for collaboration, referral, or shared care. This legislative silence has tangible consequences: an estimated 92% of people living with mental illness in South Africa never receive treatment, with the public sector estimated to have 0.97 psychologists per 100,000 uninsured population, with mental health resources concentrated in specialist hospitals rather than community-based settings (Docrat et al., 2019). Progressive policy frameworks, such as the National Mental Health Policy Framework 2023–2030, advocating for integrated services (Department of Health, 2021), are valuable considering the South African mental healthcare landscape presents a complex interface between Western psychological paradigms and African traditional healing practices. Within this context, psychologists practising in the Eastern Cape operate at a critical intersection of diverse worldviews. The region's rich cultural heritage maintains strong connections to African Traditional Healing (ATH), which is often viewed not merely as a therapeutic intervention but as a cultural heritage and a gift from ancestors (Sandlana & Mtetwa, 2008). This creates a unique practice environment where many clients simultaneously engage with both Western-trained psychologists and traditional healers, reflecting a pragmatic approach to healthcare that honours both biomedical and cultural understandings of wellness (Sandlana & Mtetwa, 2008). This study is relevant to the South African context, considering that the two health care systems are available and recent research estimating that roughly about 70% of sub-Saharan Africa's population first consults with a traditional and religious healer for mental health care (Williams et al., 2025), while in another study Ross (2008) estimated that about 80% of South Africans consult a traditional healer. It is also important to note that South Africa is diverse and has different cultures, which do not follow the same type of traditional healing processes. The nation has 12 official languages, corresponding to numerous ethnic communities that share different ancestral traditions and historical experiences.

Ancestral spirits are referred to by different names across South Africa's ethnic groups. Among the Bapedi, Batswana, and Basotho peoples, they are known as *badimo*, while the amaZulu call them *amadlozi* and amaXhosa refer to them as *izinyanya* (Mokgobi, 2014). There are also different types of traditional healers, namely amongst amaZulu and amaXhosa, there is an *Isangoma/IGqirha* (diviner) respectively; *Inyanga/Ixhwele* (one who focuses on traditional medical remedies) and *Umthandazi* (faith healer) amongst others (Zuma et al., 2016), while among the Bapedi people, traditional healers are generally called *dingaka* or *ngaka*, and include distinct types such as diviners (*Ngaka ya ditaola*), seers (*Sanusi* or *Sedupe*), traditional surgeons, and traditional birth attendants (*Babelegisi*). This underscores that traditional healing in South Africa is not a homogeneous system, but a plurality of distinct practices shaped by specific cultural, linguistic, and historical contexts.

Pluralism holds that a lack of consensus has characterised human experience and forms of life across all cultural traditions (Smith et al., 2021). This philosophical recognition of divergent worldviews finds concrete expression in the health domain through the phenomenon of medical pluralism, defined as the access to both conventional, complementary, and alternative medicines (Mohanty & Sharma, 2021). The key principle is that different people are likely to be helped by different things at different times (Smith et al., 2021). In adopting the different beliefs individuals have in the health system, it may be easier to treat them. In many African contexts, medical pluralism manifests as the simultaneous or sequential engagement with Western biomedical mental health services and African Traditional Healing practices (Adeleye, 2025; Yew-Siong, 2024). For psychologists practicing within these settings, this pluralistic landscape is not merely a theoretical abstraction but a defining feature of their clinical reality (Yew-Siong, 2024). Understanding medical pluralism is essential for psychologists seeking to provide culturally congruent care, as it directly informs assessment practices, the therapeutic alliance, and the potential for meaningful integration of diverse healing modalities into treatment. Formalised plurality of treatment within the healthcare system, especially in South Africa it is an important consideration, given the discussion that has been unpacked thus far. Consequently, if the beliefs within diverse communities propose alternative frameworks for comprehending, expressing, and addressing mental illnesses, it implies that the current healthcare system is not effectively offering clients a comprehensive support system for treatment. Secondly, it suggests that if mental healthcare is to gain momentum

within the South African context, then more understanding of the belief systems that influence people to be explored for their potential benefit to be included in the healthcare system.

The World Health Organisation (WHO, 2003) urged African governments to formally recognise traditional medicine, thereby fostering an enabling environment for its practice. Research suggests that the South African government shows signs of supporting the idea of integrating the two health care systems (Mokgobi, 2013). South Africa's integration process gained momentum with the presentation of the Traditional Health Practitioners Act 22 of 2007, which provides a legal framework for traditional health practitioners. The government gazetted this act as a way of legitimately recognising the practice of traditional medicine (Government Gazette, 2008). The Department of Health has taken steps towards the official recognition and institutionalisation of African Traditional Medicine by establishing a Directorate of Traditional Medicine within the National Department of Health, as well as enacting the Traditional Health Practitioners Act (Department of Health, 2016). However, little has been done to develop formal working spaces for traditional healers, and to date, there is an experienced exclusion of this form of healing. Furthermore, international and continental bodies like the World Health Organisation (WHO) and the African Union (AU) have advocated for the integration of traditional and mainstream medicine to enhance healthcare accessibility across Africa (AU, 2021). However, the implementation of meaningful collaboration in mental health practice remains challenging, particularly in the psychological domain, where fundamental epistemological differences between these systems become most pronounced.

1.2 Problem Statement

Despite the widespread use of traditional healing practices for mental health concerns in the Eastern Cape (White, 2015) and the coexistence of African Traditional practices alongside Western psychological treatments, limited research has explored how psychologists themselves perceive and navigate this complex therapeutic landscape. While studies have examined traditional healers' perspectives (Hlabano, 2013), client experiences (Sialubanje et al., 2015), and the views of other healthcare professionals (Mokgobi, 2014), the specific voices of psychologists, professionals trained in Western paradigms but working within African cultural contexts, remain rather limited in the literature.

This gap is particularly significant given that psychologists operate at the crucial intersection of Western psychological theory and culturally informed healing practices. Their professional training emphasises evidence-based approaches, while their clinical reality may require engagement with clients for whom spiritual explanations of mental illness and traditional healing approaches may hold profound meaning (Bitta et al., 2017; Galvin et al., 2023). Currently psychologists are thus legally bound by the Mental Health Care Act while they serve patients whose healing practices are legitimised by the Traditional Health Practitioners Act but unaccommodated by the former. This dual gap, legislative and practical, provides the rationale for examining the perceptions of psychologists.

The researcher notes that these two epistemological systems are not the same; however, there is a need for the two systems to work collaboratively to improve mental healthcare service provision. Understanding how psychologists conceptualise, experience, and negotiate this interface is essential for developing culturally responsive mental healthcare in the Eastern Cape and broader South Africa, considering the transformation of healthcare provision.

1.3 Research Aim

This study aimed to explore the perceptions of psychologists in the Eastern Cape regarding the integration of African healing practices used alongside Western psychological treatment.

1.4 Research Objectives

The study sought to achieve the following objectives:

a) To explore and describe psychologists' conceptualisation of African healing rituals.

b) To investigate and comprehend the apprehensions that psychologists have had or may hold regarding the integration of these two systems.

c) To explore psychologists’ perceptions of factors that may inform the integration of the two systems within psychological healing processes.

d) To understand how the potential integration of the two systems may take place.

1.5 Research Question

How do psychologists perceive and interpret the integration of African and Western healing modalities within psychological practice?

1.6 Significance of the Study

This research addresses a critical gap in literature by centring the perspectives of psychologists regarding the integration of ATH and Western psychology. The findings will contribute valuable insights to the ongoing developments of decolonising mental health practice in South Africa and inform the development of more culturally responsive psychological services. By understanding how psychologists currently navigate this complex interface, this study will generate knowledge that can:

- Inform training and curriculum development in psychology programs by highlighting practical strategies, ethical considerations, and culturally responsive approaches to integrating African Traditional Healing with Western paradigms.

- Guide the development of collaborative care models.

- Enhance therapeutic outcomes through better understanding of integrated approaches.

- Contribute to policy development regarding mental healthcare integration.

1.7 Definition of Key Terms

African Traditional Healing (ATH): Indigenous healing practices that utilise traditional approaches to treat various types of illness, often understood as a cultural heritage and gift from ancestors (Sandlana & Mtetwa, 2008).

Integration: The process of combining African healing practices with Western psychological treatment in mental healthcare.

Traditional Healers: Indigenous practitioners, including diviners, herbalists, bonesetters, and traditional birth attendants (Matambela, 2024).

Western Healers: A healthcare practitioner who uses western medical methodologies means those who have been trained in universities and other institutions that use western training or scientific methods

Western paradigms/methods: frameworks that prioritise empirically validated, individual-focused, and secular approaches to understanding and treating mental health, grounded in Western scientific and philosophical traditions.

Psychologists: A psychologist is a professionally trained expert in psychology who applies knowledge in counselling, research, assessment, teaching, or consulting, often requiring licensure to practice independently (American Psychological Association, 2018).

Psychological therapeutic practices: evidence-based interventions and techniques used by psychologists to assess, treat, and support individuals' mental, emotional, and behavioural well-being.

1.8 Outline of the dissertation

Chapter 1: Presents the background and rationale, and problem statement. It outlines the study's aim and objectives, the research question and provides operational definitions, and highlights the significance of the research.

Chapter 2: Reviews relevant literature from other scholars on the topic and presents the theoretical framework guiding the study.

Chapter 3: This chapter details the methodology, including research design, data collection, sampling procedures and ethical considerations.

Chapter 4: Presents the results obtained from the study participants.

Chapter 5: Discusses these findings in relation to existing literature, as well as addressing the study's limitations and offering recommendations.

Chapter 6: Provides a summary of the study, its limitations, and offers recommendations.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The chapter reviews literature from other studies in a similar field of interest. Western psychology and African traditional healing are introduced in this chapter. It outlines the spiritual and holistic underpinnings of African healing traditions and compares them to the prevailing Eurocentric psychological paradigms. It discusses the main issues with clinician positionality and epistemological conflicts that emerge in integration efforts. It also underlines the possible dangers of inadequate integration and considers the contextual elements that either support or impede effective practice. The chapter concludes by placing this topic within the context of decolonisation theory and outlining integration as a critical route to both the change of mental health practice and epistemic justice.

2.2 The Landscape of Mental Health Care in South Africa

Mental health care in South Africa exists within a complex and diverse landscape where Western biomedical paradigms coexist alongside African traditional healing systems. Cultural beliefs are learned and shared across groups of people (Weller, 2005). They affect how people feel about their health, and the cultural meanings that people attach to illness motivate how they seek treatment and where they seek help (U.S. Department of Health and Human Services, 2001). Thus, the belief a person has about their mental illness will either lead them to see a mental health practitioner or a traditional healer. According to Mokgobi (2014), African traditional healing is a healthcare model that is not part of the orthodox Western healthcare system. The major reason for the divide between Western and African forms of healing is rooted in the training, which is based on different epistemological frameworks. Western psychological training is grounded in a biomedical epistemology that assumes the universality of its knowledge base (Wondimagegn et al., 2023). In contrast, the training of African Traditional Healers is embedded within a relational cosmology where knowledge is acquired through ancestral calling and spiritual initiation rather than formal academic instruction (Marks, 2005; Ndlovu, 2025). Western healing is the mainstream form of healing that consists of professionals who have been trained in institutions and use scientific methods as a means of healing people. This is not to suggest that traditional healing is unscientific, but rather, to highlight that the scientific methods drawn upon in the training of

western versus traditional Healers are based on different worldviews. These worldviews will shape how illness, disease, and healing are understood and positioned. Given the diversity of cultures, traditional healing is not homogeneous; each culture has its own ways of addressing different illnesses (Mokgobi, 2014). People's beliefs about the cause of their distress shape who they consult. Those who attribute their suffering to ancestral displeasure, or a calling, typically consult a diviner, *isangoma* or *amagqirha*, who communicates with ancestors to provide guidance (Zuma et al., 2016), like those who suspect witchcraft. While individuals who seek foresight into future events or guidance on how to avert misfortune may consult a Sanusi (*sedupe*), a type of seer distinct from other healers (Mokgobi, 2014). Individuals seeking treatment for physical ailments often consult an *inyanga* (herbalist) for herbal remedies, while those who integrate Christian and traditional beliefs consult an *umthandazi* (faith healer), who uses prayer, water, and ash (Zuma et al., 2016). Thus, the choice of healer is not arbitrary but reflects the individual's explanatory framework.

The African context is characterised by rich cultural diversity, in which health and illness are conceptualised not merely in physical or psychological terms, but also through social, spiritual, and communal dimensions (Akol et al., 2018; Ngobe et al., 2021). Across much of the continent, traditional healing draws upon a profoundly relational and spiritual worldview in which health extends beyond the physical body. The individual is understood as part of a wider network of ancestors, community, and unseen forces whose balance is essential to well-being (Ndlovu, 2025.

In contrast, Western-trained mental health practitioners typically operate within evidence-based frameworks that emphasise biological, psychological, and socio-environmental determinants of mental illness (Mannarini & Rossi, 2019). Many Black South Africans continue to seek the services of African traditional healers for a wide range of health concerns, including mental illness (White, 2015, p.2). Such interpretations reflect the complex spiritual and cosmological context within which mental health is understood in many African settings, where psychological distress is frequently viewed through ancestral or spiritual rather than biomedical lenses. Beyond addressing illness, these beliefs and practices can offer significant benefits for mental health and wellbeing by providing culturally congruent frameworks for understanding suffering that facilitate open communication and high satisfaction (Tesfay et al., 2024), reinforcing social connectedness and community cohesion through embodied, community-based rituals (Draper-Clarke & Green, 2024), affirming identity through ancestral calling which reduces stigma

and promotes recovery (van der Zeijst et al., 2021a), offering meaningful rituals that enable nervous system regulation and trauma release (Draper-Clarke & Green, 2024), and addressing the spiritual, social, and relational dimensions of distress often neglected in biomedical care (Tesfay et al., 2024; van der Zeijst et al., 2021b).

All health providers therefore have their own worldview, whether they belong to biomedical or traditional beliefs; these views therefore guide their practice when providing health services to their clients (Moshabela et al., 2016). Recognising these different worldviews is essential for developing respectful collaboration between healing systems. Also, the African culture is diverse, and the traditional healing is not homogeneous, and each culture has its ways of dealing with different illnesses (Mokgobi, 2014). This diversity necessitates flexible, context-specific approaches to integration rather than one-size-fits-all models.

Patients often have options of where to seek treatment, just as pluralism denotes that human experience and forms of life, across all cultural traditions, are characterised by a lack of consensus (Smith et al., 2021). Medical pluralism is access to conventional, complementary, and alternative medicines (Mohanty & Sharma, 2021). In a network meta-analysis of 101 randomised controlled trials, Cuijpers et al. (2020) assessed comparative data and found that combination treatment was significantly more effective than either psychotherapy or pharmacotherapy alone in the treatment of adult depression. This highlights medical pluralism within the biomedical system and further illustrates the key principle that various people benefit from various interventions (Smith et al., 2021). Integrating systems that people believe in when they consider their health into the formal health system may assist in providing holistic and comprehensive care. Subsequently, if the beliefs within diverse communities propose alternative frameworks for comprehending, expressing, and addressing mental health, it implies that the current healthcare system is not effectively offering clients a comprehensive support system for treatment.

Despite the pervasive influence of Western paradigms, African traditional healing continues to be widely practised across South Africa, reflecting not only cultural continuity but also the enduring trust communities place in indigenous systems of care. This highlights the urgent need for integrative approaches in clinical practice, in which both systems can contribute to holistic and culturally responsive mental health care. However, integration is not straightforward. Traditional healing practitioners operate as specialised intermediaries between visible and invisible realms (Van der Watt et al., 2020). Profound differences in epistemology, diagnostic frameworks,

therapeutic aims, and notions of evidence pose significant challenges to collaboration (Schierenbeck et al., 2013; Lake & Turner, 2017).

2.3 African Healing Epistemologies and Practices

The different African traditional healing practices represent a comprehensive framework that integrates spiritual, social, physical, and psychological dimensions of wellness (Akol et al., 2018). The conceptual foundation centres on ancestral spirits who maintain active involvement in human affairs (Ngobe et al., 2021). These entities function as intermediaries between the physical and spiritual realms, influencing individual and collective welfare through various manifestations (Akol et al., 2018). When neglected, ancestors may withdraw their protection or manifest as illness, signalling that relational balance requires restoration (van der Zeijst et al., 2021).

Illness causation within African epistemologies extends beyond biological explanations to incorporate spiritual and social dimensions (Schierenbeck et al., 2013). Mental health disturbances can originate from various sources, including but not limited to disrupted relationships with ancestral spirits, community disharmony, ancestral calling or spiritual awakening (Ngobe et al., 2021). Failure to observe traditional rites may lead to ancestral displeasure, manifesting as psychological distress (Akol et al., 2018). Furthermore, interpersonal conflicts and jealousy often create pathways for spiritual forces to induce illness, reinforcing the interconnected nature of individual and communal health (Schierenbeck et al., 2013).

Their diagnostic methodologies of traditional healing, in particular diviners, incorporate spiritual consultation and divination techniques utilising sacred objects (Mojalefa, 2014). The therapeutic repertoire includes herbal preparations, ritual cleansing ceremonies, and symbolic interventions aimed at restoring balance (Nemutandani et al., 2016). These approaches emphasise active client participation in restorative processes that strengthen communal bonds and spiritual connections (Ngobe et al., 2021). Sandlana and Mtetwa (2008) highlight how African traditional healing rituals often involve deep spiritual engagement, where the healer intentionally manages their emotions to remain focused. In an ethnographic study of the Bapedi people in the Greater Sekhukhune District Municipality of Limpopo Province, Lebaka (2021) documents how the *malopo* ritual employs music and dance as mediating practices between the material and metaphysical realms. The ritual functions both as a process of appeasing ancestral presences—

believed to cause illness when relational harmony is disrupted—and as a mechanism through which individuals are called into healing roles. Through song, participants seek to "create harmony between the living and the living-dead," thereby restoring relational balance. During the ritual, trainees and established healers enter trance states described as spiritually restorative, while community members observing the performance also report experiences of well-being. The *malopo* ritual thus operates simultaneously as a therapeutic intervention, spiritual communication, and communal healing practice. Such an approach in healing embraces holistic and community-centred methods, resonating with the family systems theory that puts emphasis on interconnectedness and collective wellbeing (Minuchin, 1974). The belief that music serves as a means of expressing humanity, held by the Pedi community in South Africa, affirms its inherent healing properties (Lebaka, 2014). These therapeutic practices recognise the importance of moral and spiritual dimensions in the healing process, addressing guilt, shame, and moral injury as part of mental health treatment.

According to van der Watt et al. (2020), diviners begin diagnosing a patient struggling with mental health by placing *impepho* and candles on a mat and burning them. This ritual is done to invite the ancestors, then the ancestors would tell the healer what is wrong with the person and thereafter guide them on the treatment (van der Watt et al., 2020). A study conducted on traditional health practitioners in Johannesburg, South Africa, other traditional healers as a form of divination throw bones, *tinhlolo,* a traditional divination set used by THPs in Southern Africa, particularly in Mozambique as a way of communicating with the ancestors, it is a central divination practice used to identify the causes of illness, and guide treatment decisions, highlighting its crucial role in traditional diagnostic processes (Galvin et al., 2023). These diagnostic rituals represent sophisticated spiritual technologies for accessing information and guidance beyond ordinary perception. In addition to seeking help from the ancestors, the traditional healers also use observation and ask the patient and their family members questions to gather more information about their illness (Musyimi et al., 2018; Ngubane & Gama, 2024). This combination of spiritual and empirical assessment methods demonstrates the comprehensive approach traditional healers take to understanding illness.

According to Sandlana and Mtetwa (2008), research engagement in rituals like dance, music, divination, meditation, prayer, and dream analysis gradually introduces the client to the

spirit world. These ritual practices serve multiple therapeutic functions, including catharsis, emotional regulation, spiritual connection, and cognitive restructuring. According to Namibian traditional healers, a person suffering from mental health issues shows signs such as talking about amusing and or unrelated topics and behaving abnormally (Jonas, 2024). These behavioural observations complement spiritual diagnostics in identifying mental health challenges.

Galvin et al. (2023), noted that amongst some traditional healers in South Africa, once the source of the mental health has been determined, the traditional healer therefore uses different methods depending on the cause of the problem, for instance, if one is bewitched, they cut a small incision to protect the patient, and if the patient has angered the ancestors, then an animal is sacrificed to appease the ancestors (Galvin et al., 2023). These interventions are designed to address the identified spiritual causes of illness through culturally appropriate symbolic actions that restore balance and protection.

2.4 Western Clinical Paradigms and Their Limitations

Western mental health frameworks predominantly make use of biomedical and psychological systems to understand and treat mental disorders (Mannarini & Rossi, 2019). The biomedical approach emphasises neurobiological factors and pharmacological interventions, while psychological models focus on cognitive and behavioural patterns. These systems use standardised diagnostic criteria and evidence-based treatments within institutional healthcare settings.

The application of Western frameworks in culturally diverse contexts reveals significant limitations (Singh & Joubert, 2025). Diagnostic systems often pathologise experiences considered spiritually significant within indigenous cultures. Clinical assessments frequently misinterpret culturally normative phenomena as psychopathological symptoms, creating barriers to effective treatment (Singh & Joubert, 2025). This epistemological conflict undermines therapeutic alliances and reduces service use among populations with different health belief systems. Nwoye (2015) highlights how Western psychology's mechanistic and individualistic approach is often inadequate in culturally diverse regions like Africa, where interdependence and community are central.

This has led to alienation and underscores the need for a culture-sensitive psychology that integrates indigenous epistemologies and social realities, rather than solely relying on Western paradigms. This epistemological conflict undermines therapeutic alliances and reduces service use

among populations with different health belief systems. However, African traditional healing should be approached with cultural respect but without idealisation. While it plays an important role in many communities, uncritical romanticising can obscure real concerns such as the lack of standardised evidence, unethical practices by some healers, and the potential for harmful delays in seeking effective medical treatment.

2.5 Challenges and Opportunities for Integration

The integration of traditional and Western healing systems presents both conceptual and practical difficulties (Bojuwoye & Sodi, 2010). Western systems prioritise empirical evidence and biological mechanisms, while traditional approaches emphasise spiritual equilibrium and social harmony (Sodi & Bojuwoye, 2011). These divergent perspectives create challenges for collaborative practice and shared understanding. A study conducted among allopathic health practitioners employed by Limpopo's Department of Health revealed that they are not ready to work with traditional healers due to concerns about the quality of traditional care, fundamental differences in how each system conceptualises science and knowledge, and the absence of formal collaborative policies (Nemutandani et al., 2016). Researchers therefore recommend incorporating traditional health systems into undergraduate medical training and establishing clear policy frameworks to reduce resistance and foster collaboration (Nemutandani et al., 2016).

This mistrust was also reported in a study conducted among traditional healers, clinicians and faith healers. Traditional healers reported that clinicians hated them, they despised them and viewed them as useless (Musyimi et al., 2017, p.5). These perceptions of disrespect and discrimination create significant barriers to collaboration and must be addressed through relationship building and mutual education. Green & Colucci (2020) illustrate that both western and traditional practitioners have perceived illegitimacy, biomedical practitioners felt that traditional healers' practices lacked ethical or professional standards, while traditional health practitioners doubted the efficacy of psychiatric medication; they believed most of the mental health was caused by evil spirits and only they could heal them. These mutual doubts about efficacy and legitimacy must be acknowledged and worked through in any integration process.

Similarly, traditional healers usually feel that their skills and knowledge are deemed useless by other medical practitioners (Campbell-Hall & Petersen, 2010). This lack of communication and feedback prevents the development of collaborative relationships and integrated care pathways.

Further challenges that cause collaboration between western and traditional healers are that western practitioners claim that the medicine used by the traditional healers is not tested and certified for use (Gyasi et al., 2016; Mutola et al., 2021).

In addition, a scoping review by Jilka et al. (2025) revealed that biomedical practitioners were reluctant to equalise their status with traditional faith healers. These economic and status concerns may create significant power dynamics that must be navigated in integration efforts. Western practitioners lack knowledge of how traditional health practitioners' practice, and therefore, they victimise and call them witches, which leads to stigmatisation against traditional healing practices (Musie et al., 2022). This stigmatisation reflects deep-seated prejudices that can be addressed through education and exposure. A study in Nigeria by Akinnawo and Akpunne (2018), found that the African Traditional Healing system faces structural, regulatory, and epistemological barriers, which impede the integration of indigenous psychotherapies into mainstream healthcare.

Despite these challenges, significant opportunities exist for complementary care models (Masola & Maotoana, 2025). With only 975 psychiatrists for over 60 million people and 75% of those with untreated mental illness, the estimated 200,000 traditional healers nationally are well positioned as frontline providers and first points of contact in communities (SASOP, 2024). Research identifies governance opportunities, including formal registration, mutual recognition, and acknowledgement of spirituality in healing (Masola & Maotoana, 2025). Integration ultimately fosters a culturally sensitive, inclusive system that respects both Western and African approaches, challenging the pathologisation of African experiences of mental health (Letsoalo et al., 2024). Co-ordinated approaches can enhance treatment engagement and outcomes (Singh & Joubert, 2025). Strategic partnerships allow for early intervention through traditional networks while providing access to biomedical treatments when indicated (Masola & Maotoana, 2025). Such collaborations potentially increase cultural relevance and accessibility of mental health services.

Most of the available literature on the traditional health practitioners and perception of integration has been conducted with traditional healers, nurses, community members, and other medical professionals, but very little research has been conducted to explore the view of psychologists on integrating traditional healers in therapeutic intervention (Bitta et al., 2018;

Galvin et al., 2023; Musyimi et al., 2018; Nemutandani et al., 2016; Ngubane & Gama, 2024). This represents a significant gap in literature, where there are limited studies on the views of psychologists as they operate at the crucial intersection of Western psychological theory and culturally informed healing practices. Understanding their perspectives is essential for developing feasible integration models that respect both evidence-based practice and cultural diversity.

2.6 Clinician Identity and Emerging Directions for Decolonial Practice

Effective mental healthcare delivery requires critical awareness of professional positioning within cross-cultural contexts (Masemola et al., 2023). Clinicians must recognise how their training and cultural backgrounds influence therapeutic interactions and clinical judgments (Bojuwoye & Sodi, 2010). This reflective practice enables a more nuanced understanding of patient experiences and health beliefs.

Educational reforms represent crucial mechanisms for developing culturally responsive practitioners (Masemola et al., 2023). Training programs must incorporate indigenous knowledge systems and intercultural communication strategies. Professional development initiatives should facilitate dialogue between traditional and biomedical practitioners, fostering mutual understanding and respect across healing traditions (Bojuwoye & Sodi, 2010). In the integration of the two health systems, it would be vital to establish the patient's social and cultural background and how they understand the conditions they are presenting with (Mokgobi, 2014). This cultural assessment would help determine appropriate treatment pathways and facilitate communication between different healing systems. Progressive mental health practice requires structural and conceptual shifts toward pluralistic frameworks (Masemola et al., 2023).

Future directions emphasise the importance of contextually responsive mental healthcare that honours diverse healing traditions while maintaining scientific rigour. According to Mendu and Ross (2019), biomedical practitioners, traditional healers, and government officials responsible for formulating healthcare policies need to be involved in devising a framework that would facilitate ways of encouraging collaboration between these two healthcare systems.

2.7 Theoretical Framework: Decoloni(s)ation Theory

The historical relationship between psychology and colonisation, notably during the apartheid era has faced significant scrutiny from scholars such as Kessi and Boonzaier (2018), who argue that the discipline often reinforced ideologies of white supremacy. Decolonisation theory proposes a fundamental reordering of knowledge systems and power relations that have been shaped by centuries of colonial domination. Rather than simply adding diverse perspectives to existing frameworks, this theory calls for three radical transformations in how knowledge and practice are approached: First, it demands epistemic liberation, the freeing of knowledge production from Western scientific dominance. The theory argues that colonial powers systematically suppressed indigenous knowledge systems while establishing Western epistemology as universally valid (Tuhiwai Smith, 2021; Ndlovu-Gatsheni, 2018). Decolonisation, therefore, requires centering marginalised ways of knowing, not as alternative beliefs but as equally valid systems of knowledge (Mignolo, 2010). This means treating African healing epistemologies as sophisticated frameworks rather than cultural curiosities to be studied through Western scientific methods (Chilisa, 2012). Second, the theory advocates for ontological reclamation, the restoration of indigenous ways of being and relating to the world. This involves rejecting the individualistic, dualistic conceptions of personhood that underpin Western psychology and embracing relational ontologies like Ubuntu's "I am because we are" (Mbiti, 1990; Mugumbate & Nyanguru, 2013). It means recognising that healing occurs not through treating isolated minds but through restoring harmony within networks of relationships that include the living, ancestors, and the natural world (Mkhize, 2004; Nwoye, 2015). Third, decolonisation theory calls for methodological sovereignty, the right of communities to control research and practice concerning their own wellbeing (Tuhiwai Smith, 2021). These challenges are the extractive nature of conventional research, where outside experts study communities for academic benefit (Chilisa, 2012). Instead, it demands collaborative approaches where community knowledge holders guide the process and benefit directly from the outcomes (Caxaj, 2015).

The theory enables the study to critically examine how psychologists' views on integrating African Traditional Healing and Western paradigms may be influenced by historical and epistemic hierarchies that privilege Western models. It provides a framework for analysing the power relations and underlying assumptions shaping their interpretations of each system's legitimacy and

role. Additionally, it supports an interpretation that foregrounds the pursuit of an equitable, contextually grounded integration that recognises African Traditional Healing as an autonomous and credible knowledge system. The theory provides the analytical lens for this study, as it directly addresses the power imbalances and epistemic hierarchies between Western psychology and African Traditional Healing. It challenges the assumed universality of Western knowledge while validating Indigenous epistemologies as legitimate frameworks for understanding mental distress. Guided by this lens, the analysis will examine whether psychologists demonstrate epistemic injustice by dismissing traditional healing, or cultural humility by recognising traditional healers as equal knowledge holders. The theory thus transforms this inquiry into a critically engaged examination of how psychologists navigate colonial legacies in their practice.

2.8 Conclusion

This chapter has explored the distinct foundations of African traditional healing and Western mental health paradigms. It examined the holistic, spiritually grounded approach of African epistemologies alongside the biomedical and psychological focus of Western models. The review analysed the significant challenges to integrating these systems, including epistemological conflicts and institutional barriers. It also highlighted the promising opportunities for creating more culturally responsive care through collaboration. The discussion emphasised that successful integration requires deliberate efforts in policy reform, education, and community-engaged research. Ultimately, this synthesis underscores the need for pluralistic mental health. Finally, the chapter framed this entire discourse through the lens of decolonisation theory, positioning integration as a critical site for epistemic justice and the transformation of mental health practice. The existing literature reveals deep epistemological differences, ongoing mistrust, and significant practical challenges between Western and African healing systems. However, very little is known about how psychologists themselves understand these tensions and navigate integration in real clinical settings. The results chapter, therefore, presents the findings from this study, offering insight into psychologists' lived experiences and how these align with or diverge from the themes raised in the literature.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter provides an in-depth overview of the approach employed for conducting the study, an extensive discourse on the research design, the instruments utilised for data collection, the procedures implemented, and the methods for selecting the research sample. The chapter concludes with a comprehensive discussion on how the study was analysed, as well as a thorough review of the ethical considerations that guided the study.

3.2 Research approach and design

The research approach that was used in this study is the qualitative research approach. Qualitative research was used to study new phenomena and to capture individuals' interpretations of meaning and process. It explored the human element of the topic, thus providing deeper insight into the research topic (Given, 2008). According to Williams (2007), in qualitative research, a social phenomenon is explored from the participant's viewpoint. Tenny et al. (2024) highlight that qualitative research gathers participants' experiences, perceptions, and behaviour. It provides a detailed and in-depth understanding of real-world issues, offering insight and understanding (Moser & Korstjens, 2017). Phenomenology, as both a philosophical foundation and methodological approach, concentrates on exploring how individuals make sense of their personal and social worlds, making it particularly suitable for investigating psychologists' subjective perceptions of integrating traditional and Western healing practices (Smith et al., 2009).

A research design that is exploratory in nature was used. A research design is a general roadmap of how research questions were answered (Ussif et al., 2020). Creswell (2014) suggests that the exploratory research method is used when not much has been written about the topic and the researcher seeks to listen to the participants and build an understanding from what the participants have said. It is a way of investigating what is happening, seeking new insights, asking questions, and assessing a phenomenon in a new way (Robson 2002). The research study is considered exploratory as it aims to gain information and an understanding of the perceptions of psychologists on the integration of African and Western practices.

Consequently, a qualitative exploratory research design was considered appropriate for this study, as it sought to investigate a relatively under-researched area and understand the perceptions and lived experiences of psychologists, allowing for deep investigation into their subjective

realities, beliefs and attitudes regarding the integration of African Traditional Healing with Western psychological practice. A qualitative approach was selected over quantitative methods because the research aims required deep exploration of complex, context-dependent phenomena that cannot be adequately captured through standardised instruments or statistical analysis. The study sought to understand the nuances of psychologists' experiences, the meanings they attribute to integration, and the contextual factors influencing their perceptions, all dimensions best explored through qualitative inquiry. Lastly, the sensitive nature of discussing cultural practices and professional integration necessitated a methodological approach that could accommodate complexity, contradiction, and contextual specificity.

3.3 Participants and Sampling

Non-probability purposive sampling was employed in this study. The sampling allowed for the researcher to choose the participants needed for the study, as the main goal of purposive sampling is to focus on certain characteristics of a population that are of interest, which will best enable the researcher to answer the research question (Rai & Thapa, 2015). Purposefully selecting participants maximised the understanding of the phenomenon (Omona, 2013).

This non-probability sampling technique is consistent with IPA's emphasis on selecting participants who can offer meaningful perspectives on the phenomenon under investigation (Smith et al., 2009). The sampling strategy specifically aimed to identify psychologists who had direct clinical experience with clients who use African traditional healing practices, ensuring that participants could speak from practical experience rather than theoretical knowledge alone.

The sampling process involved multiple stages: initial identification of potential participants through professional networks in the Eastern Cape, mainly places of work, screening for relevant clinical experience in terms of years in practice, and participants were sent emails requesting them to participate in the study, while also ensuring diversity in terms of professional background and demographic characteristics. This comprehensive approach ensured that the sample could provide rich, varied perspectives on the integration phenomenon while maintaining the depth required for phenomenological analysis.

The study was initially going to include three participants; however, it ended up including four practising psychologists in the Eastern Cape province, as during data collection, an additional psychologist who met all inclusion criteria became available and offered unique perspectives on

integration, which enhanced the diversity of experiences captured without compromising methodological rigor. The study included four practising psychologists from the Eastern Cape province. This sample size aligns with IPA recommendations for maintaining depth analysis while allowing for meaningful case comparisons (Smith et al., 2009). The participant group comprised two clinical psychologists and two counselling psychologists, two Black female practitioners and two White male practitioners with clinical experience ranging from 5 to 27 years. The diversity in professional backgrounds, therapeutic approaches, and demographic characteristics enabled the exploration of both common patterns and unique variations in how psychologists perceive and navigate the integration of healing practices**.**

3.4 Data Collection Methods

Individual semi-structured interviews were used to collect data. This allowed researchers to acquire in-depth information and evidence from interviewees while considering the focus of the study (Ruslin et al., 2022). A semi-structured interview schedule was used (see Appendix E). This interview schedule was developed in a way that will allow the researcher to probe for further information (De Vos et al., 2011). This method of collecting data was suitable as it allowed for complex issues to be discussed and clarified. The interview schedule does not direct the interview; rather, it guides it, giving the researcher and participants more flexibility (De Vos et al., 2011). Each interview lasted approximately 45-60 minutes and was conducted in settings chosen by participants, specifically their work offices, to ensure comfort and confidentiality. All interviews were audio-recorded and transcribed verbatim to preserve linguistic nuances, emotional tones, and conversational patterns, and all the interviews were conducted in English, with two interviews where participants often used IsiXhosa for specific phrases and words.

3.5 Research Procedure

Before data collection, ethical clearance was received from the Rhodes University Ethical Standards Committee (RUESC). Participants who met the inclusion criteria, who were approached to participate in the study via email (see Appendix B). Those who responded and agreed were contacted, for final arrangements were made to set up for times that were convenient for interviews. Before the commencement of the interview on the day, participants were given the

consent form and requested to read and sign it 10 minutes prior, which served as an agreement between the researcher and the participant. They were further requested to sign an extra form to give consent for the interview to be recorded, which is for transcribing and data analysis purposes.

3.6 Data Analysis

3.6.1 Interpretative Phenomenological Analysis

The IPA approach can afford new and novice researchers the opportunity to explore, in more detail, the 'lived experiences' of the research participants. The principal objective of interpretative phenomenological analysis (IPA) researchers is to investigate how people construct meaning from their lived experiences (Pietkiewicz & Smith, 2012). IPA draws from the fundamental principles of phenomenology, hermeneutics, and idiography.

Husserl (1982) is credited as the founder of phenomenology, focusing on how individuals perceive and make sense of the world. The focus is on how things appear to individuals as they experience them (Pietkiewicz & Smith, 2012). According to Pietkiewicz and Smith (2012), phenomenology aims to identify the essential components of phenomena which make individuals different from others, through eidetic reduction. The focus is on understanding how individuals perceive and describe their experiences, rather than fitting them into preexisting categorical or scientific systems.

The second foundational theoretical basis of IPA is hermeneutics, which revolves around the theory of interpretation. According to Noon (2018), these interpretations are therefore bounded by both the participants' ability to articulate their experiences and the researcher's ability to analyse them. Smith et al. (2009) propose that in IPA, this twin-faceted interpretation is called the 'double hermeneutic.

Lastly, IPA is idiographic in its commitment to examining the detailed experience of each case in turn, prior to the move to more general claims (Smith & Osborn, 2015). Smith (2004) suggests that only after each case has been examined does the researcher attempt to conduct a cross-case analysis, examining how the themes identified in individual cases intersect and differ. Ideography places emphasis on how to understand the concrete, the particular and the unique whilst preserving the integrity of the participant (Eatough & Smith, 2017). I decided to use IPA

due to its strong commitment to exploring and understanding personal lived experiences, which will allow me to explore in more detail the 'lived' experiences of psychologists.

3.6.2 Methods of Data Analysis

The data analysis followed the systematic iterative process outlined by Smith et al. (2009) for IPA, with specific attention to the cross-cultural dimensions of the data. According to Tomkins (2017), IPA systematically explores personal experiences in semi-structured interviews with individual participants; in this way, we can collect rich data to better understand the complexities of human experience and have participants express their concerns. The researcher used the seven steps of IPA data analysis (Smith et al., 2009).

1. In the first phase, the researcher familiarised herself with the data by reading and re-reading the transcripts and repeatedly listening to the audio recordings. The researcher transcribed and followed an iterative reading process, allowing her to be familiar with the depth of the content from the interviews. Initial notes were made focusing on descriptive comments capturing explicit narratives, linguistic comments noting language use, metaphors and emotional tone, conceptual comments exploring broader meanings and cultural contexts and contextual comments noting the influence of South African socio-cultural dynamics.

2. During the second phase, the researcher made notes about her observations and reflections on the interview process, and any noteworthy thoughts or comments. The aim was for these notes to be transformed into emerging themes. Initial notes were made focusing on descriptive comments capturing explicit narratives, linguistic comments noting language use, metaphors and emotional tone, conceptual comments exploring broader meanings and cultural contexts and contextual comments noting the influence of South African socio-cultural dynamics.

3. Thirdly, the researcher searched for developing themes. The researcher focused on chunks of transcript and analysis notes made into themes that captured the participants' experiences, moving into more abstract conceptualisations and identifying patterns, and developed labels that captured the essence of experiences.

4. In the fourth phase, the researcher searched for connections across emergent themes, integrated the themes and considered how they relate. Some themes at this stage were dropped. The researcher ensured the participants' accounts were kept while offering interpretive insights.

5. In the fifth phase, the researcher moved on to the next case and looked at it with 'open and fresh eyes', again becoming immersed in the case, Steps 1-4, which are undertaken for each case before progressing to the next stages of the analysis.

6. In the sixth phase, the researcher sought patterns across all the cases to find themes that are identifiable across cases and made a note of any distinctive differences.

7. In the seventh phase, the researcher reviewed the themes across the data set using metaphors and temporal referents and by drawing on existing theory to further explore the analysis.

The final stage involved weaving the thematic analysis into a coherent narrative that remained grounded in participants' accounts while offering interpretative insights. This process maintained the double hermeneutic central to IPA, where the researcher is making sense of the participant making sense of their experience, while being particularly attentive to cultural translation and contextual understanding.

3.7 Use of Digital and AI Tools

Several digital and AI-assisted tools were employed to support data management and analysis throughout this study. Otter.ai (Otter.ai, 2025) was used to assist with the transcription of interview recordings, ensuring accurate capture of participants' accounts. All transcripts were subsequently reviewed, corrected, and anonymised manually by the researcher to preserve accuracy and confidentiality. Delve (Delve, 2025) was utilised to facilitate the organisation and coding of qualitative data in accordance with the principles of Interpretative Phenomenological Analysis. Mendeley (Mendeley, 2025) was employed to find, organise, and manage academic references and citations. All AI-assisted tools were used ethically and transparently, and the researcher retained full responsibility for the interpretative process, analytic decisions, and presentation of findings. Confidentiality was ensured by anonymising all participant information

before any data was analysed or stored on digital platforms. Only de-identified excerpts were used for coding and interpretation, while full transcripts were kept securely protected by the researcher. No identifiable details were shared, uploaded, or processed outside approved secure environments, ensuring that participants' privacy was maintained throughout the research process.

3.8 Ethical Considerations

Ethical approval was granted by the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department of Rhodes University and the Rhodes University Ethical Standards Committee. The approval letter is found in the appendices (see Appendix A). The researcher was guided by principles outlined by De Vos, Strydom, Fouché, and Delport (2011), namely, informed consent, confidentiality, and avoidance of harm.

3.8.1 Informed consent

Informed consent includes but is not limited to the explanation of voluntary agreement to partake in the study, the risks and the limitations (Anney, 2014). Participants were informed about the study and given adequate information on the aims and objectives of the study and the intended use of the data that will be collected. The participants signed a consent form (see Appendix C) to indicate their willingness to participate in the study and an additional consent form agreeing to be audio recorded (see Appendix D). The consent letter should clarify the main aim and objectives of the research, as well as address ethical considerations such as ensuring confidentiality and anonymity (Mirza et al., 2023). The participants in this study participated in the study voluntarily and were provided with the opportunity to ask questions before signing the consent form and before the commencement of data collection.

3.8.2 Anonymity, confidentiality, and privacy

It is always mandatory for researchers to conduct research without causing harm to their participants. The participants were informed that their identity would be kept confidential, and they would not be identified in audio-recordings and in print. Pseudonyms were used to identify participants. Thus, the researcher has not provided an elaborate, clear description of the participants' demographics anywhere in the study to protect their anonymity as there is a

possibility of the participants being easily identifiable should these be clearly stated, considering the setting in which the study took place. The researcher has protected the devices and documents from ill-use or theft and will never leave them unattended in public settings. This will ensure the protection of participants' confidentiality from other people in the study and from the public. Participants were assured that the information they provided would be treated with confidentiality. Participant data will be restricted solely to the researcher and supervisor and is stored in a password-protected drive. All records, whether written or audio, should be safely stored in a location that is still easily accessible (Mirza et al., 2023).

3.8.3 Voluntary participation

The principle of voluntary participation was rigorously upheld throughout the research. This was demonstrated when a participant who, despite initial consent, displayed hesitancy toward follow-up research involvement. While they did not explicitly decline, their subsequent non-responsiveness to follow-up interview requests was respected as a clear indication of preference to disengage. No further contact attempts were made, and no punitive measures were applied.

3.9 Researchers Positionality and Bracketing

Founder of phenomenology, Edmund Husserl (1931) introduced the concept of bracketing, which involves the deliberate suspension of all preconceptions, assumptions, and judgments about the external world. This suspension allows researchers to focus exclusively on how phenomena present themselves to consciousness, enabling a pure description of lived experience.

Given the study's focus, particular attention was paid to cultural sensitivity in research design and implementation. The researcher maintained awareness of her own positionality as someone with a personal background and lived experiences within the African traditional paradigm when engaging with psychologist participants' perspectives on traditional healing. I documented my personal biases and expectations. I allowed the themes to emerge from participants without preconceived ideas from me. I engaged in supervision about certain biases that could have influenced data analysis. Constantly returning to the data helped.

3.10 Trustworthiness

In the process of verifying the research data as accurately reflecting the views of participants and not the researcher's perceptions of their experiences, the researcher was guided by Lincoln and Guba's model of trustworthiness. According to Lincoln and Guba (1985), qualitative research should be credible, transferable, dependable, and confirmable. To achieve the above-mentioned, the researcher utilised the following principles of trustworthiness.

To ensure and enhance the credibility of the study, the researcher used the peer debriefing principle. She sought support from other professionals and from peers who were either doing qualitative research or had experience with qualitative research; this assisted in establishing that the results obtained by the researcher are credible. The research supervisor was consulted prior to, during and after the data collection. Credibility is achieved when research findings are credible and consistent, to the people we study and to our readers, and they are related to significant elements in the research context/situation (Gasson, 2004). Do the findings capture the context. Credibility is enhanced by the researcher describing his or her experiences as a researcher and verifying the research findings with the participants (Cope, 2013). In this study, the reflexivity technique was used, which allowed the researcher to be aware of her biases and maintain an objective stance during the data collection, analysis, and interpretation. This assisted in minimising potential distortions in the findings (Ahmed, 2024). Self-reflection enables qualitative researchers to discuss their position within the study and how their personal beliefs and past training have influenced the research findings.

Lincoln and Guba (1985) described transferability as the ability of the findings to be generalised to other settings or individuals. To ensure transferability, the researcher provides thick descriptions of the data to allow for comparison. Research transparency is ensured when the researcher explicitly shares information about their own role, procedures, research participants, and their relationship with the participants, providing a clear and detailed picture of the research (Morrow, 2005). In providing comprehensive explanations, researchers allow readers to evaluate how applicable the findings are to similar situations, thus improving the study's transferability (Ahmed, 2024). Cope (2013) highlights that researchers should provide sufficient information on the participants and the research context to enable the reader to assess the findings' capability of being transferable.

In this study, the researcher ensured dependability by using the audit trail technique. The researcher achieved this by reporting any changes in the phenomenon chosen for the study, as well as any changes in the design of the study. Keeping a record of decisions made during the study, including changes in methodologies or analyses, facilitates transparency and traceability. This audit trail aids in establishing the dependability of the research and provides insights into potential biases (Ahmed, 2024). According to Morrow (2005), sharing this transparent record encourages scrutiny by peers, advisors, or colleagues, promoting accountability and enhancing trust in the research findings.

Confirmability is grounded in the understanding that research is inherently subjective (Morrow, 2005). Findings should ideally reflect the researched situation rather than the personal beliefs, theories, or biases of the researcher (Gasson, 2004). The researcher kept a journal to help track evolving thoughts, biases, and reflections during the research process. This reflective practice enhances transparency and provides insights into the researcher's subjectivity, contributing to the confirmability of the findings (Ahmed, 2024).

3.11 Conclusion

The study is an exploratory qualitative study. The data was collected using semi-structured individual interviews and analysed using IPA. Ethical considerations that were adhered to in this study were also explored in this chapter. The next chapter will focus on the findings of the study.

CHAPTER 4: FINDINGS

4.1 Introduction

This chapter presents the findings and analysis of the study. It represents the most salient and significant extracts that most effectively illuminate the core research questions. The structure of this chapter progresses logically through five superordinate themes that emerged from the data analysis, beginning with fundamental conceptualisations of ATH, moving through the complex tensions and challenges inherent in integration, examining the practical realities of current practices, and concluding with future visions for this integrative work. Throughout this narrative journey, the voices of the psychologists remain central, with their direct experiences and reflections forming the essential foundation upon which the interpretative analysis is built. This approach ensures that the findings remain grounded in the actual lived realities of practitioners while providing the necessary theoretical depth to understand the broader implications of these experiences.

The participant group comprised two clinical psychologists and two counselling psychologists, including two Black female practitioners and two White male practitioners, with professional experience ranging from five to twenty-seven years. This diversity enriches the data by providing multiple perspectives on the integration phenomenon. All participants draw from various Western therapeutic approaches in their practice, including Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), psychodynamic, play-therapy, psychosynthesis and transpersonal psychology.

4.2 Superordinate Theme 1: Conceptualising African Healing

4.2.1 Holistic Worldview: The Interconnectedness of Being

The foundational understanding that emerged across participant accounts conceptualised ATH not merely as a set of techniques but as a comprehensive philosophical system organised around principles of relationality, spirituality, and communal well-being. Participant 2 articulated this holistic framework with clarity, describing ATH as:

"a form of healing that connects. It's a form of healing that isn't only focused on the physical manifestation of whatever the problem is for the individual, but it's connected in terms of their spiritual connections as well... its body, mind and its soul. So African traditional healing, for me, is exactly that – it is an interconnectedness between those three spheres of human of being human."

This multilateral conceptualisation, encompassing body, mind, and soul as interconnected spheres, appeared consistently across the data, though expressed through different linguistic frameworks depending on the participant's positionality. Participant 4 reinforced this holistic understanding while emphasising the symbolised nature of spiritual concerns, noting that *"spiritually understood ailments usually manifest as both [physical and psychological,"* indicating a non-dualistic understanding of health and illness that contrasts sharply with Western medicine's tendency toward compartmentalisation.

These narratives position ATH as what can be understood as a *relational ontology*; a way of understanding human beings that stand in absolute contrast to the Cartesian mind-body dualism that underpins much Western psychology. The persistent emphasis on "interconnectedness" reflects a worldview consistent with Ubuntu philosophy, where individual well-being emerges from and contributes to shared harmony and where health is not an individual property but arises from one's harmonious placement within systems of relationships with the self, the community, ancestors, and the natural world. This represents not merely a distinct set of interventions but a fundamental divergence in the understanding of what constitutes a person and what constitutes healing.

4.2.2 Communal and Ancestral Foundations of Healing

A second crucial dimension that emerged in participants' conceptualisations concerned the role of ancestors and community as cornerstones of ATH, fundamentally distinguishing it from Western psychological models that focus on the individual. Participant 1 provided a straightforward, practical definition that anchored the practice in its cultural context: *"African traditional healing in an African context, or traditional healing as in using a sangoma, or you know, or elders or ancestors - that'd be my understanding."* This definition, while simple,

highlights the significant role of specialised practitioners and spiritual intermediaries in the healing process.

Participant 2 powerfully illustrated the communal dimension of this healing framework, explaining that within this worldview, an individual's affliction is never theirs alone: *"Whatever this person has actually affects all of us... So African traditional healing, for me, is community as well as community-based. It's about lineage."* This perspective was vividly demonstrated in her clinical example, where a child's enuresis became a focal point for a family ritual to engage with ancestral displeasure, thereby mobilising the entire family system toward healing rather than focusing solely on the identified patient.

In notable contrast, Participant 3 offered a more observational, anthropological perspective that framed ATH as a universal human approach to healing, contextualised within a specific cultural framework*: "I'm assuming that what that means is people within that culture, either before different alternatives were available, or even now that alternatives like Western are available, that people used to reach out to those for assistance and felt that it helped."* This framing, while respectful, positioned the participant as an external observer rather than an engaged participant in the healing tradition.

The interpretative exploration of this variety of understanding reveals its analytical significance. The collectivist orientation evident in Participants 1, 2, and 4's accounts directly challenges the methodological individualism that dominates Western psychological frameworks. In ATH, pathology and healing are understood as distributed across a relational field rather than contained within an individual psyche. The self is conceptualised not as a bounded entity but as a nexus of relationships, both visible and spiritual. This collectivist epistemology frames healing as a communal responsibility and process, directly confronting the Western psychological notion that therapeutic work is primarily an intrapsychic, individual process. The variation in participants' proximity to this epistemology, from embodied understanding to external observation, highlights how a psychologist's personal and professional identity shapes their engagement with ATH and establishes critical reflexivity as an essential foundation for any integrative practice.

4.2.3 ATH as a Legitimate Knowledge System

Some participants also accorded ATH epistemic legitimacy, framing it as a structured system of knowledge. Participant 4's definition was fundamental in this regard:

"My understanding of African traditional healing is using knowledge systems that are traditionally known and understood to heal... to help someone that is ill in an effort to cure whatever ailment is there, whether it's physical, psychological or both."

Her use of the term "knowledge systems" elevates ATH from a set of cultural rituals to a classified epistemological discipline, grounded in observation, spirituality, and accumulated experience. This conceptualisation challenges the hegemony of Western scientific knowledge by asserting the validity of indigenous ways of knowing. The cultural trust in this system was emphasised by Participant 2, who observed, *"The client population actually uses traditional healing. They go for that because that is the way it has always been... It's a known practice."* This enduring trust underscores ATH's deep roots and continued relevance as a primary point of help-seeking.

4.3 Superordinate Theme 2: Navigating Integration in Clinical Practice

4.3.1 Internalised Stigma and Epistemic Disobedience

The most emotionally powerful finding to emerge from the data was the profound way in which the historical legacy of colonialism may continue to shape psychologists' professional identities and approaches to integration. Participant 2 articulated this internal conflict with exceptional vividness, giving voice to what many Black South African professionals may experience but may not name:

"We're so scared of our own light. We're terrified of it because we've been removed from it. We've been told it wasn't good enough, been told we weren't good enough... So why do we lean towards Western stuff as a discipline rather than traditional stuff?... Are we even participating in the healing of our people as it should be, or are we participating as it is proscribed, as we are told to, by whom? What is our identity?"

This extended reflection captures the core dilemma that many psychologists trained in Western paradigms but working within African contexts. The metaphor of the "light" symbolises

Indigenous knowledge and cultural wisdom, while the "terror" represents the psychological impact of colonial epistemic violence that systematically devalued African ways of knowing. Her rhetorical questioning, *"by whom?"* marks a significant moment of what decolonial theorist Walter Mignolo (2010) would term epistemic disobedience, a conscious challenging of the hegemonic assumptions underlying her Western psychological training.

This narrative positions it as a powerful embodiment of Frantz Fanon's concept of internalised inferiority (Fanon, 1952); the process through which colonised people come to believe in the superiority of the coloniser's knowledge and the inferiority of their own. For Black psychologists, this creates a fractured professional identity where their training aligns with colonial knowledge systems while their cultural heritage is systematically marginalised within those same systems. The journey toward integration thus becomes not merely a clinical choice but a personal process of decolonising the self and reclaiming cultural heritage that was historically stigmatised.

4.3.2 Epistemic Clash: Evidence-Based Paradigms versus Indigenous Knowledge Systems

A second major tension that emerged concerned the fundamental criteria for what constitutes valid knowledge in the healing process. Participant 3 articulated this epistemic clash with clarity, grounding his apprehension in the empiricist tradition central to Western psychology:

"I think that marginalised groups are trying to find a voice... but unresearched, unempirically evidenced information from previously marginalised groups are being brought into the spotlight and given a validity that maybe they shouldn't have... until proven otherwise it shouldn't be believed."

He further expressed concern that in an effort to redress historical injustices, academia might be "*overvaluing that voice,"* thereby compromising what he viewed as scientific rigour and potentially leading to uncritical acceptance of unverified claims.

This stance is identified as a classic manifestation of what Peruvian sociologist Aníbal Quijano (2000) terms the coloniality of knowledge, the hierarchical classification of knowledge systems that privileges Western scientific rationality as the universal standard of truth. This epistemological position creates an insoluble barrier for ATH, whose validity is typically derived

from ancestral lineage, spiritual revelation, and lived experience; epistemic frameworks are intentionally excluded from the positivist paradigm that dominates Western psychology. The apprehension expressed by Participant 3, therefore, is not necessarily toward ATH itself, but toward admitting a form of knowledge that threatens the very foundations of psychological science as it has been constructed in the West. This tension highlights that integration requires not just clinical flexibility but a fundamental rethinking of what counts as evidence and healing within the psychological field.

This power dynamic, where Western frameworks are perceived as dominant, was highlighted by Participant 1. His statement highlighted the pervasive influence of Western psychology, not just epistemologically, but culturally and institutionally:

"Probably Western approach, Western approach, because the Americans are so dominant. I was always anti the whole American thing. So, I've always been about Africanisation."

His double repetition of "Western approach" linguistically reinforces his perception of its overwhelming presence, while his personal stance of being "about Africanisation" positions his practice as a conscious act of resistance against this cultural and academic hegemony. This quote directly connects the epistemic clash to a broader context of global power imbalances, showing that the dominance of the Western paradigm is felt as a tangible reality by some practitioners.

4.3.3 Positionality and the Personal as Professional

A crucial finding was the extent to which each psychologist's personal history shaped their approach and thinking about integration, highlighting that one's stance is not merely an intellectual choice but is deeply rooted in embodied experience.

Participant 4 grounded her integrative orientation explicitly in her personal and professional history, expressing a balanced, co-existent view: *"I think it would definitely have to be my own upbringing and background, and practice as well. Both of those shape...my understanding of using these methods together, because I've seen the benefit of it...Traditional healing practices will never go away... So I think these systems will never, ever, ever, ever really die and go away…so there is no benefit in steering people in either this way or that way...there is a middle ground."* Her repetition of "never go away" emphasises the enduring nature of ATH, while "middle ground" encapsulates her belief in coexistence.

In contrast, Participant 3 defined his "culture" in epistemological and professional terms. He then provided a critical moment of reflexivity by directly linking his clinical practice to his racial and spiritual identity: *"The culture of my belief that evidence-based research seems to provide the most helpful... and my exposure to Christianity ... and my culture of cognitive behavioural therapy has provided me a faith in a treatment way of thinking."* For him, the formative influences were not ethnic culture but a "culture" of scientific empiricism and specific therapeutic training. He further articulated a profound ethical stance born from his positionality:

"I don't think there are ancestors who speak to us from the dead. ... Does that mean religious or traditional people are psychotic? No... In the absence of knowing that what I do is right and that what they do is wrong, it would be wrong for me to exclude other helpful possibilities... maybe the fact that I am a white person increases the chance that I send people traditionally because I can't get involved in that."

This explicit positional reflection displays exceptional self-awareness. P3's ethics derive from humility rather than conviction, his awareness of his own limitations as a Western-trained, white psychologist in engaging with ATH makes him careful, not dismissive. This culminates in a practice of endorsement through referral, not competition.

Participant 2 described her upbringing as instilling an intuitive, embodied understanding that directly informs her clinical practice: *"It actually does influence my understanding very deeply. When raised in the culture for most of my life, there are things I even know unconsciously ... That's part of who I am. So, it has influenced my openness to the individual as a whole, not just sticking to their mental state."* Her statement defines cultural knowledge as an embodied competence. Conceptually, she asserts that respect for diverse healing springs naturally from a deep, psychosocial awareness forged in childhood.

Participant 1 articulated his positionality through a narrative of personal affinity and conscious resistance to perceived Western dominance, framing his approach as a form of “Africanisation” *"I've always been open to alternative healings... If I was Black, I'd probably be a sangoma. I've had a lot of weird experiences. So, and there was I could only go to a doctor, and then the doctors would look at me like, I'm stupid, and I'd walk out saying, you can't help because I'm not sick. I'm not mentally ill. I know exactly what's going on here, but there's no one to talk to, so I needed to become that kind of a therapist where I could speak about those, those ideas."*

His account reveals how subjective experiences of invalidation within Western medical systems directly shaped his professional identity and clinical mission. The need to create therapeutic space for spiritual and cultural realities that mainstream psychology often marginalises became a driving force in his practice, positioning his work as both clinical and political.

These diverse accounts position personal identity as the foundational lens through which the colonial legacies and epistemic clashes are filtered and negotiated. A psychologist's stance on integration is not adopted in a vacuum but reflects their place within South Africa's complex social fabric. For Black psychologists like P2, the journey involves reconciling professional training with cultural roots in the face of historical stigma. For others, like P3, his white and atheist identity creates a specific form of ethical practice based on humble referral from a position of perceived outsiderness. These narratives of self are thus not inferior; they are the very mechanisms through which the macro-political issues of history and power become lived, personal, and clinical realities. The variation in participants' proximity to ATH epistemology, from P2's embodied understanding to P3's external observation, highlights how personal and professional identity fundamentally shapes engagement with traditional healing and establishes critical reflexivity as an essential foundation for any integrative practice.

4.4 Superordinate Theme 3: The Contingent Therapeutic Value of Integration

4.4.1 Conditions for Effective Integration: Toward Hermeneutic Justice

Participants identified specific clinical scenarios where the integration of ATH significantly enhanced therapeutic processes and outcomes. The primary benefit identified was integration's capacity to foster a sense of holistic validation that Western approaches alone often fail to provide. Participant 2 captured this essential insight succinctly: *"The minute you put culture outside the room, you've lost them."* This statement suggests that for many clients, therapeutic effectiveness is intrinsically linked to the psychologist's ability to acknowledge, respect, and work within the client's cultural and spiritual worldview.

Participant 4 highlighted a dimension of human experience that Western psychological models frequently overlook or pathologize*: "There's the spiritual side that your Western modalities can't account for."* When clients present with distress rooted in spiritual or ancestral explanatory

models, a purely psychological formulation can feel incomplete, invalidating, or culturally insensitive. The inclusion of ATH in such instances addresses what Participant 2 described in another context as a "*deep yearning for something,"* an existential or spiritual void that secular psychotherapy alone cannot fill. Participant 3 complemented this holistic framing, acknowledging the therapeutic value of specific traditional rituals in processing complex emotions:

"One, the ritual of going to clean the grave as a way of approaching the grave to talk to the parent, so getting them to connect in the family ritual way of going to the grave together and doing what needs to be done there, that's been done in relation to grief a lot. Because in grief, what I often notice is people not going to the gravestone because it's just too raw. And so, the traditional ritual of going and cleaning the gravestone and doing the rituals there really seems to be helpful."

His observation demonstrates how traditional rituals can provide a structured, culturally meaningful container for processing grief that might otherwise remain stuck or avoided. The ritual creates a bridge between the internal emotional experience and external cultural practices, facilitating engagement with painful material through symbolic action rather than direct confrontation.

A particularly compelling example of effective integration came from Participant 2's description of a child's enuresis that was addressed through collaborative engagement with family rituals: *"For the child... he got to realise that, oh, he's not the only problem in the family system... it removes the shame."*

In this case, the integration of traditional approaches transformed the meaning of the symptom from an individual pathology to a relational communication, thereby alleviating the child's sense of isolated responsibility and shame.

These accounts could suggest that effective integration occurs when it facilitates what philosopher Miranda Fricker (2007) terms hermeneutic justice, the right of individuals to have their experiences understood within the social and cultural frameworks that make them intelligible. When psychologists create space for ATH within the therapeutic encounter, they are not merely adding a cultural technique, they are affirming the client's entire worldview and restoring their ability to make sense of their suffering within their own meaning making framework. This act of epistemic validation can be profoundly therapeutic, restoring a sense of coherence and cultural

integrity that is essential for psychological well-being. Integration, in these cases, successfully fills the ontological and relational gaps left by strictly individualistic Western models.

4.4.2 Scenarios of Ineffectiveness: Avoidance, Conflict, and Clinical Risk

Conversely, participants provided compelling examples of circumstances where integration proved problematic, ineffective, or even harmful. A significant risk identified was the potential for ATH to be used as a form of psychological avoidance that circumvented necessary therapeutic work. Participant 3 provided a detailed clinical vignette illustrating this dynamic:

"The client completely nullifies the psychological formulation... Instead of addressing their siblings authentically... indirect rituals are done without getting these people involved. That's avoidance."

In this scenario, the spiritual explanation and prescribed rituals functioned to bypass difficult but necessary interpersonal engagement, thereby potentially reinforcing relational patterns that maintained the client's distress.

Furthermore, integration could lead to a therapeutic stalemate or internal conflict when the two healing systems worked at cross-purposes. Participant 2 described a challenging case where a client's burgeoning healer identity created what she termed an *"ego conflict,"* leading to a situation where *"both didn't work, both the psychological and the traditional*." Here, rather than creating synergistic healing, simultaneous engagement with both frameworks generated internal confusion and conflict that undermined the therapeutic process.

Participant 3 additionally noted a systemic risk regarding delayed access to evidence-based care: *"There are far too many failed traditional attempts before people get to treatments that are actually helpful."* Participant 4 added another risk*: "Some traditional healing practices can lead people down the understanding that there's a quick fix for something,"* potentially fostering unrealistic expectations. These findings demonstrate that integration is a clinically complex undertaking that requires significant skill and reflexivity to navigate effectively. From this perspective, integration is ineffective if it delays access to proven psychological or medical interventions for conditions where timely, evidence-based treatment is crucial.

These scenarios reveal that ineffectiveness arises when integration is applied unreflectively or without sophisticated clinical judgment. It fails when it reinforces psychological avoidance mechanisms, provides narratives that foster internal conflict between worldviews, or leads to delayed access to necessary care. These findings demonstrate that the integration of ATH is not a risk-free remedy but a clinically complex undertaking that requires significant skill, critical reflexivity, and a nuanced understanding of both systems to navigate effectively. It demands that psychologists function not merely as technicians applying integrative protocols but as ethically discerning clinicians who can assess when integration supports healing and when it might potentially cause harm.

4.5 Superordinate Theme 4: Navigational Strategies: Practising Integration in the Absence of a Map

Participant 1 demonstrated a strategy grounded in a philosophical commitment to epistemic pluralism and client-centred positioning. His approach begins with a deliberate process of paradigm identification, stating: *"look at who you're dealing with... one of the first questions you gotta get out the way is, what's the person's religion? So, you can decide which paradigm you are operating from? So that I'm not operating from a Christian paradigm or a Muslim paradigm or a Buddhist paradigm."* This was echoed by participant 4 "*I think that is my trouble. It becomes difficult when I get from the client, because I think this is a sensitive thing, and I usually would like the client to lead it"*.

This methodological stance emerges from participant 1's recognition of cultural diversity, that *"one has to meet someone where they at, rather than where you at. And I think that's very important to get that out of the way."* This philosophical foundation then informs his clinical interventions, where he makes explicit but non-directive suggestions: *"So I said, I'm suggesting you go get the medication, go speak to your people and maybe become a sangoma."* The reported outcome, *"And so she did both"*, demonstrates how this principled approach facilitated client agency in pursuing dual healing pathways.

Participant 2 exemplified a strategy where integration becomes the very medium of therapy through deep cultural immersion. This approach begins from the conventional stance of psychological assessment: *"So it was…obviously, you see a client in the first consultation, and*

you're thinking, it might be CBT, it might be psychodynamic work. It's play therapy. And you know, going into that in the first session, second session, doing some history, taking you, finding out who this client is."

This conventional framework transforms when cultural dimensions emerge: *"And then so the, I'd say, where the process becomes less Western and more integrated to the clients presenting problem and story is when you realise what the suffering is about, which was a cultural thing, so you can't overlook what is there in their community to help them To overcome these things based on their belief systems."*

She described working with an adult client where *"it becomes very cultural when she talks about what it looked like growing up, you know, songs with her grandmother, which were traditional, what it felt like to be in the rondavel and hearing adult chatter, you know what that sounded like, and the harmony of song, and then you realise, you know, I'm not treating someone who's just sitting on a couch, who's Western so this person is talking about cultural experiences."*

This repositioning leads to working on *"what healing looks like for this human being, not through my textbooks,"* extending to child clients where *"his play therapy was quite interesting... This child is not playing with microwaves and making cake and blowing candles, this child is saying, the cow didn't cry in the kraal."* The role transforms to using culturally grounded prompts: *"Tell me about your ancestors. Tell me about your clan name, you know, show me what the man did is that what you see for yourself."* This practice identifies it as an example of what postcolonial theorist Homi Bhabha terms a third space.

Participant 3 employed a strategy characterised by explicit transparency about professional and cultural limitations: *"I tell them that they're talking about something that seems important to them, I tell them that it's not something that I can give a comment on in here. I tell them that actually, sometimes what's helpful is two forms of therapy at the same time, whether it's psychotherapy and pharmacology, or psychotherapy and traditional therapy, and that it actually might be helpful for them also to engage in this traditionally. And as I said, like I said to them, a white man, so I can't comment on that, so I would appreciate, when you come back, that you help me to understand what's happened, so that I can understand how this has helped you psychologically or not helped you psychologically."* Participant 4 shared similar ways *"if you think that this problem is probably rooted in traditional things, consult gogo ubani. Do you want to talk*

to gog'bani, I usually, you know, lead them using family. Because traditionally, we understand that your family has your answers. The family has the answers to usually; how does this family sort this type of problem out? So, I would usually, you know, lead them back to their family, let them lean back on that support. There must be someone in the family who knows a traditional healer that the family has consulted before." This creates a collaborative learning partnership that bridges epistemological divides through mutual respect and curiosity.

Participant 4 further highlighted systemic limitations, *"and that's the trouble I'm having... There isn't a clear network for us to do that and to collaborate in that capacity of referral systems...*

The current integration practices represent individual navigation strategies rather than a standardised professional approach.

4.6 Superordinate Theme 5: Divergent Visions for the Future of Integration

4.6.1 Radical Restructuring: The Call for Formal Collaboration

Some participants envisioned a future that would require fundamental restructuring of mental healthcare delivery to create space for equitable collaboration between healing systems. Participant 2 articulated this vision through the metaphor of the multidisciplinary team:

"In a perfect world? It would work like that... like a multi-disciplinary team, the same way you'd go to a school for a child to talk to teachers, the traditional healers should be there if that's what the affliction is... Because if healing is meant to be holistic and all-inclusive of the individual, I think it is unfair to just stick to the Western model…. I wouldn't be so keen to be communicating with the traditional healer because it would blur the lines in terms of the psychotherapeutic work, and so they should do what they are doing. I should do what I am doing. The client is enough to integrate the two worlds. You know, I only have 50 minutes to spare, and so I wouldn't want that in the individual process."

This vision positions traditional healers as legitimate healthcare partners whose expertise would be routinely accessed within a collaborative framework when clinically appropriate. Participant 4 echoed this vision while emphasising the relational dimensions of collaboration: *"It should look like collaboration, referring to one another, building a working relationship."*

4.6.2 Resistance to Formalisation: The "Divisiveness" of Difference

In direct opposition to calls for structural collaboration, Participant 3 argued passionately against the formalisation of integration, framing it as a potentially regressive step that could reinforce social divisions:

"I don't think there should be some formalised approach... I'm worried that academia is turning us into an us-versus-them... I don't think we're so different that we need specialised forms of treatment, and I'm worried about that idea that, to me, sounds divisive."

4.7 Conclusion

This chapter has provided a detailed phenomenological account of how psychologists in the Eastern Cape perceive, experience, and negotiate the complex interface between African and Western healing practices. The findings reveal that this clinical consideration is deeply embedded in personal identity, historical legacy, epistemic conflicts, and divergent visions for a post-colonial future. Psychologists emerge not as neutral technicians in this process but as active agents navigating the long shadow of colonialism, creatively finding ways to honour their clients' worlds while grappling with profound questions about the nature of healing, knowledge, and justice. Their accounts suggest that integration is not a settled practice but a continuous, reflexive process of creating spaces for healing that acknowledge the complex realities of South African clients. The following chapter will synthesise these findings with the broader literature and theoretical framework, discussing their implications for decolonisation theory, psychological practice, and mental health policy in South Africa. In the next chapter, the findings of the study are discussed in the context of existing research on this topic.

CHAPTER 5: DISCUSSION

5.1 Introduction

This study has provided an exploration of psychologists' perceptions regarding the integration of African healing practices with Western psychological treatment in the Eastern Cape province of South Africa. The findings reveal a complex and nuanced landscape where clinical practice intersects with cultural identity, historical legacy, and epistemological considerations. This discussion chapter synthesises these findings, interpreting them within the broader context of mental healthcare in South Africa while examining how psychologists navigate the delicate interface between these two healing systems. The analysis demonstrates how practitioners balance their professional responsibilities with cultural sensitivity in a post-colonial context characterised by diverse healing traditions and ongoing decolonisation efforts. The findings presented in Chapter 4 will be discussed in relation to the study's objectives:

a) To explore and describe psychologists' conceptualisation of African healing rituals.

b) To investigate and comprehend the apprehensions that psychologists have had or may hold regarding the integration of these two systems.

c) To explore psychologists' perceptions of factors that may inform the integration of the two systems within psychological healing processes.

d) To understand how the potential integration of the two systems may take place.

The research has yielded rich insights into how psychologists conceptualise traditional healing, approach integration in their clinical practice, and envision future collaboration between these systems. These findings not only address the research question and objectives but also contribute significantly to our understanding of the decolonisation of mental healthcare in contemporary South Africa. The emergent themes reveal the sophisticated ways in which mental health professionals negotiate multiple healing paradigms while maintaining ethical standards and therapeutic effectiveness.

Table 1 below provides a summary of identified superordinate themes and subthemes.

Superordinate Themes	Subthemes
Theme 1: Conceptualising African Healing	Holistic Worldview: The Interconnectedness of Being
	Communal and Ancestral Foundations of Healing
	ATH as a Legitimate Knowledge System
Theme 2: Navigating Integration in Clinical Practice	Internalised Stigma and Epistemic Disobedience
	Epistemic Clash: Evidence-Based Paradigms versus Indigenous Knowledge Systems
	Positionality and the Personal as Professional
Theme 3: The Contingent Therapeutic Value of Integration	Conditions for Effective Integration: Toward Hermeneutic Justice
	Scenarios of Ineffectiveness: Avoidance, Conflict, and Clinical Risk
Theme 4: Navigational Strategies: Practising Integration in the Absence of a Map	
Theme 5: Divergent Visions for the Future of Integration	Radical Restructuring: The Call for Formal Collaboration
	Resistance to Formalisation: The "Divisiveness" of Difference

5.2 Conceptualising African Traditional Healing: Beyond Superficial Understanding

Psychologists in this study demonstrated a remarkably nuanced understanding of African Traditional Healing (ATH) that extends far beyond viewing it as merely a set of techniques or

rituals. Participants consistently described ATH as a comprehensive philosophical system grounded in relational ontology and communal well-being, which is highlighted by (Akol et al., 2018; Ngobe et al., 2021). Thus, echoes scholarly descriptions of Ubuntu philosophy that emphasise interconnectedness and collective identity (Mbiti, 1969; Mkhize, 2004). This conceptualisation aligns strongly with existing literature that positions ATH within a holistic framework addressing physical, spiritual, emotional, and psychological dimensions of health simultaneously (White, 2015). The participants' recognition of this multidimensional nature of traditional healing suggests a depth of cultural understanding that surpasses mere cultural competence and approaches genuine cultural humility.

Notably, psychologists in the study recognised ATH as a legitimate knowledge system rather than dismissing it as superstition or alternative medicine. This finding represents a significant departure from historical colonial perspectives that systematically marginalised indigenous healing practices (Ashforth, 2005) and reflects an important shift toward acknowledging epistemic diversity in healthcare. The participants' willingness to engage with ATH as a valid epistemological framework suggests what might be termed a decolonial turn in psychological practice, where multiple ways of knowing are respected and potentially integrated. A decolonising lens demands that conceptualisation move beyond surface-level description toward deep recognition of traditional healing as a coherent epistemological system with its own internal validity. This perspective is particularly significant in the South African context, where the legacy of apartheid included the systematic devaluation of indigenous knowledge systems. The psychologists' conceptualisation of ATH as containing its own internal logic and validity frameworks represents an important step toward epistemic justice in mental healthcare.

The findings further revealed that psychologists understand traditional healing as addressing what Western psychology often misses, the spiritual dimension of human experience and the importance of ancestral connections in health and wellbeing. This recognition is crucial in the Eastern Cape context, where many clients understand psychological distress through spiritual and ancestral frameworks. By acknowledging the validity of these explanatory models, psychologists demonstrate a culturally responsive approach that respects clients' worldviews while

providing evidence-based psychological care. This theme addresses the objective to explore and describe psychologists' conceptualisation of African healing rituals.

5.3 Navigating Integration in Clinical Practice

Table 2 Below outlines the four distinct strategies used by participants in practice

Strategies in Practice Currently Used by Psychologists
Paradigm Identification
Third-space creation
Transparent referral
Family-mediated referral

Some participants used an approach where they met the client where they are; this approach represents a practical enactment of epistemic justice at the micro-level of clinical interaction, where the psychologist demonstrates cultural humility and a willingness to learn from the client's world rather than positioning themselves as the sole expert. It constitutes a decolonial gesture within the confines of the therapy room, creating possibilities for integration even in the absence of broader systemic support or formal collaboration frameworks. client-led integration.

Another approach was what might be termed "client-led integration," where psychologists acknowledge and respect clients' use of traditional healing while maintaining their professional role within Western psychological paradigms. This finding resonates strongly with literature on medical pluralism in African contexts, where patients routinely navigate multiple healing systems simultaneously (Mohanty & Sharma, 2021; Puckree et al., 2002). The psychologists demonstrated remarkable flexibility in adapting their therapeutic approaches to accommodate clients' engagement with traditional healing, suggesting a pragmatic rather than ideological orientation to integration. This shared similarities with one approach where the practitioner dwelled in the client’s world, and allowed an emergent, hybrid environment that is not simply a blending of two pure traditions but creates something new through their interaction. In this therapeutic third space, the client's cultural framework is not an adjunct to the "real" therapy but becomes the central text

through which healing occurs. This demonstrated what can be understood as "culturally grounded third spaces" in their practice, creating therapeutic environments that honour clients' cultural beliefs while maintaining evidence-based psychological care. This approach echoes Homi Bhabha's (1994) concept of hybridity, where new forms of cultural practice emerge from the interaction of different systems.

These creative adaptations suggest that integration is already occurring organically in clinical practice, even in the absence of formal protocols or policies. The psychologists served as cultural brokers who helped clients navigate between different healing systems, translating concepts and frameworks in ways that promote therapeutic progress. This reflects the reality of South Africa's mental health landscape, where psychologists operate without formal frameworks for cross-paradigm collaboration. The four identified strategies emerged as practitioner-devised solutions to a systemic gap. These approaches are not merely technical choices but reflect deeper negotiations of professional identity, cultural positioning, and ethical responsibility in a post-colonial context. The variation between strategies highlights both the resourcefulness of practitioners and the urgent need for systemic support. The absence of formal protocols places the burden of integration largely on individual practitioners and their clients, resulting in uneven practices that depend heavily on a psychologist's personal background, cultural competence, and professional confidence.

Ethical considerations featured prominently in how psychologists approached integration. Participants consistently emphasised the importance of maintaining professional boundaries while respecting cultural practices, particularly regarding issues of scope of practice and professional competence. This finding suggests that South African psychologists are developing an ethically grounded approach to integration that neither uncritically embraces traditional healing nor dismisses it outright. Instead, they appear to be charting a middle path that respects cultural traditions while upholding professional ethical standards.

Several contextual factors emerged as significant influences on integration practices, highlighting the complex interplay between personal background, professional training, and historical context. Psychologists' personal backgrounds, cultural exposure, and professional experiences shaped their comfort levels and approaches to integrating traditional healing. This finding underscores the importance of positionality and reflexivity in multicultural psychological

practice, supporting literature that emphasises self-awareness as crucial for effective cross-cultural work (Sue et al., 2019). Participants with more exposure to traditional healing in their personal lives typically demonstrated greater comfort with integration, suggesting that personal cultural competence develops through lived experience rather than professional training alone.

The historical context of colonialism and apartheid continues to cast a long shadow over current integration efforts, as noted by participants who acknowledged the legacy of cultural suppression and its impact on contemporary healthcare practices. This awareness reflects decolonial theorists' term "historical consciousness", an understanding of how past injustices continue to shape present realities (Maldonado-Torres, 2007; Mignolo, 2010). The psychologists' recognition of this historical context informed their approach to integration, with many viewing respectful engagement with traditional healing as part of the broader project of decolonising mental healthcare in South Africa. This informs the research question by revealing how psychologists actively negotiate clients' cultural beliefs, ethical boundaries, and their own professional identities when engaging with the integration of the two systems.

5.4 Value of Integration Addressing Challenges and Concerns: Beyond Simple Solutions

Psychologists in the study expressed several substantive concerns regarding integration, primarily focusing on ethical boundaries, evidence base, and potential conflicts between healing systems. These apprehensions reflect genuine professional considerations rather than cultural resistance or unconscious bias. The tension between evidence-based practice and traditional healing approaches emerged as particularly significant, aligning with literature documenting the epistemological clashes between Western and indigenous healing systems (Mokgobi, 2014). Decolonisation theory has helped illuminate this tension by providing a lens to critically examine how evidence-based Western paradigms are privileged over Indigenous knowledge systems, thereby contextualising psychologists' perceptions within broader historical and epistemological power imbalances that shape the integration of African Traditional Healing and Western practice.

However, rather than rejecting traditional healing outright, psychologists in this study sought to understand its therapeutic mechanisms and potential benefits, demonstrating a nuanced approach to evaluating healing practices across different cultural frameworks.

The management of potential conflicts between healing systems emerged as a significant theme in the findings. Psychologists described situations where traditional healing practices might contradict psychological approaches or where clients might use spiritual explanations to avoid psychological work. Rather than dismissing these conflicts as cultural differences, participants approached them as therapeutic opportunities, exploring the meanings behind clients' engagement with different healing systems and helping them develop integrated understandings of their experiences. This nuanced approach demonstrates clinical sophistication that transcends simplistic multiculturalism and engages with the complex reality of medical pluralism.

The challenge of assessing the efficacy and safety of traditional healing practices represented significant concern for participants. Without dismissing these practices, psychologists expressed legitimate questions about how to evaluate traditional healing approaches using both Western scientific frameworks and indigenous validation methods. This represents an important area for future development in the integration discourse, the creation of culturally responsive evaluation frameworks that can assess traditional healing practices without imposing exclusively Western scientific standards. The participants' engagement with this challenge suggests a sophisticated understanding of the complexities involved in evaluating healing practices across epistemological boundaries.

Another significant challenge identified was the potential for harm within some traditional healing practices. These concerns highlight the importance of developing regulatory frameworks for traditional healing that protect clients while respecting cultural traditions.

The logistical challenges of integration also featured prominently in the findings. Psychologists described the difficulty of making appropriate referrals to traditional healers, the lack of communication between healing systems, and the absence of collaborative frameworks. These practical barriers represent significant obstacles to meaningful integration and highlight the need for structural solutions that facilitate collaboration between Western mental health professionals and traditional healers. The participants' experiences suggest that while individual psychologists may be willing to engage with traditional healing, systemic barriers often prevent effective collaboration. Psychologists’ apprehensions regarding potential harm, ethical boundaries, and logistical challenges highlight the practical and epistemological tensions between African Traditional Healing and Western paradigms. These concerns reflect both structural barriers, such

as the lack of referral pathways and communication, and the historical privileging of Western evidence-based approaches. Their caution underscores the complexities involved in fostering culturally sensitive, ethically responsible, and collaborative integration.

5.5 Future Directions: Different Views

The majority of the participants called for formalised integration processes. This vision is identified as representative of what can be termed decolonial praxis, concrete action aimed at dismantling colonial structures and hierarchies. It seeks to materially reorganise mental healthcare by challenging the professional monopoly of Western psychology and creating institutional space for what decolonial theorists call pluriversality, a world where multiple knowledge systems coexist and interact on equal terms. This vision moves beyond discussions about integration as a clinical technique to call for the systemic recognition of ATH as a co-equal healing discipline rather than a supplementary cultural artefact. However, one participant saw this as rather divisive. This perspective advocates a universalist approach to psychotherapy, suggesting that core principles of human connection, empathy, and established psychological techniques are sufficient to cater to all clients regardless of cultural background. From this viewpoint, emphasising cultural difference through specialised integrative approaches risks fragmenting the therapeutic relationship and reinforcing separateness rather than common humanity. Suggesting that while it is likely well-intentioned in its desire for human unity, it can be understood through a decolonial lens as a form of epistemic ignorance, a failure to recognise that the "universal" human psychology it appeals to is itself a culturally and historically specific construct heavily influenced by Western norms and values. By viewing the recognition of difference as inherently "divisive," this stance risks perpetuating the very coloniality of power it seeks to overcome, by refusing to acknowledge the particular historical and epistemic violence inflicted upon African knowledge systems and the need for their deliberate affirmation in the post-colonial context. This fundamental tension between universalist and pluralist visions of mental healthcare represents one of the core philosophical divides that South African psychology must navigate as it grapples with its colonial legacy and imagines its future.

5.6 Conclusion

This study addressed a significant gap in the literature by centring the lived experiences of psychologists in the Eastern Cape, specifically exploring their perceptions of integrating African Traditional Healing with Western psychological practice. This chapter presented a discussion of the study's findings, organised around the themes that emerged and interpreted, considering existing literature. The following chapter offers a summary and conclusion of the research. The chapter revealed that psychologists' perceptions of integrating African Traditional Healing with Western paradigms are shaped by a combination of cultural, ethical, epistemological, and practical considerations. Themes such as allowing clients' beliefs to guide therapy, navigating professional and personal identity, managing ethical boundaries, addressing potential harm, and overcoming logistical barriers highlight both the opportunities and challenges of integration. This study uniquely contributes by revealing the micro-practices of decolonisation as enacted by psychologists in the therapy room, bridging the macro-theory of decolonisation with the microrealities of clinical practice. Framed through decolonisation theory, these findings underscore the influence of historical power imbalances and the privileging of Western evidence-based approaches, while also pointing to the potential for culturally grounded, collaborative, and ethically responsible mental health care. Collectively, the findings suggest that meaningful integration requires structural support, respectful acknowledgement of Indigenous knowledge systems, and ongoing reflexivity among practitioners. The findings reveal that conceptualisations shape apprehensions, apprehensions influence which factors psychologists prioritise, and together these envisioned pathways for integration. The significance lies in providing practitioner-informed guidance for training curricula, ethical frameworks, and policy development that reflect the real-world complexities psychologists navigate. By centring those already positioned to collaborate, this study shifts the discourse from "whether integration should happen" to "how to support those ready to make it happen," contributing both empirical data and theoretical insight into how decolonisation can unfold in everyday clinical practice.

CHAPTER 6: SUMMARY AND CONCLUSION

6.1 Introduction

The study aimed to explore the insights of psychologists on the integration of African Traditional healing methods and psychotherapy. A summary of the study is provided in this chapter, followed by recommendations for future research and limitations of the study.

6.2 Summary

The findings suggest several important implications for psychological practice in South Africa. First, there is a clear need for greater cultural humility regarding traditional healing practices among psychologists. This extends beyond basic awareness to developing a nuanced understanding of how these practices function within specific cultural contexts. Training programs might incorporate supervised exposure to traditional healing communities and practitioners to build this competence. The development of specific competencies for working with clients who engage with traditional healing represents an important direction for the profession.

Second, the study highlights the potential benefits of developing formal collaboration frameworks between psychologists and traditional healers. Such frameworks could facilitate respectful referral pathways, interdisciplinary dialogue, and shared care arrangements that benefit clients while maintaining professional standards. This aligns with calls in the literature for structured collaboration between biomedical and traditional healing systems (Moshabela et al., 2016; Campbell-Hall & Petersen, 2010). The findings suggest that psychologists are ready for such collaboration but require structural support to make it effective.

Third, the research indicates a need for ethical guidelines specifically addressing the integration of traditional healing in psychological practice. Current ethical codes provide limited guidance for navigating the complex ethical issues that arise when working across healing systems. The development of such guidelines would help psychologists navigate issues of confidentiality, professional boundaries, and scope of practice when clients are simultaneously engaged with traditional healers.

Fourth, the findings suggest that supervision and continuing professional development should include a specific focus on working with traditional healing. Psychologists need spaces to process their experiences with integration and develop their skills in navigating the challenges that

arise. Supervision that explicitly addresses cultural and spiritual issues in therapy could enhance psychologists' confidence and competence in working with clients who use traditional healing. The study found that psychologists in the Eastern Cape acknowledge the value of integrating African healing and Western psychology yet encounter substantial professional challenges. Their views reflect a clear tension between the cultural importance of such integration and the practical difficulties of applying it in practice. Major obstacles include insufficient formal training, ethical questions around accountability, and fundamental differences in worldview between the two approaches. These findings point to a need for structured professional guidelines and formal collaborative systems for progress to occur. The research confirms that meaningful development in South African psychology relies on systematically resolving these structural barriers to create a truly contextual and responsive practice. Integration is a complex, identity-laden process of navigating colonial legacies, and that progress depends on supporting the innovative micro-practices of psychologists with macro-level structural and epistemic change.

6.3 Limitations and Future Research Directions

This study has several limitations that suggest directions for future research. The exclusive focus on psychologists' perspectives provides only one viewpoint on integration with a small sample size; future research should include client experiences to develop a more comprehensive understanding of integration dynamics. The Eastern Cape context, while rich in traditional healing practices, may not represent all South African contexts, suggesting the need for broader geographical sampling to understand regional variations in integration practices.

Future research might explore specific models of collaboration between psychologists and traditional healers, examining what structures and processes most effectively support integrated care. Intervention studies could investigate the outcomes of different integration approaches, providing evidence for best practices in collaborative care. Longitudinal research could examine how integration practices evolve as psychologists gain experience and as the broader healthcare context changes.

Additionally, research is needed to develop and validate assessment tools that can evaluate traditional healing outcomes in culturally appropriate ways. Such tools would help psychologists and traditional healers alike to understand the effectiveness of different healing approaches and

make informed decisions about collaboration. Research on the development of cultural competence regarding traditional healing would also be valuable, identifying the most effective methods for training psychologists to work across healing systems.

Finally, policy research is needed to understand how healthcare policies can better support integration efforts. Studies examining regulatory frameworks for traditional healing in other contexts could inform South African policy development, while research on funding models for integrated care could help make collaboration financially sustainable.

6.4 Conclusion

This study demonstrates that psychologists in the Eastern Cape are actively and thoughtfully engaged in negotiating the complex interface between Western psychology and African traditional healing. Rather than rejecting traditional practices, they are developing sophisticated and creative approaches to integration that honour cultural traditions while maintaining professional standards. Their experiences reveal that successful integration requires cultural humility, ethical clarity, clinical flexibility, and a willingness to engage with different epistemological frameworks.

The findings make a significant contribution to the ongoing decolonisation of mental healthcare in South Africa by highlighting how psychological practice can respectfully and effectively engage with indigenous healing traditions. The psychologists' approaches suggest a path forward that neither uncritically embraces traditional healing nor dismisses it but rather engages with it thoughtfully and respectfully. As South Africa continues to transform its healthcare system, the insights from this study can inform the development of more culturally responsive and effective mental health services that draw on the strengths of both Western and African healing traditions.

The research ultimately suggests that meaningful integration requires engagement at multiple levels, from individual clinical practice to organisational policies to broader healthcare systems. Psychologists in the Eastern Cape have begun this important work, developing innovative approaches to integration despite significant challenges. Their experiences provide valuable lessons for the broader project of creating mental healthcare that is both culturally respectful and therapeutically effective in post-colonial contexts.

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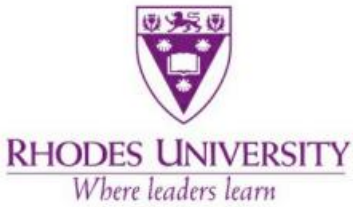
APPENDICES

APPENDIX A: ETHICAL CLEARANCE



Rhodes University Human Research Ethics Committee
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NHREC Registration number: RC-241114-045
https://www.ru.ac.za/researchgateway/ethics/

06 January 2025

Ms Buhle Buthelezi

Email: g24b9134@campus.ru.ac.za

Review Reference: 2024-8232-9323

Dear Ms Buthelezi,

Title: An integration of African traditional healing rituals with psychological therapeutic practices: Insights of psychologists.

Researcher: Ms. Buhle Buthelezi

Supervisor: Ms Sandisiwe Nabo-Bazana

This letter confirms that the above research proposal has been reviewed and **APPROVED** by the Humanities Faculty Research Ethics Committee (HF-REC). Your Approval number is: 2024-8232-9323

Approval has been granted for 1 year. An annual progress report will be required in order to renew approval for an additional period. You will receive an email notifying you when the annual report is due.

Please ensure that the Humanities Faculty REC is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators. Please also ensure that a brief report is submitted to the ethics committee on the completion of the research. The purpose of this report is to indicate whether the research was conducted successfully, if any aspects could not be completed, or if any problems arose that the Humanities Faculty REC should be aware of. If a thesis or dissertation arising from this research is submitted to the library's electronic theses and dissertations (ETD) repository, please notify the committee of the date of submission and/or any reference or cataloguing number allocated.

Sincerely,

Dr Priscilla Boshoff

Chair: Humanities Faculty Research Ethics Committee

APPENDIX B: PARTICIPANT INFORMATION LETTER

Faculty of Humanities

Rhodes University

Makhanda

6139

Date:

Information Letter for Prospective Research Participants: Invitation to Take Part in a Research Study

Good day,

I am Buhle Buthelezi, a Master of Arts Clinical Psychology student from Rhodes University Department of Psychology. Under the supervision of Ms Sandisiwe Nabo-Bazana, I am conducting a study titled "Integration of African Traditional Healing Rituals with Psychological Therapeutic Practices: Insights of Psychologists." This research aims to explore psychologists' perceptions in the Eastern Cape regarding the integration of African healing practices with western psychological treatment. The objectives include understanding psychologists' conceptualisations of African healing rituals, exploring their apprehensions regarding integration, and assessing the effectiveness of blending African and Western healing practices in psychological treatment. Your expertise and insight as a psychologist would be of great value to my study.

Who can participate?

i) Individuals who are registered psychologists with the HPCSA for at least 3 years.

ii) Individuals who are familiar with African Traditional healing rituals.

iii) Individuals who speak English.

You are cordially invited to take part in a research study. Your participation is entirely voluntary, and preceding the interview, you will be asked to complete a consent form. Once permission has been granted,

an audio recorder will be utilized to gather data during the interview. It is important to emphasize that you should not feel pressured by the researcher to participate in the study under any circumstances. If you decide to join, you maintain the right to withdraw at any time. Your privacy and confidentiality are paramount, and all information shared will be treated with the utmost discretion. The collected data and any transcripts will be securely stored, accessible only to the researcher and supervisor. Your identity will remain confidential, and pseudonyms will be used in reporting the findings. Interviews are expected to last approximately forty-five minutes to one hour. While there are no incentives for participation, rest assured that your involvement will not cause harm. However, should you experience any distress during or after the interview, debriefing will be available to you. Please contact the researcher or supervisor if you have any questions, or concerns or need additional information.

Researcher:g24b9134@campus.ru.ac.za/ kbuhlebuthelezi@gmail.com

Supervisor: Sandisiwe.nabo-bazana@ru.ac.za or call 046 603 7113

Thank You,

Buhle Buthelezi — Researcher

Sandisiwe Nabo-Bazana — Supervisor

APPENDIX C: INFORMED CONSENT FORM

Participant consent form: Interview participation

I (_____), agree to participate in the study titled *"An Integration of African Traditional Healing rituals with psychological therapeutic practices: Insights of psychologists",* conducted by Buhle Buthelezi who is a master's degree student from the department of Psychology at Rhodes University.

I have read the information letter explaining the purpose of this research and the letter was further read to me and I understand that:

- Participating in this study is voluntary.
- Rhodes University has given ethical clearance to this research project ***(Ethics Approval Number)*** and I have seen/may request to see the clearance certificate by contacting the Ethics Coordinator (ethics-committee@ru.ac.za).
- My information will be kept confidential.
- My name will not be identifiable or used in any written reports/ presentations, I will remain anonymous.
- An audio recorder will be used for data collection.
- Should I want to withdraw from the study, I can do so without any consequences at any point.
- I will not be compensated for participating in the research, but my out-of-pocket expenses will be reimbursed.
- I can contact the researcher and supervisor of the study, should I need any additional information.
- The Researcher intends to publish the research results in the form of a thesis. However, confidentiality and anonymity of records will be maintained, and my name and identity will not be revealed to anyone who has not been involved in conducting the research, unless

I indicate to the contrary/recognise that as a public figure, my identity will inevitably be/become known in which case I agree to and accept the loss of confidentiality.

- In terms of the Protection of Personal Information Act, it remains my right to request the Researcher to provide me with a detailed explanation of exactly how confidentiality and anonymity will be achieved. I may request to know how my personal information will be stored securely, for how long it will be stored, and whether it is likely to be used again in further research.
- In terms of the Protection of Personal Information Act, I possess the right to receive feedback about this research. This will take the form of an email, unless I elect not to receive feedback.
- Any further questions that I might have regarding the research, or my participation will be answered by Buhle Buthelezi, kbuhlebuthelezi@gmail.com.
- By signing this informed consent declaration, I am not waiving any legal claims, rights or remedies.
- A copy of this informed consent declaration will be given to me, and the original will be kept on record.

I, ……., have read the above information / confirm that the above information has been explained to me in a language that I understand, and I am aware of this document's contents. I have asked all the questions that I wished to ask, and these have been answered to my satisfaction. I fully understand what is expected of me during the research.

I have not been pressurised in any way and I voluntarily agree to participate in the above-mentioned project.

I **agree/disagree** (SELECT APPLICABLE) to the Researcher's request to take photographs and/or videos of me as part of this research project, recognising that agreement here is likely to raise the risk of

compromising my anonymity and that steps will be taken to ensure this does not happen if my approval is granted.

I **agree/disagree** to the Researcher's request to voice record my comments and opinions during interviews, the purpose of which is to ensure the accurate recording of my views. Furthermore, I have the right to request a copy of interview transcriptions to confirm that my opinions are accurately recorded.

……. …….

Participants signature Date

APPENDIX D: PERMISSION TO RECORD

Rhodes University – Department of Psychology

USE OF RECORDINGS FOR RESEARCH PURPOSES PERMISSION AND RELEASE FORM

Name of participant			
Participants contact details	**Email address:** **Phone number:**		
Name of researcher			
Level of research	**Honours**	**Masters**	**PhD**
Brief title of project			
Name of supervisor			

DECLARATION

(please initial/tick next to the relevant statements)

1.	**The nature of the research and the nature of my participation have been explained to me.**	**verbally**	
		In writing	
2.	**I agree to be interviewed and to allow recordings to be made of the interview**	**audiotape**	
		videotape	
3.	**I agree to_____ and to allow to recordings to be made**		
4.	**The tape recordings maybe be transcribed.**	**Without conditions**	
		Only by the researcher	
		By one or more nominated third parties	
5.			

	I have been informed by the researcher that the tape recordings will be erased once the study is complete and the report has been written. **OR** **I give permission for the tape recordings to be retained after the study and for them to be utilised for the following purposes and under the following conditions.**	

Signature of participant: _____ Date: _____

Witnessed by researcher: _____ Date: _____

APPENDIX E: INTERVIEW SCHEDULE

Good day,

My name is Buhle Buthelezi; I am a Master of Arts in Clinical Psychology student in the Department of Psychology at Rhodes University. I am conducting a study on the integration of African Traditional and Western healing practices, titled *"An Integration of African Traditional Healing rituals with psychological therapeutic practices: Insights of psychologists".* I am conducting this study under the supervision of Ms Sandisiwe Nabo-Bazana, from the Department of Psychology.

This study seeks to explore the insights of psychologists on the African traditional healing rituals alongside Western healing methods (psychological counselling). The understanding of the experiences of these individuals is important for the discipline of psychology, given that the belief systems embedded within South African cultures, tends to lend itself to interpretations and understandings of mental illnesses which extend traditional western understandings. The study aims to evaluate the quality of healthcare from different epistemologies in South Africa. In the research interview, you will be required to answer questions about African traditional and Western healing practices.

Thank you so much for your time. The effort and time given to participate in this study is highly appreciated. Should at any point of this interview session you feel like you need to stop, please do not hesitate to inform me. I have an audio recorder ready and set up. I am going to ask a couple of questions, please feel free to answer openly, do you allow me to proceed? (If yes then I will proceed by asking the following questions)

Questions:

1. How long have you been practicing as a psychologist?
2. What is your religion?

Probe: What is African Traditional Healing for you?

3. In your experience, what do you think is utilized more between the two forms of healing?

Probe: in your understanding, what provokes a person to seek psychological aid?

4. Is using African healing practices and western healing practices beneficial for psychological healing?

5. What informs your perspective on the integration?

6. Which mental health conditions are typically addressed through a combination of African traditional healing rituals and psychological therapeutic approaches?

7. What would you say are the disadvantages of using the two systems at the same time?

8. What forms of treatment is received from you?

9. Do you believe that traditional healing practices add something to the treatment of mental health that western psychology does not?

10. How does your cultural background influence your understanding of such a practice?

11. Do you think South Africa's mental health system is flexible enough for such an integration?

12. In your own words, how should an integrated model of both African and mainstream psychology look like?

13. Do you think this is an integration that is needed by South Africa's clients?

That was the last of the questions I have for you, before I conclude is there any additional comment you would like to make?

Once again, thank you for your time, I appreciate it. Thank you for agreeing to be interviewed. Should you need access to the research findings; the dissertation will be available at the Rhodes University Library once the study is completed in 2025.

I hope you have a great afternoon.