PINS 66 (2), 2024, 45 – 66, ***DOI:*** *https://doi.org/10.17159/pins2024Vol66iss2a6320*

Challenging the nexus: Integrating Western psychology and African cultural beliefs in South African mental health care

Abstract

This article delves into the unique sociocultural landscape of mental healthcare in South Africa, spotlighting the divergent conceptualisations of mental illness inherent in African and Western cultures. While acknowledging certain similarities, it emphasises the importance of integrating African-centred perspectives into psychology's training and practice. We contend that the prevailing focus on Western approaches to mental illness not only marginalises indigenous beliefs but also perpetuates the dominance of Western medical paradigms in healthcare systems. This trend risks pathologising the African experience of mental health and narrowing the understanding of African humanity through a lens of psychiatrisation and medicalisation. The article advocates for a more formal, integrative approach to mental healthcare that recognises and incorporates African notions of illness and health, underscoring the centrality of culture in the healing process. Our discourse calls for a paradigm shift towards an integrative model that respects and combines the strengths of both Western and African approaches to mental health, thereby fostering a culturally sensitive, inclusive, and effective mental healthcare system in South Africa.

Introduction

The growing discourse on African psychology, enriched by the contributions of thinkers like Ratele (2014, 2017) and other esteemed scholars, underscores the vital need for a psychological framework that truly resonates with the African context. This growing discourse critiques traditional Euro-American psychological frameworks and calls for a psychology that authentically represents the experiences and cultures of the African continent.

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Keywords

African perspective, culture, integrative approach, mental illness, mental healthcare, Western psychology

African psychology, as systematically studied and defined by scholars such as Baloyi and Ramose (2016), Cooper (2013), Mkhize (2004), Nwoye (2015), and Oppong (2022), emphasises a holistic view of human life and culture, integrating both pre- and post-colonial African contexts. This perspective, diverging from mainstream Western psychology, focuses on communal interconnectedness and situates individual experiences within a broader environmental and social context (Adelowo, 2015).

The evolution of African psychology has undergone several phases, beginning with an uncritical acceptance of Western approaches in the 1940s, as noted by Nwoye (2015). The subsequent phases saw a growing appreciation and integration of African and Western perspectives, culminating in the current phase which advocates for innovative strategies and theories that address contemporary challenges specific to Africa.

As practitioners and educators in psychology, we recognise our discipline's historical reliance on Western theories and principles, with its empirical origins rooted in the contributions of several familiar figures, including but not limited to Wundt (1879), Freud (1905), Pavlov (1927), Rogers (1951), and Beck (1976). However, the global mental health landscape is gradually changing, as evidenced by the increased emphasis on the Cultural Formulation Interview (CFI) (Aggarwal & Lewis-Fernández, 2015), reflecting a growing recognition of diverse cultural perspectives on mental health. CFIs assist mental healthcare practitioners by providing a structured method to understand the cultural background and context of patients. This can help identify culturally relevant stressors, supports, and coping mechanisms, leading to more effective and culturally sensitive treatment plans (Lewis-Fernández et al., 2020). Despite these advancements, there remains a tendency to fit diverse belief systems into existing Western models of illness and recovery.

This tendency particularly resonates in African contexts, where sociocultural dynamics often contrast with biomedical conceptualisations of health and illness (Mapaling & Naidu, 2023). Mabaso and Kotze (2020) found that awareness of CFIs in South Africa is low, and practitioners who are aware of it tend not to implement it in their practice. Lewis-Fernández et al.'s (2020) research on the uptake of CFIs in training and practice supports this by indicating limited integration despite acknowledging the need for cultural sensitivity, primarily due to the tension between standardisation and flexibility. Effective dissemination and practical implementation strategies are essential for encouraging adoption and sustainability in varied practice settings. While CFIs holds significant potential; awareness, training, further research, and real-world testing are needed to address the interview's user-friendliness and practicality in day-to-day practice.

In this article, we aim to position mental illness within the African cultural context, acknowledging the existence of spiritual or supernatural dimensions that extend beyond the biomedical model. Our argument advocates for an integrative approach in South

Africa, especially considering the indigenous population's reliance on traditional healers. We propose that psychology as a discipline should not entirely shift away from current methodologies, but rather embrace an inclusive model that incorporates African-centred perspectives. The critical question we explore is: *Are there possibilities of merging African and Western perspectives to effectively address serious mental illness?* By integrating these diverse perspectives, we aspire to establish a holistic and culturally relevant framework for mental healthcare that resonates with the lived experiences and worldviews of African communities.

Conceptualisation of Mental Illness in Western Culture(s)

The Western orientation to mental illness relies on biomedical reasoning (for instance, neurochemical imbalance) (Freitas-Silva & Ortega, 2016), and its diagnosis and treatment are systematic, relying on the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) and the International Classification of Diseases (World Health Organization, 2019). Unfortunately, the process of mainstream diagnosis and treatment in hospitals, clinics, and private practices have been Western-based for most cultures globally (Briskman et al., 2012) and this is not surprising as theories and scholars have given more attention to Western culture when it comes to mental illness (Beck, 2011; Brown, 1999; De Shazer & Molnar, 1984; Rector & Beck, 2012, Truax, 1966; Walker, 2001). Consequently, other cultures and belief systems are often neglected and pathologised in the therapeutic setting.

In Western therapeutic settings, there is a focus on parameters of normal conduct, and misconduct behaviour, dissimilarities in the symptom clusters of diagnosable disorders that seem not to be in line with universal patterns and cultural beliefs regarding treatment and phenomenological meaning (Hassan, 2021; Lefley, 1990; Lewis-Fernández et al., 2010). We found most common psychiatric illnesses such as schizophrenia, depression, autism spectrum disorder (ASD), and other mental disorders being commonly diagnosed and treated using Western instruments or psychological tests. For example, some instruments used for schizophrenia are the Brief Psychiatric Rating Scale [BPRS] (Overall & Gorham, 1988) and the Positive and Negative Syndrome Scale [PANSS] (Kay et al., 1987). The Beck Depression Inventory [BDI] (Beck et al., 1961) is used for depression and the Autism Diagnostic Observation Schedule [ADOS] (Lord et al., 2000) for ASD. There are also many different pharmacological treatments.

Psychiatric hospitalisations have been a place of treatment used in Western cultures, underpinning the biomedical perspective. When mentally ill people are admitted to a psychiatric hospital in well-resourced Western countries, they receive mental healthcare from multidisciplinary teams [psychiatrists, psychologists, professional nurses, occupational therapists, social workers and dieticians] (Mezzina, 2014; Pec, 2019; Rickwood et al., 2019). There is collaborative healthcare to provide the mentally ill with

holistic professional care, although this is not always the case. During discharge to the community, people who are mentally ill receive follow-up care from the multidisciplinary teams to ensure that there is no revolving door (Doupnik et al., 2020; Haselden et al., 2019). While this is the standard treatment plan, this is not always followed and is dependent on resource availability and service delivery efficiency. However, mental illness treatment in most Western cultures is restricted to the above-mentioned professionals who, by training, are still predominantly biomedical.

Mental healthcare can become financially costly in countries where public healthcare services are limited, overburdened, or not easily accessible. In developing nations, especially in African countries, public healthcare is not always easily accessible, giving medical aid a monopoly on the market. This further exacerbates the high levels of socio-economic inequality. Thus, people tend to seek alternative options including new age methods or traditional help, which is not only easily accessible, familiar, and affordable (Letsoalo et al., 2021; Ngobe et al., 2021) but also align well with their beliefs of disease causality. A patient, in Africa, suffering from mental illness, such as schizophrenia or depression, is more likely to receive healthcare from traditional healers (Shange & Ross, 2022). While seeking healthcare from traditional healers holds significant benefits, it also holds its limitations. The methods of traditional healers for mental health are largely unknown, as their approaches are often kept secret, so there is no set of ethical guidelines or parameters of standardisation (Shange & Ross, 2022). Importantly, while the patient's mental illness can be rooted in spirituality, it can also be rooted and treated through biomedical interventions. This can lead to over-spiritualisation, stigmatisation, and medical neglect. Mental illness and the patient in context are a complex intertwined tapestry. The patient's biology, psychology, social context, culture, spirituality, and even environment intersect to influence mental illness. These aspects are not mutually exclusive; thus, an integration of both Western and African approaches is essential, ensuring that mental healthcare is accessible and aligns with the diverse needs and beliefs of the population.

Clinical observations (Gazzillo et al., 2020), impressions (Bouchard & Rizzo, 2019), and standardised psychometric tests (El-Den et al., 2018; Yıldırım et al., 2018) are regarded as essential in making an accurate diagnosis of mental illnesses. Theories guiding these methods are from the Western culture (Sampson & Group, 1986). Little to no formal theories guiding the approach to mental illness in African contexts can be found in mainstream psychology, a situation which has historically led to the adoption of Western approaches in most African cultures. This trend towards Western models was influenced by their formal documentation and extensive research support but also significantly by the legacy of colonialism (Nwoye, 2015). During the colonial era, colonial powers systematically marginalised and even banned traditional medicine while promoting biomedicine as a symbol of modernity and progress (Abdullahi, 2011). This not only

devalued traditional African practices and understandings of mental health but also legally and socially suppressed them, resulting in a predominance of Western methods in the field of mental healthcare (Abdullahi, 2011). This historical context is crucial in understanding why Western approaches have become standardised in many African societies, often at the expense of indigenous knowledge and practices.

The argument is that mental illness differs based on individuals' social environmental factors (culture, traditions, and past experiences) (Gopalkrishnan, 2018). Environmental variables correlate with mental illnesses in the form of prognosis and intercultural differences (Abbo et al., 2008; Kotera et al., 2020; Lefley, 1990; Wittchen & Jacobi, 2005). In Western cultures, individuals diagnosed with mental illness are more commonly treated using Western methods, which include psychosocial education, psychotherapy, social support, and pharmacology (Koç & Kafa, 2019; Van Weeghel et al., 2019). Such methods have ingredients which need to be delivered by Western-trained professionals to treat mental illness. Up to the present, Western cultural paradigms continue to exert significant influence over the global discourse in mental health, shaping the perspectives of scholars, theorists, and practitioners (Limenih et al., 2024). This dominant influence often overlooks the unique contextual factors that are crucial in understanding mental illness across diverse cultural backgrounds (Shange & Ross, 2022). However, there is an increasing recognition of the need to advocate for a mental health framework that is more reflective of the various cultural nuances (Lewis-Fernández et al., 2020).

Western culture has practised treatment for serious mental illness for centuries. There is ample evidence that a combination of psychopharmacology and psychotherapeutic techniques has been effective in the treatment of serious mental illness [mental disorders] (Kao et al., 2020; Ryle & Kerr, 2020; Shalaby & Agyapong, 2020). In other cases, depending on the patient's presentation, psychopharmacology can be used alone for treatment, while others require both psychopharmacology and psychotherapy (Greenway & Rees Edwards, 2020; Javelot et al., 2021; Needs et al., 2019). Psychopharmacology (medication) alone does not wholly treat serious mental illness, it rather subsides the diagnosed mental illness (Greenway & Rees Edwards, 2020). Therefore, it could be argued that the combination of psychopharmacology and psychotherapy is more effective.

Psychotherapeutic treatments draw on a range of techniques as dictated by the type of mental illness and suitability of the modality, for example, psychoanalysis, cognitive behavioural therapy (CBT), supportive therapy, psychodynamic therapy, interpersonal therapy, and dialectical behavioural therapy [DBT] (Calderon et al., 2019; Conceição et al., 2019; Mohamadi et al., 2019; Novalis et al., 2019; Peri Herzovich & Govrin, 2021; Schweiger et al., 2019; Van Bronswijk et al., 2021). These techniques are provided by well-trained and registered professionals (for example, clinical psychologists; psychiatrists)

who are certified by professional boards which license and authorise their practice. In some cases, therapy is provided to individuals, families, groups, and couples (Carr, 2019; Hogue et al., 2022; Tadros et al., 2019). For psychotherapeutic techniques to be more effective, there is a likely possibility that patients will be advised to use both psychopharmacology and psychotherapeutic treatment (Heinonen & Nissen-Lie, 2020; Wampold, 2019). Incongruence due to different cultural perspectives in the context of Western psychological mindsets on treatment is more likely to be possible among social groups universally (Awaad & Reicherter, 2016).

Brief History of Mental Illness in African Culture(s)

In this exploration of the history of mental health in African cultures, it is important to acknowledge the ongoing debate surrounding the terminology used to describe mental health issues. Increasingly, there is a preference for terms like 'mental health problems' or 'mental health conditions' over 'mental illness', reflecting a shift in understanding and a preference for euphemistic language within the field (Price, 2022). The shifts observed in Price's (2022) study are particularly relevant to our discussion, as they align with one of the core arguments of this article: the experience and narrative of what constitutes 'illness' can vary significantly across different cultures.

In many African belief systems, individuals may understand what Western perspectives categorise as 'illness' in entirely different terms, which carry varied connotations and implications (Mji, 2020; Omonzejele, 2008). This cultural variance in understanding mental health challenges the conventional use of the term 'mental illness'. Therefore, while we use the term 'mental illness' in this article, it is with the recognition of its diverse interpretations and meanings. This usage is intended to facilitate a focused discussion within the specific context of this work, rather than to endorse a universally applicable definition. We acknowledge and respect the varying connotations of 'mental illness' and the importance of culturally sensitive approaches in understanding mental health across different African cultures.

Mental illness has always been part of all societies and, on this note, it is irrefutable that humankind has faced challenges in dealing with its presence and treatment. With such a conundrum at hand, there was a necessity to find ways to address it (Mothibe & Sibanda, 2019). Healers, diviners, herbalists, and priests have always been part of indigenous healing and so are their practices (Kpobi & Swartz; 2019; Odejide et al., 1989). The latter role players were useful in the treatment of mental illness then, they are useful now, and will likely continue to be useful in the future as evidenced by the percentage of people who do not only consult them but use them as their first point of mental healthcare (Burns & Tomita, 2015; Gureje et al., 2015; Ngobe et al., 2021; Seedat et al., 2009; Sorsdahl et al., 2013; Whiteford et al., 2013). Most of those who consult indigenous healers as the first line of treatment for mental healthcare were found by Barlow and Durand (2005) and

Odejide et al. (1989) in their studies conducted in various African countries to attribute mental illness to supernatural forces in the form of possession by evil spirits, witchcraft, and wrath of the ancestors. Despite limited pre-colonial writings on the history of mental illness in African culture(s), there is some 'therapeutic' (archaeological) evidence that supports the belief that mental illness was attributed to supernatural forces, for example, skulls that were drilled in the cranial region which date back to 5000 BCE. Such practices, based on the belief that drilling could release spirits responsible for mental difficulties (Cartwright, 2008), further reinforce the idea that understanding and treating mental illness has always been an integral part of human history, including among indigenous African peoples.

Earlier, it was mentioned that traditional healers are often the first point of consultation before medical practitioners in certain African contexts. Further expanding on this, research by Shai and Sodi (2015) indicates a trend where acute symptoms are typically addressed through Western medicine. However, for chronic but manageable symptoms, there is a noticeable shift towards traditional medicine, a practice also reflected in the limitations of psychiatry, as discussed by Read (2012). Read's (2012) study in rural Ghana highlights that while biomedicine is often regarded as the gold standard, the reality of its limitations and the incomplete understanding of mental health often led to dissatisfaction, thereby reinforcing supernatural belief systems. Consequently, when biomedicine does not yield the desired results, people tend to revert to other methods, seeking a more comprehensive and lasting healing.

This inclination towards traditional methods and the resulting efficacy further underscores the trust that indigenous African people place in the expertise of traditional healers to bring them relief, as highlighted by Ngobe et al. (2021). This not only demonstrates a deep-rooted confidence in indigenous knowledge systems, but also suggests a pressing need for psychology to understand and integrate these belief systems into its framework. Importantly, this integration should be done respectfully and thoughtfully, avoiding the pathologisation of such beliefs as mere symptoms of a Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) diagnosis. Acknowledging and valuing these traditional perspectives can pave way for a more holistic and culturally sensitive approach to mental healthcare, one that resonates more deeply with the lived experiences and worldviews of African communities.

While we acknowledge and advocate for the respectful integration of traditional belief systems into psychological frameworks, it is also crucial to differentiate between cultural beliefs and pathological symptoms. We do not refute the importance of diagnosis and the treatment of associated symptoms in the context of mental healthcare. However, it is important to recognise that supernatural beliefs, prevalent and deeply rooted in many

cultures, are not inherently pathological. Psychology, at times, tends to misconstrue such ideas shared by clients as delusions. For example, in many cultures in South Africa, the belief in bewitchment is an integral part of the belief system. This cultural belief, while differing markedly from Western medical paradigms, should not be dismissed or pathologised, but rather understood within its cultural context. Witches are believed to have the capacity to cause harm, and misfortunes and mental and physical illnesses are therewith associated. Typically, a traditional healer can assist a person being bewitched and would often include a consultation (where the client shares with the healer their experiences), the use of herbs and natural substances (healers usually prescribe the use of certain potions or mixtures, that are made from natural elements, like plants), rituals and ceremonies (it is likely that a person would have to slaughter an animal, talk to the ancestors – essentially, engaging in behaviour to counter the misfortunes). While some of these medicines and potions might have counter-reactions with medication (Adorisio et al., 2016), there are minimally reported violations. Important to note from this is that the belief a person holds will direct the behaviours they attach to healing.

All cultures have a theoretical system that is used as a base to explain the causality of illness, in this case, mental illness (Chipfakacha, 1994). That is, although mental illness is common in all societies, the causes, the different types, and the way they are diagnosed and treated differ from one culture to the other. Therefore, for a better understanding of how various cultures appraise mental illness, one must take time and appreciate the cosmological assumptions of that culture (Ngobe et al., 2021). The latter was comprehensively captured by Amuyunzu-Nyamongo (2013, p. 59):

> Mental health is a socially constructed and defined concept, implying that different societies, groups, cultures, institutions, and professions have diverse ways of conceptualising its nature and causes, determining what is mentally healthy and unhealthy, and deciding what interventions, if any, are appropriate.

We found through a collation of studies that causes of mental illness across various cultural groups in Africa fall within two broad categories, namely bewitchment or possession by evil spirits (i.e., stepping over a dangerous track; poisoning with soil and ants from the grave) and the effects of the ancestors [such as failure to perform a ritual or refusing to accept an ancestral calling] (Amuyunzu-Nyamongo, 2013; Ensink & Robertson, 1996; Ngobe et al., 2021; Sorsdahl et al., 2013). The above-mentioned causes are briefly explained below:

- Bewitchment - it is believed that witches possess the ability to mobilise and use evil powers to harm other people. *Amafufunyana* (Zulu) or *mafufunyane* (Northern Sotho) are the terms used amongst these two South African cultural groups to denote mental illness due to witchcraft.

- Effects of the ancestors – it is believed that when ancestors want someone to become a traditional healer and the chosen person does not listen or refuses, they (ancestors) can cause problems for that person and the person might behave like they are mentally ill and if not attended, this can lead to permanent mental illness. The common term used to describe this amongst the Xhosa ethnic group in South Africa is *Ukuthwasa*.

While the concepts of bewitchment and the effects of the ancestors, as seen in the examples of *Amafufunyana* (Zulu) or *mafufunyane* (Northern Sotho) and *Ukuthwasa* (Xhosa), primarily focus on what might be categorised as severe mental illness, it is crucial to recognise that the spectrum of mental health in African cultures extends beyond these intense manifestations. An illustrative example of this broader spectrum can be found in the Shona concept of *kufungisisa*, meaning 'thinking too much', which represents a form of mental distress that may not necessarily fit into the category of severe mental illness. This highlights an important aspect of mental health conceptualisation in African cultures – the recognition and inclusion of less severe, yet significant mental health concerns. It is a reminder that while certain indigenous terms might initially appear to align with severe mental illness, the scope of these terms and concepts can be quite broad and encompass a range of mental health experiences.

Considering this, our article argues for a flexible and sensitive approach to understanding how mental illness is conceptualised within African cultures. Indigenous names and terms should not be interpreted rigidly and fixedly, but rather viewed as categories that provide diverse explanations and insights into mental health. This understanding, as suggested by Ensink and Robertson (1996), allows for a more nuanced and comprehensive appreciation of the various ways mental health is understood and addressed within African cultural contexts.

Treatment of Mental Illness from an African Perspective

Although theories of mental illness causality differ between Western and African cultures, commonality is observed in the manifestation of core symptoms across these cultural contexts (Jablensky et al., 1992; Ngobe et al., 2021; Sartorius et al., 1974). For example, persecutory delusions (the belief that others are plotting against or planning to harm an individual in one way or the other) which is one of the positive symptoms of mental illness was found to cut across all cultures and this was underpinned by trans-cultural and cross-cultural international studies (Connell et al., 2015; Kalra et al., 2012; Stompe et al., 1999).

Despite similarities noted regarding the core symptoms of mental illness across both cultures (Western and African), differences were noted in what some of these symptoms mean or are indicative of. One such area was in the content of the delusions and hallucinations and the meaning thereof. In a study conducted by Ngobe et al.

(2021) among Xhosa traditional healers in South Africa, it was found that auditory hallucinations were believed to be indicative of two things (a) either a visitation by the ancestors to offer some guidance or (b) intrusions by evil spirits. The latter beliefs contrast with the belief in Western culture, whereby hearing of voices is viewed as an indication that something went haywire biologically (Freitas-Silva & Ortega, 2016) which, if it is the case, medication will be the solution. The former and the latter indicate that explanations of mental illness in both cultures are underpinned by each culture's beliefs, which inform the treatment approach thereof and the potential first point of consultation, strengthening the need for both cultures to formally work side by side.

Treatment of mental illness among African culture(s) depends on what is believed to be the cause, and it is also holistic in nature (Koç & Kafa, 2019; Ngobe et al., 2021). The most common methods used to treat mental illness include among others, cleansing, the performance of rituals (i.e., slaughtering of a goat), burning of herbs, offering of sacrifices and practices of purification. While this article touches on the various methods employed by traditional healers in addressing mental health issues, such as the use of nasal inhalations, herbs, and other substances, it is not our primary focus to delve into the specifics of these practices. The detailed description of methods like the use of animal substances (*tinsiti*), powdered roots (*emakhatsakhatsa*), boiled roots, leaves, or barks (*timbita*), and the role of divination bones (*ditaola* in Northern Sotho) for guidance in traditional healing, as documented by researchers like Abbo et al. (2019) and Ngobe et al. (2021), is beyond the scope of this article. However, for readers interested in a more in-depth understanding of these specific traditional methods and their application in mental healthcare, we recommend referring to the works of these authors.

Our main argument is to advocate for a broader reconsideration of what is deemed appropriate care in mental health, particularly in the context of African cultures. This includes acknowledging and respecting the diverse array of practices and beliefs that exist within these cultures and understanding their significance in the mental health landscape. In doing so, we aim to highlight the importance of integrating these indigenous approaches into a more holistic and culturally sensitive framework of mental healthcare, rather than focusing solely on the specifics of each method.

A common treatment method used for those who have mental illness because of ancestral calling is initiation (Ngobe et al., 2021). Individuals who receive this treatment do so because their ancestors want them to become traditional healers. However, for one to get better in this case, s/he must accept the calling and complete the initiation, failure of which will result in severe mental illness and, in the worst cases, even death. The training occurs under the guidance of another traditional healer, mostly a senior traditional healer (*gobela*) and the training can take months and, in some cases, even years (Ngobe et al., 2021). Throughout the training, the initiate will not only learn

humility, traditional herbs (*muti*) and respect for the ancestors, but they also undergo other traditional rituals as deemed necessary (Ngobe et al., 2021). For mental illness due to bewitchment and breaking of taboos, cleansing, incisions (*kugata* in Xhosa), sacrifices and rituals are used to repel and appease the ancestors.

Having explored the distinct treatment methods prevalent in both African and Western cultures, we are now prompted to consider the potential for an integrative approach. This approach could synergistically combine the strengths of each culture's perspective on mental illness treatment. Taking a deconstructed view of the biomedical further informs our belief that mental illness can be assessed, diagnosed, and treated (Mapaling & Naidu, 2023) holistically in an integrative approach.

A Call for an Urgent Integrative Approach

In many African countries, including South Africa, Kenya, Ghana, and Uganda, a significant portion of the population prefers traditional healers as their primary healthcare providers for various ailments (Abbo et al., 2008; Ae-Ngibise et al., 2010; Freitas-Silva & Ortega, 2016; Letsoalo et al., 2021; Mothibe & Sibanda, 2019; Ndetei et al., 2013; Sorsdahle et al., 2013; Van Niekerk et al., 2014). This preference is rooted in factors such as familiarity, accessibility, affordability, and a deep alignment with cultural belief systems (Burns & Tomita, 2015; Gureje et al., 2015; Mothibe & Sibanda, 2019; Ngobe et al., 2021; Seedat et al., 2009; Sorsdahl et al., 2013; Whiteford et al., 2013). The widespread trust and reliance on indigenous healers underscore a critical aspect of African healthcare: the inextricable link between cultural beliefs and treatment methods.

Considering the historical and cultural context of African psychology and the influence of Western urbanisation, an integrative approach to mental healthcare is crucial. Such an approach would not only respect and incorporate traditional African methods, but also blend them with effective Western psychological practices. This synergy can create a holistic and culturally sensitive mental healthcare system, one that truly addresses the diverse needs and beliefs of African populations.

However, the path to integration is not without its challenges. It requires overcoming systemic biases, addressing logistical hurdles, and ensuring that both traditional and Western methods are given equal respect and consideration. If the integration of African treatment approaches into the formal healthcare sector continues to be sidelined, the goal of inclusive and responsive healthcare will remain elusive.

The benefits of integrating both African and Western approaches to mental healthcare are manifold. It would not only honour the deeply held beliefs of African people, but also provide a more comprehensive and effective form of care. The benefit of African approaches, backed by evidence and theory, is indeed significant and should not

be dismissed. Conversely, failure to do so risks perpetuating the marginalisation of indigenous practices and alienating a significant portion of the population who rely on these methods. However, it is crucial to consider the diversity within South Africa, encompassing various cultural beliefs, including those related to traditional medicine. Prolonged delays in this integration will only serve to disadvantage those who trust in indigenous healing methods. It is time to acknowledge the value of these practices and embrace a more inclusive and effective approach to mental healthcare in Africa.

Conclusion

This article has navigated the complex landscape of mental health treatment, contrasting and comparing the Western and African approaches. It has become increasingly evident that a synergistic integration of these diverse perspectives is not just beneficial, but essential to address the unique mental healthcare needs within African contexts. The convergence of these approaches can pave the way for a more inclusive, culturally sensitive, and effective mental healthcare system. By embracing both Western and African methods, we can create a more holistic and responsive healthcare paradigm that honours the cultural values, beliefs, and traditions of African communities, while also leveraging the advancements in Western medical practices. It is time to move beyond the binary of Western versus African approaches and foster a collaborative model that brings the best of both worlds to the forefront of mental health treatment. Such an integrative approach will not only respect the diverse cultural landscape of Africa but will also mark a significant step towards addressing mental healthcare needs in a manner that is both culturally relevant and scientifically sound.

At the same time, it is important to acknowledge the need for researchers from Africa to produce their own theories and guidelines, rather than solely relying on integration. The development of African-centred approaches, grounded in local knowledge and practices, is crucial for addressing the unique mental health challenges faced by African people. However, we firmly believe the best approach would be for researchers to work closely with traditional healers to generate integrated theories and guidelines that can inform mental healthcare practices. This collaborative effort is a crucial step in empowering African researchers and practitioners to take the lead in shaping mental healthcare solutions tailored to the specific needs and cultural contexts of their communities. The lack of African-centred theory and evidence-based approaches is a significant gap that must be addressed.

By embracing this integrative approach, we can challenge the nexus between Western and African approaches, moving beyond the binary of either/or and towards a more inclusive model that honours the diversity of African cultures and traditions. This is a crucial step in developing mental healthcare solutions that are both culturally relevant and scientifically sound.

Acknowledgements

The authors would like to extend their gratitude to Ms Kamogelo Mooketsi (University of Johannesburg) for her assistance in sourcing literature. Our gratitude also to the British Academy for their support through the International Writing Workshop award 'Qualitative and Visual Mental Health Research in Ghana and Indonesia' (WW22\100194), which has significantly contributed to the development of this article. Through this workshop, we were fortunate to receive invaluable insights from Dr Lily N. A. Kpobi (University of Ghana) whose critical reading greatly enhanced this manuscript.

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