Examining the ways and extent to which counselors in Botswana are utilizing indigenous cultural practices and structures

Dan-Bush Bhusumane
EXAMINING THE WAYS AND EXTENT TO WHICH COUNSELORS IN BOTSWANA ARE UTILIZING INDIGENOUS CULTURAL PRACTICES AND STRUCTURES

by

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Submitted in partial fulfillment of the requirements for the degree Doctor of Philosophy

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August 2007
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EXAMINING THE WAYS AND EXTENT TO WHICH COUNSELORS IN BOTSWANA ARE UTILIZING INDIGENOUS CULTURAL PRACTICES AND STRUCTURES

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Abstract

The primary purpose of this qualitative study was to identify and examine the ways in which and the extent to which counselors in Botswana incorporate and utilize indigenous cultural practices and structures in counseling. This applied research involved interviewing 30 counselors from different parts of Botswana. Data collection was through a semi-structured interview guide while audiotaping was the main method of recording the interviews. The study showed that while counselors in Botswana appreciate the need to utilize indigenous cultural practices and structures, they rarely incorporate cultural practices into counseling. In addition, the study revealed that most counselors have limited knowledge and skills on how to handle indigenous cultural beliefs of clients. The data showed that the deficiencies in counselor education curriculum and the negative attitudes towards indigenous cultural practices and healing systems contribute significantly to their limited utilization by counselors. Furthermore, counselor training inadequately prepares counselors on how to respond in a culturally appropriate manner. Most importantly, the colonial legacy, postcolonial government’s apathy towards indigenous culture, and missionary and post-missionary teachings against indigenous cultural practices have resulted in negative attitudes towards indigenous cultural practices and methods. These influences contribute to Batswana’s introjections of Western values, and perceived superiority of Western interventions. Although counselors had positive views about the inherent power, influence, and superiority of indigenous healers in handling indigenous religious and cultural beliefs, they had misgivings concerning working with healers. It is clear from the findings of this study that most counselors generally involve the extended family network as a means of helping the client establish a support system, and as a way of facilitating reconnecting with other family members for security, compassion, and care. This study revealed the need for counselors’ cultural grounding, and to respond appropriately to the belief systems and psychosocial problems of clients in Botswana’s collectivistic cultural context. By embracing the indigenous cultural
practices, counselors would be taking a positive step towards facilitating a more fruitful dialogue with indigenous practitioners, widely used by many Batswana. Collaboration between counselors and indigenous healers may reduce suspicion and improve communication between the two groups.
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ACKNOWLEDGEMENTS

I thank my parents, siblings, and my children for the support and encouragement during this final lag of my studies. Their understanding has been a driving force for me to continue with writing this dissertation and complete it as soon as I could. May the Grace of the Lord, be upon them.

I appreciate the advice and expertise of Dr Lisa Lopez Levers, my supervisor for this dissertation. Her comments were most valuable in making this research a success. I appreciate her support and commitment to my project. I am indebted to Drs William Casile and Emma Mosley who are on my dissertation committee. Their feedback and support has been invaluable and, therefore, highly appreciated. The comments they made help reshape and clarify some of the issues and critical elements that the reader, from a different culture, might need to know.

I owe a debt of gratitude to all those counselors who participated in this research. I highly appreciate their willingness to participate despite their busy schedules and workload. Their participation shows their commitment to the issues this study sought to examine. Many thanks also go to the Training and Development section of the University of Botswana for availing funds for me to conduct interviews in different parts of Botswana. I also extend my appreciation to the faculty in the Executive Counselor Education and Supervision (ExCES) program at Duquesne University and my colleagues in the Department of Educational Foundations at the University of Botswana for their support and encouragement. My sincere gratitude goes to Juliana Kabwe whose moral support and encouragement kept me going even in times when I faced challenges in my life during my writing of this dissertation.
African proverb: Giant silk cotton trees grow out of very tiny seeds.
CHAPTER I
INTRODUCTION

Recognition of the need to incorporate indigenous cultural practices and structures in Western-based counseling is gaining wide acceptance among counselors in different parts of the world, including Botswana in Southern African. Most significantly, the consensus among helping professionals and researchers in non-western settings is that Western-based counseling approaches and other emerging human and social support systems should integrate indigenous cultural and healing practices, knowledge systems, and social structures. As Maes (1995) aptly put it, guidance and counseling in Botswana should incorporate the best of the indigenous cultural practices and strategies for combating social and personality problems faced by clients in various social settings. Witmer (1990) expressed similar sentiments when he advised that counselors in Botswana always must be cognizant of cultural conditions and changes. He has suggested combining the best of traditional medicine and family life and emerging human and social services of modernization to enhance the wellbeing of those served. In her consultancy report on the implementation of the guidance and counseling program in Botswana, Mapp-Robinson (1987) remarked, “it is worth knowing to what extent guidance and counselling programmes are utilising cultural practices” (p. 86). These remarks have influenced the focus of this study.

Among the most important recommendations by consultants (e.g., Maes, 1995; Mapp-Robinson, 1987; Witmer, 1990) regarding Botswana were that practitioners and program developers must utilize indigenous cultural practices and healing systems in counseling. Several international conferences (e.g., Guidance and Counseling conference, 2001; ACA convention, 2003 & 2006; Counseling in the Americas, 2004; AAGC conference, 2005; Career Development and Public Policy symposium, 2006; SSCSA conference, 2006; Global Mental Health conference, 2006) expressed similar feelings. This frequent focus on incorporation of cultural
practice is indicative of the growing realization among professionals in different parts of the world that counselors need to recognize and appreciate the crucial role culture plays in influencing behavior and responses to counseling interventions. The main argument in these international gatherings has been that imposition of Western approaches on non-western cultural settings has not yielded positive results whenever practitioners did not take into account issues of cultural relevance and appropriateness.

With the growing need for effective intervention strategies and programs to address the HIV/AIDS pandemic in sub-Saharan Africa, the efficacy and utility of some of the prevention and control programs have been under constant scrutiny. The contentious issues here are those related to relevance, appropriateness, and cultural sensitivity. Subrick (2006) had this to say about the inappropriateness of the AIDS prevention program strategy in Botswana: “… it developed a plan based on Western medicine and expected changes in behavior to follow. These changes did not happen because the tenets of Western medicine had little resonance with the Batswana conception of disease” (p. 6). He has concluded that the practice of “overlooking the strength of the cultural influences led to the failure of the national AIDS strategy” (p. 3). Further, he has suggested that the neglect of a traditional understanding of disease undermined the effectiveness of the AIDS campaign. Selected projects reviewed according to UNAIDS Best Practice Criteria, have shown that the involvement of indigenous healers, and the utilization of local knowledge in AIDS prevention strategies in a number of countries in sub-Saharan Africa (including Botswana) resulted in significant improvements in effectiveness and collaboration between indigenous and ‘modern’ systems of care (UNAIDS, 2000).

I submit that culture-specific interventions and incorporation of the belief systems and practices of those receiving help are key elements to the success and responsiveness of Western-based counseling in Botswana. The limitations of the Western-based strategies have generally been attributed to their lack of or underutilization of the indigenous knowledge, cultural beliefs,
and healing systems that large proportions of African peoples continue to depend upon for their health care and general wellbeing (Hills, Finch, & Garanganga, 2006; Levers, 2006a; Subrick, 2006; UNAIDS, 2000; UNAIDS, 2007). Literature on HIV/AIDS has shown that in most parts of Africa, indigenous practitioners still remain the main source of health care and wellbeing, if not the only one particularly for those in sub-Saharan Africa (UNAIDS, 2007, ¶ 4). Contrary to stereotypic views suggesting that those with higher education, and socioeconomic status would not use indigenous practitioners, there are indications that people from all walks of life in Botswana have consulted healers for various kinds of psychosocial, financial, and spiritual concerns (Dembow & Thebe, 2006; Devos, 2004; Subrick, 2006).

Reports (e.g., UNAIDS, 2000) on HIV/AIDS prevention and control programs have suggested that as many as 80% of the people in Africa use indigenous healing structures to meet their health-care needs. While there may be conflicting reports in terms of this statistical information, for example, some ascribing it to developing countries (e.g., Liverpool et al., 2004), and yet others to world population (Ba-N’Daw & Nkala, 2003), there is, however, consensus that a majority of people, particularly in sub-Saharan Africa, use indigenous healing. A majority of Batswana (singular: Motswana) continues to use indigenous healing for their psychosocial and general wellbeing. According to a UNAIDS 2000 joint United Nations program on HIV/AIDS called Collaboration with traditional healers in prevention and care in sub-Saharan Africa: A literature review, indigenous healers are easily available, accessible, and an affordable resource in most African countries. In this report, reference is made to a 1990 World Health Organization (WHO) program, which came to Botswana to “consider ways to involve traditional health practitioners more actively in measures to prevent and control HIV infection and AIDS in African communities” (p. 10). Studies (e.g., Levers, 2006b; Subrick, 2006) have consistently reported the negative impact of leaving out healers in responding to the HIV/AIDS prevention in Botswana. Based on this negative experience with the HIV/AIDS prevention in Botswana, I
argue that unless professional counselors incorporate indigenous healing methods and structures, they may not be able to respond effectively to the psychosocial needs and the general wellbeing of most clients in Botswana.

Another significant move by WHO in 1994 offered further observations and direction regarding indigenous healers, these went as far as suggesting upgrading of skills of these indigenous practitioners. This suggestion was adopted by UNAIDS that have followed up by initiating a number of training workshops for healers in different countries, including South Africa. This growing move toward accommodating indigenous practitioners has led to more research aimed at establishing the strengths and pitfalls of involving indigenous practitioners, especially healers, in dealing with the HIV/AIDS pandemic. Current research (e.g., Levers, 2006a, 2006b; Liddell, Barrett, & Bydawell, 2005; Liverpool et al., 2004; Subrick, 2006; UNAIDS, 2000) on HIV/AIDS has documented the potential benefits of collaboration between indigenous healing practices and the Western-based care systems. This research has highlighted the need for Western-based practitioners to recognize the contributions of indigenous healers in addressing problems faced by communities in Africa. It is the intent of this study to investigate ways in which counselors in Botswana view indigenous healing methods and how they use them, both as referral and in partnership.

As indicated in the 2000 collaboration review by UNAIDS, several factors were favored collaborating with healers. These factors included the healers’ accessibility, availability, and affordability of their services. The review has pointed out that in addition to offering many effective treatment methods, the healers “provide client-centered, personalized care that is culturally appropriate, holistic, and tailored to meet the needs and expectations of the patient” (UNAIDS, 2000, p. 10). It also has shown that healers were culturally close to clients, thus facilitating communication about the issues. In addition, other positive views about indigenous practitioners identified through the review were: that they often see patients in the presence of
their families, thus promoting social stability and counseling; that they abstain from harmful practices when educated about the risks when there is dialogue and cooperation with them. The review also noted that healers address a variety of psychosocial problems that arise from conflicting expectations of the rapidly changing society. Furthermore, the healers are generally respected care providers and have greater credibility than conventional practitioners with respect to social and spiritual matters. These conflicting expectations may not be in resonance with the cultural conceptions of illness (Liddell, Barrett, & Bydawell, 2005; Subrick, 2006).

In their investigation of the indigenous representations of illness in sub-Saharan Africa, Liddell, Barrett, and Bydawell (2005) have concluded that “ignoring indigenous beliefs about illness, which African societies have long construed as essential for their survival and well-being, seems counterproductive to the development of culturally grounded and responsive AIDS prevention programs” (p. 698). Liverpool et al. (2004) have reported that some patients even refused surgery or other medical treatment unless their healer had sanctioned it. In their study, Liverpool et al. have opined that “if well-utilized” (p. 825), indigenous healers could play an important role in preventing HIV/AIDS and Sexually Transmitted Diseases (STDs). As noted by many scholars (e.g., Liddell, Barrett, & Bydawell, 2005; Subrick, 2006) it would be futile to ignore the influence and respect of indigenous healers. These scholars have noted that this perceived authority of the healers has a significant impact upon the decisions that clients make about other services available to them.

While evidence has shown that a large proportion of African people access indigenous healing as their health care system, “it is also evident that those who make use of indigenous medicine do so in addition to Western medicine” (Shuping, 1999, p. 97), partly, because of the perceived ineffectiveness of the Western medicine in curing certain illnesses and diseases (Skjønsberg, 1989). However, most intriguing in the literature was that some people sought help from the Western-based services as a last resort, and when, as Skjønsberg (1989) reported, “it is
often too late” (p. 160). This could probably be because of their perceptions and attitude toward these services. In addition, the lack of knowledge about the Western-based services offered by the formalized systems of help may have influenced these perceptions.

As poignantly noted by Liddell et al. (2005), there is extensive documentation of the “failure” of Western biomedical messages in African societies, especially in the health sector. For example, some scholars (e.g., Chilisa, 2005; Subrick, 2006) have observed that the messages disseminated to the local population in Botswana do not incorporate local knowledge and cultural beliefs. Subrick (2006) has noted that these messages based on scientific approaches that were “at odds with the way the typical Batswana understood disease, which was based on the traditional beliefs promulgated by influential healers” (p. 3). Even though the same language used to write the messages is the same as the one used by local people, the value system, worldviews, or conception of the problem consistently reflected an alien perspective that may not resonate with the general populace in Botswana. The failure of the messages to communicate appropriately has limited people’s understanding of and connection with the programs and interventions set forth for them. Chilisa has argued that these messages were:

Written from a colonizing perspective . . . take for example, the billboards that read: ‘Don’t Be Stupid, Condomise’; ‘Are you careless, ignorant and stupid?’ The messages are offensive, degrading and written from the perspective of a superior observer who casts the recipients of the message as ignorant. The billboards also seem to suggest that condoms are the major solutions to the spread of HIV/AIDS. Such hegemonizing content does not leave space for the marginalized majority people to name other multiple solutions from their own perspective. (p. 673)

Chilisa’s article has revealed the various ethnocentric pitfalls of current practices in research about Africa. The challenge for most researchers is how to incorporate the indigenous psychology and philosophy of the marginalized majority of people in Africa. As Liddell et al.
have observed, “whether rightly or wrongly, psychologists commonly rely on Western models as a baseline for investigating behaviours in other cultures” (p. 691). In this study, I argue that in order to understand the behaviors of clients in Botswana, counselors must use both indigenous Botswana methods and Western models of investigating human behavior.

To achieve the development of culturally grounded interventions and strategies, indigenous knowledge and people’s wisdom must inform this process. Millar’s (2004) proposal to interface the local knowledge and science in Africa speaks to the “failure of interventions from the Western world to provide the envisaged benefits [and] has gone to buttress the need for an alternative to the dominant approach” (p. 1). As noted by Chilisa, “knowledge on HIV/AIDS based on Western ways of knowing competes with knowledge produced by indigenous people . . . Since the latter constitutes suppressed knowledges, this leads to slow progress in curbing the HIV/AIDS epidemic” (p. 680) in Botswana. Subrick shares similar views in his discussion in an article about AIDS and traditional beliefs of Batswana.

More often than not, those responsible for programs rarely solicit the views and beliefs of indigenous practitioners in the determination of effective interventions and strategies for addressing some of the problems faced by communities in their areas. A conference paper by Mokaila (2001) has suggested that indigenous practitioners were rarely part of the decision-making institutions, hence excluded their agendas when designing prevention programs and interventions. In most cases, if not always, program developers viewed these practitioners, or even the communities they served, as lacking in the appropriate knowledge and skill required in addressing their own issues and concerns. Yet, research (e.g., Salole, 1992; Subrick, 2006) has shown that whenever communities were involved in determining the strategies for solving their problems, there were significant benefits. History, and indeed, research, can attest to this. Invariably, the tendency by Western-based practitioners and program developers has been to relegate the local people’s views, practices, beliefs, values, and knowledge systems to the past.
Interestingly, the reviewed literature has shown that community practices and systems have continued to remain part of the contemporary culture of these societies. Like in other African countries, Botswana has faced the challenge of receiving “prepackaged” alien intervention strategies based on theoretical models rarely informed by indigenous wisdom. Consequently, these strategies have failed to fit into the day-to-day realities and experiences of a majority of Batswana. Maes (1995) has suggested that Batswana must “shape programs in a way that is sensitive to and complementary of cultural values and practices” (p. 19). It was with this logic in mind that the general focus of the present study addressed the following question: How do counselors in Botswana incorporate the indigenous cultural practices and structures of Batswana?

Statement of the Problem

Professional counselors in Botswana, like their counterparts in most African countries, deal with clients influenced by Western cultural values and behavior yet deeply entrenched in indigenous cultural beliefs and worldviews. As Millar (2004) asserted, “Africa is changing fast and there exists a mix of dominantly traditional, dominantly modern and more hybrid subcultures. Some aspects of indigenous knowledge are expressed openly, whilst other aspects are secretive and hidden from outsiders” (p. 4). In addition, Millar has observed that, “nowadays, thinking among Africans ranges from traditional to modern, but in many cases both systems of thinking can be observed parallel to each other” (p. 1). He noted that traditional worldviews and traditional institutions play an important role. Although Western cultural influence and increasing ‘modern’ technology and science has had significant impact on life in Botswana, many people still use indigenous cultural practices and healing systems to address psychosocial, physical, spiritual, and mental health needs. Indigenous healing systems and beliefs remain entrenched in Botswana society. Indigenous intervention strategies and rituals remain an integral part of the everyday activities. Today’s ceremonies such as weddings, funerals, and religious
services still use indigenous rituals and rites. All this has significant implications on how counselors respond to this complex cultural setting.

Contemporary experience with HIV/AIDS in Botswana has revealed that intervention strategies that do not incorporate indigenous cultural practices and local knowledge proved ineffective and inappropriate. AIDS and traditional belief: How an inappropriate AIDS prevention strategy undermined Botswana’s health published by Subrick in 2006, has provided valuable insights about the negative impact of leaving out local knowledge and indigenous healing practices in responding to social problems faced by clients in Botswana. One valuable insight was that relying solely on the scientific approach and Western understanding of human behavior and conceptions of reality, without incorporating how Batswana, as a people, perceived the problem, has proved futile. It also was clear from Subrick’s article that leaving out indigenous healers in tackling psychosocial problems has had serious ramifications, and that overlooking the strength of cultural influence has led to failure of the HIV prevention strategy in Botswana. This study seeks to find out how counselors incorporate indigenous practices and how they use culturally appropriate strategies and messages that resonate with the beliefs of Batswana. The challenge for counselors in Botswana is, therefore, how to become responsive to the cultural mix of indigenous Botswana culture and Western cultural values without imposing the Western worldview and value system as the criteria for attending to the needs of all clients.

In the area of health, some studies (e.g., Lefley, 2001) have suggested an interface Western medicine and indigenous healing systems while others (e.g., Levers & Maki, 1994; Leung, 2003) cautioned against a wholesale importation of Western models to non-western settings. What kind of blending of counseling practices would reflect this character of Botswana society?

Among the challenges faced by Botswana in addressing some of the social problems, including those associated with the AIDS pandemic, has been shortage of trained professionals, particularly those who understand the culture of the people in need. This has significantly
undermined the provision of culturally appropriate responses to AIDS and its related social problems. A great many of those with higher qualifications at graduate level either received their counselor training in the West or using curricula reflective of Western philosophy and psychology. A general profile of training programs has revealed limited incorporation of Botswana’s indigenous cultural practices and local knowledge. The central theme of this dissertation is that integration of the Western-based interventions with that which is historically and culturally reflective of Batswana is an important part of ensuring that counseling becomes culturally sensitive and relevant to Botswana.

Despite the postulations about the importance of integrating cultural practices and structures in dealing with human behavior, there is very little reported about the ways in which and the extent to which counselors in Botswana use such practices and structures. There is a paucity of literature on the incorporation of indigenous cultural practices and structures by counselors in Botswana. This begs the following question: How do counselors in Botswana apply indigenous cultural practices and structures? The insights from the study would help further the search for culturally responsive interventions and inform policy formulation and counselor education.

Purpose of the Study

The primary purpose of this study was to identify and examine the extent to which professional counselors in Botswana utilized the indigenous cultural practices and structures in their services and programs. There have been concerns whether counselors in Botswana incorporate indigenous cultural practices (Maes, 1995; Mapp-Robinson, 1987; Witmer, 1990). Studies (e.g., Chilisa, 2005; Subrick, 2006) have revealed that Western responses to HIV/AIDS in Botswana do not resonate with Batswana’s understanding and beliefs. To increase the probability that counseling programs will be effective in Botswana, these programs and counseling strategies must be culturally relevant, culturally sensitive, and complementary of the
cultural values and practices of Botswana (Maes, 1995). To achieve this purpose, it is first important to examine how counselors in Botswana provide culturally appropriate counseling. Further, the study explored counselors’ experiences, ideas, beliefs, and attitudes towards using indigenous cultural practices and structures. Another important area addressed by this study was whether counselors collaborate with indigenous practitioners. In addition, the study strove to identify and discuss the indigenous cultural practices used by counselors and the barriers to using these practices and structures.

Research Questions

The guiding question asked in this study was: How do counselors in Botswana incorporate cultural practices and structures into counseling? This was partly a response to a question posed in consulting reports (e.g., Maes, 1995; Mapp-Robinson, 1987) and studies (e.g., Subrick, 2006) on Botswana, made constant reference to the need to address this important question. The study is also a response to the current debate on cultural issues in counseling for non-western cultures. The study addressed the following specific questions that served to inform the guiding question:

1. What indigenous cultural practices and structures professional counselors in Botswana utilize?
2. What indigenous structures do counselors utilize in their practice?
3. How do counselors utilize indigenous cultural practices and structures?
4. How do you handle some of the cultural beliefs upheld by your clients?
5. What are your views about indigenous healing methods?
6. To what extent do you use the cultural practices and structures in counseling?
7. What are some of the issues and challenges you face when you utilize some of the cultural practices and structures?
Theoretical Framework of the Study

This interdisciplinary qualitative study, using in-depth interviews and content analysis, sought to examine the ways in which and extent to which counselors in Botswana incorporate indigenous cultural practices and structures into this work. In this section, I discuss the main theoretical assumptions and descriptive conceptual framework used in designing the study. Although the aim of this study was not to test any theories, systems perspectives and a bio-ecological approach to human behavior largely influenced it. The systems perspective of understanding social problems and human behavior has continued to gain prominence in research (Bertalanffy, 1968; Bertalanffy, 1975; Bronfenbrenner, 1979; Laszlo, 1972; Lewin, 1936; Patton, 2002) and in therapy (e.g., Wilson, 2003). Patton has observed that a systems perspective in research has become “increasingly important in dealing with and understanding real-world complexities, viewing things as whole entities embedded in context and still large wholes” (p. 120). To understand how counselors use indigenous cultural practices and structures, I sought to establish how counselors relate to the different systems, and how they view them within the context of their practice.

Central to a systems perspective are the notions of holistic thinking, interconnectedness and interdependence (Patton, 2002), and interrelatedness (Laszlo, 1972). Patton suggested that the parts of a system are “so interconnected and interdependent that any cause-effect analysis distorts more than it illuminates” (p. 120). He has maintained that a description and interpretation of a person’s social environment is essential for overall understanding of what is in an interview. This approach “assumes that the whole person is understood as a complex system that is greater than the sum of its parts” (Patton, p. 59). Within the context of this study, a person is a complete entity, and, therefore, understood not by just looking at the mind or body, but by attending to all aspects of his or her life. My belief is that there is need to address the whole system if one aspect
of a person’s life is affected. The system’s structures can be both a social support and facilitate therapeutic interventions.

The bio-ecological conception of the relationship between a person and his or her environment looks at relations between settings, and the interconnections within given settings. Bronfenbrenner (1979) suggested this perspective as a “conception of the developing person, of the environment, and especially of the evolving interaction between the two” (p. 3). Within this context, the environment has a significant influence “in the way in which a person perceives and deals with his (sic) environment” (p. 3). In this study, there is consideration of the different ecological environment (i.e., family, community, culture, and religious groups) as critical in addressing the client’s problem. The various relationships among the different environments go beyond family, and to include all other settings that the counselor could use to address the client’s concerns. As Bronfenbrenner has observed, there are complex interrelations among the different settings, which has great influence upon the individual. He has pointed out that, “regarded as of equal importance are connections between other persons present in the setting, the nature of these links, and their direct influence on the developing person through their effect on those who deal with him at first hand” (p. 7). His contention was that this perspective evokes the individual’s development; profoundly affected by events occurring in settings in which the person is not even present. Bronfrenbrenner’s position about the ecological perspective was:

A theoretical conception of the environment extending beyond the behavior of individuals to encompass functional systems both within and between settings, systems that can also be modified and expanded, contrasts sharply with prevailing research models. These established models typically employ a scientific lens that restricts, darkens, and even blinds the researcher’s vision of environmental obstacles and opportunities and of the remarkable potential of human beings to respond constructively to an ecologically compatible milieu
once it is made available. As a result, human capacities and strengths tend to be underestimated. (p. 7)

As an interdisciplinary study, this study drew its concepts, terms, and theories of conception of causation from medical anthropology and traditional medicine and healing systems. The literature from these areas has provided indigenous cultural understandings of wellbeing, causes of illness and misfortune, and the influences of belief systems and worldviews on the perception of reality. The literature search has revealed little written about the use of indigenous cultural practices and structures by counselors in Botswana.

Significance of the Study

Counselor educators and practitioners, students in counseling and human services, researchers in cross-cultural and diversity issues, international counseling associations, program developers, and those concerned specifically with cultural relevance of current intervention strategies may find this study theoretically significant and practically useful. This study contributes to the current debate and dialogue on cultural relevance of the Western-based counseling strategies and practices used in Botswana. The widespread attention and dialogue by helping professionals on the relevance of the intervention strategies and practices as reflected in conferences, seminars, consultancy reports, and contemporary research on HIV/AIDS point to the need to take a closer look at counseling practice in Botswana. Numerous studies (e.g., Chilisa, 2005; Levers, 2006b; Subrick, 2006) have highlighted the negative effects of leaving out indigenous healing and local knowledge systems in addressing problems embedded in the African cultural context. Yet, there were no published studies about utilizing indigenous cultural practices in counseling. This study is among the first to focus on counseling and indigenous cultural practices in Botswana.

In this world where communities face serious social problems and the daunting experiences created by the HIV/AIDS pandemic, it is worth noting that integrating indigenous cultural...
practices into counseling could lead to culturally appropriate counseling interventions. This study was to investigate ways in which counselors in Botswana are using culturally appropriate strategies. When viewed within the context of cultural relevance, the examination of the ways in which and the extent to which counselors utilize cultural practices and structures is an important topic to investigate. Further, this study fulfills the goals of the Botswana national policy on culture (Republic of Botswana, 2001), which calls for more research on indigenous cultural practices and systems of care in Botswana.

The theoretical significance of this study lies in its focus on the examination of issues of relevance and appropriateness of counseling practices in Botswana. Although culture is a major contributor to counselor effectiveness, there are few studies in Botswana, which have attempted to investigate its impact on counseling. This limited knowledge on how counselors use cultural practices has implications for counselor education and counseling practice. Counselors’ understanding of the cultural context and conception of reality by Batswana would invariably influence the effectiveness of their interventions.

This study contributes considerably to the knowledge about utility of cultural practices in counseling in Botswana and serves as a valuable resource for future research regarding this topic in other parts of Africa. Most significantly, it can stimulate more discussions on the issue of cultural appropriateness of intervention strategies used by counselors in Botswana today. Studying the utilization of indigenous cultural practices of Botswana in counseling provides an impetus for further research on healers and counseling, topics that have continued to be evaded by most counselors.

Delimitations and Scope of the Study

The study delimited to interviewing 30 counselors in Botswana who received Western-based training. The selected counselors were in senior secondary schools, higher education institutions, and government departments, hospitals, and non-governmental organizations that
offer counseling services. Both urban centers and rural settings in different parts of the country were included in the study. The minimal academic level for participants in this study was a diploma in counseling, which is currently the minimum professional level-of-training for counselors in Botswana. The study focused on the ways and extent to which counselors in Botswana utilize indigenous cultural practices and structures. Counselor’s ways and utilization of cultural practices and structures are not discrete elements. The sampling procedures and size was perceived as appropriate for generating enough data to determine the views, beliefs, experiences, and attitudes of counselors in Botswana.

Definitions of Terms

*Indigenous:* that which is historically and culturally reflective of a particular society even prior to the external influences; or simply put, not of ‘foreign’ origin, or germane to the culture and ethos of a group.

*Indigenous cultural practices and structures:* those practices and structures that have always been part of the culture of Botswana society reflective of her values, customs, beliefs, and way of life even before external influence associated with colonialism, missionary activities, and Westernization. In this study, this refers to all the indigenous practices and cultural structures that existed before the introduction of Western counseling strategies. Most of these practices and structures have continued to be part of Botswana culture until today.

*Professional counselors:* professional counselors trained using contemporary Western-based theoretical models and abiding by their ethical codes and standards. Considering that the materials and curricula for training counselors is relatively the same in Botswana as in Western settings, there is not much difference whether the counselor is a Botswana national or not. The word counselor in this study refers to professional counselors.

*African worldview:* perception of the world influenced by African thought, cosmology, ethos, and belief systems.
Non-western: anything practice or that does not originate from or is not associated with the Western culture and setting.

Indigenous healer: The term here is synonymous to traditional healer. Includes diviner, traditional doctor, spirit medium and prophets, herbalist, spiritual healers, and any other indigenous practitioner whose role is to facilitate healing or provide therapeutic interventions of various sorts and natures.

Batswana: refers here to people of Botswana, as opposed to Setswana-speaking ethnic groups, as the term is sometimes used.

Indigenous practitioners: all those who practitioners provide services using Botswana indigenous ways and practices, including birth attendants and all healers.

Helping professionals: includes all those whose main role is to assist clients with their personal, social, physiological, mental health, and psychological concerns.

Organization of the Dissertation

This dissertation has five main chapters subdivided into various subsections. Chapter I provides a background to the problem, covers the theoretical framework of the study, and the statement of the problem and purpose of the study. The chapter also presents the significance of the study, delimitations and scope of the study, definition of terms, and organization of the dissertation.

Chapter II presents a review of the relevant literature. The review focused on studies: that explored the cultural practices and structures in Botswana; that examined Batswana cultural views on causes of illness and misfortune; investigated how missionaries influenced changes in cultural practices and structures in Botswana. I explore the colonial legacy and the introjections of Western values to highlight the influences of colonialism, Westernization, and missionary teachings on Batswana’s self-image, self-identity, and negative attitudes towards indigenous cultural practices and systems. The review also discussed role of culture in determining
counselor effectiveness, and the importance of respecting the clients’ worldviews and belief systems. Issues and assumptions about diagnosis discussed with a view to highlight the how cultural differences have a bearing on diagnosis and intervention. I reviewed some of the studies that focused on interdependence and interconnectedness as determinants for wellbeing to show how counselors can respond to the client’s needs using the systems perspective and the ecological counseling approaches. This was to address the concepts of interrelatedness and holistic thinking which are critical in systems perspective and bio-ecological approach. The literature exploring the debate on integration and collaboration between counselors and indigenous practitioners reviewed to identify some of the challenges and barriers to establishing a working relationship among the different systems of care available to clients in Botswana. The discussion of the changing ideological perspectives in counseling addresses the contemporary issues associated with the call for paradigm shift in Africa. The last part will be a summary of the chapter.

Chapter III presents the method and research design. This chapter has eight sections. The first section, qualitative inquiry and systems perspective describes the systems perspective to qualitative inquiry and applied research design. The section on assumptions of the qualitative inquiry delineates the theoretical assumptions to qualitative research. The design of the study also describes the setting and selection of participants, and ethical issues and rights of subjects. The chapter also presents descriptions of the data collection methods and data analysis, covering instruments and description of pilot study, content analysis, and interpretation of data. The description of the reporting of data presents procedures for presentation results. The chapter concludes with a summary.

Chapter IV presents the results of the interview data. Subsections include the following: (1) characteristics of the participants, which include the demographic and vocational characteristics, (2) the results for each question of the interview, (3) a summary of the chapter. Chapter V offers
a summary, discussion, and the recommendations of the study. The summary section includes, the overview of the study, covering the problem and the purpose of the study, methodology, and data analysis, summary of the results. The implications for policy formulation, curriculum design, counseling practice and theory, and recommendations for further research follow the discussion section. The chapter concludes with a summary. After the references section there are appendices for the study.
CHAPTER II
LITERATURE REVIEW

This chapter provides a review of the literature related to the study. The chapter has seven main sections. The first section looks at the cultural practices and structures in Botswana. I will then show how cultural views on causes of illness and misfortune, including beliefs in witchcraft and sorcery, ancestral spirits and transcendental forces, and disconnectedness with social and spiritual environments influence client’s conception of reality and their wellbeing. I will explore literature on missionary activities and the impact they had on Botswana cultural practices. I will discuss the literature on the role of culture as a key factor in counselor effectiveness, and the influence of cultural expectations on the counseling outcome. I will review literature showing how the environment (i.e., social, physical, spiritual, cultural) contributes to the counseling process.

I will review literature suggesting that embracing the clients’ worldview and belief systems is critical in counseling. This will include discussing the importance of recognizing and accepting the client’s assumptions and beliefs about life and the world around them. I will explore the mind-body connection and the holistic perspective, and the use of symbols and rituals in healing. The review of literature identified some of the issues and assumptions about diagnosis and cultural differences. The concepts of interdependence and interconnectedness explored as determinants for wellbeing highlighted that everything is interrelated and therefore maintaining balance and interconnections is central in establishing one’s wellbeing. The sixth section discusses issues about partnerships between counselors and indigenous practitioners. I intend to look at possible ways of collaboration between counselors and indigenous practitioners in Botswana. The chapter ends with a summary of all the main sections of the review.
Cultural Practices and Structures in Botswana

This section discusses the crucial role of the extended family network as a social support system for clients in Botswana. The section also explores the healing system and its function in the individual’s wellbeing. The cultural conceptions of illness and misfortune will follow this. These conceptions include witchcraft, sorcery, transcendental forces, and disconnectedness as perceived factors in causation of illness and misfortune.

Extended Family Network

The extended family network remains a very important social support system and an easily accessible cultural structure for most people in Botswana. Many people experience compassion and unconditional support from parents, siblings, and relatives whenever faced with challenges in life or any form of mental and psychological distress. In case of young people, the expectation is that family nurtures and helps them grow up into responsible and productive members of their communities. Caring, protection, guidance, and counseling have remained the most significant roles of family in Botswana. Turnbull (1971) has maintained that family in every African society is as almost sacred and that every member has certain obligations to the other members, while enjoying certain rights and privileges. His conclusion was that since a family feels bound together all through life; children grow up and get married, and continue to remain responsible for their parents. In such a setting, according to Turnbull:

Nobody is ever left alone, not even the very old or sick. If a person really has no relatives left, or is an orphan, or a stranger, he will be adopted into a family, and from then onward will be considered and treated just like any of the others. This ‘family feeling’ can be seen right through African societies, helping bind them together, giving their members a feeling that they belong. (p. 9)
In her study examining implications of Botswana cultural beliefs and practices for methods of caring for AIDS orphans and vulnerable children, Tshitswana (2003) has identified extended family as one of the cultural structures expected to serve orphans and vulnerable children. This has implications for counseling in Botswana. Counselors in Botswana have to consider the role family could play in facilitating therapy and wellbeing. Perceptions of care, in the case of orphans, according to Tshitswana are deeply rooted in the cultural beliefs of Batswana. Tshitswana’s suggestion was that any effort to establish alternative forms of care not solely through family ties should be aware of the cultural perceptions, and should attempt to gain society’s support. Her contention has been that sense of belonging, sibling bonds, support, and security where members share many resources and assets, characterize the kinship system in Botswana. Paternal aunts, uncles, grandparents, and cousins took on the care-giving functions of the deceased parents, thus making the extended family a social security system (Foster, 2002; Tshitswana, 2003). In addition, members of the family were responsible for the protection of those who were vulnerable, cared for those who were sick, and catered for the poor (Foster, 2002; Tshitswana, 2003). It is within this context that Foster has described extended family as an important safety net.

Foster (2002) and Tshitswana (2003) have identified the transmission of social values as another crucial responsibility for extended family. Furthermore, Tshitswana has observed that it remains paramount to note that:

To date, there are few alternative methods of care that have been found to yield desirable outcomes in child welfare and survival. The assumption in Botswana, as in many other parts of Africa, is that families can and will always support their own relatives. It is still argued that the extended family, being the best first line of response should be supported and encouraged to
continue this practice. However, there is substantial evidence that extended family safety nets have been stretched beyond their capacity and therefore are not coping any more. (p. 13)

Such an observation that family has lost its capacity to cope with some of its roles has serious implications for counseling in Botswana. One most critical issue has to do with how counselors could bridge the gap created by the inability for family to meet its social obligations and responsibility of caring for its members. Counselors may have to facilitate the establishment of other social support systems to augment what the family does.

While one can maintain a position that the extended family continues to remain a viable structure in Botswana society, there are indications that it has been subjected to both internal and external pressures that sometimes render it ineffective in providing ample support and care to those in need. This breakdown in this social structure has created a gap in the protection of those who are experiencing distress or vulnerable members of society. Kealotswe (1995) has attributed the breakdown of both nuclear and extended families to the increasing loss of the sanctity of marriage and family, charging that the increase in the number of divorces is due to urbanization, rapid social change, and education and declining Batswana and Christian moral values. His belief was that the loss of extended family values contributes to individualism with its emphasis on personal rights over those of the community. The youth have “no real models on which to shape their lives . . . there is urgent need for pre-marital counseling before couples are united together in marriage” (Kealotswe, 1995, p. 10). In spite of the changes that have taken place in the family system in Botswana, its role in the wellbeing of the individual be acknowledged. It is within the context of this study to examine the role played by other structures in the wellbeing of clients. A review of literature on healing systems in individual wellbeing will follow.
The Healing System and its Role

Many cultures of the world have established healing systems. Somé (1999) has declared that indigenous healing systems have and will remain central in addressing the physiological, psychological, and other vulnerabilities in Africa. He has asserted that healing has always been part of human existence and is the core of creating harmony and balance in the individual, and in the community. Part of this study was to investigate the interconnections among the Western-based interventions and indigenous healing systems of care.

There has been ample evidence in the literature attesting to the critical role played by healers among Batswana. For instance, some writers (e.g., Amanze, 2002; Bolten, 1998; Dembow & Thebe, 2006; Levers, 2006b; Staugård, 1985; Subrick, 2006) have acknowledged the influence the healers have, and the respect they receive from their respective communities in Botswana. These writers have noted that despite the efforts by external forces such as missionaries and Westernization many Batswana continue to use indigenous healing services as part of their health care and mental health system. The media and other reports have shown that regardless of education level, religious background, social status, and political affiliation people in Botswana utilize these services for a variety of reasons. A news article by Sigi Devos in 2004, an NBC news producer based in Botswana, had this interesting report about Botswana; “in a country where up to 70 percent of people, including the well-heeled and educated consult a traditional healer in matters ranging from health to wealth, these gatekeepers of community life are integral to any behavioral change” (¶ 16).

Samita’s (1997) review of *Healers and traditional medicine in Botswana* by A. B. T. Byaruhanga-Akiiki and O. N. O. Kealotswe reported that some healers in Botswana provide ‘protective medicine’ for protection against malevolent spirits, imminent danger, calamities, misfortunes, as well as improve opportunities for success in one’s business ventures or job. The question for this
study remains: How do counselors work with these healers to help their clients who generally use both the healing and Western interventions to address their issues?

According to the Director of Policy, Evidence and Partnerships at UNAIDS, Purnima Mani, “people all over the world have always sought advice from both biomedical doctors and traditional healers for all kinds of physical, emotional and spiritual problems” (UNAIDS, 2007, ¶ 3). Invariably, in many parts of Africa people seek help from healers for all kinds of social dilemmas to major medical illnesses (Hewson, 1998). Hewson has suggested that the indigenous healer has multiple roles, including serving as a physician, counselor, psychiatrist, and priest. Sobiecki (n.d., Shamanic societies section, ¶ 1), on the other hand, has described the healer as a community leader, spiritual leader, social worker, and intercessor between humans and the spirit world. Samita’s book review has stated that the healer intercedes with God, the Supreme healer, through ancestors to restore connection and balance in the life of the individual. Berg (2003) has even suggested another role; that the “traditional healers are highly trained therapists” (p. 196). Berg’s position has been that the healers’ extensive and rigorous years of initiation into the healing process qualifies them as skilled psychiatrists. Berg has strongly discredited (and rightly so) any use of the word ‘witchdoctor’ in reference to the healer arguing that the term reflected colonial views “evoking exotic images of cunning, dark forces” (p. 196).

Like Western medical practitioners, healers in Botswana are not just one homogenous group but are different specialists, including diviners, herbalists, spiritual healers, and many others. The general tendency is to lump all of these different types of practitioners into one category. This would be like putting pharmacists, surgeons, medical practitioners, and psychiatrists into one group and to describe them as if they perform the same role. The other common thing has been to ascribe the
negative qualities of one of these groups to all of them. For instance, just because some indigenous practitioners are associated with unethical practices such as witchcraft, all of them viewed in those lines. However, today there are efforts by Botswana government and health care systems to engage indigenous healers in providing health care and information to the communities they serve. Subrick’s article on AIDS and traditional beliefs has highlighted some of the problems associated with leaving out indigenous healers when addressing issues affecting the Botswana communities. This raises an important question that is part of this study: How do counselors collaborate with indigenous practitioners to provide care and information to clients?

World Health Organization (WHO) has endorsed the involvement of indigenous healing systems in addressing health issues; especially those associated with the HIV/AIDS prevention and control programs. Recent UNAIDS reports (e.g., UNAIDS, 2000, 2007) have identified projects and training initiatives aimed at bringing healers on board in the fight against the HIV/AIDS pandemic. Indigenous healers trained through such initiatives assisted as educators and counselors to disseminate information on HIV and sexually transmitted infections to communities and their peers (UNAIDS, 2007¶ 4). This effort intended at promoting cooperation between indigenous healing structures and modern medical institutions such as hospitals and health centers. A UNAIDS literature review on Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan Africa has revealed that:

Traditional healers are generally respected health care providers and opinion leaders in their communities, and thus are treating large numbers of people living with HIV/AIDS. Healers have greater credibility than village health workers (who are often their counterparts in village settings), especially with respect to social and spiritual matters. (UNAIDS, 2000, p. 10)
The results for collaboration between indigenous healers and the medical systems have been that it stimulated referral networking with formal health sector and healers (UNAIDS, 2007, ¶ 11).

I believe that for any initiative to succeed it is dependent largely on how it uses the local resources and knowledge systems. As history has shown, making use of indigenous knowledge systems and resources has always been neglected, thereby resulting in failures of intervention strategies. Subrick (2006) has eloquently articulated the negative consequences of leaving out local knowledge and overlooking the influence of healers in addressing HIV/AIDS in Botswana. As it has been the case with the emergence of Independent Churches, many people left mainstream churches because they felt that the latter did not incorporate indigenous cultural practices and rituals (Dembow & Thebe, 2006; Moyo, 1996). It is important to investigate how counselors in Botswana incorporate indigenous knowledge, locally available resources, and the richness of some of the healing practices and social institutions. I believe that failure to make counseling respond to the cultural experiences and expectations of clients may result in some of them seeking help elsewhere, especially from indigenous healers.

Several writers (e.g., Dembow & Thebe, 2006; Moyo, 1996) have attributed the emergence of African independent churches, especially those inclined towards prophetic practices, to both the perceived lack of cultural sensitivity by mainstream churches and the latter’s failure to meet the local people’s spiritual needs, the irrelevance and lack of meaningfulness of the Western influenced church practices. Moyo (1996) has identified as some of the reasons for the mushrooming of these independent churches to include the fact that African Christians did not find much of an African ethos in the missionary founded churches. These African Christians, according to Moyo, wanted churches in which they could express their Christian symbols and images, churches where they could feel at home, so to speak. The Christianity as:
Proclaimed by the missionaries was for them not comprehensive enough to meet their spiritual needs; hence, many people even today secretly continue to participate in African traditional rituals. There was no serious attempt on the part of historical churches to understand African traditional spirituality and culture. Instead, many traditional beliefs and practices were simply labeled ‘heathen’ or ‘superstitious’ and were thus forbidden. (Moyo, 1996, p. 287)

As Moyo has observed, the emergence of indigenous churches was a response to the “missionaries’ discouragement of practice such as faith healing, prophecy, and speaking in tongues (all of which were practiced in the early church); and, finally, the missionaries’ disapproval of polygamy, ancestor veneration, witches, and traditional medicine” (p. 288). The prophet inspired by the Holy Spirit, according to Moyo, assumed the functions of diviners and mediums, resulting in the substitution of traditional rites and Christian rites.

Even many years after European missionaries left Botswana, the mainstream Christian denominations continued the struggle of trying to eliminate the integration of indigenous practices and rites into the church. Dembow and Thebe (2006) have reported that despite the concerted efforts by mainstream churches to get rid of the fusion of divination and healing into the church “most indigenous Christian churches such as the Zionist Christian Church (ZCC) have co-opted spiritual healing with its songs and dances of purification and renewal as part of their ritual liturgy” (pp. 191-192). For Christianity to be meaningful and relevant it had to address issues of vital concerns to Africans, including protection against witchcraft, sorcery, and other forces of evil that they believed in (Moyo, 1996). One may safely argue that for Western-based counseling to be relevant in Botswana it has to be culturally responsive, and that counselors have to understand some of the cultural issues such as belief in the influence of ancestors, witchcraft, and other perceived malevolent and transcendental forces.
Bolten (1998) has observed that Christians and non-Christians alike in Botswana, used protective and fertility magic, believed in witchcraft thus sought out help from indigenous healers in case of illness. She has posited that indigenous rituals still regarded as the premium method used to ensure health, because the approach taken by the healers not only cured the body but also repaired social ties and one’s relationship with their ancestors. Staugård (1985), on the other hand, has noted, “Because the advice of the traditional healer is well integrated in the religious and moral concepts and beliefs prevailing in society, the Ngaka [indigenous healer] thus assumes a stabilizing role in social control” (p. 54).

Despite the rapid expansion of the provision of Western medicine to various parts of Botswana and the educational programs aimed at informing the public about AIDS, many Batswana still rely on indigenous cultural ways of healing to address their health and psychosocial concerns. The response to the AIDS crisis has included a “concomitant resurgence in ancestral cleansing ceremonies (phekolo) led by prophets (baporofiti) who claim to communicate with ancestral spirits (badimo) who help them treat (go alafa) diseases such as AIDS that appear to lie outside the capabilities of Western medicine” (Dembow & Thebe, 2006, p. 45). The inherent cost and ineffectiveness of Western therapies even turned more people to seeking help from their “ancestors and divinely inspired prophets for relief” (Dembow & Thebe, 2006, p. 45). According to Dembow and Thebe, even the response to the increasing death toll due to AIDS reflected grounding in traditional belief.

To date, indigenous healers and spiritual healing churches have remained a significant resource for individuals undergoing psychological distress and illnesses of whatever kind. Bolten’s (1998) discussion of Christianity and healers may shed light on the possible reasons for the fusion of Western approaches and traditional healing among Batswana. She has reported that Batswana have
“always welcomed to knowledge of foreign doctors in order to increase their own repertoire” (p. 49). She has observed that Batswana saw Christian prayers as performing the same function as rituals of the ancestral spirits; for example, of asking for rain, and others that were now performed by the church leaders. This, according to Bolten, has led to the development of a distorted view of Christianity where Batswana saw little difference between the two religions, hence many who converted to Christianity continued to practice traditional divining and rituals. The blending of belief systems and practices among Batswana, has been explored by Dembow and Thebe (2006) when writing:

Today Christianity has taken on a number of blended forms as modern prophets and priests combine elements of traditional belief in ancestors and spirit possession with prophetic interpretations of Christian doctrine while seeking advice, guidance, and spiritual inspirations to help people cope with their problems. (p. 45)

In Botswana, indigenous healing systems and other culturally grounded methods of handling distress have continued to exist side by side with the Western-based approaches and programs. According to Dembow and Thebe (2006):

Many Batswana would probably describe themselves as following traditional religious beliefs, but a substantial number are also affiliated with one of the denominations of Christianity. But even the most Westernized Christian sects incorporate rites, such as the fruits ceremonies and prayers for rain, that have been adopted from traditional practices. (p. 38)

It is therefore not surprising that a client in Botswana may seek help from several sources of help in an attempt to address a problem. For instance, a client might visit an indigenous healer, a spiritual healing church, or seek help from a family member in addition to going to see a counselor or other
care services in the community. This eclectic approach to addressing a problem is rooted in the cultural practices and belief systems of Batswana. Furthermore, the success by indigenous interventions to respond in a culturally appropriate way to the common questions by many clients: ‘Why me?’ ‘Why this time?’ ‘What have I done to deserve this?’ Some writers (e.g., Eagle, 2005; Lichstein, 1992) have reported that by addressing these questions it helps clients to cope with anxieties and uncertainties created by distress. It is important for counselors to understand what models of explaining phenomenon their clients use. Failure to explain within the context of the client’s culture may have ramifications for the efficacy of the intervention and client’s response to therapy.

Bolten (1998) has reported that for illnesses brought in by Europeans, which healers possessed no cure for, Western treatments were superior in treating them. However, for those illnesses where there were no Western trained practitioners Batswana relied on healers (Bolten, 1998). In such cases, Bolten has observed that indigenous healing remained superior. Some writers (e.g., Amanze, 1995) have delineated a number of factors that contributed to the erosion indigenous belief systems and intervention strategies. Acculturation and Botswana government’s ban on spiritual practices and a push toward government services such as hospitals encouraged the dismantling of indigenous practices (Bolten, 1998). Amanze (1995) has maintained that government’s ban on divining has led to the incorporation of divining and other indigenous belief systems and rituals by most independent churches in Botswana. Citing A. B. T. Byaruhanga-Aikiiki and O. N. O. Kealotswe’s book, Samita (1997) has attributed the negative attitude towards indigenous healing practices to the teachings of spiritual healing churches; accusing healers for associating with ancestors in their healing methods. The association with ancestors was in contravention with the belief in Jesus Christ as savior and only healer (Amanze, 1995). These differences in worldviews about healing have sometimes generated
tension between and among those who staunchly espouse fundamental Christian beliefs and those who utilize both practices (Amanze, 1995; Bolten, 1998).

There were those writers (e.g., Blaustein, 1992) who have challenged the notion that other medical traditions are rapidly disappearing in the wake of advances in Western medicine. This view supports the phenomenon of the resilience of indigenous healing systems in Botswana (e.g., Amanze, 2002; Bolten, 1998; Staugård, 1985) when faced with the competing external forces created by the introduction of Western therapeutic systems. Other writers elsewhere (e.g., Blaustein, 1992; Erasmus, 1977; Hufford, 1992; Landy, 1977; Mathews, 1992) have also acknowledged the persistence of indigenous healing therapies in the wake of the expansion of Western medical systems and the attempts to uproot these indigenous healing modalities. Nonetheless, literature has reported tensions and contest between Western approaches and the existing indigenous cultural practices in non-western cultures.

The literature has shown that despite the pressures against indigenous practices many people have continued to utilize their cultural healing and therapeutic practices amid the development of Western approaches. This implies that while non-western cultures have embraced Western approaches they still accessed their practices, especially when the latter yielded limited positive results. For example, the description given by Skjønsberg (1989) about Headman Kefa has illustrated this point:

Most villagers make use of traditional as well as Western medicine. If the one does not produce results they switch to the other. Headman Kefa is one of them…. In spite of the pills that he was given his other hand started swelling as well and he became convinced that he was bewitched. As it is generally accepted that Western medicine has no power over witchcraft, Kefa resorted to traditional medicine. (p. 159)
As noted by Erasmus (1977) in his writings on folk beliefs, “despite an often ready acceptance of Western medicine these South American populations do not necessarily accept the accompanying ‘scientific’ explanation, and that indeed for many illnesses” (p. 264). Erasmus has noted that despite the availability of modern medicine these populations preferred nature medicine and healing.

Botswana’s indigenous healing practices have continued to serve an important social function in the lives of individuals and communities. One cannot wish these practices would just disappear and be replaced by Western based therapies. Mathews’ (1992) observation has shed light on this:

Traditional beliefs and practices do not develop in isolation but are part of an integrated set of social institutions within a cultural system. Consequently, they serve many functions for adherents and are often highly resistant to change even when the cultural tradition itself is no longer viable. (p. 1)

Landy (1977), on the other hand, has attributed the revival of indigenous practices to governments’ facilitation. As in the case of Botswana and other countries in Southern Africa (e.g., South Africa) the continued attempts to integrate indigenous healers into the health care and prevention programs is evidence of government’s efforts to bridge the gap that exists in the health system. This move by government could be an attempt to tap on the expertise provided by both systems. Botswana government has recognized the coexistence of the indigenous healing systems and Western-based healthcare practices. The current Botswana policy on culture attests to the realization that the bridging the gap between these two coexisting systems used by Batswana would enhance their utility and congruence with Botswana’s cultural ethos.

The National Policy on Culture (Republic of Botswana, 2001) has directed that “Botswana, like other societies, has both a traditional and medical health care systems, which must be synthesised to achieve a well coordinated and functional health care programme” (¶ 6.9). The
policy has further stated that “all necessary mechanisms should be put in place such that the two health care systems can complement each other, based on the cultural beliefs, norms, and practices of the Botswana” (¶ 6.9). As reflected in the strategies proposed by the abovementioned policy, the government’s intention is to “facilitate and support research, including the social, psychological and scientific curative effects of local herbs and plants on various real and perceived ailments/illnesses” (Republic of Botswana, 2001, ¶ 6.10b). The other strategy stresses the “value of certain traditional healing procedures and how they can influence, compliment [sic.] and district healthy life practices” (¶ 6.10c).

Counselors cannot ignore the relationship between healing and religion in Botswana. This means that to understand the relationship between healing and Western-based counseling there is a need to recognize the role played by religious beliefs and spirituality in the daily lives of Batswana. With regards to addressing policy issues on religion and traditional belief systems, the Botswana government has based its strategy on the understanding that:

Every society has traditional beliefs which act as its cultural bond. Even before the advent of modern civilization, Botswana had traditional beliefs some of which need to be researched on, improved and enhanced. Beliefs which are not in conflict with modern religion and social ethics should be retained. (Republic of Botswana, 2001, ¶ 6.10)

While these legislative directives mainly focused on traditional medicine and modern medical science, of significance to this study was their relevance to investigating, the indigenous cultural practices and systems related to counseling and other psychosocial support structures. I subscribe to Salole’s (1992) view about building on the existing indigenous practices and structures already available, familiar, and evolved by the people we intend to help. Salole’s has advised that:
We should, at the very least, have an inkling about what is already going on before we invent bad copies of coping mechanisms that people have evolved for themselves. It is ironic that, despite the abundance and vitality of voluntary associations, they have been completely overlooked as partners or agents in development work. Indeed, the very intimacy and familiarity that the ordinary person has with these institutions are so much part of the social fabric that they are often not recognized or identified even by their own members as an integral part of the development process. In some cases these institutions are regarded as archaic and redundant even by individuals who themselves take part in the activities. (p. 8)

Reading the policy it was clear that government intends to preserve and to promote the best of the existing indigenous cultural practices. These practices and structures could lay foundation for more effective and culturally appropriate intervention strategies for addressing the health and psychosocial needs of Batswana. This therefore suggests the importance of this study in examining the existing strategies that fit Batswana cultural views of causation, and used effectively by counselors to address the psychosocial needs of their clients.

Causes of Illness and Misfortune

Although Botswana society is culturally diverse and pluralistic in its religious practices, traditions, and languages the different ethnic groups do share a lot in common in terms of perceptions about the origins of illness, misfortune, and other forms of distress. Evidently, like in most African societies religion and illness causation, are closely interwoven, with the belief in the role of the supernatural world, the ancestors, and other perceived transcendental powers that play a significant part in the lives of the living (Sobiecki, n.d., Introduction section, ¶ 9).

Furthermore, there are certain beliefs, values, and attitudes which influence how Batswana explain the universe and its supernatural mysteries and perceived cosmic forces that sometimes
bring human suffering and pain, unleash untold calamities and other traumatic human conditions. Invariably, some people believe that there always are certain transcendental powers beyond them, which generally have great influence in their lives. The general belief is that these powers would affect individuals if they violated certain taboos, or became disconnected with the spirit world and other elements of the universe. Many societies have a “multitude of beliefs and practices to express, explain and give meaning to the cosmos” (Greenwood & Airely, 2006, p. 13). This is very true of Batswana. This study explored the ways in which counselors handled clients’ cultural beliefs.

In his article on indigenous healing in Southern Africa, Sobiecki (n.d., Introduction section, ¶ 3) has advised that to understand indigenous healing, one needs to understand the worldview of the people in this region. His argument was that cultures vary in their explanatory models, that is, how a culture makes sense of illness and misfortune and how they treat themselves. What was clear from most of the writings about Africa was that various factors cause illness. These factors included sociocultural, physical, supernatural, and spiritual forces. Sussman (2004) has observed that the most common beliefs about illness and other misfortunes in Africa included natural and supernatural factors or agents. She has maintained that within the African setting, illness is as an imbalance or disharmony in an individual’s life.

Somé’s (1999) writings on the healing wisdom of Africa have presented illness within an indigenous African setting, as “the inability to perceive, the inability to understand” (p. 29). These inabilities, according to Somé, are symptomatic of an illness. He has articulated that, “if your psyche is disordered or deficient or overcharged, blocks are created in you that prevent comprehension and remembering” (p. 29). His contention has been that only an indigenous healer could handle these
kinds of illnesses. Skjønsberg (1989), on the other hand, has associated these illnesses to spirit possession, which he believed could manifest itself in the form of a trance, or a seizure.

*Ancestral Spirits and Other Transcendental Forces*

In contrast to Western thinking whose primary goal is to deal with the intrinsic forces and the individual phenomena (Staugård, 1985), Batswana may attribute the cause of illness to both a physical phenomena and the metaphysical realm. When addressing a problem it is common for people to seek other explanations that would involve exploring the metaphysical sphere. Staugård (1985) has pointed out that “the ‘real’ cause will usually be sought in the context of the horizontal relations of the individual with the community physically surrounding him or in the context of his *vertical* (emphasis in original) relations with the *Badimo* [ancestors]” (p. 67).

Displeased ancestral spirits could cause illness (Eagle, 2005; Lieban, 1977). They could do this in a variety of ways such as invoking by the living or on their own volition without invocation (Middleton, 1967). As Middleton (1967) has pointed out, an elder has the power to invoke spirits to bring sickness to any of the descendents if they or their family behaves in a manner that displeases or was improper or dangerous to the wellbeing of the group. Moreover, the belief was that it was bad omen to threaten a young person with ‘angry words’ for this is believed could invoke the wrath of spirits and cause illness or misfortune to them (Middleton, 1967). According to Middleton, a ‘silence in the face of an offence’ or even a mere statement to the fact, ‘you will see me later’ from an elder or kinsman could be ominous thus could invoke spirits. When such an encounter occurred the advice was to engage in immediate reparation to avert the invocation of the malevolent forces. It was generally common to hear a client express fear because they had a conflict with a parent or an elder in the family. Normally, clients would express the need to make peace with that family member they
have offended as a way of resolving the problem they are having. For the most part, failure to make peace was believed to cause illness or misfortune.

Ancestral spirits could convey God’s reward through blessings. Worst still, ancestral spirits could convey His wrath by punishing “their earthly relatives themselves” (Staugård, 1985, p. 50) or by cursing or reversing their fortunes (Amanze, 2002). Amanze has intimated that “when wrongdoing happens in the family the ancestors resent it and punish the evil-doers, since they are guardians of public morality and of traditions of the elders” (p. 69). Liverpool et al. (2004), on the other hand, have attributed this perception that ancestors were guardians of codes of morality and values to the fact that they were widely respected and well-known members of the community.

While contemporary Christian practices have sometimes taught against ancestor veneration, evidence that many Batswana have continued to find solace in believing in the power and protection of their ancestors has dominated literature on traditional healing and medicine (e.g., Amanze, 2002; Dembow & Thebe, 2006; Samita, 1997; Staugård, 1985). The literature has shown that in times of disasters or life-threatening circumstances and vulnerability, the individual or group sought guidance and peace in their departed members of the family. Several scholars (e.g., Amanze, 2002; Beattie & Middleton, 1969; Berg, 2003; Fortes, 1971; Samita, 1997; Sobiecki, n.d. [a], ¶ 9; Staugård, 1985) have reported that ancestors pervade the life of many Africans, and have great influence in the affairs of their living descendants. This reported influence has been associated with the perceived mediating role of ancestors and their important place in the day-to-day lives of people. Fortes (1971), for instance, has suggested that ancestors “are regarded as fully functioning members of their kin groups even though they are deceased” (p. 207). Among many African communities, ancestral spirits “continue to take close interest in the destiny of their relatives in the village and actually supervise and guide every aspect of their life” (Staugård, 1985, p. 50). Dembow and Thebe (2006)
have used this interesting analogy to describe this intimate relationship between the ancestors and their living descendants:

Like the air one breathes, religious cosmology and a belief that the ancestors (*Badimo*) participate in the daily affairs of the living are part of the taken-for-granted matrix within which life is lived and understood. Almost all aspects of personhood – success or failure, health or sickness, charisma or repulsiveness, wealth or poverty – are understood to have spiritual dimensions. (p. 37)

In-keeping with the widespread belief about ancestors, Berg (2003) has claimed that in the context of African thought the dead played a very important part in the whole universe of forces, and that they continue to interact causally with ‘the living’. Berg has further observed that “there is a human, alive relationship between the individual and his/her ancestors” (p. 197). In addition, she has indicated that the ancestors acted as guides and mentors, and that their presence was the most important factor in maintaining good health. Thus, the living descendants honored them through ceremonies; in return, they received for their protection, mentoring, bestowing blessings, and wisdom and guidance (Bemak & Chung, 2004; Berg, 2003; Moyo, 1996), and other benefits such as good health, prosperity, and fertility (Amanze, 2002; Beattie & Middleton, 1969). Yet, ancestors are responsible for disciplining, and causing illness among the living (Bemak & Chung, 2004). To offend the ancestors, according to Amanze, would result in loss of favors, and may bring serious calamities in one’s life. Berg has pointed out that withdrawal of the protection could lead to a break in connection with the ancestors, and an exposure to evil forces such as witchcraft. In the event the living descendants experienced misfortune, sickness, death, or calamity they consulted ancestral spirits and divinities to communicate with the spirit world to determine the cause of the problem and to seek possible solutions (Moyo, 1996). For some people the goal would be to ensure that they do
not neglect their ancestors, hence they appease them all the time. The need to maintain the strong connection with and reverence to one’s ancestors has implications for counselors dealing with clients who believe that they are suffering or have misfortune because of their ancestors’ anger or displeasure. At times, an individual or family may seek the help of a spiritualist to act as an intermediary or go-between “communicating with ancestors to establish the cause of the problem as well as subsequent solutions” (Bemak & Chung, 2004, p. 126). This study sought to establish how counselors helped clients who believed that their problems were due to either spirit possession or the influence of their ancestors.

Like most African societies, Batswana believe that because God (different names are used by different ethnic groups) is “too remote to be approached directly” (Staugård, 1985, p. 50) they have to engage ancestral spirits as intermediaries. This is because ancestors are closer to God in proximity and nature. As Amanze (2002) once put it, “because of their close association with the living and their proximity to God, the ancestral spirits are considered as the most effective and the most reliable means of communication between God and man (sic)” (p. 69). Any break in connection and communication with the ancestors could result in a disconnection with God thus leading to a failure to get His blessings. The veneration of the ancestral spirits maintains the connection.

Africans do not worship ancestors but venerate them (Amanze, 2002; Berg, 2003; Moyo, 1996). The label ‘ancestor worship’, as Berg has rightly observed, could be reflective of a Eurocentric attitude and limited view of the religious worldview and social structure of the African peoples. Veneration, according to Aceves (1974), has been associated with societies where there are strong kinship bonds. Conversely, Fortes (1971) has argued that veneration symbolizes and reinforces filial submission and group solidarity. Fortes’ contention has been that breaking of these filial ties or failure to meet one’s obligations could result in punishment or withdrawal of rewards.
Numerous studies (e.g., Aceves, 1974; Berg, 2003; Fortes, 1971; Middleton, 1967) elsewhere, and publications on traditional medicine in Botswana (e.g., Amanze, 2002; Samita, 1997; Staugård, 1985) have acknowledged that ancestors are venerated by their descendents because of the power and important role they play in their lives. The wisdom and guidance of ancestors are valued, hence their descendents respect, revere, and honor them (Bemak & Chung, 2004). Berg (2003) has concluded that ancestral reverence and “its accompanying rituals may positively influence the mental health of the individual and the community” (p. 194). She has pointed out that through rituals the living created a connection and communion with others, including the ancestors for that matter. She has observed that rituals at important points in the life cycle or whenever there is a need to reestablish communion or link with the ancestors. The important question asked was: How do counselors assist clients who believed that unless they participated in certain rituals nothing would go right in their lives?

In order to restore the broken relationship between a family member and the ancestors, there has to be propitiating acts (e.g., in the form of gifts, signs, prayers, signs of respect, rituals) towards them so that they could continue to be responsible for their welfare and protection. This indicated how one’s wellbeing was not dependent solely on the individual “but on his (sic) relations and connections with others” (Staugård, 1985, p. 67), and the reciprocity that existed with the spirit world (Aceves, 1974). The wellbeing of an individual in Botswana society, according to Dembow and Thebe (2006), “is not a personal affair but is a function of his or her relationship with other people, ancestral spirits, and even nature” (p. 38). In addition, Dembow and Thebe have suggested, the health and survival of the community is a consequence of behavior of the individual. Dembow and Thebe have concluded that:
For Batswana, then, the world is composed of a complex set of inseparable relations between social, and psycho-physiological realms in which ‘the greatest good for all can be achieved if all live according to the basic virtue of harmony; the harmony between people, nature, ancestors, and Modimo [God]. If the harmony is disrupted, it is explained as illness’.

Cosmological and spiritual beliefs are thus central to daily life and practice and not reserved only for special religious places or rites. Perhaps as a result, most people in Botswana consider themselves followers of traditional religions. (p. 38)

Furthermore, they have noted that any kind of illness or distressful condition has a social context (where ancestors become part of the social structure) and that appropriate intervention is communal. Therapeutic interventions that seek to restore harmony in the individual or to facilitate the wellbeing of a client would not exclude harnessing the social relationships and connections with the environment (i.e., spiritual, social, physical, cultural). The different elements of this environment therefore become an important factor in achieving this personal harmony and improved wellbeing.

This study sought to investigate how counselors took cognizance of these important interrelationships and interconnections that bring about harmony in an individual’s life.

*Disconnectedness with Social and Spiritual Environments*

An individual’s connection with the environment, that is, the physical, social, and spiritual is key to their healthy wellbeing. As suggested in the previous section, the relationship to, and the connections with others, including the ancestors, influenced a person’s wellbeing. Scholars (e.g., Hewson, 1998; Staugård, 1985) have reported that African peoples believed that an individual’s wellbeing and good health is associated with a positive relationship with others, being at peace with oneself, ancestors, and the Supreme Being, God. This implies that any break in the relationship and harmony with these different key players in one’s life brought about disharmony and an imbalance
in one’s life. The most important thing for an individual involved constantly checking and restoring this relationship and connection. Any discord with any one of these relationships could result in the loss of connection with all the environments thus causing disharmony or psychological and physiological distress. The counselor, therefore, needs to explore the nature of the relationships and connections the clients have with the environment.

Staugård (1985) has made fundamental observations about sense of belonging as a factor in one’s wellbeing among Batswana. “The psychosocial belonging to the community in the Tswana culture is the necessary precondition for health . . .. Any disturbance of this state of belonging leads to disease, illness or bad luck for the individual” (p. 67), Staugård asserted. Other writers (e.g., Berg, 2003; Hewson, 1998) have insinuated that disconnectedness could cause profound suffering. Berg (2003) has identified rituals as a way of reestablishing connectedness. She has argued that through rituals, “links are concretely and actively made between the individual, the family and the community, between the body and mind, and between the conscious and unconscious of the psyche” (p. 202).

Notably, the belief is that for any intervention to be effective the therapist must deal with the client’s issue holistically. Such a holistic intervention focused on the client’s personal relations, but included ancestors as key players in the everyday life and religious experience. This is, of course, in contravention to Western logic where the focus is mainly on the individual and the intrinsic motivations. The holistic approach presupposes that to effectively resolve a client’s problem one has to restore a balance between the individual and the surroundings (Staugård, 1985).

Since lack of closeness to and the disconnection with others causes psychological distress, the individual has to reestablish the lost connection with their environment. The counselor’s help must also include preparing the individual to breakdown the barriers and internal or external forces that
inhibit this connection with the environments. Participating in communal rituals, sacrifices, or offerings are other ways of reconnecting with others, including the ancestors. As plainly articulated by Amanze (1997):

Sacrifices and offerings quite often entail the act of bringing together two or more people who have become alienated from each other and the restoration to a peaceful state of those who have been estranged. It means an act of reconciliation. It is reckoned that without sacrifice or offering there can be no reconciliation with God, no forgiveness of faults committed, no restoration to former position and no remission of the penalty of alienation. (p. 22)

Interestingly, indigenous healers and spiritual healing churches pay close attention to the perceived factors that make it difficult for the individual to overcome the external forces that constantly strive to destroy the individual. Various forms of ritualistic performances and activities help the individual generate power within them to overcome these forces. The focus of rituals is to help restore and reconcile the individual with the self and perceived powers that create peace and harmony in them.

Studies on healing (e.g., Finker, 2004; Francis, 2004; Jilek, 2004) have suggested that ceremonials that incorporated rituals (e.g., prayer, psychic powers, interpretation of dreams, singing and dancing) and other cultural interventions helped the individual redirect their energy to positive powers, which are sources of relief. These studies have offered important insights into the power of the network of the group as support mechanism for the new behavior. They revealed that the individual’s encounter in the group reestablishes connection thus making the individual not feel disconnected and separated from others. As Messing (1967) has observed, the individual found security and recognition offered by the group. The challenge then is: How do counselors help clients
reconnect with their social, cultural, physical, spiritual environments to minimize disharmony and disconnection with the world around them?

Jilek’s (2004) description of therapeutic aspects of spirit dance ceremonials was that, “as a ritual group therapy, the ceremonial provides participants with support, acceptance, and stimulation” (p. 154). Emphasis, according to Jilek, was on group solidarity through the ritualists’ speeches, yet the therapeutic aspect was that “those who participate in it are turned from egocentric preoccupation to the pursuit of collective goals” (pp. 155-156). The group solidarity “provides frequent opportunities for cathartic abreaction in front of accepting and empathic audience” (Jilek, 2004, p. 156), while the dance leads to effective discharge and dramatic acting. Dance, as part of healing, facilitates restoration of the “state of imbalance or disharmony that is associated with the patient’s illness must be corrected before wellness can be restored…. the movements of the dancers reestablish the orderly” (Francis, 2004, p.143) conditions. Fish (2004) has reported that believers consulted Spiritist mediums for help with personal and physical problems, as they might a therapist or physician. What he noted was that “during these religious services, which include extended periods of dancing to percussive rhythms, participants are possessed by spirits from Brazil’s past, either of old slaves or of Indians” (p. 78). All this revealed that different societies uphold different views about illness and its causation by transcendental forces such as spirits.

Studies (e.g., Colson, 1969; Freed & Freed, 1967; Middleton, 1969) have shown that some illnesses are associated with spirit possession. Skjønsberg (1989), on the other hand, has maintained that in spirit possession there is a “cultural dualism that seems to flow together into one enigmatic and deeply significant manifestation” (pp. 162-163). He has suggested that spirits were revered and respected due to their status as elders, and that they could confer benefits and cause illness when displeased. This, according to Skjønsberg, was the cause for the ambivalence towards them. In
Botswana there are numerous instances reported in institutions and schools where clients presented that their problems are due to spirit possession, or that they are haunted through dreams by the spirit of a departed parent or grandparent. Invariably, the client may seek permission from school authorities to go have the spirit that is bothering them exorcised. The challenge in dealing with spirit possession is that it is sometimes associated with various behaviors. For example, Freed and Freed (1967) have suggested that spirit possession closely resembles hysteria, a rationalization reflective of a code given to a condition presented in this manner. They have explained that the basic conditions of spirit possession are psychological, and that the precipitating conditions included cultural events or situations, which exhibit difficulty with relatives. They have argued that this condition included low expectations of aid and support. They have further stressed that the primary goal of an attack of spirit possession was to relieve the individual’s intra-psychic tension, while secondary benefit included attention, sympathy, and influencing relatives. The question to ask then is: How can counselors address some of these manifestations in a culturally appropriate way to ensure client satisfaction? This study solicited the views counselors in Botswana have about the indigenous methods of healing.

Furthermore, Freed and Freed have commented that there was a readiness of people to attribute a wide variety of illnesses and misfortune to spirit possession. Among the methods used by different cultures to handle spirit possession, according to Freed and Freed, was exorcism with amulets and other substances that are unpleasant to the possessing spirit. Counselors in Botswana face the challenge of finding culturally appropriate methods of dealing with spirit possession phenomenon as a cause of illness or distress. Other causes of illness reported in the literature included violation of taboos or due to transgressions against transcendental powers such as ancestors.
Transgressions and Violation of Taboos

Many cultures have different taboos or prohibitions that religiously observed or without even determining what their meanings are. There are taboos associated with sex, sexual relations, and many others that bring about problems and serious consequences to the individual if their teachings violated. Violations invoke the wrath of transcendental powers such as nature spirits, and bring about calamities or misfortune to the individual. Anthropological literature is replete with constant reference to the belief in transcendental powers and violations of taboos as causes of illness and misfortune. Gluckman (1965) has reported that misfortunes result from lineage spirits who punish certain derelictions, or associated with the wrath of elders, or to the breach of taboos. Yet Rogerson (n.d.), a registered, South African-trained Canadian indigenous healer, has listed the following as some of the reasons for patient and community discord: natural causes, ancestral forces, breach of taboos, hereditary illness, negligence of the calling, and sorcery. Murdock (1980), on the other hand, has proclaimed that:

Africa ranks very high in theories of mystical retribution, which are reported for all but one of its societies and are important (i.e., either predominant or significant) in half of them.

Violation of sex and etiquette taboos are more common as precipitating factors than in any other region. Spirit aggression and sorcery are also prevalent theories, and of about equal importance. (p. 48)

Spirits, according to Skjønsberg (1989), could enter a human body and use it to communicate or perform certain activities. They were a link between the two worlds (Skjønsberg, 1989); that of the living and the supernatural. A harmonious relationship between the individual and the environment, which included one’s ancestors and other community members, could lead to health (Wessels & Monteiro, 2004). Yet, “any gap in that harmony is attributed to harmful interference of ancestors’
spirits, which are dissatisfied as the result of inappropriate behavior of the living” (Wessels & Monteiro, 2004, p. 326). Illness, in this context, was due to imbalances in the interaction of the natural, social, and spiritual forces; and to transgressions or omissions that anger the ancestors (Wessels & Monteiro, 2004). According to Wessels and Monteiro, illness affected the whole person. If illness affected the whole person, therefore, treatment must focus on the whole person not just feelings, thoughts, beliefs, and leave out other aspects of their being.

Contrasting African and Western worldviews, Skjønsberg (1989) has observed that the close linkage that existed between the everyday world and that of the ancestors, the normal and paranormal, the natural and the supernatural, the conscious and the unconscious, differentiates the African perception of reality from that of Western society. This suggested that the therapist has to realign the interventions to fit the worldview of the client (Bemak & Chung, 2004; Eagle, 2005). Counselors may find themselves having to deal with issues associated with spirit possession or their perceived manifestations. Other unnatural causes of illness reported in the anthropological literature are witchcraft and sorcery.

Witchcraft and Sorcery

Witchcraft and sorcery are among the most researched upon topics in relation to causes of illness and misfortune. Some scholars (e.g., Aceves, 1974; Eagle, 2005; Fox, 1967; Liddell, Barrett, & Bydawell, 2004; Middleton, 1967; Nadel, 1967) have written about witchcraft and sorcery as explanations of cause of illness and misfortune among the different cultures of the world. Aceves (1974) has commented that among many peoples witchcraft serves as a means of explaining phenomena that appear to have no other explanation. For example, failures, illnesses, and accidents are associated with witchcraft. Middleton (1967) has emphasized that there is need to understand witchcraft within a social context and that it has a coherent logic of its own. He has concluded that
even though it may not be easy to prove the mystical powers of certain human beings, they “provide explanations for coincidences and disasters” (p. x). This belief in these powers, in Middleton’s view, has enabled individuals to project their hopes, fears and disappointments onto other human beings, and by personalizing the forces of ‘fate’ or ‘chance’ enabling those afflicted by them to deal with them by direct social action against the assumed evildoers. In *Witchcraft in Africa*, Bloomhill (1962) has suggested that “sometimes, when death or serious illness takes place among Africans, the nearest of kin to the afflicted person harbour a firm suspicion of witchcraft against someone – naturally, an enemy with whom they have had a quarrel” (p. 64).

As a cause of illness, witchcraft is seen as a living force, a personification of evil and a ready cause for all the suffering in this world, a source of power not only to those who use it, but also to those who have the power to counter it (Skjønsberg, 1989). Sussman (2004), however, has identified unnatural causes of illness to include those associated with witchcraft and sorcery. She has argued that some malign human intervention calling upon the supernatural resources cause illness. She has also categorized, as supernatural causes of illness, divine retribution for improper behavior toward other people, toward the deceased, or other spiritual beings. The literature has revealed that the general perception about witchcraft is that it is a secret and solitary activity performed under the cloak of darkness. Although it is difficult to ascertain, because of fear of reprisal, people avoid challenging its effect and thus making it a complex enterprise (Skjønsberg, 1989). Skjønsberg has argued that the fact that the modern world denies the existence of witchcraft does not simplify anything. This study investigated how counselors in Botswana handled such culturally grounded beliefs.

Among Batswana, there is a widespread belief that witchcraft, ancestral spirits, and other machinations of the spirit world are hostile forces that supposedly cause various sources of
illness, misfortune, and other calamities. Further, witches and sorcerers have mystical powers, possess harmful spirits, and use medicines or agents to cause harm to others (Sobiecki, n.d., ¶ 10). The important thing for counselors is to remember that:

However unusual or strange the religious or magical practices of society may be, they are quite natural to the people who practice them, so natural that, in fact, many societies do not make a hard and fast distinction between natural and supernatural along the lines that we in the Western tradition do. (Aceves, 1974, p. 22)

To further illustrate Aceves’ argument we can look at Hartland’s (1904) assertion that although many beliefs and superstitions are founded upon insufficient data and erroneous meaning and inaccurate reasoning, and premises, “none of them, not none, is founded upon nothing” (p. 2).

Amanze (2002) has observed that “belief in witchcraft and sorcery as well as their practice have continued to dominate the social and religious life of Batswana” (p. 233) despite efforts by missionaries and Botswana government to eradicate them. It was assumed by government that by legislating against witchcraft this would eliminate its beliefs and practices, hence the enactment of an Act of parliament that made it an offence to practice or even to profess to be a witch (Amanze, 2002). Reflecting on the era of colonial administrations in Africa, Malinowski (1945) has concluded, “All efforts of European missionaries, educationalists, and administrators have failed until now in their treatment of witchcraft. We find everywhere reports that it is on the increase … while the tremendous sway of such witch finding organizations.” (p. 94).

Misguidedly, legislation and missionary teachings against witchcraft, as Malinowski has correctly observed, drove it from open recognition into some clandestine practice. Malinowski’s point was that by attempting to rid the Africans of witchcraft, the Europeans proceeded without even an adequate knowledge of the facts or an intelligent handling of principles. He has affirmed that
witchcraft, as a state of mind, deeply entrenched and founded, “not in accidental superstition but in universal human psychology, cannot be abolished, by legislation” (p. 95) and mere non-recognition and denial of its existence. He has suggested, Witchcraft “is primarily rooted in the psychological reactions of those suffering from ill health, misfortunes, inability to control their destiny and fortunes” (p. 96).

According to Amanze (2002), “people conduct their daily activities under tension, suspicion and fears of bewitchment” (p. 233) because of the beliefs in witchcraft. Fox’s (1967) inference was that the pathological fear of witches causing illness is associated with paranoia. Fox’s position was that paranoiac traits and cultural beliefs in witches reinforced each other. He theorized that when a person fell ill, the suspicion was witchcraft, which in turn accentuated the illness. Kearney (1979), however, has regarded witches as insidious; attacking their victims either from a distance by magic or poisoning as “typical of paranoic [sic] projections in general in that they are seen as malignant forces, which with a little rhyme or reason may attack the relatively defenceless victim” (p. 28). Kearney has upheld that through the mechanism of projection, people living in a:

Noxious and stressful situation create additional symbolic threats which since they are taken as real, exacerbate stress and resultant anxiety. Indeed, many such individuals appear to spend more time and effort at protecting themselves and seeking cure from the effects of these reified threats than in coping with the primary stresses which generate them. (p. 28)

Amanze has professed that due to pathological fear people, Batswana are constantly perceive evil powers, which are believed to destroy their lives. He has maintained that “belief that human misfortunes such as sickness, death, lightning, drought and other social and physical misfortunes are not caused by God but by some evil powers” (p. 234) was common among Batswana. The causes of this fear were that witchcraft and sorcery, as identified causation of illness, were associated with
causing harm to another person (Murdock, 1980). Hayes (1995) has stated that the power to harm others was by supernatural means and that the person who used it was not aware of it. A witch, according to Hayes’ claim, does not choose to be a witch, and the supposed harm does not necessarily arise from malice or intent. Since witchcraft constitutes inherited mystical power (Landy, 1977), therefore, it is not an acquired skill (Murdock, 1980). According to Landy, any person endowed with this power has the propensity for evil.

Moyo (1996), however, has portrayed witches as wicked and malicious human beings whose intention is simply to kill through poisoning or cursing their victims. He has declared, “witches, sorcerers, and angry spirits are usually identified as the major causes of misfortune or death in a family” (p. 282). Murdock, on the other hand, has argued that witchcraft is usually deflected to or displaced to other noticeable but the unpopular types of people such as foreigners, hunchbacks, senile women, or individuals with piercing stares. A witch is either solitary individual, believed to be constantly brooding over his or her wrongs or an over-jovial person friendly with everyone (Middleton, 1967).

On the other hand, sorcery is a learned behavior, which may involve the use of incantations, ritual, and various substances in order to do harm (Hayes, 1995). Sorcery practiced by anyone who has appropriate techniques (Landy, 1977; Murdock, 1980). Generally, Batswana do not have two distinct terms that refer to witchcraft and sorcery. The common term used, without differentiating the practices is Boloi (a Setswana word for either witchcraft or sorcery). Commenting on the use of the two terms Murdock (1980) has stated that students and laymen invariably confuse them, and that “even professional anthropologists are not always clear about their distinction. Such mistakes are not surprising since few educated people have had any first-hand experience with either” (p. 64). Attempting to establish the distinction between witchcraft and sorcery in the context of the Shona
people, Crawford (1967) has argued that it is not applicable. He has mentioned that the terms are used to mean, among other things a ‘true witch’, the sorcerer who uses powers to harm others, one who causes harm through breach of some taboo, the ‘poisoner’ and even trouble-maker. As Crawford has observed, the distinction between a psychic act and an act of sorcery is not clear.

Nadel (1967) has put a twist on the conception of witchcraft; arguing that its beliefs are related to specific anxieties and stresses arising in social life. Witchcraft accusations, according to Nadel, reflect tension and aggressive behavior impulses from maladjusted institutions, which cause them thereby helping these institutions to continue to operate. Further, the witchcraft beliefs, Nadel has pointed out:

Enable a society to go on functioning in a given manner, fraught with conflicts and contradictions which the society is helpless to resolve; the witchcraft beliefs this absolve the society from a task apparently too difficult for it, namely some radical readjustment. (p. 218)

Sobiecki (n.d.), on the other hand, has noted that these “social tensions, conflicts, political or economic factors often underlie witchcraft accusations, and thus witchcraft can be used as a scapegoat for social frustrations, see Ngubane (1977) for more on this” (¶ 12).

Morley (1979) has acknowledged that witchcraft belief system’s efficacy is difficult to challenge or refute because it is not ‘testable’ in ‘real’ world of the believer. According to Morley, believers in witchcraft causality are not satisfied with explanations which do not go beyond informing them how (italics in original) a certain misfortune or illness occurred. Morley has observed that when such a situation happens the search for meaning continues, taking the believer in the direction of witchcraft system. He has argued that this search seeks to answer the question ‘why?’ where questions such as: ‘Why this particular time?’ Why this one?’ are addressed. Sobiecki
(n.d., Introduction section, ¶ 12) has intimated that dealing with the fear about witchcraft requires giving doubt and uncertainty in life a human face. It is this ‘trans-humanization’ of the problem, according to Sobiecki’s observation, that helps reduce witchcraft’s mystical powers. The medicinal, magical, or rituals are some of the ways of seeking ‘trans-human’ assistance, protection or to give thanks to such powers (Sobiecki, n.d., Introduction section, ¶ 12).

In *Culture, health, and illness*, Sobiecki’s (2003) has written that different interpretations, explanations, and treatment options depend on one’s culture. He has further presented that with every culture, after determining the pathogenic factors as a virus there is normally questions in response to the ‘why’ questions of life. He has concluded that a “belief in witchcraft is as valid as a belief in bad karma when explaining why a person and not another falls ill” (¶ 6). Whenever scientific theories of causation fall short of addressing these critical questions, some people ascribe the phenomena to witchcraft not chance or coincidence. Morley, however, has stated that the belief in witchcraft does not provide whole interpretation, hence the use of expressed observation and scientific understanding.

To properly study the beliefs in witchcraft and its manifestations one has to do it in the context of society from which it originates (Crawford, 1967). Sobiecki (n.d., Introduction section, ¶ 12) has suggested that interpretation of misfortune, anxieties, and distress must be within a cultural context in order to address it effectively and meaningfully. However by merely increasing scientific knowledge, Crawford has advised, does not necessarily destroy beliefs in wizardry. Crawford has posited that the scientific knowledge generally fails to address the question: ‘Why it happened to the person or at that particular time?’ Crawford’s opinion has been that “by providing a reason for unexpected behavior and events, beliefs in wizardry make that which is difficult to understand, comprehensible” (p.68). Sobiecki has reported that by giving identity to the “unknown causes
behind misfortune, the unknown can be made known and be dealt with by people by using real and practical on countermeasures (protective rituals)” (¶ 12). Crawford has maintained that although the countermeasures such as magic may, in themselves, be useless but the feelings of confidence inspired by them at the best enables other, more effective, measures to be successfully undertaken or, at worst, improves morale.

Beliefs in witchcraft, according to Crawford, have a definite social and psychological value in enabling people to act purposefully in the face of adversity. Crawford has stated that people’s beliefs can have little relevance to their everyday conduct, and that to attribute witchcraft, as a cause does not fully account for the social relevance of such beliefs and emotions raised by an accusation of witchcraft. He has viewed the belief in witchcraft as people’s attempts to rationalize and understand the malevolent forces of nature, and of misfortunes of life.

Morley (1979) has remarked that within the context of the witchcraft belief system, the emphasis is on disturbed personal relations. He has charged that modern Western medicine, blinded by the success of the germ theory of disease, has for a long time, ignored the relationship between social disturbance and individual affliction. There are two interesting points raised by Morley; one that while the patients may submit to scientifically based treatment and to understand that bacteria, germs, and viruses could be the cause, they do not generally understand the complexity of the treatment they are getting. The second has been that these patients are just participating in a belief system. Indigenous societies, according to Morley, integrate the institutions and cosmology of the society as a whole.

Malinowski’s (1945) has maintained that once we understand the psychological, social and moral roots, or we see witchcraft, far from being an unmitigated evil, but rather, in many ways as source of comfort and hope. As a sociological phenomenon, witchcraft, Malinowski has argued
is based on the scapegoat psychology, and therefore the most likely people to be blamed are those with whom conflict most readily occurs. Again, as Malinowski has observed, the belief in witchcraft will always remain a symptom of economic distress, of some tension, of political or social oppression. Malinowski has written that:

> While education may operate as a factor in decreasing the belief in witchcraft, in my opinion it plays a far lesser than usually assumed. No amount of education has helped to prevent modern forms of witch-hunting in Germany, Russia, and Italy. In this instance, prosperity may be of greater value than wisdom. (p. 99)

Attempting to provide an explanation for the disappearance of witchcraft in industrialized society, Middleton (1967) has stressed that credit should not be given to the growth of religion or rationalism, but rather to the development of a society in which a large proportion of its day-to-day relationships are impersonal and segmented ones. In such a society, he has contended that tensions may be isolated and compartmentalized, and expressed in forms very different from those of a society small enough in scale and dominated by personal influence. Although the advent of new religions such as Christianity had no significant impact in changing people’s views about beliefs such as witchcraft, it led to negative changes in some of the cultural practices. The last chapter of Bloomhill’s (1962) book, ‘Is there anything in African witchcraft?’ is an important question to explore. After innumerable cases that to prove the existence of witchcraft and examples of people of high profile who believed in it, Bloomhill has noted that despite the laws banning it:

> Once again we are faced with the dilemma: how much shall we accede to African witchcraft? Thus all our theorizing, all our sociological and scientific investigations, all our treatises and commissions, end once more, as so often such things do, in a single great
question mark. … The puzzle of African witchcraft, it appears, can be solved only by time. (p. 169)

Let us discuss some of the influences of Christian missionary activity on Botswana cultural practices and healing systems.

Missionaries, Indigenous Cultural Practices, and Healing Systems

Among the major changes missionaries brought to Botswana culture were new rituals, which in some cases replaced the old, ‘tribal’ rites, and instituted partially new moral rules and sanctions (Staugård, 1985). Notwithstanding the positive impact some missionaries may have had in Africa, it is worth noting that the negative Eurocentric prejudices and the suppression of some of the cultural practices and beliefs they “planted” continue to pervade most African societies today. Also, we need to acknowledge the fact that in spite of all their endeavors to displace these practices and to replace them with Western values, belief systems and rituals, missionaries “have not been able to suppress the value attached to ancestors, funerals, and a host of other traditional practices” (Millar, 2004, p. 4), including the indigenous healing. This has resulted, in most cases, both Western and indigenous Botswana value systems existing side by side, at times creating tensions among the different generations.

Mgadla’s (1989) summary of the “impact of missionary education between 1859 and 1904 among the Bangwato [one of the ethnic groups in Botswana] was both pervasive in both its positive and negative aspects. The missionaries’ aim was evangelization, but evangelization was inextricably bound up with a host of Western values” (p. 39). Such values have remained at the core of Botswana’s education, and have continued to influence people’s perceptions of self and their general understanding of the dichotomous worldview.
One of the stark criticisms leveled against missionaries, as reported in Samita’s (1997) review of *Healers and protective medicine in Botswana*, is their claim that their healing processes were superior to those of the indigenous Africans. Another criticism had to do with viewing African therapeutic methods with suspicion and skepticism. Samita review has noted that the missionaries suppressed African medicine and therapies, portraying them as “despicable, devilish, and primarily consisting of unscientific practices that were quite dangerous to the individual” (¶ 3). Discussing the impact of Christianity and Western culture, Kealotswe (1995) has concluded that missionaries attacked and despised Batswana customs and traditions, including those associated with marriage systems (e.g., polygamy, bride wealth), initiation ceremonies, and beliefs about family life. Most interestingly, this seems to have been a common attitude of missionaries in many parts of Africa. For example, Hatch (1960) has given similar accounts of an onslaught on these customs and practices by missionaries.

Sillery’s (1954) portrayal of Robert Moffat (a missionary who worked among Batswana), has shown a man who was ‘contemptuous and slightful’ in his attitude towards the Africans. His contemptuous description of the Ndebele king has shed light about the views some missionaries had about African peoples. Sillery has written that Moffat:

Had little interest in Africans as human personalities, but regarded them chiefly as objects of conversion to his own idea of Christian living. To the end of his life he would not admit that the African had a religion of his own, and the reluctance of the tribesmen to abandon their own beliefs and to adopt those which he sought to instill was always to him a source of indignation and naïve astonishment. Customs which to the modern mind are innocent enough he regarded as a hindrance to the spread of the Gospel, and hence to be attacked and destroyed. They were all either ridiculous or sinful, and in any case undesirable. (p. 75)
However, this aggressive approach and contemptuous outlook failed to completely annihilate the cultural practices and beliefs of Batswana. Kealotswe (1997) has attributed some of the failure of missionaries to the imposition of Christianity wrapped by Western culture as opposed to facilitating cultural transformation by helping it adapt to Botswana culture. He has observed that the “London Missionary Society (LMS) missionaries who came to Botswana despised some of the religious practices and religious leaders but they never succeeded because the people still resort to them in times of need” (p. 64). Whereas the missionaries maintained a conservative position on the role of the indigenous healers, the latter adapted to accommodate some of the practices and technology used by the Western medical practitioners. For example, “To an increasing extent they seem to focus their interest on such elements of traditional healing, which fit into Western concepts of ‘rationality’ such as herbalism” (Staugård, 1985, p. 52). According to Samita (1997) book review the missionaries’ understanding about sickness replaced indigenous views and Africans were forced to adopt Western approaches to diagnosing and treating illness. This resulted in many educated and Christian Africans losing faith in indigenous practices. It would be interesting to find out how much of such impact affects counselors’ views about indigenous cultural practices today.

Current debate on religion in Botswana has highlighted some of the serious misconceptions missionaries had about the belief systems and cultural practices of Batswana. Simmons (1962) has laid blame on missionaries like Robert Moffat, like some of his counterparts in other parts of Africa, who:

Were not willing to study and observe the people first and to base their opinions and their policy on what they saw: they had ready-made code, and they applied it automatically. That is why the account they gave of Africa and though it edified their readers, contributed so much less than it might have done to the better appreciation of African problems. (p. 22)
Simmons has alleged that missionaries viewed whites as having immense superior wisdom, and that “the standards by which they judged Africans were rigid, and quite unlike any that Africans themselves know or subscribed to” (p. 22). Most travel accounts of the missionaries, according to Nkomazana (2002), have revealed the cultural bias of Europeans about beliefs and practices of Africans. These accounts “were based on inaccurate information and cultural prejudice” (Nkomazana, 2002, p. 54). Nkomazana has gone on to charge that these missionaries “made Tswana religion to appear to be a morass of bizarre beliefs and practices of a people generally believed to be savages and primitive” (p. 54). The expectations that missionaries were coming to covert heathens and promote civilization, Nkomazana has felt, influenced their attitude towards African way of life and mentality. Their only cultural model, Nkomazana has concluded, was European and their views of indigenous beliefs and practices lacked depth.

Other writers (e.g., Hatch, 1960) have also reported the negative impact missionaries had on indigenous cultural practices of African peoples. According to Hatch’s (1960) view, “missions brought the first glimmerings of learning, some medicine and the Bible, though often their application of European standards and habits to primitive societies produced tragic results” (p. 18). To the Europeans African customs appeared immoral and barbaric, and thus destroying them was tantamount to destroying the whole fabric of society (Hatch, 1960). The negative attitude of missionaries toward Botswana culture had a serious impact on the way Batswana view themselves today. Examining the missionary approach in Botswana, Amanze (1997) has concluded that:

It appears that the artificial dichotomy that has been drawn in the missionary field between the biblical message and African cultures has made Africans a people of split personalities with one foot in Christianity and another foot in the religion of their fathers. (p. 16)
The Colonial Legacy and the Introjections of Western Values

The colonial legacy, the media, Western educational values, and other forms of colonial and postcolonial cultural and technological domination, Batswana, as their counterparts in Africa have a tendency to introject Western values, believe in the superiority of Western knowledge and intervention strategies, and generally, project a negative attitude towards indigenous cultural practices. The negative attitudes and sense of inadequacy could also be reflective of the teachings against Botswana cultural practices during the colonial period, and the lack of redress by postcolonial government to restore a positive view towards indigenous culture and its social institutions. The elite continued to be products of an education system and curricula based on the former colonial administrations. In the case of Botswana, it was up until late 1990’s senior secondary students in Botswana used the Cambridge Overseas Schools Certificate (COSC), based on British education system, giving illustrations reflective of British social and cultural setting. For example, in some of the curricula materials students were to write about the world under the sea, or describe snow, and other phenomena not reflective of Botswana setting. There was, basically, limited information in the syllabi, specific to Botswana society and the glories of Batswana as a people. This limited integration of Botswana social life, values, and cultural experiences in the curricula insidiously injected feelings of inadequacy, the self-introjections, and the lack of appreciation of indigenous culture and its context.

Most notably, the negative labels attached to Botswana’s cultural practices and the constant denunciation by, firstly, missionaries and the postcolonial institutions have had far-reaching consequences on the perceptions Batswana have about their culture and their self-image. Hatch has reported that missionaries often condemned these practices, and where possible replaced them with European religious values which they regarded “so absolute that they prevented an understanding of
the significance of such element of African society” (p. 18). Likewise, Hartland (1904) has painted a rather glorious and at the same time deplorable picture of the European missionaries in Africa. He has described them as superbly brave and noble-minded people who risked their lives, “but it is their methods of working that have produced in West Africa the results which all truly interested in West Africa must deplore” (p. 35) for they rendered the African useless.

In his book, *The African phenomenon*, Said (1968) has described such an African as a cultural misfit, without roots or genuine values. He has suggested that such an African is “confused by a conflict of values in search for identity” (p. 39) due to colonialism, which left behind it a complex legacy of inadequacy. Fanon’s (1967), *Black skin, white masks*, can be viewed as a portrayal of the psychological impact colonial domination has had on the African’s self-identity and self-image. This is the kind of self-image characterized by self-introjections, and an attempt to dissociate with anything African to embrace everything associated with that perceived to be “superior” has led to the failure of many intervention strategies aimed for the African peoples. While physical colonial domination has been ‘rooted out’, its legacy and its values have continued to pervade most African societies particularly that of Botswana. Mphahlele’s (1962), *The African Image*, highlights some of the issues, challenges, and contradictions ushered in by the colonial experience in Africa particularly for the educated African. Akosah-Sarpong (2001) has stated that non-Africans will find it difficult to understand the assault on indigenous Africans’ minds on contact with the novel ideas and images from the outside world. Akosah-Sarpong has argued that Western education is increasingly alienating the young from their core African traditional values. These Africans, according to Akosah-Sarpong, want to live different from their elders. Some Africans look down upon shrines used for initiation rites (Akosah-Sarpong, 2001). Western imported missionaries and their African cohorts often told young Africans that their customs were primitive and barbaric. This has a significant
impact on how the Africans view(ed) themselves, a view characterized by the negation of the African self yet not in harmony with the other parallel view they have received.

Said (1968) has explored the phenomenon of negation of self in terms of the tension between Western and African values, suggesting that “the new African is the victim, caught between the ‘ideals’ of the West and the ‘realities’ of his own societies” (p. 48). Said has further observed that many African leaders are victims of an upbringing, which makes them only superficially modern and only superficially African. These leaders, according to Said, see their “culture in its uncreative, ossified, passive side – the side which allowed Africa to be dominated for so long” (p. 39). Dembow and Thebe’s (2006) discussion of the situation about music and dance has revealed some of cultural impact of Western influence on Botswana culture and social identity activities. They have written that drums, flutes, songs, and traditional chants that used to enchant the Botswana villages during religious prayers and thanksgiving ceremonies are now largely silent because of the combined efforts of the missionaries, colonial censure, and the media.

While colonial administrations and missionaries had impact on indigenous African cultural practices and healing systems, postcolonial governments contributed significantly in alienating the African peoples from their indigenous cultural practices and systems of care. Postcolonial governments have done very little to address the negative effects of colonial domination and its impact on self-image of the African. Bolten (1998) has underrated the significant role of the missionaries in degrading cultural structures but accredit this breakdown to Botswana government’s lack of effort in preserving traditional lifestyle of Botswana. In Botswana, the general practice by missionaries was to have those chiefs who accepted Christianity pass laws that forbade traditional customs and practices that they believed did not fit the Christian perspective. Bolten (1998) has the opinion that:
The arrival of the missionaries in 1848 had little immediate effect on traditional healing. The missionaries tried to convert the chiefs to Christianity before converting the rest of the tribe, since once the chief was converted the rest of the tribe would usually follow his example. Though seemingly logical, this progression was not always the case with Tswana people. Sometimes a converted chief had his authority challenged by the people, as is the case with chief Khama . . .. He had passed a proclamation banning witchcraft and divination in his district … in 1889, but decided not to enforce it to avert more war. (p. 47)

While Batswana cultural practices and beliefs remain influential on how they “perceive themselves, their relationships with their families, their friends and neighbors, and their interpretations of daily events” (Dembow & Thebe, 2006, p. 37), the lack of congruence between the cultural context and the proposed interventions are barriers to providing effective delivery of care.

The major challenge is how to deal with the negative impact of the introjections of the Western values without addressing the various factors that have, and continue to contribute to this phenomenon. The contradictory belief systems and the tendency to have wholesale adoption of intervention strategies and development programs that do not integrate Botswana culture permeate Botswana’s social and development institutions. The experience with the responses to HIV/AIDS problem is a case in point. What then should counselors do to avoid repeating the past mistakes of those in health? Are counselors equipped to deal with their own introjections of Western values and the influence of some of the teachings against indigenous Batswana cultural experience and the complex reality of their clients? How much of the negative influence and the continued negative view about indigenous cultural practices are at play when working with clients who adhere to
indigenous beliefs? Would the professional counselor understand the cultural beliefs and worldview of the client?

Culture and Counselor Effectiveness

Culture influences people’s behavior and responses to situations. In his attempt to offer an interpretive theory of culture, Geertz (1973) has made reference to Clyde Kluckhohn’s definition where culture is viewed as, among other things, a way of life of a people; a way of thinking, feeling, and believing; an abstraction of behavior, and a learned behavior. Furthermore, citing Wittgenstein’s argument Geertz has emphasized the point that:

One human being can be a complete enigma to another. We learn this when we come into a strange country with entirely strange traditions, and, what is more, even given a mastery of the country’s language. We do not understand the people (And not because of not knowing what they are saying to themselves) we cannot find our feet with them. (p. 13)

The import of Geetz’s assertion about interpretive theory of culture is that culture defines who we are and our view of the world, and how we experience and respond to it. Simply put, our culture reflects our responses, expectations, and articulation of what all that goes around us mean to our existence.

Aponte (2004) has asserted that “culture influences all levels of the treatment process, including entry into the mental health system … important to understand how culture influences the predisposing, relationship, and contextual factors, as well as the treatment strategies and teachings” (p. 115). He has made inferences that these factors have an impact on the therapeutic outcome. This suggests the importance of understanding the cultural background of the clients in order to “provide effective and culturally responsive services” (Bemak & Chung, 2004, p. 126). Bemak and Chung (2004) have concluded that the beliefs about mental health may differ from
Western views of mental health. They believed that beliefs about mental health would have an influence on the manifestation of problems, help-seeking behaviors, and expectations in treatment and services. Morley (1979) has highlighted the critical role-expectations play in determining the therapeutic outcome. He has proposed that practitioners “must focus on what people hope for and expect from their medical system, as well as what they define as etiologically significant and as therapeutically efficacious” (p. 5). Marsella’s (1985) position has been that internally, culture “is represented by various values, belief systems, world views, and representations. All these forces are in simultaneous interaction and at any point in time” (p. 288). Yet, Sinacore-Guinn (1995) has pointed out that cultural systems and structures must be understood to include such elements as community structure, family, schools, interaction styles, concept of illness, life stage development, coping patterns, and immigration history.

Literature has revealed divergent views about cultural conceptions of illness. Though Fox’s (1967) understanding of illness has encompassed both mental and physical, and “based on universal psychological factors, is in its expression highly culturally patterned” (p. 255). Fox has endorsed the notion that conception of illness differs from one culture to another; has acknowledged that behavior labeled as ‘sickness’ in one culture may count as religious ecstasy in another. Fox has maintained that the sociocultural context of which the individual is a member provides the stresses that cause the illness, the medium of expression of the illness and a theory of disease. Sinacore-Guinn has noted that “coping patterns are culturally affected. Various cultural systems, such as families, may have rules about coping that are important in understanding how the client has been socialized” (p. 21). Since illness is experienced within the context of a group or family, “it is usually within this context that illnesses are managed, with or without the advice or help or a healing specialist” (Sussman, 2004, p. 39). Sussman has upheld that lay people, family members, and others who are in contact
with the person become significant players in resolving the problem. All these groups of people are part of the therapeutic network from which the individual can obtain advice and suggestions on how to handle the illness or problem. Family therefore as a social structure and organization, according to Sussman, plays a significant role in illness interpretation and management. Her contention has been that:

It is overwhelmingly within the context of the family and household that illness is marginalized and managed throughout the world. The conditions of individuals are assessed and individuals are labeled by the social group as ‘sick’, thereby assigning individuals to the ‘sick role’ and granting them culturally defined rights, privileges, and obligations of that role. (p. 50)

Examining the extent to which counselors in Botswana use cultural structures such as the extended family network was one of the aims of this study. While in some cultures the family may have a superseding authority to that of the individual, others may have the individual and the therapist predominantly responsible for making decisions (Sussman, 2004). Therefore, a counselor may need to appreciate the differences in the existing decision making processes available to their clients. This would minimize creating tensions within the organizational structure within which the client operates. Sinacore-Guinn’s observation has been that counselors often view coping patterns as pathological rather than comprehend them as cultural. According to Sinacore-Guinn, if one understands the coping pattern as cultural, his or her understanding of the nature of the problem alters too. Sinacore-Guinn’s observation has shown that instead of the therapist assuming the individual is pathological in the method of coping, as defined by the dominant culture; it may mean that the individual needs to learn the implications of applying coping patterns across cultures. The
client, on the other hand, must understand that what is effective coping in one culture may not work in another.

To understand coping patterns a counselor must decode the culture and experience of the clients. This is one of the most crucial process issues in counseling clients in cultures different from one’s own. A number of writers (Amos, 1981; Bony, 1981; Marsella, 1985; Sinacore-Guinn, 1995) have alluded to the importance of understanding and ‘unpacking’ the client’s cultural experience if a counselor intends to be effective in helping the clients. Blaustein (1992) has stated that “every culture provides the individuals who have internalized it with a shared frame of reference consisting of sets of basic assumptions through which we interpret and make sense out of the experiential universe” (p. 37). His view was that the cultural belief systems provide clients with cognitive structure that helps them with the anxieties and uncertainties of the illness. Central to this argument is that counselor exposure to the culture and experience of their potential clients as part of their training is very important.

Marsella (1985) has mentioned that cultural experience conditions the self as much as it conditions our values, ways of thinking, and social relations. While I accept the notion that there is some degree of universality of physiological characteristics of humans, I believe that practitioners need to recognize that people’s cultural experiences differ significantly, and that these experiences have a bearing on their view of the world and their expectations. These experiences, according to Hahn (1995), shaped by the unique client’s life stories or narratives, grounded on the sociocultural and religious context. It is within this context that I argue that the level of knowledge and understanding of the culture and the experience of clients may affect counselor effectiveness.

Understanding the culture calls for the appreciation as well as unpacking of the worldview and experiences of clients. This unpacking requires exploring the values, beliefs, interaction styles, and
general behavior patterns, generally influenced by the customs, traditions, and habits. Every culture has control mechanisms, instructions, rules, plans, and symbols such as drawings and gestures (Geertz, 1973), all of which provide a picture of the kind of individual or community we have to deal with as counselors. Marsella has stated that “the person is the repository of all these influences and in reflection of their properties as they have been internalized via biological and psychological codification” (p. 288). Counselors in Botswana face the challenge of decoding all these codified properties within the limited encounter they have with a client to appreciate these codified influences.

The other challenge is how to address the various cultural contradictions created by the impact of the European culture, especially during the colonial era, which gave birth to parallel worldviews by many Africans. Amanze’s (1997) characterization of Batswana as having split personality caused by having one foot in Christianity and another in the religion of their forefathers exemplified some of the contradictions created by living in dichotomously coexisting worlds, one distinctly Western and the other uniquely African. These parallel worldviews may become a challenge for counselors when trying to reconcile these two worldviews, starkly irreconcilable because they are premised on two different philosophical assumptions about human behavior, one emphasizing the individual yet the other putting collective involvement to the forefront.

Williams’ (2003) review of an article on rethinking individualism and collectivism has supported links that exist between worldview and the psychological variables of self-concept, wellbeing, attribution style, and rationality. Among the salient differences delineated by the article were that whereas individualism centralizes the personal goals, uniqueness, control, and marginalizes the social, the collectivistic paradigm assumes that groups bind and mutually obligate the individual. The collectivistic worldview emphasizes the social dimension. The different
worldview dimensions influenced ways in which individuals viewed themselves and the world around them. The article highlights the need to employ different strategies in dealing with clients who ascribe to these two divergent worldviews. This study investigated ways in which counselors in Botswana handled the different belief systems and the divergent worldviews of clients.

Ivey (1993) has argued that all helping practice has a set of cultural assumptions. His view was that the values and beliefs of other groups could change and enrich the counseling practice. Lefley (2001), on the other hand, has charged that the form and content of mental health service delivery has a constellation of cultural variables and socioeconomic realities. Her observation has been that “belief systems, values and value-organizations, religious and medical practices, family structure, economic organizations and resources, and societal needs for protection and order have all affected identification and treatment of mental illness” (p. 263). As noted by Levers (2004) “contextual influences relating to the worldview of a particular culture are embedded in that culture and remain important to how members of the culture make meaning of their lives” (p. 4). How much of this worldview has a bearing on the perceived effectiveness or lack thereof during counseling? If culture influences an individual’s perception of the world around them then culture and its inherent practices and structures must become a centerpiece for counseling. Kondo (2004) has argued that culture not only assigns a name to an occupation through its language, but also shapes the form this occupation takes and the imbued meaning. Kondo’s thesis was that:

When an individual chooses an occupation, psychological and concerns as well as cultural practices, values, and beliefs come into play. Although occupational therapists are trained to be culturally competent their grasps of the importance of cultural considerations can be enhanced through detailed accounts of the way in which such concerns affect clinical practice. (p. 174)
Discussing the cultural variation in the nature of self, Marsella (1985) has suggested that “cultural experience conditions the self as much as it conditions our values, ways of thinking, and social relations” (p. 298). If culture influences our thinking and relations, then there is need for counselors to explore and to understand the culture of the groups they are dealing with if they have to be effective in assisting them. A number of writers (e.g., Amos, 1981; Bony, 1981; Marsella, 1985; Sinacore-Guinn, 1995) have discussed the importance of understanding culture in dealing with human behavior. A study by Amos (1981) has revealed that cultural familiarity is a determinant for counselor effectiveness. The study has shown that the perceptions of counselor effectiveness were associated with the counselor’s cultural awareness, skill, and experience than by ethnic or language factors. In addition, the study has indicated that experience, skill, and cultural knowledge and sensitivity are more important than the ethnicity of the counselor or client. These findings have highlighted the importance of cultural exposure, and the need for substantial knowledge about the clients. The counselors should consider that the services they provide must reflect the culture of their potential clients. While writing about the Libyan society, Bony (1981) suggested that the guidance and counseling services should arise out of the needs, objectives, and the goals of the student masses; that they should grow out of the existing conditions of the Libyan or the Arab Muslim culture, and that they should be made to meet the particular needs of that society.

Appreciate the influence of culture has been described by Corey (1991), as an important characteristics of an effective counselor. There is a growing body of literature associating counselor effectiveness with cultural competence. In her manual, Randall-David (1994) has defined cultural competency as “the ability to work effectively with culturally diverse clients and communities because the individual agency or system exhibits culturally appropriate attitudes, beliefs, behaviors, and policies” (p. 1). The manual has identified ways in which counselors could put into practice
culturally appropriate interventions and ways of relating. These ways of relating and interventions must meet the cultural expectations of the client.

Influences of Cultural Expectations

Counselor’s inability to understand or lack of knowledge of the cultural beliefs and social expectations regarding interpersonal communication of distress may lead to cultural conflict (Blaustein, 1992). To illustrate the influence of expectations, a counselor should bear in mind that all healing or therapies “result from the cultural specific beliefs and expectancies of the participants, as well as from the emotional persuasiveness of the experience, which is also culturally specific” (Fish, 2004, p. 78). Fish (2004) has further stated that the “power of expectancy to alter behavior (especially ‘involuntary’ behavior) helps us to understand why different psychological therapies, and even ones based on mutually contradictory rationales, can have positive effects, as can various forms of shamanism and religious healing” (p. 77).

Lei, Lee, Askeroth, Burshteyn, and Einhorn (2004), on the other hand, have suggested that “if you happen to grow up in a certain culture, in which some healing modalities come to you naturally as an indigenous method to alleviate illness, you are more likely to enjoy its efficacy” (p. 243). They have attributed this belief in the efficacy of the method to the belief in the modality itself, which could contribute to the placebo effect. According to this effect, the modality’s efficacy is regardless of whether it really manipulates the individual’s system in the way the healer expects it to. Lei et al. again believed that the client’s “faith in these therapies is deep-rooted, and through a mind-body connection it could result in the activation of the parasympathetic nervous system, enhancement of the immune function, and the reduction of physical symptoms” (p. 243).

Sammons (1992) has reported that the literature on placebo treatment clearly indicates that if a person has confidence in a procedure, it greatly enhances the chances that the procedure will be
effective, and that that a person’s doubts can decrease the efficacy of a proven effective medication. Other scholars (e.g., Blaustein, 1992) have suggested that it is the confidence in the practitioner and belief in the efficacy of the proposed treatment that is significantly responsible for cueing the healing process. Blaustein has written that the emotional value which the patient invests in a given mode of treatment and a particular practitioner has a great deal to do with the success or failure of any therapeutic regimen. He has further argued that the practitioner’s ability to understand client’s frame of reference as reflected in the presentation and interpretation of symptoms influenced compliance to an appropriate regimen and in initiating success. The Western-based counselor engages the client on more cerebral, abstract, sedentary activity, while African indigenous approach involves the participant in an emotive and active experience through dance and songs (Shuping, 1999). Sometimes part of the difficulties by professional counselors in connecting with clients in non-western settings may stem from the lack of understanding and no appreciation of these significantly different worldviews and culturally specific expectations.

Most counselors, according to Sue (1999), have received training in a Western ontology that neither embraces indigenous nor alternative healing approaches. Sue’s observation has been that, if anything, the Western approach actively rejects such alternative approaches as unscientific and supernatural. However, Morley (1979) has pushed this point even further by cautioning that:

One must seriously ask oneself whether superstition and myth in the derogatory or non-scientific connotations of these words, are not due to our judging a given people from our conceptual standpoint, rather than theirs. ... When the trouble was taken to find their concepts, then it became evident that everything made sense and that their behavior and cultural norms followed as naturally and consistently from their particular categories of natural experience as ours do from our own. I believe it is just as much an error to suppose there was no people
anywhere who insisted on empirically, and hence scientifically, verified basic concepts before
Galileo. Prevalent as the latter belief is, it is nonetheless rubbish. (p. 1)

Invariably, counselors using the Western models are encouraged to rely on sensory information,
defined by the physical plane of existence rather than the spiritual one (Sue, 1999). Sue has
described such a stance as rigid and shortsighted, thereby resulting in most counselors having
limited experience in indigenous methods. He has added that:

Because counselors are increasingly being asked to work with culturally different clients, and
because they now realize that the conventional one-to-one, in-the-office, talk-form of treatment
may be at odds with the cultural views of their clients, they are finding their traditional
therapeutic role ineffective. (p. 146)

There is a need to challenge the Eurocentric view that presents the Western culture as reality
and universalizes its therapeutic interventions, theoretical postulations and causal explanations,
and techniques. Fish’s (2004) position has been that if we do not challenge this view “we would be
passing off an unverifiable Western” (p. 71) explanation as a universal one. Cross-cultural studies
comparing Western and non-western approaches to therapy have revealed that “many traditional
cultures have healing that are dramatic (or appear so to Western eyes) and in which the suffering
individual undergoes physically and/or emotionally stressful treatment and expresses intense
emotion” (Fish, 2004, pp. 70-71). It is clear from this statement that there is a need to confirm
before generalizing any behavior to other cultures. To use one’s own philosophical lens to
interpret a behavior of a client from another cultural experience without exploring the client’s
cultural frame of reference may be misleading. The counselor needs to view the behavior from the
client’s cultural experience rather than basing it solely on prescribed labels of symptoms. What
needs noting though is that response expectations differ from one cultural group to another.
Fish (2004) has suggested three things that may help understand why and how therapeutic procedures may work in a particular culture but not another. First, one may choose to make use of elements that work in other cultures. Second, one could seek to know the therapeutic approaches that might work best in other cultures. The third thing is to try to figure out how the therapeutic procedures modified so that they could be of use in other cultures. A number of writers (e.g., Bodibe, 1999; Shuping, 1999; Somé, 1999; Sue, 1999) have highlighted the importance of exposing counselors exposed to the indigenous healing practices. Sue has found that many counselors who have limited skills in indigenous methods of healing. He argues that some counselors have difficulty working with clients who believe in the following: spirit possession, special powers of the Shaman, the spirit world, and rituals (e.g., chanting, incense burning, symbolic sacrifice, etc.) as only methods of cure. The tendency by such counselors has been to convince the client that they are suffering from irrational thoughts, lack contact with reality, and to “convince them that spirits do not exist” (Sue, 1999, p. 143). Counselors have to acknowledge and to consider the cultural environment within which these thoughts and beliefs exist, and how to utilize the environment to facilitate therapy rather just dismissing them as irrational.

*Environment as a Contributory and Relief Factor*

The environment (i.e., social, physical, cultural, and spiritual) plays a significant part in causing or relieving of distress or illness. Counselors could play a crucial role in helping clients use the environment as an important factor in ensuring their wellbeing. Sue (1999) has identified six advocacy roles of a counselor. These roles included (1) active helping, (2) working outside office (where client is based), (3) focusing on changing environmental conditions as opposed to focusing on changing the client, (4) not emphasizing pathology, (5) emphasis on prevention and remediation, and (6) determining course and outcome of the helping process. Changing
environmental conditions, therefore, includes paying attention to some of the factors in the social, physical, and cultural settings that to eliminate those that cause disharmony or imbalance in the client’s life. Hahn (1995) has stated that effective systems must recognize the sociocultural environment in which the sicknesses occur. In addition, he has observed that relief of illness is likely to require attention to persons and their environments as the target of interventions. He has reported that in African settings, explanations of sickness as caused by grudges and witchcraft are of illness accounts yet in Western society, the popular belief in ‘stress’ as the pressures of the social environment.

The client’s framework for thinking about sickness, according to Hahn, is the persons and their environments, including their society, culture, and physical environment. “Persons affect and are affected by their environments; and each part of a person (body, mind, experience, relationships) may affect other parts” (Hahn, 1995, p. 27). In line with the systems perspective, diagnosis and treatment would encompass all aspects of the client’s life. Most notably, the bio-ecological approach would pay attention to the mutual relations between the organisms and their environment (Lieban, 1977). Sickness has been associated with the cosmological forces, the social relationships, and interpersonal conflict (Hahn, 1995). Good social relationships are associated with a supportive social environment. A strong supportive social environment and the expectations of the clients contribute immensely to healing (Hahn, 1995). For example, Hahn reported that such a social environment was common in non-western systems seemed to be beneficial to mothers. Hahn has suggested that clients’ bodies and minds may play a prominent role in their own healing of others. He has maintained that the impersonal forces such as the physical environment may also play a healing role. For example, a holiday at the beach or sightseeing as a way of changing the environmental conditions is one such physical setting.
The physical setting for counseling has a significant impact on the therapeutic atmosphere. The setting may enhance interpersonal relations and the expectations of the client. Hahn (1995) has remarked that whereas in Western setting, the institutions where therapy takes place (e.g., doctor’s office, clinics, hospitals, schools) commonly occupy separate physical settings, in non-western cultures, healing institutions not distinct from other social structures. These healing institutions generally form part of the social structures that the client is familiar with; making the client feel more at ‘home’ or comfortable participating in them. These structures may be more welcoming environments than an office or some facility that the client might be visiting for the first time. The indigenous practitioners’ place for treatment is normally the home, where even family members may be present to offer social support to the afflicted member. Discussing the environment under which indigenous healers operate, Doctor Semathu, a member of the association of healers in Botswana noted that “traditional healers work with a holistic approach that includes not only the present community that the patient lives in, but also the spirit community of deceased ancestors. Isolate the patient, he said, and you lose all important community support” (Devos, 2004, ¶ 19). Counselors need to be aware of and to understand the cultural environment of their clients. Commenting on cultural understanding, Sue has maintained that:

Cultural competent counselors must begin to expand their definition of the helping role to encompass greater community involvement. The conventional counselor role, oftentimes, is nonfunctional in minority communities. Becoming an effective advocate for indigenous healing requires increased sensitivity and knowledge acquisition. (p. 14)

Increased sensitivity to and understanding of indigenous cultural environment also help counselors appreciate that people sometimes access various treatments simultaneously or alternately. The
counselor, therefore, should not assume that a particular therapeutic perspective is superior to another (Sue, 1999).

Studies (e.g., Dembow & Thebe, 2006; Lieban, 1977) have found that some people have alternated between “modern” practices and those interventions of their indigenous culture. For example, in the area of health, Lieban has found evidence that people who make use of both modern and indigenous medical systems tend to place illnesses in two broad categories: those illnesses likely to be cured by a physician, and those more inclined to responding to the ministrations of a healer. Lieban has reported that the course of illness, the outcome of the previous treatment for the same condition, and a variety of other factors may cause the patient to redefine it and to shift from one medical system to the other. He has also observed that people will utilize modern medicine because of its demonstrated successes while retaining their traditional beliefs about disease causality. Furthermore, he pointed out that people might continue their traditional activity or add new practices while retaining their old ones when they do not perceive the benefit of discarding the old customs. Other factors noted by Lieban included fatalistic attitude toward illness, which sometimes impeded medical efforts. Individuals with such attitudes believed that the outcome of the illness is inevitable; that it is unalterable by any human action and believing that symptoms are beyond human ability and perceiving remedial action to be futile (Lieban, 1977). This study sought to establish how counselors handled such belief systems such as those described by Lieban in this section.

Sue (1999) has delineated some of the assumptions that most non-western indigenous healing beliefs share. The first assumption is that problems reside in relationships with people and spirits. The second premise is that harmony and balance in the family and nature are desirable. Thirdly, that healing must involve the entire group and not just an individual. The fourth assumption is that spirituality prayer and ritual are important aspects of healing. The fifth assumption is that the helper
is a respected elder of the family or community. Last, the method of healing is culture specific. Most counselors, according to Sue, would find great difficulty in working with clients who use such methods. Sue has maintained that it is important for counselors to understand indigenous helping practices as well as their role as advocates of these practices. He has proposed that mental helping professionals must be willing and be able to form partnerships with indigenous healers to develop community liaisons if they are to be effective advocates. This study also examined some of the partnerships counselors had with indigenous healers; and sought to identify some of the barriers and challenges to collaboration between counselors and healers in Botswana.

The literature on healing is replete with illustrations on how indigenous healing approaches differ from Western methods of counseling. Some writers have characterized indigenous healers as directive, that they laid emphasis on giving advice, purportedly from the superior wisdom of ancestors, yet the Western-based practitioners left the responsibility for change, decision-making, and actions with the client. While the non-directive tendencies of the Western-based counselor might fit very well the expectations of the client in Western setting, the client in some African cultural environment may view them as a limitation. The strength for healers lies with that they “offer information, counseling and treatment to patients and their families in a personal manner as well as having an understanding of their client’s environment” (Mokaila, 2001, ¶ 1). What is critical here is how these differences may influence the clients’ choice between the two approaches to their problems? How do professional counselors in Botswana respond to the different worldviews and belief systems of their clients? The discussion that follows explores literature on worldviews and belief systems in relation to counseling.
Worldviews and Belief Systems

Describing the African worldviews and belief systems, Millar (2004) has stated that traditional African ways of thinking and reasoning differ in many respects from the dominant international approach. He has pointed out that despite Western influence, the Africans still base their decisions about health management on the concepts of African traditions. Further, he has noted that at the village level the spiritual leaders, although often not clearly observed by outsiders, are quite influential. “Nowadays, thinking amongst Africans ranges from traditional to modern, but in many cases both systems can be observed parallel to each other. Traditional worldviews and traditional institutions play an important role” (Millar, 2004, p. 1). Millar’s argument has reflected that the African and Western worldviews and systems of thinking coexist, in various shades and combinations of both, as several parallels within the same continuum. What then is worldview? Geertz (1973) has defined worldview as the “picture of the way things in sheer actuality are, their concepts of nature, of self, of society” (p. 126). His opinion has been that worldview demonstrates meaningful relationship between values people uphold and the general order of existence. This study has explored ways in which Professional counselors in Botswana dealt with cultural belief systems and worldviews of clients.

Western approaches and intervention strategies for addressing complex cultural manifestations of problems and inexplicable cases have proven to have minimal impact in solving the indigenous problems (Bodibe, 1999; Lindell, Barrett, & Bydawell, 2004; Shuping, 1999). Founded on different historical, cultural, and theoretical assumptions about human behavior, the Western and indigenous Botswana helping systems, are bound to differ significantly in their intervention strategies. According to Fish (2004), the “different cultural norms would lead to different strategies for different behavior” (p. 77). This is emphasized by Sobiecki (n.d.[b], Culture and substance section, ¶
Many cultures differ radically in their worldviews, systems of logic, and conceptualisation of existence.” Morley (1979), however, has advised that the “differences in worldview do not reflect superiority or inferiority but that people are thinking in patterns of thought provided us by the societies in which we live” (p. 8). This difference in worldview defines what it means to be human and how individuals place themselves in their world. Rogerson (n.d.) has argued that cultural beliefs influenced the way people respond to the world around them. A number of writings (e.g., Eagle, 2005; Rollins, 2007) on intercultural interventions have emphasized the respect for the client’s cultural beliefs. Counselors need to understand what these cultural beliefs mean to their clients. It is not enough to just be culturally sensitive. Counselors need to acknowledge these beliefs and to honor their place in helping clients.

Some scholars (e.g., Bemak & Chung, 2004; Bodibe, 1999; Fish, 2004; Hirsh, 2004; Marsella, 1985; Shuping, 1999) have emphasized the need for counselors to take heed of the cultural context and to strive to embrace the worldviews of non-western cultures. An important question to ask is: How can counselors in Botswana embrace the client’s belief systems and cultural ways of responding to pain, and the views about illness? Counselors must acknowledge that there are various worldviews out there, and to respect them if they seek to become culturally appropriate and effective. Williams’ (2003) article on the worldview dimensions of individualism and collectivism has delineated important implications for these two contrasting worldviews. Both of these dimensions have their core set of values and principles on interpersonal and intrapersonal relationships. These values and principles are key to counselor effectiveness. Williams’ article has provided insights about the “complex and widespread impact that the worldview dimensions of individualism and collectivism have on the counseling process” (p. 373). Moreover, the article has revealed that “a competent counselor is one who not only understands how his or her worldview
influences the counseling process, but who also takes an active stance toward understanding the worldview of his or her clients” (p. 373). Furthermore, Williams has shown that multicultural models’ categorization of worldview variations according to race, ethnicity, or national group membership, is inadequate.

Hirsch (2004), however, has concluded that indigenous non-western therapeutic approaches embrace a holistic approach to therapy. She has also written that Western treatment needs to “rediscover the elements of holistic treatment in response to a disgruntled population tired of being perceived as ‘disease’ instead of individuals worthy of interpersonal interactions and human contact” (p. 96). Like indigenous healing practices, the holistic therapeutic perspective, pushes for therapies that focus on the whole person, that is, the physical, social, spiritual, and the self. According to this perspective, a person’s beliefs and expectations of illness and health, influenced by both psychological and sociological factors, can directly interact with their health status (Hirsch, 2004). The approach presupposes that failure to consider this interconnectedness and interrelatedness among the different aspect of an individual may limit the ability to respond holistically to the client’s total experience. Other important characteristics of indigenous healing include its group orientation, individualization of treatment, and identification of a multitude of causation or contributory factors (Staugård, 1985). The therapist must consider all these factors. Staugård (1985) has stated that, as a rule in indigenous healing, treatment involved as many of the people affected in the disease process present. Another significant characteristic that helps the individual reconnect is that “treatment tends to activate the patient and demands his (sic) participation, both during the diagnostic phase … and during the treatment” (p. 83). Treatment may involvement, among other things, use of symbols, rituals, and other diagnostic and treatment paraphernalia.
Use of Symbols, Rituals, and Tangibles

Shuping (1999) has identified some of the key differences between Western-based counseling and indigenous healing practices to include those related to approach, principles, and activity. In addition, Shuping has presented that symbolism, intuition, and integrating the beliefs and cosmology are central in the African approach. Conversely, Western-based approach, according to Shuping, founded on scientific and logical principles; does not tap on the religious beliefs and symbolism. Geertz (1973), on the other hand, has suggested that symbols such as The Cross, the crescent, and other religious objects bear a sense of intrinsic obligation, they encourage devotion, and they enforce emotional commitment. Geertz has summed up the discussion about symbols by stating, “for those whom they are resonant, what is known about the way the world is, the quality of emotional life it supports, and the way one ought to behave while in it” (p. 127). He has mentioned that symbols give what is otherwise actual, a comprehensive normative import. Writing about the impact of symbols on the brain and thoughts, Blaustein (1992) has stated that:

Intangibles like words and symbols, when leveraged through a brain whose major form of exchange is such thoughts, can be powerful. Words can be scalpels. They can generate thoughts, feelings, and beliefs in our brain which can be communicated to the cells of our body and even to the chemicals within the cells. (p. 38)

Bloomhill (1962), on the other hand, goes at length to describe the regalia and its curative effect, pointing out that the “bizarre trappings are intended to inspire awe in his clients, for he realizes that faith in a doctor’s healing powers is the greatest of all curative agents” (p. 49). Hewson (1998) has suggested the effect of the healer’s regalia and paraphernalia on the therapeutic process.

Blaustein has thought that the most important integrative resources are social support and traditional expressive culture. His view was that the formal aesthetic features of healing charms and
rituals contribute to their therapeutic value, thus “rhythm, meter, balance, and symmetry may literally cut through the subjective chaos of unmediated distress and restore the control of the symbol-generating cerebral cortex over the hypothalamus and limbic system” (p. 38). If symbols and rituals are significant in therapy, the question to explore is: How does lack of symbols and other tangibles in counseling influence clients’ views about efficacy of the interventions?

There is need to understand indigenous healing within the cultural context in which it occurs (Hirsch, 2004). Somé (1999) has maintained that the indigenous people believe that “the natural world and the spirit world are closely related” (p. 23). He has argued that gestures, touch, sound, melody, cadence, symbols, and other activities characterized by spontaneity, unpredictability, and harmonious symbiosis form some of the rituals for healing. According to Somé, rituals rejuvenate, create a feeling of transformation among those who participate in them; they create an opportunity for a person to grow and to experience reality. Somé has suggested that people connect with unseen realities, visible in symbols, which is crucial to the wellbeing of their psyches. Wellbeing is a product of interconnections between the physical and spiritual, a mind-body connection interaction.

The Mind-Body Connection and the Holistic Perspective

The debate about duality of mind and body has dominated many studies on the etiology of disease. The mind and body dichotomy remains a highly contested terrain. While the Western-based counselor may place emphasis on the psychological sphere (i.e., the person’s feelings, thoughts, and observable behavior), the African indigenous practitioner pays attention to the holistic approach to diagnosis and treatment, to unity of mind and body, and to community welfare and participation. The comment Blaustein (1992) made about modern medicine would definitely apply to Western-based counseling. His comment was that medicine “must come to terms with the whole person as a social, cultural, and spiritual being, rather than treating the body as a senseless automation and the
mind as a meaningless illusion” (p. 39). Viewed from the systems perspective and bio-ecological approach, Western-based counseling must strive to integrate the body, mind, and environment as inseparable elements of a whole person. Blaustein has thought that future progress of Western treatment is dependent upon its ability to recognize its limitations. He has suggested that Western approach needs to be cognizant of the interdependence of mind and body, individual and society, humanity and the natural world. The spirit and the mind are one, thus:

If you instead address the energy of the mind and Spirit, whose status is affecting the physical body, then you are likely to heal truly. Hence, in the wisdom of indigenous concepts of healing, all healing must begin by first addressing the energetic problems, and ritual is the crucible where this transformation and healing occur. (Somé, 1999, p. 30)

Somé has asserted that the indigenous mind does not admit impossibility. He has pointed out that, instead “it defines itself by not rejecting the unfamiliar, and it therefore thrives on mysteries and magic . . .. Such a mind gives ample space to the invisible because the invisible holds the key to the wisdom of the universe” (p. 31). Most intriguing has been his view about the physical being and the spirit person.

Eventually such awareness becomes an honoring of the shadowy and hidden parts of ourselves, those parts of ourselves that are invisible. There is such a thing as a spirit person and physical person, and more often than not the physical being is so detached from the spirit that one feels split inside. Awareness should ultimately lead to an attempt to bring these parts of the person together to become one. (Somé, 1999, p. 31)

The body and spirit are inseparable, with the spirit world being their interconnection base, and the rituals help open the channel of communication between the two entities (Somé, 1999). Rituals, in this case, are part of daily lives of people, and help rekindle the intensity that keeps people on the
path of the purpose. Humans look to the spirit world to assist them in fulfilling their purpose. Somé (1999) has maintained that a physical body alone cannot have any sort of direction in this life. He has professed that the body and the spirit are extensions of each other and that they are inseparable, with a two-way communication. To describe this connectedness between body and spirit, Somé has used this analogy:

It is as though we are adrift in space during our life, and like an astronaut circling the earth we too need to keep in touch with a base that will tell us how to navigate and maneuver. Our base is in the Spirit World, a ritual helps us open our channel again to that world. (p. 31)

According to Somé, the belief in the existence of the spirit shows that humans strive for instructions in “navigating an often-uncertain world” (p. 31). This implies that without the mind the body cannot function.

The notion of mind-body connection reflects the general indigenous African holistic perspective. To tip the balance on this connection can result in both the physical and mental unrest in the individual. Hirsch (2004) has seen this connection as one of the reasoning that “there are physical determinants of psychological states” (p. 84). Bemak and Chung (2004), on the other hand, have observed that “Western perspective continues to dichotomize the mind and body, whereas many non-westerns … conceive of the mind and body as integral parts of the whole (Chung & Kagawa-Singer, 1995; Pedersen, 2000)” (p. 126). This dichotomization of mind and body, according to Bemak and Chung, affects the outcome of therapy. The holistic perspective of understanding of the human entity would necessitate that the focus of therapy be on every element of the human being. Whenever a person experiences a problem, even those around would experience the unpleasant condition. For example, when one has AIDS it is not just the physical, feelings, thoughts, and attitudes that affected but the spiritual and social relationships. Not only does a counselor have
to we help the person diagnosed with the disease but needs to consider all aspects of their life, including those around them.

Maclean (1979) has acknowledged the importance of social and psychological factors both in the occurrence of disease and in the process of care and cure. Maclean has recognized that:

We are aware that bad interpersonal relations can make us feel ill and that the death of a loved relative can for a time make our own demise more likely; also we acknowledge that patients’ return to health can take place more rapidly in an atmosphere of sympathy and caring. We have been late in on realizing about the mutual involvement of mind and body, partly because the initial successes of modern medicine were built upon a mechanistic model which either assumed a dichotomy between the mind and body or even proceeded on the assumption that bodily diseases could be managed virtually without reference to the person experiencing them. (p. 154)

To many peoples of the world, “the distinction between physical and mental illness and our separation of the individual from his (sic) social nexus are meaningless, and they have not even made a distinction between sickness and other severe misfortunes” (Maclean, 1979, p. 154).

Mathews (1992), however, has stated that illness and misfortune are likely to result whenever the individual fails to maintain a balance between competing forces, whether natural or magical. She has observed that indigenous system makes a distinction between illnesses of the mind and that of the body, and between illnesses having natural as opposed to unnatural origin. These distinctions, according to Mathews, have implications for treatment choice. Mathews’ position has been that natural causes occur when individuals fail to maintain harmony in the physical or spiritual world. Her view was that unnatural illnesses, by contrast, stem directly from the evil acts of others who use magic. Her conclusion has shown that the indigenous system of treatment is based on a view of life
as union of body, mind and soul, and a definition of health as blending of physical, social, and emotional wellbeing. She has argued that such treatment is from a variety of practitioners, none of whom has monopoly over the ability to cure.

In their definition of the local concepts of health, illness, and healing, Wessels and Monteiro (2004) have point out that these concepts “are holistic and spiritually oriented, and distinctions between mind, body, and spirit do not carry the same weight they do in most Western societies” (p. 326). The mind-body basic tenet is that “the mind and body are inseparable and operate in unison” (Hirsch, 2004, p. 55). This integrative view of the human person may influence the way a counselor may respond to a client’s problem. Such a response would not just focus on the mind but all other aspects, including the social, physical, spiritual, psychological, and emotional because they are likely to be all affected by the problem. Yet for a counselor who believes in the mind-body separation may not pay attention to all aspects of a person’s life but one or some, for example, feelings, thoughts, and downplay the other factors. All this has implications for diagnosis of the problem of the client.

Issues and Assumptions about Diagnosis

The ways in which people express emotional problems, spiritual issues, exhibit psychological behaviors, loneliness, stress and depression, and present suicidal tendencies reflect a cultural influence. Diagnosis and therapeutic interventions on these must “be consistent with client’s cultural belief system, values, and healing practices (Bemak & Chung, 2004, p. 126). Sinacore-Guinn (1995) has asserted that culture systems and structural variables have specific meaning. Each one of these variables has their specific meaning, and:

The diagnostician must determine cultural meaning of these systems and structure from the client. Clients may be struggling with a structure within their culture or a conflict between two
or more cultures of which they are a part. What may be misconstrued as an adjustment disorder may in fact be a cultural conflict in which the client is trying to negotiate and satisfactorily meet the demands of separate cultural systems. (Sinacore-Guinn, 1995, p. 21)

Discussing the cultural factors in therapy, Fish (2004) has argued that “problem behavior and its solutions are expressive of culturally determined patterns of normative and deviant behavior . . . beliefs about how behavior changes” (p. 76). According to Fish, while some beliefs that are exotic and magical in the West, they may be ordinary and practical to those who hold them.

The decision in another culture to undergo a dramatic and dangerous healing ritual to rid oneself of evil illness-causing spirits is essentially the same as the decision in our own culture to undergo a dramatic and dangerous operation to rid oneself of a brain tumor. (Fish, 2004, p. 76)

Sue (1999) has reported that even the American Psychiatric Association warns that clinicians who work with immigrant and ethnic minorities must take into account the following: the predominant means of manifesting disorders (e.g., possessing spirits, nerves, fatalism, and inexplicable misfortune), the culture-specific explanatory models, and the preferences for indigenous sources of care. Sue has advised that it would be helpful for counselors to read books about non-western belief systems, and to attend seminars and lectures on the topic. However, he has stated that “live experience” must supplement understanding culturally different perspectives. He has also suggested that counselors need to consider attending cultural events, meetings, and activities of culturally different groups in the community. His conviction has been that hearing from church leaders, and attending open community forums and celebrations would be opportunity to sense the strengths of the minority, to observe leadership in action, and to personalize understanding. He has
maintained that this allows the counselor to identify potential guides and advisors to their self-enlightenment.

The utility of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and other assessment instruments, especially in non-western societies, has continued to receive negative criticism. Part of the criticism has been associated with its historical, cultural, and theoretical origin, which does not reflect the non-western experience and cultural contexts. Commenting on the use of DSM-IV, Shuping (1999) has noted that Africans have a different concept of illness and suffering from that of Western culture. For example, the notion of mental ill health is fundamentally different in Western understanding of psychopathology as shown in the DSM-IV (Shuping, 1999). Critics of the DSM-IV as diagnostic tool have argued against its direct utilization in non-western settings without establishing its efficacy, especially Africa. Other observations have to do with the fact that it has limited use of studies about the different African populations.

According to Fabriega (2004), labeling, codification of experiences or illness have characterized diagnosis. Fabriega has observed that concepts from the medical model have influenced the categorization of these experiences. He has observed that the model is a disease-oriented way of thinking, and a universalization of psychopathology. Furthermore, he has described the problem associated with universalistic account of psychopathology as:

A distinctive set of cultural categories, assumptions, and values – one that has produced distinctive psychologies and approaches to behavior, emotion, and personal identity – lies embedded in the official system of diagnosis. This is the culture of middle-class, Anglo-European populations of the modern era. (p. 32)

He has written that cultural groups manifest different psychologies, different ways of behaving, experiencing, and expressing emotions, “hence it is natural that they should conceive of and show
psychopathology in distinctive ways” (p. 32). His understanding has included that a clinician who is culturally oriented would take into account the different social and cultural backgrounds of the person on diagnosing psychopathology. He has emphasized the limitations of a culture-free approach to diagnosis and therapy. He has expressed the necessity of taking into consideration cultural factors affecting experience and behavior at every level and at every stage of the clinical practice enterprise. In addition, he has intimated that cultural factors play an influential role on conceptualizing and handling human behavior problems.

Due to globalization, colonization, and domination the Western practical imperative has become an “increasingly universal system of understanding mental illness” (Fabriega, 2004, p. 32). Fabriega has pointed out that cultural factors influence psychopathology, and perhaps graphically illustrated in non-western societies “where one finds wholly different traditions and worldviews that affect personal experience and behavior” (p. 32). He has contended that:

It is a truism that local understanding of self, appropriate social behavior, emotions, and what anthropologists term the behavioral environment are influential and indeed determinative of how behavior, including psychopathology, is construed. What is configured and handled as normality or abnormality, on the one hand, and medical, religious, or political, on the other, is determined by systems of meaning glossed by our concept of culture. There is reason to anticipate that the same assumptions about behavior, including striking behavioral anomalies or eccentricities that Western diagnostic systems qualify as medical or illness related and defined under psychopathology, will be found cross-culturally. (p. 32)

He has concluded that the Western imperative cannot operate effectively when applied to other cultures and subcultures in contemporary pluralistic societies unless the contrasting systems of meaning taken into consideration. His view of psychopathology has been that it depends on how
community has configured and handled it. He has argued that how best one may bring to bear
resources of healing and restoration requires taking into consideration cultural systems of meaning
and conventions about personal experience and behavior. Fabriega has also noted that:

A key assumption is that human psychologies are necessarily also cultural psychologies. It is
the nature of natural selection to produce ways of thinking, teaching, and behaving that
necessarily incorporate local conventions of meaning about social reality, the cosmos,
spirituality, and the natural and supernatural world. In short, there is no inconsistency in
claiming that human behavior, and psychopathology along with it, are universal and culture-
specific. (p. 33)

Literature has shown that culture plays a significant part in our definitions, interpretations, and
management of illness. Sussman (2004) has observed that individuals learn how to view the world,
experience it, and behave in it through acculturation. She has maintained that the “beliefs and
practices related to illness and healing are inextricably linked to other components of the culture,
such as social organization, religion, the economic system, and values” (p. 37). Because the
biomedical system is a culturally derived system, the patients may have diverse perceptions of
illness, and conflicting treatment goals. Sussman has stated that “Beliefs and practices related to
illness reflect the cultural lens through which members of the society view the world. They do not
exist as isolated so-called folk beliefs, folk remedies, or superstitions removed from the wider
cultural context” (p. 38). Sussman has cited Helman’s characterization of a medical system, which
encompasses the ways in which people recognize illness, the ways that they present this illness to
other people; the attributes of those they present their illness to, and the ways they deal with the
illness. If culture provides a framework for viewing illness, therefore, the tools for diagnosing illness
should be based on definitions and codes for interpreting illness that are derived from that culture.
Furthermore, if counselors in Botswana are not equipped to adapt diagnostic tools and frames of reference designed and codified for other cultural settings their application of these would be problematic. It is within the parameters of this study to examine some of the issues counselors face in using culturally grounded methods and structures.

The other major issues to examine are beliefs about the causes of illness, the norms governing choice and the evaluation of treatment, the socially legitimated statuses, roles, power relations, interaction settings, and institutions. As Sussman has pointed out, there are laymen and specialists who adhere to a particular therapeutic system, and that in most societies today, a number of different therapeutic systems coexist, although one system may dominate. Sussman has suggested that “several different therapeutic systems may be used by an individual either for different illnesses or for a single illness with or no perceived ideological conflict” (p. 39). Fabriega (2004) has noted that “practical, mundane knowledge of sickness and healing was conjoined with esoteric, sacred knowledge and with associated religious/spiritual experiences in which trance and possession constituted embryonic ceremonies having diverse functions in the group” (p. 26). Also, he has asserts that:

All sorts of imagined, remembered, and anticipated incidents and agents could be brought into a picture of psychological distress that contributed to an incident of psychopathology. Such things as worries, doubts, fears, suspicions, a sense of profound emptiness, despondency at the loss of valued objects, jealousies, temptations to transgress, and unfounded beliefs all became possible sources of mental agony and behavioral alterations that served to undermine adaptative coping. (p. 26)

Further, altered mental states, including trance and possession, according to Fabriega, could form a part of a picture of sickness and psychopathology, or of a healing response. Fabriega has suggested
that “altered states of consciousness, particularly when they involved confounded and ambiguated the interpretation of psychopathology in emergent communities of modern humans, in some instances blurring the sickness/healing part and in others the personally aggrandizing and socially divisive part” (Fabriega, 2004, p. 28). He has mentioned that the evolution on sickness or healing and psychopathology led to the emphasis on problems of sickness and healing centered on disease. In Fabriega’s view, this has resulted in treatment being directed at either removing, undoing, or neutralizing the effects of disease. This approach, as noted by Fabriega, shows a significant contrast from indigenous perspective where psychosomatic and somatopsychic integrated view of the person prevailed. She has concluded that in this holistic view, the organic or bodily manifestations of sickness, and the character of individual’s life, habits, and behaviors given salient consideration. The holistic perspective, with its systems orientation, seeks to establish an interconnection among the different factors that contribute to illness or those that promote wellbeing.

Interconnectedness and Wellbeing

African peoples are group-oriented in their problem solving and decision-making. Writers (e.g., Busia, 1962; Chilisa, 2005) have identified this unique feature of indigenous African culture. Chilisa (2005) has suggested that most African communities view human existence in relation to the existence of others. She has pointed out that this is in direct contrast to the Western worldview, which emphasizes the individual as the center of existence. She has observed that “most African worldviews emphasize belongingness, connectedness, community participation and people centeredness” (p. 679). Yet, others have ascribed this quality to non-western cultures in general. Non-western societies tend to emphasize the “unity and interconnectedness of all life (humans, nature, and the cosmos) while Western societies often focus on reductionism, dualism and scientific empirical paradigms” (Sobiecki, n.d.[b], Shamanic worldview section ¶ 1). Unlike in Western
society where humans have to “conquer” their surrounding most non-western cultures perceive relationship with environment differently; that is, the person lives “directly off the earth and are responsible for maintaining harmony with it. See Perkins (1994)” (Sobiecki, n.d.[b], Shamanic worldview section, ¶ 1). There is interdependence and connectedness with the spirit world, the social and the physical environment. As reflection of this interdependence and interconnectedness, a lot of consultation has to take place before making a decision. This also ensures support from the rest of the members of the group.

In indigenous Botswana cultural setting, serious life decisions involve the rest of the group or family. All those who have participated are accountable for the failure of the decision made. All those who were involved have to ensure that all succeeds. If one member has a problem, the rest of the family members have to participate in resolving it. For example, during preparations for a wedding those involved consult all key players (e.g., uncles, aunts, and others). Failure to do so creates a problem, especially if the married couple faces problems later on. All those who have been involved during the process act as witnesses and a support system throughout the marriage life of the two. In cases of misunderstanding, the parties can involve any one of the uncles, aunts, or a member of the family whom they trust and have confidence would handle the problem. In the case of bereavement, all relatives and the community provide social support and, at times material support to those directly affected. The bereaved members of the family are assisted as much as possible to go through the process of grieving. According to Busia (1962),:

For in the kingroup, the emphasis is in helpfulness and generosity, and a member fulfils his obligation not by what he accumulates for himself, but by what he gives to the other members.

The donations at funerals and the publicity given to them illustrate ways in which the group
encourages the enjoined virtues of active concern and generosity. Esteem and prestige depend on what a member gives to his group. (p. 34)

Although there have been significant changes in the role of family in caring for its members, the expectations still remain entrenched in Botswana society. Tshitswana (2003) has suggested that perceptions towards the care of orphans are deeply rooted in the cultural beliefs of Batswana. Any effort, according to Tshitswana, to establish alternative forms of care not solely through family ties should be aware of the cultural perceptions and should attempt to gain society’s support. This shows the crucial role of the family; particularly the extended family system as an indigenous cultural structure of Botswana, and how it helps in meeting the needs of vulnerable children. Salole (1992) has portrayed the extended family as “the most obvious strength and resource that children have in Africa” (p. 13). This reflects a different setup from that of Western society where there are institutionalized resources for those who are vulnerable, and those with no social security. These differences in organizational setup and value system have an influence on how people respond to the services made available to them. Exploring the impact of culture for Korean families, Song (2002) has noted that formal mental services offered in traditional Western settings were neither appropriate for, nor accessible to Korean Americans who were adjusting to divorce. According to Song,:

Effective interventions for work with this population (single parent Korean American families) must include consideration of issues related to culture-based shame, Eastern perspectives regarding the limits of self-disclosure, a hierarchical social structure, the acculturation process, and linguistic differences. (p. 1)

The import of Song’s findings highlights the need to use culturally appropriate interventions that reflect people’s value system. Botswana society, like most African communities, cherishes collective value system. In such a system collective involvement and voluntary active participation is the
cornerstone of social support and wellbeing of every member. The characteristics of the collective system are:

Cooperation and mutual helpfulness are virtues enjoined as essential; without them, the kindgroup cannot long endure. Its survival depends on its solidarity. Such a concept of group life makes for warm personal relationships in which every individual has a maximum involvement in the life of the group. This is hardly congruous with life in a large, heterogeneous, competitive society. (Busia, 1962, p. 34)

Busia has further explained that when persons reared and prepared emotionally for cooperative life with near kinsfolk, are thrust into an impersonal, a severely competitive and acquisitive society, the psychological readjustment demanded of them can be traumatic.

When counselors in Botswana deal with clients, particularly in urban settings, they need to understand some of the effects of ‘leaping’ from a cooperative and emotionally supporting society to a competitive and individualistic entity. In an individualistic environment, individuals have to face the harsh realities of life with minimal or no community involvement, except when professional help has to be solicited to address the problem. Yet, those who have spent most of their lives in rural settings where social support is generally available, they would experience difficulty coping with the impersonal social setting of a semi-westernized urban environment. To such individuals the lack of social support and the limited cooperation from those around them can sometimes generate distress. Witmer (1990) has advised that “always be cognizant of cultural conditions and changes. The best of traditional medicine and family life and emerging human and social services of modernization should be combined to enhance the well-being of those served” (p. 27).

Achieving wellbeing requires interventions that are congruent with the existing cultural conditions of the time. Unlike Western interventions, healing rituals in Africa help create bonding
among all those who participate in them (Somé, 1999). Somé has observed that as people gather to perform a ritual they establish a reconnection with others and the invisible world. Life, in Somé’s view, is full of public rituals that mark various processes of transformation in our lives. He has stressed that “there can be no support system capable of curbing the intense sense of aloneness that haunts the psyche of the modern person. Only being part of a community will address the loneliness of modern people” (Somé, 1999, p. 28). Hirsch has deemed the social and the interpersonal interactions to be the critical elements of healing approaches. In indigenous setting, the individual’s healing is dependent on that of the whole community (Hirsch, 2004). Citing Kinsley’s 1996 study among the !Kung of the Kalahari desert in Botswana, Hirsch (2004) has pointed out that the !Kung’s healing dances restore vigor to each member of the group and to the group as a corporate body. In bio-ecological perspective, the whole community, at macro-level acts as a support system for the individual, thus ensuring the sustenance of the intervention. This study has examined ways in which counselors in Botswana partner with family and other cultural structures, including healers.

Collaboration with Indigenous Practitioners

The media and a number of research studies on health issues in Botswana have called for the collaboration between health professionals and indigenous healers. For example, Devos (2004) reported that Dr Levers, teaching in Duquesne University pointed out the need to have healers on board the AIDS prevention campaign. Dr Levers’ position has been that the healers are “the first port of call for most Batswana and we ignore them at our peril” (Devos, 2004, Incorporating traditional healers section, ¶ 18). This section of the chapter explores literature addressing the issues of collaboration between Professional counselors and indigenous practitioners, particularly the healers. There is limited information about the collaboration that exists between Professional
counselors and indigenous healers in Botswana. This study examined the ways in which counselors in Botswana perceived indigenous healing methods, and how they use them during counseling.

Mathews (1992) has argued that the integration of traditional healing systems with Western biomedical systems would lead to the improvement of the delivery of care. While integration of the systems is seen as an important step, there is evidence that people are likely to sometimes choose between the two or use them simultaneously. As Mathews has reported, adherents of traditional medicine “do not necessarily embrace all aspects of the scientific system when it becomes available to them” (p. 2). This has sometimes resulted in the coexistence of the two systems of care. In their discussion of ways of integrating indigenous healing with mainstream medicine, Lei, Lee, Askeroth, Burshteyn, and Einhorn (2004) have highlighted the synergetic power of coexistence of the two systems using the analogy the stars in the dark sky:

If the human organism can be viewed as the dark sky, perhaps the variety of healing modalities (including medical) should be seen as stars in the sky. Each of the stars sheds its specific light on the darkness, and at the same time the stars mutually highlight each other, and thus the illumination they contribute together is greater than the sum of each specific light alone. In that sense, it would be better to have more than less different healing modalities, which should synergistically coexist in an amicable rather than antagonistic way. (p. 243)

The idea of coexistence of therapeutic interventions raises many questions about how counselors relate to other systems available to their clients. Is there a synergistic or antagonistic relationship? These are fundamental questions associated with integration of cultural practices and the collaboration with healers.

Research (e.g., Bemak & Chung, 2004; Gibson, 1995; Sue, 1999) has recommended that practitioners should forge partnerships with indigenous healers to treat specific problems and to
establish openness to collaboration. For instance, Gibson (1995) has studied the potential collaboration between biomedicine and traditional healers in Sierra Leone; found possibilities of interpersonal or micro-level collaboration. Sue (1999) has maintained that “mental health professionals must be willing and able to form partnerships with indigenous healers or develop community liaisons if they are to become effective advocates” (p. 147). He has identified the following advantages to such outreach activities: the knowledge sharing and insights into clients’ population, which would be helpful in the delivery of counseling services; the enhancement of cultural credibility of counselors; and that it allows for referrals to traditional healers (Shamans, religious leaders, etc.) in which treatment is rooted in cultural traditions. He has suggested that to accomplish these goals counselors must respect the universal Shamanic tradition still embedded in a Western psychological tradition. “Most culturally different clients are open to a blend of both Western and non-western approaches” (Sue, 1999, p. 148).

Fish (2004) has advised that to apply principles of psychological treatments from other cultures there is need to look into how the operation of general principles of social influence that have been established by Western science have affected them. His view was that the alien cultural specifics would seem irrelevant or misleading to Western clinicians. He attributed this to the fact that these clinicians would be unlikely to attempt to understand how exotic-appearing elements function in order to seek out new general principles of social influence. Fish has argued that:

Psychologists’ assumption that there is nothing to discover would seem to imply that, at least in this area, psychology is more ethnocentric than medicine, and that both disciplines share a folk belief that the study of biological determinants of behavior is somehow more scientific than the study of social determinants of behavior. (p. 72)
Salole’s (1992) discussion of socialization and resiliency has highlighted some of the pertinent elements that are critical to appreciating the debate on utilizing the best of the indigenous cultural practices of African societies. He has observed that it is often the case that lip-service is paid to the strengths of indigenous culture while the implications of indigenous people’s strengths are disregarded in actual project design. He has suggested that there is need to build on people’s strengths. He has noted that “recognizing and enhancing people’s innate strengths is, therefore, essentially a question of being prepared to look and listen for hidden strengths, to suspend facile judgment, and the conscious development of an ability to interpret circumstances without imposing one’s own solution” (p. 1).

Salole has further argued that the tendency is to overlook the positive and successful aspects of the everyday life of the poor as if they were indeed invisible. He has observed that there is:

A tendency to focus on much more discernible change usually possible with new resources brought in from outside . . . The collapsing structure seems destined to be replaced by new “modern” substitutes and there is little thought given to the fact that the very act of putting up completely new structures is damaging and harming some of the older structures that are still standing. In extreme cases, the underestimation of the ability of ordinary people to deal adequately with problems can lead to projects that are theoretically designed to ‘help’, but that are actually counterproductive and detrimental to the beneficiary. (p. 2)

There is evidently an urgent need to question and to engage in some soul searching regarding our developmental models (Salole, 1992). “The notion of borrowing is important because it provides a lucid example where modern techniques and knowledge have successfully been introduced in a way that is complementary to the traditional structure” (Salole, 1992, p. 13.). Salole has stated that the hostile or insensitivity of the modern education system to the tradition and culture is, partly, a legacy
of colonialism. Fish (2004), on the other hand, has illustrated the various ways in which non-western and Western therapies could successfully appropriate elements from other cultures yet be less concerned with the reactions concerning the inappropriateness of their use. Fish has summed it by stating that the desire to spread Western ‘scientific’ ways of understanding and changing behavior predominates over the desire to learn from those approaches. Salole has intimated that there is a need for a deeper and more intimate understanding of the invisible social fabric that holds society together. He has noted the “need to learn how to give value and recognition to what is already taking place” (p. 11). His proposal was that changes in perspective are called for within the education, health, and social services, and at decision-making and policy levels. He has called for teacher training institutions to develop respect for traditional practices so that new teachers embarking on this existing profession cease to think of themselves as the ones with knowledge but must be sensitive to other socializing agents within the community.

Examining some of the stereotypes about traditional healing, Blaustein (1992) found that “folk therapies are still meaningful to many people, not only in the lowland South but throughout the modern world” (p. 33). Western scientific medicine, Blaustein has argued, “is only one of many therapeutic options available to Carolinians and other contemporary Americans, and not necessarily the option of first or last resort” (p. 33). Blaustein’s suggestion was that:

Medical practitioners and educators need to come to grips with the various alternatives to official medicine… and also take into account of the complex beliefs, values, attitudes, protocols, and communication styles which patients and (emphasis in original) health care providers bring into the clinical situation. (p. 33)

Blaustein has maintained that alternative healthcare systems are extremely vigorous and persistent and that, contrary to stereotyped expectations, people in the higher echelons of society are deeply
involved in alternative therapies of various types. Another significant point Blaustein has stated is that:

It would be incorrect to assume that all adherents to a given therapeutic system are completely and uniformly in accord with its tenets; the individual’s own beliefs, values, and attitudes should be carefully elicited, otherwise the practitioner is once again in danger of being misguided by the stereotyped notions which obscure the actual complexity and diversity of modern cultural and social life in United States and elsewhere. (p. 34)

Studies (e.g., Liddell et al., 2004; UNAIDS, 2000) suggest that the limited utilization and lack of recognition of indigenous cultural practices has had negative results on the delivery of health care of most countries, especially in sub-Saharan Africa. Others (e.g., Levers, 2006b; Subrick, 2006) have noted the need for counselors to solicit the support and cooperation of indigenous healers, especially in facing the reality of HIV/AIDS in Africa. The move to work cooperatively with indigenous healers would require a change in the ideological perspectives for counseling in Botswana.

Changing Ideological Perspectives in Counseling

As the Western-based counseling approaches continue to find their roots in Botswana society, the issues of cultural sensitivity and their appropriateness will remain at the center stage of the debate about cultural relevance. Such issues have already gained prominence concerning the delivery of comprehensive care and treatment of HIV/AIDS clients. One of the major issues regarding the delivery of care has been the limited involvement of healers. In his conference presentation on African renaissance, Bodibe (1999) has called for a new paradigm shift in counseling. He has suggested that:

We need now to shift to the East and to Africa (emphasis in original) to learn how they have grappled with mental afflictions over many millennia. There are certainly approaches that
worked for these people – despite them never having deciphered Freud and others in their lives. They found optimal ways to deal with adversities that confronted them. (p. 8)

Bodibe has maintained that counselors and clinicians could not hope to be effective by “resorting solely to Western practices” (p. 11). Shuping (1999), on the other hand, has recommended that the merits of the African and Western biomedical views should be recognized and developed, and a spirit of cooperation fostered. This suggests a shift in paradigm to embrace the best of indigenous African practices that African communities have used in addressing distress and other mental health challenges.

A paradigm shift calls for counselor educators and trainees, counselors, and other helping professionals to recognize, as observed by Leung (2003), that indigenous practices and models are vital to the development of global counseling discipline. Research on indigenous healing practices has challenged the continued imposition of methods and systems from Western context on non-western indigenous settings. Leung maintained that counselors should avoid a wholesale importation of mainstream counseling psychology into their cultures. Levers and Maki (1994) have expressed similar sentiments and cautioned against transporting a Western model to non-western contexts. Fish (2004) has noted that “there is a limit to the cultural variability across which therapies can be transported, even if a culturally sensitive attempt is made to adapt them” (p. 77). Lefley (2001), on the other hand, has suggested an interface between Western medicine and indigenous healing systems. Interface involves the use of elements and strategies from both systems. If every society has structures and services that serve to address, or to alleviate human sufferings then there is need to consider the useful qualities of each system when counseling. To realize the approach there has to be a study of ways in which interfacing these systems to ensure effectiveness and responsiveness of counselors.
There is no doubt that this new approach to counseling in Botswana would require a new understanding that suggests “a model of counseling that does not rely exclusively upon Euro-American methods, but rather, includes indigenous best practices” (Levers, 2006a, p. 88). However, in light of the prevailing belief in the superiority of Western approaches, and the negative influence on cultural practices and customs, to bring about change for counselors to embrace a new model that includes indigenous practices may be an uphill battle. This would require changing the belief system, attitudes, and values of counselors.

Recent studies and papers (e.g., Hewson, 1998; Levers, 2006a; Liverpool et al., 2004) on indigenous healing in Africa, have cautioned against leaving out indigenous healers in providing healthcare, especially with regards to HIV/AIDS. The literature has revealed that indigenous healers have significant influence in most African communities. Associated with the influence is the wealth of indigenous knowledge these healers possess. Levers (2006a) has argued that “it is particularly important for African counselors to engage the cultural relevance of this indigenous knowledge system, especially in the face of the HIV/AIDS pandemic and the reality that many Africans continue to seek health care services from traditional healers” (p. 87). “The basic Western psychologies continue to focus on individualistic societies rather than on collectivistic cultures” (Bemak & Chung, 2004, p. 126) despite an increase in the research suggesting counselor effectiveness can be influenced by using the client’s cultural heritage. The challenge is how to ensure that Professional counselors can apply their knowledge and skills in a Botswana cultural setting. Salole (1992) has advised that:

To some extent one also must allow for the insidious way which people are made to feel ashamed of their cultural repertoire, so that people who are ‘educated’ are somehow made to feel that they must eschew or repudiate what is regarded as traditional. This results in the
curious phenomenon whereby people who should know better, who have personal
experience of functioning traditional coping mechanisms, are the first to deny their role in
ordinary life. (p. 9)

Somé (1999) has argued that “Westerners need to recognize that indigenous thought is here to stay
as well” (p. 13). He has noted that the need to redefine the indigenous world and that it will
“continue to pervade the fabric of modernity” (p. 13). He has maintained that indigenous wisdom is
bound to continue undisturbed beneath the transformations that can take place in society.

A new wave of thinking in the counseling movement in Africa has invoked the African
renaissance. A number of conferences (e.g., Botswana, 1999; Rwanda, 2005; South Africa, 2006)
have paid special attention to the revival of cultural ways of dealing with the African experience and
worldview. This new wave of thinking has continued to reflect on the negative consequences of the
colonial and missionary influences with its accompanying cultural degradation. The need for change
in ideological perspective of the counseling movement in Botswana requires a new paradigm shift.
The new perspective must strive to create a more positive image of some of the best cultural
practices and structures that have significant therapeutic functions. For instance, Jilek (2004) has
observed that the revival of the North American Indian ceremonials brought about a deflation of the
once glorious Western self-image and the abandonment of the once dominant Eurocentric
worldview, together with Western superiority claims. Jilek has reported that while these changes
were ushered in “at the same time the Western image of non-western culture and spirituality
upgraded” (p. 157). This, according to Jilek, changed the Western perception of the shamanic healer
from that of “a diabolic charlatan or madman to that of a model psychotherapist” (p. 157). Finker
(2004), however, has observed that “despite biomedicine’s extraordinary achievements, a multitude
of alternative healing forms continue to flourish” (p. 161), and that significant change in how
indigenous healers are viewed has occurred. Western scientists are coming to terms with indigenous African healers’ grasp of medicinal or nutritional value of species of plants for humans. Akosah-Sarpong (2001) has alleged that outside Africa, people with mental problems are using African shrines transported to the Western hemisphere as psychiatric therapies and healing. In some African countries, indigenous healers and practices are getting new respect and regard (Akosah-Sarpong, 2001). This study investigated ways in which counselors in Botswana relate to indigenous healers.

Summary

This chapter presented a review of the literature on cultural practices and structures in Botswana, and utilizing culture, worldviews, and indigenous systems to enhance counselor effectiveness. The first section of the literature review focused on cultural practices and structures in Botswana. This section explored the extended family and healing systems as cultural structures that counselors in Botswana could use. Further, there was a review of literature on the impact of missionary activities on indigenous Botswana cultural practices. I also discuss the colonial legacy and its influence on attitudes towards cultural practices, and how the introjections of Western values by Batswana reflects the negative impact of the colonial and postcolonial experience.

The second section discussed how respecting client’s culture could have an influence on counselor effectiveness. The literature revealed that culture defines people’s worldview and behavior as well as how they respond to pain or any form of distress, the client’s general predisposition towards treatment and its efficacy. Some writers have shown the influence of client cultural expectations of the therapeutic outcomes on the efficacy of the proposed interventions.

Research indicated the counselor’s appreciation of the differences in coping patterns and assumptions through which the clients interpret and make sense of their universe, can alter his or her understanding of the problem as well as determine how the interventions to be utilized. The
literature revealed the importance of decoding the client’s cultural experience as a critical step in facilitating counselor efficacy. Yet, studies showed that the environment (i.e., social, physical, cultural, and religious and spiritual) contributes significantly to facilitating the therapeutic process and outcome. To this end, changing environmental conditions as opposed to the client determined the course and outcome of the counseling process. There was a belief that a strong supportive environment contributes immensely to healing.

The third section of this chapter focused on the indications for counselors to consider the cultural context and embrace the worldviews and belief systems of their clients. The research on worldviews of Western and non-western cultures revealed that differences existed, and that sometimes these views coexisted or at times were mutually parallel to each other. What some findings suggested was that counselors had difficulties addressing some of the cultural and complex manifestations associated with indigenous worldviews and belief systems. The literature suggested that integrating the belief systems and cosmology of clients is very important. There were also indications in the literature that some of the major differences between Western-based counseling and indigenous healing practices had to do with approach, principles, and the activities as well as the latter’s use of symbols, rituals, and tangibles. Another significant difference between the two approaches was about the body-mind relationship, which has continued to be a contested terrain among scholars.

While the Western society’s philosophic thought, with its foundation in medical and scientific fields, maintains that the body and mind are separate and autonomous entities, indigenous perspectives treated these as inseparable and thus interdependent and interconnected in their existence and operation. The other non-western view discussed in the literature was that there is
connection between the individual’s wellbeing and harmony and all aspects of his or her life, hence the need for a holistic approach to treatment.

The fourth section of this chapter reviewed literature linked to issues and assumptions about diagnosis and cultural differences. Some writers indicated that diagnosis and therapeutic interventions must be consistent with the cultural beliefs, values, and healing practices of the client. Others noted that the labels and codification of behaviors by one society might not receive universal acceptance since they reflect cultural assumptions and values from a different philosophical and psychological data about human behavior.

The fifth section explored literature discussing the concepts of interdependence and interconnectedness as determinants of an individual’s wellbeing. Some reviewed studies described the African’s worldview as emphatic on issues of belongingness and social support, community primacy, interdependency and interconnectedness with others and the spirit world, and harmony and balance within the individual as well as with the community. Any loss of this balance and harmony contributed negatively to one’s wellbeing. The literature exploring possible integration and collaboration between counselors and indigenous practitioners revealed some of the challenges and issues associated with ways in which they can work together. What the literature suggested was that there is growing need for conventional practitioners to work very closely with indigenous healers and integrate healing systems.

The last section of this chapter examines literature proposing a new paradigm shift in the current ideological perspectives and strategies for counselors in Africa. What was evident from the literature was that counselors could not continue to rely solely on Western practices. Research highlighted a growing awareness and limitations created by the continued imposition of the Western methods and systems on non-western settings.
CHAPTER III
THE METHOD AND RESEARCH DESIGN

This chapter describes the research methods and research design used in this investigation of Botswana counselors. The first section of the chapter discusses the non-positivist assumptions of qualitative designs and the type of design for this study. Included in this section is a description of sampling procedures, sample size, the recruitment of subjects, and clarification of consent issues. The next describes the data collection procedures, including instrumentation and pilot testing techniques. There is also a description of the data recording procedures. The data analysis section covers procedures for data analysis, that is, content analysis as a qualitative data analysis procedure, and then describes the steps for the content analysis technique employed in this study. There is specification of steps for verification, and then discussion of the limitations of the study. The last part of the chapter gives an overall summary of the whole chapter.

Qualitative Inquiry and the Systems Perspective

Various research paradigms exist today. While some paradigms have reflected a linear approach, there are those that have emphasized the systems view of the world. The debate between linear and organic constructions of reality (Patton, 2002) continues to rage in the research arena. The underpinning view in a systems perspective to research is its emphasis on holistic thinking. According to this view, studying a phenomenon does not require taking it apart into discrete elements but explaining it as “interconnected and interdependent that any simple cause-effect analysis distorts more than it illuminates” (Patton, 2002, p. 120). A system, according to Patton, “cannot validly be divided into independent parts as discrete entities of inquiry because the effects of the behavior of the parts on the whole depend on what is happening to the other parts” (p. 120).
As a qualitative inquiry, systems perspective has featured international development efforts, farming systems, evaluation of interventions and development (Patton, 2002). Laszlo (1972) has suggested that human phenomenon has always been viewed with a cosmic context and that to understand a person one must understand their world. According to Laszlo, “the systems view of man (sic) links him again with the world he lives in, for he is seen as emerging in that world and reflecting into general character” (p. 79). He has strongly argued against studying a person without regard to other things. This study, which used in-depth interviews and content analysis, premised on the philosophical assumptions of interconnectedness, interdependence, and interrelatedness, used systems perspective to investigate ways and the extent to which counselors utilized cultural practices and structures. The aim of this study was not to prove that systems theory works but use its concepts to explore how counselors make use of the various systems around them, namely the client, the culture and its inherent structures, and how they handle the belief systems, spiritual, and religious orientations. Another critical position in systems perspective that is pertinent to this study design is the focus on the interrelations between the different systems affecting counseling in Botswana.

Assumptions of the Qualitative Inquiry

Unlike quantitative research, qualitative inquiry has a number of assumptions about research methodology. Writers (e.g., Creswell, 1994; Merriam, 1998; Miles & Huberman, 1994; Patton, 2002; Wolcott, 2001) have identified the features of qualitative inquiry to include the emphasis on gaining insights, discovery, and understanding the phenomenon rather than testing theory. Patton (2002) has observed that qualitative inquiry by nature is exploratory, inductive, and discovery oriented, and that it focuses on the interrelationships that “emerge from the data without making prior assumptions or specifying hypotheses” (p. 56) about the phenomenon. Merriam (1998), on the other hand, has delineated several assumptions about qualitative research. First, that the focus of
Another important assumption is that qualitative research involves going to the people or sources of data in order to observe the phenomenon in its natural setting. According to Merriam, familiarity with the phenomenon studied is essential. Qualitative research primarily employs inductive research strategy thus it builds abstractions, concepts, hypothesis, or theories, rather than testing existing theories. The data analysis procedure used in this study was content analysis. This kind of analysis involves categorization, generation of themes or concepts, development of hypotheses, or building new theories. For this study, there were various themes generated and explored. As this qualitative study is descriptive, reporting of data was predominantly descriptive and at times direct citations of participants’ own words.

As applied research, this qualitative study investigated how counselors in Botswana incorporated indigenous cultural practices and structures with a view to understand and to explain the nature of the problems as perceived by counselors themselves. The applied research design was fitting for this study because of its contributions to theories that can help develop culturally grounded counselor education programs and interventions. Although the results in applied research can have limited application, they can help “policy-makers, directors and managers of the intervention organizations, and professionals working on problems” (Patton, 2002, p. 217). Patton has suggested that applied research studies “test applications [emphasis on original] of basic theory
Design of the Study

The systems perspective and bio-ecological approach to human understanding and development influenced this research design. However, the purpose of this study is not to establish the efficacy of systems theory and the bio-ecological approaches but these guided the perspectives about human nature and conception of reality. Both, the systems and bio-ecological research perspectives emphasize the holistic view of a problem under study. These perspectives pay attention to the principles of interrelatedness, interconnectedness, and interdependence within and among the systems within which the individual operates. Systems and bio-ecological understanding of human behavior require looking at all the aspects of an individual, including the self, and the environmental factors (i.e., social, cultural, spiritual, physical, religious beliefs and worldview). Literature reviewed was on culture, medical anthropology, religion in Botswana, and traditional medicine and healing. This literature provided knowledge and understanding of the concepts and theories of causation, and the views about wellbeing. Systems perspective and bio-ecological conceptions of human understanding helped frame the study using the holistic view about responding to clients’ problems and concerns. The different parts of Botswana were included for data collection.

Bounding the Study and Selection procedures

The setting. I conducted this study in Botswana. Botswana, a landlocked, 581,730 square kilometers country in Southern Africa, has a population of approximately 1,639,833, according to 2006 estimate (CIA World Factbook, 2006). She was a former British protectorate from September 30, 1885 until September 30, 1966 when she acclaimed independence. There are five countries bordering her, namely South Africa (South), Namibia (West), Zambia (North), and Zimbabwe.
(North East). She is generally described as a shining example of democracy in Africa, well known for her long tradition of democratic rule, respect for ethnic and racial differences, freedom of the press, and governmental involvement in supporting development programs (Dembow & Thebe, 2006). She is one of the few countries in the world where there is minimal tension between the customary and common law. These two legal systems, the former reflecting the ‘traditional’ customs, traditions, and rules of the different ethnic groups, and the latter, common law is the Roman-Dutch law. The Kgotla (customary court), an indigenous cultural forum for resolving disputes, discussing social and development issues remains relatively a unique feature of Botswana’s culture, legal, and political practice. Botswana’s international profile reports her as Africa’s most economically and politically stable country, and the world’s largest producer of diamonds, the main source of revenue that helped the country to become one of the fastest growing economies in the region. Whereas around 20% of her population is in major urban centers, 70% remains in rural and semi-urban areas.

Botswana has diverse ethnic composition and pluralistic religious character. Several ethnic groups with their different customs, traditions, and religious and cultural practices, have lived harmoniously as one nation bound together by one national identity and a common past. Despite the different cultural practices and the varied ethnic origins, Batswana have lived together with minimal or no significant ethnic tensions and political conflict that has characterized certain parts of the African continent resulting in relentless bloodshed, constant coups, and sporadic civil wars. There has been significant cross-cultural exchanges and assimilations among the different ethnic groups, characterized and influenced by inter-ethnic marriages, cross-country migration and deployment of culturally diverse public servants regardless of ethnic origin, the ethnic integration in education as well as regional and national cultural interactions among young
people, and a common national curriculum and school materials. Literacy has increased to 72 percent in 2000 (Dembow & Thebe, 2006).

The religious pluralistic character of Botswana remains evident despite the country’s declaration to be a Christian state. While over 60% of the population may profess and practice Christianity (Department of Tourism of Botswana, 2001), there is a large number of Christians who simultaneously adhere to other religious practices, including indigenous ones. This blending of Christianity with indigenous religious practices (Dembow & Thebe, 2006), is evidenced by ancestor veneration, divination, prophetic practices, and other rituals and ceremonies uniquely cultural. Numerous church denominations, including the Roman Catholic, Methodist, Lutheran, Dutch Reformed, Seventh-day Adventist, and several African independent apostolic and spiritual healing churches exist side by side in different parts of the country. Other religious faiths such as Islam, Hindu, and Bahai form part of the religious pluralism of Botswana. All these characteristics and social influences of Botswana have significant implications for counseling practice.

Participants. Participants in the study were 30 counselors who received Western-based training. They were counselors working in different organizations such as the University of Botswana (UB), a college of education, the Guidance and Counseling Division (G&CD) in the Ministry of Education, Botswana College of Distance and Open Learning, Secondary Education Department, three senior secondary schools, a hospital, and a non-governmental organization. All participants have worked as counselors for a minimum of one year, and held a minimum of a diploma in counseling. They were from different parts of the country (i.e., rural and urban), and the different geographical locations, including the North, North West, and North East. These three geographical locations were included because they are likely to have a predominance of ethnic groups with cultures that are distinct from the rest of the Setswana-speaking populations. The aim
was to capture the possible ethnic and cultural differences that counselors could be dealing with. Among the participants, there was male and female representation, those who deal with adult population, and those who serve the student population.

**Selecting Participants to the Study**

Selection of participants to the study was through a maximum-variation purposeful sampling procedure (Merriam, 1998; Patton, 2002). Maximum variation sampling is non-probability sampling procedure (Merriam, 1998). Seidman (1991) has asserted that maximum variation procedure provides the most effective basic strategy for selecting participants for interviews. He has observed that it allows access to a maximum range of sites and people that constitute the population. He has stated that there is never exhaustive range of characteristics variations in the population selected for study. Like other purposeful sampling procedures, maximum variation aims at selecting information-rich cases (Merriam, 1998; Patton, 2002). Information-rich cases “are those from which one can learn a great deal about issues of central importance to the purpose of the inquiry” (Patton, 2002, p. 230), and that can yield insights and in-depth understanding.

Purposeful sampling requires determination of selection criteria for choosing the sample (Merriam, 1998). Choosing maximum variation procedure was to ensure that the sample comprised “those who represent the widest possible range of the characteristics of interest for the study” (Merriam, 1998, p. 63). Maximum variation procedure ensures consideration of all possible influences and conditions when selecting the participants for the study. According to Patton (2002), the logic of using maximum variation is that “any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared dimensions of a setting or phenomenon” (p. 235). The main criterion for selection to participate in the study was
that the individual had received Western-based training in counseling at diploma level or above, and had been involved in counseling for more than a year.

To maximize the variation in this study, diverse characteristics of the sample were determined first. These characteristics included gender, place where training was received, level and type of training, regions of the country where they were based, and type of clients they dealt with when selecting participants. The inclusion of these characteristics during selection was to ensure incorporation of the different factors that may influence the use of indigenous cultural practices and structures. For example, those participants working in urban settings are likely to deal with clients whose influence is different from rural settings where indigenous cultural beliefs could be stronger. Selecting participants from different geographical regions was also to ensure ethnic variations. This sampling procedure “is based on the assumption that the investigator wants to discover, understand and gain insight and therefore must select a sample from which the most can be learned” (Merriam, 1998, p. 61). According to Merriam (1998), this type of sampling procedure begins with determination of selection criteria in choosing people or sites.

The counselors were from different organizations and centers. These organizations included the university, colleges of education, Ministry of Education departments, senior secondary schools, colleges of distance learning, and few non-governmental organizations. However, a majority of the participants identified was at the university counseling center and the Ministry of Education departments because that is where most of those who met the qualification criteria are working. The inclusion of a large number in the study was to provide an opportunity to ensure a wide variation of characteristics and experiences as well as the breadth of ideas about incorporation of indigenous cultural practices and structures.
Ethical Considerations and Rights of Subjects

Part of the preparation for the study included the submission of the Institutional Review Board (IRB) documentation together with the proposal to Duquesne University’s IRB office. The documentation included a consent form delineating participants’ rights, protection, and confidentiality issues. Once the IRB office granted approval to conduct the study, I sought permission from the Botswana government to approach counselors in the country. I wrote to the Permanent Secretary to the Ministry of Education (see Appendix A) requesting authorization to conduct research among the counselors in different parts of the country. After getting authorization from the Ministry of Education (See Appendix C) to conduct the study, I invited counselors to participate in the study. The invitation was through a letter of transmittal (see Appendix B) asking them to indicate their willingness to participate in the study by filling out a consent form (See Appendix E). The participants were to sign a consent form and return it in a stamped, self-addressed envelope enclosed in the mailed package. Participants were also asked to give permission to be audio taped during the interview.

The consent form included full disclosure about the study and assurances about confidentiality and the protection of participants. An offer to share a summary of the findings with the participants was included in the form. The form informed potential participants of their rights to withdraw from the study if they chose to, and that this would not affect their future professional relationship with the researcher. In addition, the form explained the purpose of the study and it included an offer to send participants a copy of the summary of the results. Those participants who wished to receive a summary of the findings were to mail a stamped, self-addressed envelope and return it to me. A code number was assigned to all those who were selected. The code numbers were for purposes of
ensuring confidentiality. All names of the participants, and the codes recorded separately in a confidential file.

Data Collection Methods

Semi-structured Face-to-face Interviews

The collection of data was from July 22 through September 26, 2006. Participants were reminded of the following: that personal data would not be shared with anyone; that excerpts, in the form of direct quotations from their statements would be anonymously reported; that the audiotapes and transcripts would remain in my custody; and that they were free to withdraw their participation at any time during the interview. I also reminded participants that if they had interest in receiving a summary of the results they had to provide a self-addressed envelope. Every interview began by asking the interviewees to briefly talk about work their experience as counselors, their training and specialization, place of training, and types of clients they served. I conducted the interviews in a safe place suggested by the participants. All appointments for the interview were by phone.

Semi-structured face-to-face interviews were the main method of data collection. Each interview lasted 1 to 2 hours. I used open-ended questions because they provide an opportunity to get direct quotations from people about their experiences, opinions, feelings, and knowledge (Patton, 2002). Open-ended responses permit one to understand the world as seen by participants, and to enable understanding and capturing of “points of view of other people without predetermining those points of view through prior selection of questionnaire categories” (Patton, 2002, p. 21). According to Seidman (1991), open-ended questions allow the participants to take any direction they want yet do not presume an answer to the questions. The questions establish a territory explored during the interviews (Seidman, 1991). Seidman has stated that these questions allow participants to reconstruct meaning rather than gather answers or corroborate opinions.
Audiotaping interviews, as a recording method, ensures preservation of data for analysis (Merriam, 1998). It allows access to original data (Seidman, 1991). I downloaded every interview into a laptop for preservation and safekeeping until transcription. Each interview label was a pseudonym. As a precaution, I erased any identifying information from the tape to ensure confidentiality in case the computer was lost, or accessed by someone. To ensure confidentiality, I was responsible for transcriptions, which involved verbatim transference of participants’ responses. Merriam has argued that in qualitative inquiry data collection and analysis can take place simultaneously. During interviews, some notes on some of the emerging themes, hunches, tentative hypotheses, and insights (Merriam, 1998), and jotted down any observations. These notes also helped explore some of the insights or issues during subsequent interviews. During the evening, I wrote down anything important that I could remember about the interviews. I performed transcription, coding, and analysis later after returning to Duquesne University.

Description of Instruments

Interview guide. I used a semi-structured interview guide (see Appendix D) as a data collection instrument. Seidman (1991) has advised that researchers should use interview guides cautiously and that open-ended questions be included. This interview format “allows the researcher to respond to the situation at hand, to the emerging worldview of the participant, and to new ideas on the topic” (Merriam, 1998, p. 74). Further, this type of instrument offers opportunities for follow-up questions, which would educe more affective information (Merriam, 1998). Patton (2002) has described the interview guide as listing questions or issues explored in the course of the interview. The interviewer, according to Patton, can “explore, probe, and ask questions that will elucidate and illuminate that particular subject” (p. 343). The guide provides structure and focus of the study. It makes interviewing “more systematic and comprehensive by delimiting in advance the issues to be
explored” (Patton, 2002, p. 343), and it helps with sequencing of questions, and decision about the amount of information to be covered.

In terms of this study, the interview began by asking participants to provide information about their experience as a counselor, training and specialization, types of clients they dealt with, organization they work for, and other sociodemographic data they wanted to share. The next question was for participants to identify and describe the type of cultural practices and structures they utilized during counseling. The participants described the structures they collaborated with, or liaised with in serving their clients. They were to discuss how they used these structures, and the extent to which they used them in counseling. The participants were to talk about some of the beliefs by their clients and how they handled them.

Possible follow-up questions were to include how they would deal with issues of bewitchment, ancestral spirits, fatalistic attitudes, and belief that prayer would be the only method to resolve a problem, and any issues associated with religious and spiritual matters. The guide required participants to talk about their views about indigenous healing practices and methods; discuss how these practices would fit in their counseling; and then discuss how they worked with indigenous practitioners, particularly healers. This question explored issues of collaboration and liaison between counselors and healers. The other question included in the guide was that participants identify some of the indigenous cultural practices and structures people in their communities continued to use regardless of the services offered by counselors. The last part of the guide was about identifying and discussing some of the issues and challenges they faced when incorporating cultural practices and structures during counseling. This was to examine some of the barriers to utilizing indigenous cultural practices in counseling.
As part of the development of the data collection instrument, a panel of expert judges, well-versed in qualitative research and data analysis method for this study gave feedback on the proposed instruments. The judges’ feedback was to facilitate revision of the instrument. Before the study, I submitted the interview guide to colleagues at the University of Botswana who had expertise for evaluation to help with information relevant in the final revision of the instruments. These colleagues were mainly people with expertise in qualitative research methods.

Three potential participants participated in pilot testing of the instruments. Seidman (1991) has stated that “the unanticipated twists and turns of the interviewing process and the complexities of the interviewing relationship deserve exploration before the researchers plunge headlong into the thick of their projects” (p. 29). He has noted that piloting helps the researcher learn about the appropriateness of the study envisioned, and to come to grips with practical aspects of access, making contacts, and conducting the interview. The data gathered through pilot testing were not included in the analysis. The information collected through the pilot study helped to check on the accuracy and understandability of the items, appropriateness of the language or statements used, length of the data collection instruments, ambiguity of the questions, and to establish the feasibility of the intended data coding systems. Because of the pilot testing, I incorporated a section into the interview guide to collect professional and vocational information. This part asked every participant to talk briefly about their length of service as a counselor, their specialization, place of training, and types of clients they dealt with. There were also two more questions added to the interview guide. These included one item addressing the beliefs of the clients they dealt with. The next step was to ask participants to talk about how they handled clients’ beliefs and worldviews. The interviewees shared their views about indigenous healing methods and practitioners. A follow-up question was about how these methods and practices fitted in their counseling.
I used content analysis to analyze interview data. As a qualitative data analysis approach, content analysis includes category construction according to recurring patterns of themes or factors (Merriam, 1998, Patton, 2002). Constructing categories is a systematic and intuitive process informed by the researcher’s orientation, knowledge, purpose of the study, and “the meanings made explicit by the participants themselves” (Merriam, 1998, p. 179). Merriam has suggested that when constructing categories data are sorted into groupings that have something in common. As a research tool, content analysis involves determination of presence of certain words or concepts within texts or sets of texts (Merriam, 1998, Patton, 2002). Patton (2002) has stated that content analysis usually has to do with analyzing interview transcripts, diaries, or documents not observational field notes. He has suggested that in general, content analysis refers to “any qualitative data reduction and sense-making effort that takes a volume of qualitative material and attempts to identify core consistencies and meanings” (p. 453). Content analysis “involves identifying, coding, categorizing, and labeling the primary patterns in the data (Patton, 2002, p. 463). The researcher quantifies and analyzes the presence, meanings, and relationships of such words and concepts, then makes inferences about the messages within the texts, audience, and even the culture and time. “The process involves the simultaneous coding of raw data and the construction of categories that capture relevant characteristics of the document’s content” (Merriam, 1998, p. 160).

Although sometimes viewed as devoid of theoretical base and time-consuming (Merriam, 1998) this method of data analysis of interview data was selected because of its capacity to include all forms of communication that take place in interview (Borg & Gall, 1989) and that it minimizes biases and ensures order (Berelson, 1952). In addition, content analysis is reliable because of its coding consistency, replicability of the category classification, and accuracy while its validity can be
easily achieved through the process of triangulation (Creswell, 1994; Merriam, 1998; Patton, 2002) as well as audit trail (Merriam, 1998). I asked some colleagues in counselor education to validate the results. Content analysis “themes, patterns, understandings, and insights that emerge” (Patton, 2002, p. 5) were the most appropriate method for this study.

Treatment of Data

Before analyzing the data, I made verbatim transcriptions of all the interviews. After transcribing all the data, codes were developed. The step-by-step process of content analysis was followed for analyzing the data. The first step was to read all the general notes made during and after every interview, together with the insights and observations jotted down written during the interviews. As I read the notes, I wrote down all the concepts generated. I arranged all the transcripts; with the more detailed interview at the top. Interviews were broken down into manageable entries on a variety of phrases, or sentences. This, according to Patton, is the first step of analysis. As I read each transcript, I wrote down the concepts, themes, and anything that emerged on the margins or against each sentence, paragraph, or word. I read all the transcripts several times to identify “what emerges as important and of interest from the text” (Seidman, 1991, p. 89).

The second step in analysis was to define the types of relationships in the data. This process involved the establishment of possible categories. I identified the different forms of categorization of the concepts, or themes until all narrowed down to broad small categories. Examples of labeled categories generated through this study included “involvement of family”, “place of therapy and paraphernalia used”, “holistic focus”, “limited training and curriculum deficits”, and so on. The third step involved generating codes from the transcribed data using information generated through the first and second step. This involved coding all the statements from each transcript. Codes could be the number of occurrences of a word or concept in the text, or the number of times the single word,
phrase, or sentence appeared in the sentence, or passage. In addition, I ignored all irrelevant information such as words that do not add anything to the value of the text, or that do not reflect any idea, belief, attitude, or perception of the participant.

During coding I had to read through the transcription and manually writing down concept occurrences. Concepts could be recorded as the same even when they appear in different forms. At this stage, I extracted direct quotations from transcripts. These quotes could be a whole sentence, a phrase, or word. The identified concepts, or codes were a guide for selecting quotations. I organized the concepts into categories while listing direct quotations under each category. For each category, I recorded all the occurrences of the different concepts, statements, words, phrases, or sentences. Although the idea was not to do any statistical analysis, quantifying the number of times the statement, phrase, word appeared indicated the value counselors attached to the identified cultural structure, for example, “family” during counseling. I then identified labels for each category or sub-category before grouping them. For example, under category “family” a sub-category such as “social support system” becomes a sub-category label.

I generated the coding system sing the selected consonants from both the first and last name followed by a number representing the sequencing of the transcripts. An example of a code is RCH1. The next step involved grouping all the categories with their codes. Table 3.1 shows a sample of the grouping of part of each response that mentioned family as a structure they used during counseling, and the codes for each statement. I did all the categories until the coded statements, or phrases were under each category. For some categories, analysis included showing the different relationships that existed, and how these illuminate the interconnectedness and interdependence that characterize systems perspective to understanding reality. The main part of the analysis was through concept mappings or relational maps that created to represent the inferential relationships between ideas,
perceptions, beliefs, attitudes, and information available from interviews. The mapping would show the web of relationships that characterize the connections among the issues and challenges associated with incorporation of indigenous cultural practices and structures.

Table 3.1

Involving Family

| RCH1. “… bring parents in when counseling couples” |
| RCH1. “….facilitate that they bring parents . . . works well in most cases” |
| MBM3. “..no way in Africa you can deal with a problem for a client without family support” |
| MBM3. “… extended family … aunts, uncles, grandparents a people I source support from” |
| BMV6. “…utilize family….” |
| BMV6. “…always bring in …family members interested in the client’s welfare” |

Interpretation, according to Patton (2002), goes beyond descriptive data to include establishing “significance to what was found, making sense of findings, offering explanations, drawing conclusions, extrapolating lessons, making inferences, considering meanings, and otherwise imposing order on an unruly but surely patterned world” (p. 480). Seidman (1991) has argued that “marking passages that are of interest, labeling them, grouping them and categorization are all part of interpretation and analysis. Categories must speak for themselves and provide connections in the experiences and views of the participants (Seidman, 1991). The main focus of the interpretation would be to establish the interdependence, interconnections, and interrelationships among the different issues associated with using cultural practices and structures during counseling. The concept maps made it easier to establish interrelationships and interconnections that were exist among counselors and other elements of the system.
Reporting the Results

In writing the report, each question of the study addressed separately. This means that the interview guide provides an analytic and organizational framework for recording responses and guides the structure of the report (Patton, 2002). As Patton has observed, “with interview guide approach, answers from different people can be grouped by topics, but the relevant data won’t be found in the same place in each interview” (p. 440). Report writing included, among other things, direct quotations from participants. Direct quotations, according to Patton, “are a basic source of raw data in qualitative inquiry, revealing participant’s depth of emotion, the ways they have organized their world, their thoughts about what is happening, their experiences, and their basic perceptions” (p. 21). Under each question, concept maps and tables presented some of the themes generated by the study.

Limitations of the Study

As an exploratory study, the study covers only the breadth of issues associated with ways and extent to which counselors utilize cultural practices and structures in counseling. Focus groups could avail an opportunity for participants to engage on a more in-depth exploration of a wide range of experiences and opinions (Morgan, 1998). Obviously, employing multiple data gathering methods (Patton, 2002), including case studies, surveys, and focus groups could generate more data that could illuminate the interrelationships and interconnectedness that exists among the different structures and systems that provide counseling and healing in Botswana. Patton has observed that gathering data on multiple aspects:

Means that a the time of data collection, each case, event, or setting understudy, though treated as a unique entity with its own particular meaning and its own constellation of relationships
emerging from and related to the context with which it occurs, is also thought of as a window into a whole. (p. 60)

More counselors from other fields such as health, particularly those dealing with adult population, would shed more light on the challenges they face in trying to use cultural issues.

Further, indigenous practices are difficult to delineate easily and separated from non-indigenous ones. There are few studies on counseling and indigenous healing systems, hence the reliance on literature from other fields other than counseling. In an ideal world where there are no time constraints, cost ramifications and other factors I would have loved to include focus group as part of the research methods.

Summary

The general purpose of this chapter was to present the method and research design. The first part of the chapter provided a description of the systems perspective as a qualitative inquiry, and identified some of the key concepts associated with this perspective. The chapter also delineated and discussed the various assumptions of qualitative inquiry, highlighting the approach to studying phenomenon, data analysis, interpreting, and reporting findings. The description of the design of the study presented the bounding of the study and selection procedures, the selection of participants, and the ethical considerations and rights of subjects. The description of the data collection process and analyses procedures covered the description of instruments and content analysis approach. This part focused on showing why I chose the method of data gathering and the analysis procedure I used in the study. This chapter also describes the treatment of data, interpretation, and reporting of results.
CHAPTER IV

THE RESULTS

This chapter summarizes the research results on the examination of the ways and extent to which counselors in Botswana utilize indigenous cultural practices and structures. The first part of the chapter presents a description of the characteristics of the participants. The next would be a brief discussion of the interview data collection, the sampling procedure, and the data analysis procedures. Summaries of results reported under each question of the study. The last part presents an overall summary of the chapter.

Characteristics of the Participants

Participants were from the two cities of Gaborone and Francistown, and major villages such as Molepolole, Maun, Masunga, and Gantsi. A majority of the participants interviewed was from Gaborone and Francistown. From this group, most of them were at the University of Botswana (UB) and the Guidance and Counseling Division of the Ministry of Education. These two organizations have the highest number of trained counselors. Among the identified characteristics of the participants were demographic, professional, and vocational. Table 4.1 shows the characteristics of participants. Below is a description of the characteristics of the participants.

Demographic and Vocational Characteristics

The sample of 30 counselors did not have equal representation by gender. Females represented the majority (n = 20) while males were one third of those interviewed. There was no major significant age difference among the participants. The average was middle age (30 – 50 years). A majority (n = 23) of participants had Masters-level training in counseling. Specializations in counseling varied, including counseling psychology, systemic counseling, counseling and human
services, family therapy, and career counseling. Only one participant had a doctoral-level degree, while another was in the process of completing a doctoral-level training.

*Table 4.1*

*Demographic and Vocational Characteristics of Participants*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Factor</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>20</td>
</tr>
<tr>
<td>Level of training</td>
<td>PGDCE</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Bachelors degree</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Masters degree</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Doctoral degree</td>
<td>1</td>
</tr>
<tr>
<td>Place of training</td>
<td>Europe</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>North America</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Other African country</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Botswana</td>
<td>17</td>
</tr>
<tr>
<td>Organization worked for</td>
<td>School</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Institute of High Learning</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Government department</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Non-governmental</td>
<td>1</td>
</tr>
<tr>
<td>Types of clients served</td>
<td>Students</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Community</td>
<td>9</td>
</tr>
<tr>
<td>Religious background</td>
<td>Declared Christian religious affiliation</td>
<td>28</td>
</tr>
</tbody>
</table>
Two participants had a Postgraduate Diploma in Counseling (PGDCE), which the University of Botswana offered before the commencement of the Masters degree in Counseling and Human Services. Only four had received bachelor’s degree qualification. Eleven participants received their training in North America (i.e., in the US and Canada) and one from Europe (i.e., in the UK) while 17 studied in Africa. The 17 who completed the counseling programs in Africa included 16 who did their training in Botswana and one in Zimbabwe. All those who had graduate training in Botswana had acquired a PGDCE before completing their Masters level training. This is because most of those counselors who completed PGDCE opted to further their studies when UB introduced the Masters degree program.

No participant had served less than two years work experience. Participants offered services to student populations (n = 21) at the different levels of education such as senior secondary schools (n = 5), institute of higher learning (n = 15), and distance learning (n = 3). Although a majority of participants worked in organizations that cater for student populations, some also offered voluntary services to the community, particularly couples, and the families of students they dealt with.

Results of Interview Data

I reported the results for each question separately, following the framework provided by the interview guide. The reporting included the descriptive narrative and direct quotations from participants. In addition, tables and figures depicting some of the interrelationships and data were included together with the description. The descriptive narrative provided general summary rather than individual interviews. Direct quotations were within the description under each category.

Question 1 and 2

The participants were to identify and describe some of the indigenous cultural practices and structures they used during counseling. Asking participants to discuss ways in which they utilized
each of the cultural practices and structures they had identified followed up this question. Table 4.2 presents the content analysis of counselors’ utilization of cultural structures they used during counseling.

*Table 4.2*

**Content Analysis of Utilization of Cultural Structures**

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family (41)</td>
<td>• Social support system (16)</td>
</tr>
<tr>
<td></td>
<td>• Consultation (10)</td>
</tr>
<tr>
<td></td>
<td>• Mediation (9)</td>
</tr>
<tr>
<td></td>
<td>• Security and safety (4)</td>
</tr>
<tr>
<td></td>
<td>• Monitoring and control (2)</td>
</tr>
<tr>
<td></td>
<td>• Primary counseling level (1)</td>
</tr>
<tr>
<td>Customary and legal arbitration (16)</td>
<td>• Settling of disputes (12)</td>
</tr>
<tr>
<td></td>
<td>• Marriage and inheritance (2)</td>
</tr>
<tr>
<td></td>
<td>• Law enforcement (2)</td>
</tr>
<tr>
<td>Healing systems (*)</td>
<td>• Religious and spiritual matters (*)</td>
</tr>
<tr>
<td></td>
<td>• Partaking in ceremonies, rituals (*)</td>
</tr>
<tr>
<td></td>
<td>• Prayers (5)</td>
</tr>
<tr>
<td>Institutionalized Referral Systems (8)</td>
<td>• Medical and health concerns (3)</td>
</tr>
<tr>
<td></td>
<td>• Social welfare (5)</td>
</tr>
</tbody>
</table>

*Note. *There was no direct utilization of indigenous healing systems.*
Part of this section will also discuss the issues related to structures counselors have to collaborate with, or to liaise with in helping their clients. This will include a description of how they use the structures they collaborated with.

Content analysis of the interview data associated with this question resulted in four categories of cultural structures that were used during counseling: family, customary and legal arbitration structures, healing systems, and institutionalized referral systems. The number indicated against each category represents the occurrences of the statements, phrases, or words under each category. Then the statements, words, or phrases counted to determine the number of times participants mentioned something associated with that particular category. Below is a discussion of each of the categories in Table 4.2.

*Utilizing extended family.* In this study, participants identified the involvement of family during counseling as an important indigenous cultural structure. Statements associated with using family during counseling appeared 41 times in the transcripts. However, there seems to be a variety of reasons why participants involved family during counseling: as a social support system (16), for consultation (10), for mediation (9), as a security and safety net (4), for assisting with monitoring and control (2), and for ‘primary’ counseling (1). The interview data suggests that engaging family members as a social support system for their clients is a common practice. According to one participant who provides counseling to students at university level, “extended family, including uncles, aunts, and grandparents are an important source of support, and there is no way in Africa you can deal with a client’s problem without family support.” Other participants, whose clientele comprises student populations at senior secondary school and college levels, expressed similar sentiments. They reported that they always found it necessary to consult family members whenever they had to deal with behavioral issues and concerns about the
academic performance of the students. Whenever there were concerns about the student’s behavior and academic performance, the counselor solicited the parent’s support in addressing the problem.

Involving family or parents, according to some participants, ensures continuity of newly established behavior because the clients can access family at any time they feel the need. Many participants echoed this view that family ensures adherence to established behavior. According to one participant, “the extended family as a support system can be used to minimize the recurrence of the behavior.” At times, the counselor had to invite the family to the school, or to facilitate that the student goes home for the family to attend to the problem, particularly if the problem is associated with cultural issues that the counselor cannot handle without family participation. Apart from consulting with family to address issues of concern, other reasons for involving parents during counseling had to do with facilitation of career choice, especially when there is a conflict between a parent and client over what career he or she should pursue. The counselor had to invite the parent to the school, or in case of the university, to the counseling center to help resolve the conflict. Such conflicts were common at university level where a student might have to decide to choose a course while a parent prefers a different career path.

Concomitant with the general trend of consulting and soliciting family support and cooperation, using family as a mechanism for mediation, especially on those issues hinging on customs and belief systems was identified nine times. The common customs identified by participants were those associated with handling marriage disputes, or conflict between couples. Intervening in such cases would require an understanding of the cultural practices and customs of the clients. Examples where using family for mediation purposes was prevalent was when the counselor was dealing with issues of inheritance, and problems associated with matrimonial
obligations and responsibilities. There would be need to find out about customs of different ethnic
groups as well as marriage laws of Botswana. The general trend with regards to mediation was to
involve family to help over settling a marriage dispute, or to resolve a marriage problems that the
counselor felt would require family intervention before it ends up in courts, or it gets out of hand.
One participant stated that he “always inquired if they [couple] had at some point involved the
family, and then I explore what was discussed. …what was agreed upon? Bringing in parents when
counseling couples I believe creates a bond between couples and parents.” Others have brought in
family to mediate on complex spiritual or religious matters that they believed would require family
to intervene according to its practices of family of origin. Some of these interventions include family
rituals and ceremonies, or seeking the help of an indigenous healer, or a practitioner skilled in
handling such areas, especially those associated with supernatural inclinations.

Family was identified as a means of security and safety four times, especially for those clients,
for example, orphans and depressed patients who are susceptible to distress and vulnerabilities.
“Family is like a safety valve and everyone needs support from family, even adults,” remarked one
participant who counsels both students and couples. His contention was that connection with other
family members and the need for their support are important qualities of African culture. He singled
out maternal uncle as “the most important person in times of distress, happiness, and so forth;”
citing his role during weddings, funerals, marriage disputes as examples where he features
prominently.

While soliciting family to get involved in interventions seemed common among participants,
there were two occurrences about family as a useful control and monitoring mechanism for those
clients with aberrant behaviors, and for couples. Commenting on the need to involve family when
counseling adolescents and couples, one participant asserted that in case of adolescents:
I facilitate that they bring along parents to the session and this has worked well for me in most cases I have handled. Because I view myself as providing counseling at secondary level while family is at primary level. Involving parents or family when dealing with couples creates bonds between the couple and their parents, thereby instilling trust from family as a support mechanism. Family at primary level of counseling becomes a monitoring mechanism because couples are likely to conform unlike at secondary level where a professional has no obligation and is not available all the time after the session is over.

Participants reported that family plays a significant role for those in need of home-based care, especially in case of HIV/AIDS patients released by hospitals to be under the care of their families and relatives. They identified family in terms of facilitating on issues of compliance for those receiving anti-retroviral (ARV) therapy.

For those participants who dealt with young people or student population they reported some of the customary issues associated with seeking help from indigenous healers. They noted that culture does not allow a young person or child to consult an indigenous healer or diviner unaccompanied by a parent or adult. “Culturally,” one participant proclaimed, “you cannot send someone’s child to a traditional healer.” Some participants identified this practice as one of the factors that make it difficult for counselors to use healers as part of their referral network. For a majority of cases, especially students, participants seemed to play more of an advocacy role when it came to dealing with indigenous practices associated with healing. For example, counselors facilitated mainly in acquiring students’ release from school. The participants reported that normally counselors have to write a letter supporting students’ withdrawal from school so that they continue later after the problem has been resolved. In cases where the client’s distress is due to, for example, missing an important family ritual and wishes to go home “the counselor has to help the client go
and participate in this ritual,” suggested a participant at the university. Parents could also request for the release of the child to go and participate in some family ritual, or to consult an indigenous practitioner.

The prominent role of a counselor, as summed aptly by one participant, “is to facilitate the establishment of a relationship between the client and family.” Another participant in the same organization echoes when he remarked; “counselors need to help clients reconnect with their families.” Expressing this view within the context of partnering with the family to address the problems of clients, especially children, one participant who supervises counseling services in schools, asserted that “I believe that we are so much connected with other people and, therefore, I cannot deal with a client without finding out how they connects with others.” She further remarked; “people are social beings and therefore they always link up with others and that their feelings of inadequacy are generally socially induced.” Most participants seemed to use family during counseling for a variety of reasons. The involvement of family seemed to happen just out of necessity, not because practice demands that one should engage family to create support for the client, or to address the client’s issues and concerns. Another structure that participants identified was the customary and legal arbitration system.

Customary and legal arbitration. Participants mentioned arbitration structures they used during counseling 16 times during the interviews. The customary court (known as Kgotla in Setswana) identified 12 times, as a means of conflict resolution and handling behavioral issues. The customary court deals with customary law, or laws associated with the customs, traditions, and practices of the different ethnic groups in Botswana. Each community has a place or structure where community members gather to try cases, handle disputes, and deal with development issues. While magistrate courts generally handle criminal cases and other issues covered by the common law,
there are those cases that are dealt with by customary courts, where they would be dealt with in accordance of the customs of the particular ethnic group. Yet, the district commissioner’s office and the law enforcement services such as the police were cited twice each. The customary and legal structures are important when handling cases associated with settlement of disputes, marriage, inheritance, and in disciplinary related problems. In reference to the customary court, one participant observed that “you cannot achieve anything without involving the community through its leaders.”

*Healing systems.* While there were several references to the healers’ holistic approach and their abilities to handle religious-spiritual concerns as well as responding effectively to the “why me question”, no participant mentioned that they engaged indigenous healing systems directly. Most references to associating with healers, for example, were about facilitating releasing a student when parents made a request to take away their child to see a healer, or when the student insisted that they needed to go and participate in some cultural ritual. Data reveals that most participants seemed to harbor serious misgivings about engaging healers as part of their referral system and the consultation network. While there was constant reference to the need for collaborating with healers so as to address some of the gaps in the services offered by counselors in Botswana, nothing in the transcripts shows any clear articulation as to how they used them during counseling.

Several participants, however, reported that many clients they dealt with do seek help from healers; even at the same time, they are engaged in a counseling relationship with them. The most common scenario, however, is that described by one participant who stated that “African people would consult all the resources around them simultaneously; for example, consulting a diviner, counselor, spiritual healer, and a medical doctor.” “At times, clients still go to see a traditional doctor instead of going to seek help from a counselor,” declared another participant. She also
charged that many clients still blend indigenous cultural practices with other introduced services in
spite of the Christian teachings against indigenous Botswana cultural methods and practices of
healing.

Some participants raised concerns about the unavailability of information and knowledge
about indigenous healers and cultural methods and practices. They observed that no printed
materials or directories of indigenous practitioners are available to refer to if they wanted to
establish some contacts with them. Others argued that indigenous healers are secretive about their
operations and practice thus, creating a mystery about what they do. Yet, there were those who
challenged counselors for not searching for the relevant information and resources they needed to
establish dialogue and communication with indigenous practitioners.

I discerned from the data that there was a tendency, among participants, to view indigenous
practitioners, especially healers, as one homogenous group without distinction and specialization.
“People’s tendency is to bundle everything together negatively when referring to traditional ways of
healing without looking at what is good and helpful,” concluded one participant. He added that “it
would help to talk about healing properties without attaching spiritism, which sometimes makes it
mystical and, at times, viewed as demonic.” Concomitant with this conception of healers as a
homogenous group is the attribution of qualities and practices of one group among healers to the
entire healing system and practice. Some of the statements made by participants about healers were:

“I have a struggle with the manner in which the healers help people”

“Traditional doctors were associated with negative things, hence we don’t trust them”

“People are secretive about dealing with indigenous healers”

“Healers give some tangible material or things yet counselors do not give a client anything.”
“It is a mysterious area and you never know what is going to happen when a client gets to see the healer. There is fear of the unknown.”

“The problem is with the chemical composition of the medicine they give to patients. That is why people are skeptical about getting treatment from healers.”

“The healer gives wholesome help.”

“The healer’s facility is available all the time.”

“I cannot refer clients to indigenous healers because of my Christian background. But if they need a prayer I can either pray with them or talk to a pastor to deal with them.”

“When a person says they want to be assisted by a healer I don’t deal with them.”

“Healers bond quickly with the clients.”

Most intriguing, is that some participants acknowledged that their own personal values, and Christian influence had a bearing on their position against utilizing indigenous healers. Responding to the question of whether they would refer clients to healers, some participants indicated that they would not have healers as part of their referral network even when it was the clients’ choice to see a healer. One participant acknowledged the influence of her value system and beliefs about the counseling process, and its impact on why she would no have healers as part of her referral system. She remarked that “For me, it is a personal struggle, and as a human being I have to be comfortable with the services healers offer.” She added that:

I am not sure if I would be the best person where healers have to be involved because I do not believe in what they do. Personally, I do not believe in traditional healing. I do not think I would take myself to a healer. I can refer a client to all other places but not traditional doctor. I would rather find another person to intervene if a client wants to see a healer. Instead of struggling with that client, I would take him or her to a social worker because I cannot relate to
the mystery of the traditional doctor. That is where I kick in, hence my anxieties dealing with healers.

While some participants attributed their inability to collaborate with indigenous practitioners and structures to their lack of knowledge of what the latter do, there are those who believed that government’s policies did not allow them to refer clients to indigenous practitioners. Surprisingly, some participants proclaimed that they would refer their clients to a clergy despite the fact that the latter are not identified, by either government, or the counseling practice, as part of the formal referral structure. Most intriguing, some reported that they were selective when it came to the clergy. They noted that they would exclude spiritual healing churches and other apostolic groups that include prophesying as part of their intervention practice. Whereas, there were differences in terms of where to make referral to, none indicated that they would influence a client not to go seek help from other groups. Most participants acknowledged that large numbers of people continue to seek help from healers in spite of the services they offer as counselors.

Institutionalized referral systems. Reference to some institutionalized formal referral system appeared eight times in the transcripts. Although health and welfare services were not identified as indigenous structures, some participants described them as formally recognized referral systems they utilized, especially on health related matters, and for the needy population. Some examples of social welfare services included soliciting the intervention of social workers, especially for students who are in need of material resources and other social needs that government generally provides for. “What is the need for counseling a hungry client?” one participant posed a rhetorical question. “You need to help the client deal with poverty by either referring him or her to social welfare services that facilitate provision of resources, or help find ways of dealing with that,” she continued.
**Question 3**

I asked participants to discuss some of their clients’ beliefs and worldviews, and to present the different ways in which they handled them. The following is a discussion of some of the beliefs participants identified as commonly presented by clients during counseling.

Participants identified six beliefs that clients seem to present most of the time. Table 4.3 presents the common beliefs that counselors dealt with: witchcraft (24), have bad luck (6), ancestors (6), prayer as a solution to problems (5), spirit possession (5), have a ‘calling’ (4), there are evil forces (2). Belief in witchcraft seems to be the most common belief that clients report as a cause of their problems.

*Table 4.3*

<table>
<thead>
<tr>
<th>Belief</th>
<th>Number of times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witchcraft</td>
<td>24</td>
</tr>
<tr>
<td>Ancestors</td>
<td>6</td>
</tr>
<tr>
<td>Bad luck</td>
<td>6</td>
</tr>
<tr>
<td>Spirit possession</td>
<td>5</td>
</tr>
<tr>
<td>Prayer as a solution</td>
<td>5</td>
</tr>
<tr>
<td>Have a ‘calling’</td>
<td>4</td>
</tr>
<tr>
<td>Evil forces</td>
<td>2</td>
</tr>
</tbody>
</table>

In the transcripts, mentioned the belief in witchcraft 24 times. “People strongly believe in witchcraft,” one participant observed. Others gave instances where their clients expressed that they were bewitched. “As you discuss with a client you come to appreciate that the client believes that he
or she has been bewitched, and has consulted either a diviner, or spiritual healer who confirmed, or is handling this,” disclosed one participant. A majority of participants expressed feelings that it was common for people to feel threatened by some powerful malevolent forces that worked against them most of the time.

According to most participants, handling problems associated with spiritual inclinations, or the clients’ belief systems seems to be the most complex and challenging to handle. There was a general view, among participants, that the counselor training they received did not prepare them to tackle these beliefs and manifestations that are common among the clients they serve. One participant summed it up this way, “issues of witchcraft are difficult to handle, and I have never made any breakthrough with them, hence clients never come back once they realize that I don’t understand, or have no appreciation of their beliefs.” Another participant noted that:

There is witchcraft but I do not know why I immediately dismiss it and see it as psychological. To me the belief in witchcraft constitutes irrational thinking and I immediately try to change the client’s perception…. This discussion we are having right now makes me begin to question my views about reality. ‘Are we talking about my reality or that of the client?’ This is something I believe I need to explore instead of dispelling it forthright.

Participants recounted that some clients come to seek help because they feel that their problems were a result of ancestors turning against them. In the case of students, they would come to seek assistance so that they go home to participate in some ritual for appeasing their ancestors. Others would state that they have problems because they missed a family ritual, and they would like to go home to perform the ritual. Yet, there would be those who would like to reconcile with either their uncle or a significant member of the family because they believe that this member’s anger is invoking the spirits to turn against them. Those from the Christian faith, on the other hand, reported
that they resorted to prayer whenever they had a problem. One participant recounted a story of a student who wanted to travel to South Africa to attend a church ceremony in Moria, the headquarters of the Zionist Christian Church so that their problems at school could be resolved. There were many cases mentioned about clients seeking help from spiritual healing churches. Others reported that clients seek help because they want to withdraw from their studies claiming that they have a ‘calling’ to become a diviner or spirit medium. Those participants who work with students reported several instances where they dealt with a student who would fall into a trance in class due to spirit possession. Such cases have baffled most participants because they felt handicapped in dealing with them. The following discussion presents some of the ways in which participants have dealt with belief systems and worldviews of their clients.

During the interviews participants had to respond to a question on how they handled belief systems and worldviews of their clients. Table 4.4 presents the participants’ views on how they handle clients’ belief systems and worldviews.

Table 4.4

*Content Analysis of Participants’ Views on Handling Clients’ Beliefs*

<table>
<thead>
<tr>
<th>Views</th>
<th>Number of times</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respect client’s beliefs and worldviews</td>
<td>27</td>
</tr>
<tr>
<td>Difficult to deal with</td>
<td>14</td>
</tr>
<tr>
<td>Utilize client’s beliefs to explore problem</td>
<td>4</td>
</tr>
<tr>
<td>Change client’s beliefs and worldviews</td>
<td>3</td>
</tr>
<tr>
<td>Refer client to other services</td>
<td>2</td>
</tr>
</tbody>
</table>
Content analysis of the transcripts resulted in four main categories ways in which participants dealt with clients’ beliefs: respect for the clients’ beliefs and worldview (27), difficult to deal with (14), change client’s worldview (7), utilize the belief system of the client to explore the problem (4), and refer the client (2). Below is a detail presentation of each of these categories.

*Respect Clients’ Beliefs and Worldviews.* Participants mentioned respecting client’s beliefs and worldviews 27 times. This could imply that participants’ view respecting and appreciating the beliefs and worldviews of the clients as very important in counseling. Invariably, participants cautioned against attempts to “reshape”, “dismiss”, “discredit”, “belittle” the client’s worldview,” or “ignore” the client’s beliefs during counseling. As one participant advised, “You have to acknowledge and embrace your client’s beliefs rather than dismiss or belittle them.” She suggested that “where you are not sure ask so that the client can explain in detail.” Some participants reported that some clients never came back once they felt that the counselor did not understand, “where they are coming from.” As one participant advised, “By accepting the client’s beliefs, he or she may become ready to tore a middle line.” He noted that the worst thing a counselor could do is to negate the client’s belief system. His view was that you have to help the client along the lines of his or her beliefs. “Clients”, he argued, “see beliefs as part of them, and you cannot just dismiss them within an hour’s session.” His position was that “it is better to complement the client’s beliefs with yours rather than destroy all that they believed in for many years.” The following are some of the excerpts that reflected the view that counselors must respect the client’s views:

> RCH1. “Ask yourself what made them come to you. The worst thing you can do is to quash their belief system. You do not want to say, ‘it can’t be that!’ You need to help the client along those lines … not negate it and then after that replace it with nothing.”
RVM2. “Even prayer is acceptable if it addressed the need. They have to be comfortable with what you are trying to do. There are those who would be comfortable if you say, ‘in the name of Jesus’, yet others would prefer ‘Mary’ and so forth. During the counseling, you want to respect the religious convictions of the client, and not give them a person that cannot help in that area. The clients present how they feel the problem could be addressed, and you proceed from there.”

MBM3. “In Africa, some people believe that there is a connection with the deceased. Moreover, if someone says ‘I have to go and get soil from the grave and bath with it’, you cannot dismiss it. You have to appreciate that. Sometimes a client might need to go home to attend to whatever might be bothering them. You cannot rule out the traditional customs, or culture of the client or what they believe in and they might value them so much. You might have to assist the institution release them to go and participate in the rituals they expected to do. The client might not be function at school because they cannot sleep, and they would have to take a break from studies . . .. The problem is that institutions can only accept a medical report even though some of the problems are not medical. Anyway, since the client might have headaches due to lack of sleep, the medical doctor might have to assist in dealing with that, but not with the spiritual issues or cultural beliefs. There is need to do something about this kind of practice. … You cannot nullify what someone believes in.”

MTM4. “If you are from a place where such a belief is not common you should try to understand what these things mean to the client instead of spending time trying to rationalizing about the unscientific aspect of their belief. I do not dismiss a client’s beliefs. For example, if a client brings in indigenous beliefs about a cause for their illness I explore it with the client all the options and differentiate between Western and indigenous Setswana
beliefs about the cause of this illness. We discuss question such as: What are their beliefs about the cause of the problem? What is the Western view about it? How do both systems treat it? After exploring all the options and have differentiated between the causes of illness then we can come to a common understanding.”

SGP7. “The tendency is that when someone dies in the family the relatives would like an explanation even if there is a medical explanation. The relatives always say that someone had a hand in the death of their family member, and it seems that they feel better when they get that explanation. They like to know why it happened to them. The common question they ask is, ‘Why me?’ If they come and give me information about the health of the person, I would explain a bit about that but would not deny them going to see an indigenous practitioner for help.”

Numerous statements given by participants reflected their views about respecting the beliefs of their clients. The statements cited above were just few examples that I selected to illustrate the point that respecting the client’s beliefs and worldviews seems to be a value that ascribed to by most participants. Responding to a question about respecting client’s beliefs, one participant proclaimed that as long as there is no harm in what the client wants to do you allow them to go ahead and do it. “If, for example, bathing with water with soil from the graveyard does not cause harm, why stop them,” she defended her position.

*Change client’s beliefs and worldviews.* The view that a counselor must strive to change the client’s beliefs and worldviews appears only three times in the transcripts. This could imply that participants are likely to avoid changing the client’s beliefs and worldviews during counseling. One participant observed that her tendency is to dismiss some of the issues without
even exploring the problem fully. The following excerpt is an example given by one of the participants.

OKG20. “I operate from the Cognitive Behavioral Therapy mode. And, whenever I look at that belief I want to change it. … As long as they are not rationale, CBT works. Again, what is rationale for one might be different for the other. … I depend on the DSM-IV. What it says and how it labels the behavior, I deal with it in accordance with that.”

MNO8. “I tend to shift to Cognitive Therapy. To me that constitutes irrational thinking, and I immediately try to change the client’s perception.”

Yet, MNO8 still wondered how a counselor would “convince a client that what they believe in does not exist when the client has examples of instances that led to this thinking.” Her opinion was that “counselors and clients may have different worldviews, and the counselor needs to help the client understand herself better instead of trying to change the client’s worldview to fit her own.” Another participant suggested that it is not helpful to spend time trying to convince the client to see things differently, or to view the world from your own perspective as a counselor. “If a client says there is a ghost we agree that there is one, and then explore it rather than make the client feel that there is nothing like that,” suggested one participant.

Others have seen belief systems as foundation for counseling thus; “you cannot address a client’s problem without exploring ‘where they come from’.” There was constant reference to the fact that beliefs are central in counseling. Some arguments were that to ignore the different belief systems would not help a counselor get to the root of the problem of the client. As one participant observed, “Batswana are predominantly religious, and most of their lives are influenced by their beliefs and values.”
Utilize the belief system of the client. Some participants maintain that the best way of handling beliefs is by utilizing the belief system of the client to explore the problem presented by the client. Reference to using clients to explore the problem appeared only four times in the transcripts. In line with the argument that a counselor should respect the client’s beliefs, there were participants who felt it was important to stick to the belief system presented by the client. For example, one participant contended that:

If a client puts culture before everything else in their life, I use that same culture in handling the problem. I don’t use a different belief system, but stick to their cultural beliefs and explore these beliefs with them and not move away from that. Deviation from his belief system may lead to losing the client. I focus on what the client presents to me as a problem rather than what I just perceive to be the problem. For example, when a client says that they are bewitched, why should I spend time examining their self-concept or dealing with his self-esteem or negative feelings which I may feel he has?

According to this participant, “if you are from a place where such a belief is not practiced you should try to understand what it means to a client to be bewitched instead of trying to rationalize with him about the nonexistence, or the unscientific nature of witchcraft.” She further proclaimed, “I explore all different options and differentiate between Western and indigenous Batswana perspectives on the issue, and ways in which such problems are treated by both systems.”

Refer to other services. Referring clients to other services is only twice in the transcripts. Those participants who mentioned this indicated that they felt inadequate in handling cases that involved indigenous cultural beliefs and religious-spiritual issues. Others indicated that they would be comfortable handling a client with a Christian worldview and beliefs than those with African traditional religious beliefs and worldview. For these participants, any cultural religious
beliefs would pose a challenge for them, hence they would refer such clients to other services. They indicated that they would handle those with Christian beliefs because they share the same belief system, and that such beliefs and worldview fits their own philosophy of life. “In an African context,” one participant remarked:

I know there are supernatural happenings, which cannot only be addressed using Western models. Other forms of therapy can be used. When happenings take place in schools I suggest to them that they refer the student to a proper person to deal with it. For instance dealing with issues related to spirit possession or ancestors I feel intimidated. I do believe that there are certain people who are affected by ancestors.

Such sentiments were common among those participants in the school system where they sometimes handle behaviors associated with religious or spiritual matters. According to one participant from a senior secondary school who felt handicapped in handling some of the beliefs of his clients:

We are sensitive to those religious beliefs where a student falls in class due to spirit possession. We do not know these beliefs, for example, when we see that a student is talking to ‘someone’ while he or she is in a trance and we cannot see that person or tap into their experience so that we can help. We do not know how to deal with it. Some instances we can see that the child is physically affected. And, we can even see that student is weak after the episode. Yet, we are limited in our understanding of this experience the student is going through. We sometimes talk to parents so that they can shed light as to what we can do but remains a complex reality we have to face. We sometimes feel handicapped because the student is in a trance or a state we do not know what to do.
Difficult to deal with. The transcripts refer to “difficulty dealing with beliefs” 14 times. The following excerpts are just a sample of the statements that referred to the difficulty in dealing with clients’ beliefs and worldviews.

MNO8. “For example, dealing with issues related to spirit possession or ancestors I feel intimidated. ... How do I know what is happening, or even how to deal with it?”

PMW15. “We attend to medical issues but do not know what to do with spiritual issues. For example, when a student falls down because some spirit possesses them, what should a counselor do? For some cases we do not know what their life is like but we would hear from friends about their situation.”

PMW15. “Students sometimes fall into a trance in class, and we do not know how to handle it.”

PKL10. “I don’t know how you handle belief systems. And once you start attacking their belief system you make them vulnerable because the beliefs are at the core of their values.”

Those who expressed difficulty handling beliefs and worldviews of clients attributed the problem to their lack of training on how to handle these cultural beliefs. They felt handicapped by the lack of knowledge and understanding on how to deal with the various complex manifestations presented to them by their clients. This problem was predominant with those who dealt with young people, especially within the school system. Because they cannot refer someone else’s child to seek help from healers who deal with these issues, they can only facilitate releasing the child to their families to handle the problem.

Question 4

I asked participants to express their views about indigenous healing methods and practitioners. Data analysis classified the responses into the following themes: holistic focus, place of therapy and
paraphernalia, time and duration of therapy, practitioner’s role and qualities, and diagnosis and interventions. Table 4.5 has listed the main themes and the sub-themes that emerged from analyzing the data. The following is a discussion of each of these categories generated through content analysis of the transcripts.

**Holistic focus of indigenous methods and practitioners.** Content analysis of the interview data revealed that participants perceived differences between indigenous intervention methods and Western-based methods of counseling. Generally, they described indigenous methods as holistic, with a focus on all aspects of the individual, that is, the personal, social, physical, and spiritual and religious dimensions. One participant made this comment: “Think broadly, for you to have a holistic approach. Do not think that there is only one strategy to solving a problem”. There were a number of references to indigenous methods as focusing on the whole person. Conversely, “Western approach to counseling”, summed up one participant, “generally attends to one aspect of a person’s issue and would utilize one intervention based on a specific approach.” “Western way of counseling,” he argued, “leaves out spiritual issues. And as long as the spiritual element is not addressed, even the best intervention won’t be effective.” In an attempt to illustrate this point, one participant made these observations:

A healer addresses all aspects of the individual. For example, since the client still has to go back to his or her ailing social environment, the healer has to treat that environment too. The healer may even have to visit the home of the client so that he or she treats the whole person, including the surroundings as well as those around him or her. To treat a person as if entirely separate from their social environment is not helpful. There is need to treat the client within the social context.
**Table 4.5**

*Content Analysis of Perceptions of Healing Methods and Practitioners*

<table>
<thead>
<tr>
<th>Perceptions</th>
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<tbody>
<tr>
<td><strong>Holistic focus</strong></td>
</tr>
<tr>
<td>▪ Pays attention to the physical environment (e.g., home, work) of client</td>
</tr>
<tr>
<td>▪ Dealing with the personal dimension, that is, the state of mind or demeanor</td>
</tr>
<tr>
<td>▪ Client’s interpersonal and social relationships</td>
</tr>
<tr>
<td>▪ Includes spiritual and/or religious matters</td>
</tr>
<tr>
<td><strong>Place of therapy and paraphernalia used</strong></td>
</tr>
<tr>
<td>▪ Homely and welcoming atmosphere</td>
</tr>
<tr>
<td>▪ Has an aura or feeling of some presence</td>
</tr>
<tr>
<td>▪ Not confined to an office</td>
</tr>
<tr>
<td>▪ Regalia and demeanor associated</td>
</tr>
<tr>
<td>▪ Could be at home or place preferred by a client</td>
</tr>
<tr>
<td><strong>Time and duration of therapy</strong></td>
</tr>
<tr>
<td>▪ Not limited to hourly sessions</td>
</tr>
<tr>
<td>▪ Addresses immediate concerns</td>
</tr>
<tr>
<td>▪ Accessible anytime even outside working hours</td>
</tr>
<tr>
<td><strong>Diagnosis and interventions</strong></td>
</tr>
<tr>
<td>▪ Predictive behavior</td>
</tr>
<tr>
<td>▪ Include intangibles</td>
</tr>
<tr>
<td>▪ Address the question ‘why me?’</td>
</tr>
<tr>
<td>▪ Active and skillful facilitation</td>
</tr>
<tr>
<td><strong>Therapist role</strong></td>
</tr>
<tr>
<td>▪ Goes beyond symptoms</td>
</tr>
<tr>
<td>▪ Attends to client’s expectations</td>
</tr>
<tr>
<td>▪ Guided by client’s cues</td>
</tr>
<tr>
<td>▪ Harmonizing role</td>
</tr>
<tr>
<td>▪ Mediating role with spirit world</td>
</tr>
<tr>
<td>▪ Commands authority and presence</td>
</tr>
</tbody>
</table>
The perceived clients’ sources of the problem that might drive them to go and see a counselor may include the physical environment. For instance, if a client’s life seems to be in disarray and he or she believes that it all stems from his or her home; that there are some malevolent forces at his or her place of abode which are causing the problem, how then do you just focus on the client before you, and leave the environment unattended? This seems to be the gist of the argument about treating the physical environment. The indigenous healers, according to some participants, pay attention to the physical environment and the belief associated with those forces they perceive to be threatening the wellbeing and harmony of the client. This could account for the reason some clients still visit the healer after seeing a counselor, whom they believe does not fully address that part of the problem.

Concerning the importance of addressing the physical environment, one participant described a case where students refused to enter their classroom because someone had smeared the floor with human feces. Because the students believed that this was some sort of witchcraft, they would not go into the classroom before someone came to cleanse it. Just cleaning the classroom was not enough for them to feel comfortable to step into it. The students preferred a proper ritual be performed, or cleansing of the classroom. Imagine the time spent pleading with them to go back into the classroom, and the psychological impact of sitting in a classroom they perceived was bewitched. How long would it take to convince them that witchcraft does not exist? Obviously, that would be a long time.

*Place of therapy and paraphernalia used.* Participants viewed the place where therapy takes place and the things associated with it as important. The indigenous healer’s place was described as “homely” and “having a welcoming atmosphere.” According to a participant, “the environment and how the practitioner operates are critical to therapy”. She added that
“indigenous healers’ places of operation are homely compared to the counselor’s work setting.”

There were also statements that focused on the way an indigenous healer changed the setting during the session to create an atmosphere suitable for therapy. “Unlike the counselor”, one participant made a comparison:

The healer always changes the setting to create an atmosphere for the session. For example, before beginning the session the healer may put on regalia, which could either, be a robe, gown, or any paraphernalia associated with the treatment. The change could also be created by sudden adoption of a new medium of communication such as a change in voice or speech, or even the practice of taking off shoes before entering the place where the session takes place. Yet, the counselor’s office remains the same for every session or activity.

Others alluded to the healer’s place for therapy invoking a new feeling during the session. One participant put it this way, “the healers have the regalia that makes the client feel he is coming to a place where he would get help . . .. A client would rather go to a healer who has the regalia than go to a counselor. That is because there is everything at the healer’s place that makes the client feel some kind of ‘presence’ and is being helped.” Concomitant with the issue of the regalia, is the question of commanding authority and the power that is associated with the healer. One participant described it thus:

Batswana have respect for authority. Unfortunately, counselors do not have the same authority as healers. For example, if a healer puts on the regalia, it is like entering into a transformed state and this makes the client feel experiences a different atmosphere from that he or she would get ordinarily. This is because now he or she is dealing with a new, transformed person. This may motivate the client to engage in a process of transformation and become a new person too.
Change in environment or setting before beginning the session reminds the client that now, “you are engaging in a serious ritual.” Even just the mere fact of asking the individual to close their eyes before prayer begins can change the atmosphere under which the event takes place. This change in setting, some participants observed, helps to engage the client, and it facilitates connection between the client and therapist quickly.

_Time and duration of therapy_. One of the criticisms leveled against Western-based counseling by participants is on the issue of time and duration of therapy. “People in Botswana are used to taking their time in dealing with a problem. Instead of just one hour, there is a time limitation with counseling. Hence, counselors just after scratching the surface, they have to arrange for the next appointment,” said one participant. The general perception that was mentioned was that Western-based counseling is time-driven thus, not fitting the expectation of the client who would expect that the therapist would have all the time to help them until they feel satisfied that they have been attended to. Rather than having the clock control the session, the client might expect that they would have all the time they need until the problem is resolved. “Treatment in indigenous setting takes long,” said one participant, pointing out that it becomes complicated for schools, especially when a parent has requested the student to take them to see a healer. This seems to contradict some of the statements that indigenous healing strategies are direct to the point.

Other statements suggested that counseling is limiting. As one participant described it, “because it is business-like, it sometimes makes clients feel that they are not given full attention due to counselor’s focus on ensuring that the paperwork is done and then go to the next client.” He proposed that “we have to be readily available to those we assist, and not when you set time restrictions, which might make it difficult when the client really needs a counselor to talk to.”

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must not,” he added, “be business-minded, but we need to know whom we are dealing with and what their expectations in terms of assistance they need are.” Yet, a comment made by another participant seems to contradict this argument when he says that “healers provide a reason for a behavior while counselors would spend some time exploring the issues”. One statement was that the healer gets to the root cause of the problem while counseling becomes a long process.

“The clients want immediate solution to the problem,” suggested one participant. He then gave this example: “If a client says ‘I failed an exam what can I do now? I want you to tell me.’ A counselor may want to explore what could have caused the problem, and by the time he or she completes several sessions of exploring the problem it may be too late.” “Indigenous healers provide answers yet counselors spend most of their time asking clients questions,” explained one participant. “Most clients do not come to see a counselor to be asked questions. They want some answers not to be asked what they think should be done to address the problem”, reported one participant. One participant suggested that some clients want to get ready-made answers to their problems, and do not view a counselor as facilitator. When a counselor fails to give them the answers, or to meet their expectation they leave the office disappointed. Some participants noted that other clients come with expectations that they would get answers that favor them and if that does not happen, they ever came back for other sessions. According to one participant:

The counselors’ setup for the services they offer is not conducive because if people knock off at 4.30pm, and a client has a problem after that time he or she can only wait until the following session, which may even be a week later when the next appointment has been scheduled. Yet, the indigenous healer’s facility is available all the time and the healer is part of the community. And, there are no time restrictions and limits for the healer. A client can see the healer any time for as much as the problem resurfaces.
Diagnosis and interventions. According to some participants, healers have good predictive skills and ability to go beyond observable symptoms in their diagnosis of problems. One statement was that their diagnosis includes the perceived extraterrestrial happenings that reflect the worldview of a large number of clients counselors serve in Botswana. “Counselors are not trained to diagnose things that seem to go beyond the scientific realm,” one responded noted. He professed that because “indigenous methods are very strong in predictive behavior, and that they would not couch you but hit the nail on the head, so to speak.” His view was that this “eliminates the process of the client finding out what the issue is.” A client would go to a healer who would sort him out immediately instead of several sessions to address the problem. “Because counselors are not trained to utilize cultural practices they tend to confine themselves to the way they are trained,” observed one participant. The healers are believed to successfully answer the question: “Why me?” They pay attention to the non-verbal cues. “As you enter their premises they observe how you present yourself, or your demeanor and then attend to what they observed,” remarked one participant. They do not only focus on one piece. But they explore all aspects of a client’s life. “Healers”, one participant suggested, “are skilled to have a client lead a session without them realizing that they are doing so. What the healers do is to have the clients confirm or dispute whatever they say.”

Therapist’s role and qualities. The transcripts referred to the therapist role and qualities several times. Several participants identified various skills, personality traits, and roles that indigenous healers possessed that they believed counselors lacked. There were those who perceived healers as active and skillful in facilitating a therapeutic process. Others felt that healers used their indigenous psychology and effective observation skills to observe nonverbal cues and demeanor of clients and responded accordingly. Other positive qualities described by
some participants were active listening and ability to quickly establish interpersonal connection with clients. “Traditional doctors establish a relationship with the client not just in a one-hour session”, one participant pointed out. Others attributed this to the fact that the healers are generally part of the community and they share the same or related conception of the problem and expectations of therapy as the client.

Describing the differences between counselors and healers, one participant pointed out that “indigenous healers give some tangible material or things to a client yet counselors simply empower the client.” Several participants have expressed this view about healers. For instance, one participant stated that “most people are visual and when they come to see a counselor they find themselves engaged in a discussion with nothing tangible to be given. People connect to the visual stuff they are given during therapy by a healer.” Another participant described it this way:

Batswana believe in something concrete. Something you can touch. Something physical or tangible yet counselors do not provide the client with anything concrete, something to hold and feel. The client ends up going back to the healer to give them something that addresses the beliefs. For example, if a client came to see a counselor because she felt that her environment was not safe or felt vulnerable, she goes back without necessarily dealing with safety issue in a concrete way. While the healer would either give something for the client to go and deal with the environment, or the healer may choose to visit the place to perform some ritual to make the client feel safe. It might be necessary to marry the two systems of helping, counseling and healing.

Question 5

I asked participants to identify and discuss some of the issues and challenges they faced when utilizing indigenous cultural practices and structures. Two issues emerged during the analysis of data
related to this question, namely the ambivalence towards the utilization of indigenous healing practices in counseling, and the difficulty in identifying cultural practices they used during counseling. While it was not clear from the data, how the participants utilized cultural practices, there were indications that they engaged some of the structures. However, a majority of participants reported using the extended family network for a variety of purposes. This section classified responses into six major areas: limited knowledge of indigenous cultural practices and methods, limited training and counselor education curriculum deficit, attitudinal factors and conflicting belief systems, and policy dimensions and lack of institutionalization of indigenous cultural practices and structures. These areas reflect some of the barriers participants experienced when trying to incorporate indigenous cultural practices into counseling: First, I discuss the issue of ambivalence towards using cultural practices and structures before exploring the issues and challenges identified by participants.

**Ambivalence towards indigenous practices and structures.** From the interview data, one could discern that participants had mixed feelings and limited knowledge regarding ways they could utilize cultural practices and structures. The participants’ constant reference to not using indigenous cultural practices yet they consider it important to do so reflects some of the ambivalence. They acknowledge that it was a challenge to deal with cultural beliefs and culture-specific issues during counseling. However, many participants felt that indigenous practitioners particularly healers were skilled in handling cultural beliefs and spiritual issues. According to one participant who deals with adult learners, “misconceptions play a significant role in having people avoid utilizing cultural practices.” She attributed these misconceptions to the fact that “African cultural practices are very complex because they are embedded in our way of life”. She added that “some educated Africans, or those who are Christians have difficulties dealing with
the indigenous practices, and that they are torn between two cultures, the Western and indigenous Botswana culture.” In line with this argument is that most participants, who expressed problems utilizing indigenous healing systems as referral, cited their Christian beliefs as a reason for not doing so.

Notwithstanding the challenges and barriers identified by most participants, a majority of participants expressed the need to utilize indigenous cultural practices and structures. However, the daunting question was: How do you incorporate indigenous cultural practices into counseling? As one participant argued, “you cannot do counseling in Africa without bringing the cultural context”. The general viewpoint held by most participants was that counselors must understand and utilize methods that fit the culture, the belief system, and the expectations of clients in Botswana. Nonetheless, to realize this ideal seemed to be a challenge to most of those who participated in the study. “We cannot go totally Western when dealing with an African, and ignore their experience and their view of the world around them,” pointed out one participant. “There is no way”, she added, “we can say we are bringing Western way of helping without considering indigenous cultural practices and structures.” It became clear that a number of factors contribute to these mixed feelings or the ambivalence among the participants concerning using or incorporating indigenous cultural practices. It also became apparent that indigenous cultural practices of helping were constantly associated with indigenous healers. Generally, participants had some difficulty identifying specific indigenous cultural practices and structures they utilized when counseling their clients. It could be due to a number of reasons. The following section examines some of the issues and challenges that participants identified. These include factors that act as barriers to the incorporation of indigenous cultural practices and structures during counseling.
Limited knowledge of indigenous cultural practices and methods. Transcripts mentioned limited knowledge and understanding of the cultural practices and methods several times. While participants acknowledged the existence of useful reservoir of indigenous wisdom that can help them deal with clients’ problems without necessarily undermining the current practices of counseling, most of them did not feel that they were grounded and fully exposed to the nitty-gritty of using cultural practices and systems. According to one participant, “you need to be grounded in the culture of the people you are dealing with so that you avoid misunderstandings and misconceptions. And you need to know when to give space, and find out what clients normally do when they get into a situation, that is, how they find their way out.” To address this issue of limited exposure, one participant described what counselors must do. She stated that they must “participate in community ceremonies and rituals so that they become exposed to the culture, and to appreciate what it is like to have such an experience.” The suggestion was that the counselor becoming part of the community is a useful strategy for increasing knowledge and acceptance as a counselor. One participant even argued that the office-based setting of the job of a counselor was limiting because it “does not allow us to be out there to see clients yet this has proved to be most effective in our cultural setting.” She observed that going out to be involved with clients in their settings would also address some of the barriers to communication such as language. “I find that people are more accepting if you spend more time with them and you work with them,” she argued.

Lack of information about what indigenous practitioners do was among the challenges counselors face. For example, one participant proclaimed that “we have very little information on how these healers work.” Another participant echoed this by stating that:

I have accessed medical doctors but for other practitioners, especially indigenous healers, there is no information available about them. There is this mystery about helping generally because
we do not know what others are doing. A client might not even talk to me about the fact that
they are seeing a healer and when they recover, I might think it is because of my intervention.
Yet, it may be due to another source of help they are getting somewhere else. The client might
even tell me whom else they are seeing concerning their problem but I may not have any
insight about the services they are getting.

One participant went even beyond just the issue of lack of information, and pointed out that there is
“not even a booklet showing where the indigenous healers can be located since they are not listed
anywhere.” She added that “You never know what is going to happen when a client gets to see a
healer.”

The call for dialogue between counselors and healers dominated the responses during the
interviews. While most participants viewed this as one way of improving what they do, many saw it
as another way of expanding their knowledge and understanding of what other practitioners do,
especially those accessed by most of their clients. The benefits of collaboration with indigenous
healers, as noted by one participant were that:

Not knowing how the indigenous systems work is a serious challenge. There is a need to open
a dialogue with these indigenous healers so that I can learn about what they do, identify
support structures so that we can know one another and break those walls that act as barriers.
Some of these indigenous resources out there are doing things we do not know. We need to
come to terms with what they do. Not being able to meet and create a dialogue and to open a
public discourse creates a mystery about what each one of us does. Bringing some of the issues
out would help address the barriers. Yet not acknowledging that there is a problem is an issue
for counselors to examine. The discourse is necessary so that we can begin to explore these
issues publicly.
Among the difficulties to collaboration, as identified by some participants, were that “we generally expect those healers to come to us. It is not we going to them. It would be a positive move if we, as counselors, go to healers instead of expecting them to coming to us.” One participant emphasized the pitfalls of this one-way approach to engaging the healers, when he observed the “lopsided nature of integration of the systems. Because there are no instances where you hear an ambulance rushing a patient to a healer even on illnesses that research has proved that healers are superior.”

Others believed that networking with healers would minimize the problem of clients choosing not to continue with counseling once advised against doing so by the indigenous practitioner. One critical issue identified by some participants was: “How do you work with these healers to help the client?” This was even more critical when working with HIV/AIDS clients who might be taking antiretroviral drugs simultaneously with other treatment they are getting from either a spiritual healer or indigenous doctor or herbalist. The concerns were about the problems of reactions that may arise due to combination of drugs. These are issues that counselors must handle appropriately, or with great sensitivity, or else the client may choose never to come back for therapy.

Limited training and curriculum deficit. Limited training and culturally inappropriate preparation for counseling was identified as having a significant impact on the ability to handle culture-specific problems, especially those related to belief systems. One participant suggested that there is need to address Batswana belief systems during training because beliefs are very critical “yet counselors seem to have more problems handling these issues.” She observed that “the problem with people trained from outside Botswana is that we try to change the client’s belief system yet we cannot change that.” Commenting on the need for training counselors to handle cultural issues, one participant observed that even “the current multicultural training falls short of providing skills on how to deal with issues not addressed specifically by the current theories of counseling.” Another
participant argued that “training should not just brush over issues but must go deep into issues such as those counselors are grappling with in Botswana.”

A number of participants felt that their training did not prepare them to incorporate cultural practices and structures during counseling. One participant stated that:

Cultural practices are missing in training. And the theories that are taught are predominantly Western. Unless counselors in Botswana begin to define scientifically this indigenous knowledge, some of it would be acquiesced to Western knowledge even if it were not.

…Things are changing because people are beginning to accept that counselors should be homely. Western type of counseling is rigid and therefore may not meet the needs of people who are not necessarily Western cultured. For example, if a client says they bewitched, or has a ‘calling’, the training that I have becomes limited.

Another challenge highlighted by another participant was that:

Many counselors in Botswana believe that their ways are inferior. Therefore, they tend to approach counseling with that view. During training, they are not even made to recognize that indigenous approaches and practices that exist, and that there can be a marriage of the two. Usually you have to learn about conventional Western approaches but very little about ways in which you bring the other in addressing a client’s problem.

**Attitudinal factors and conflicting belief systems.** Collaboration with indigenous healers and the conflicting belief systems seems to be a serious challenge for counselors. Some participants expressed the difficulty they would have associating with healers since that would be against their Christian beliefs. Among this group, there were those who indicated that they would have problems referring to, or working with a healer to help a client. However, they would be comfortable when it comes to involving certain church denominations or clergy from some church groups. Others were
even prepared to pray with a client, or to refer to a pastor a client who felt that prayer would help
them address their problem yet it would be a challenge if the client expressed interest in consulting
diviner or some healer. While most of this group of participants maintained that they would avoid
influencing clients not seek help from healers, they were ambivalent concerning referring a client to
a healer. “If I have to deal with healers then my beliefs might come in,” said one participant. “My
belief system,” she continued, “is likely to be affected because I will be operating against it as a
Christian.” According to one participant, “whenever a client who brings in a Christian issue it
becomes easy for me to deal with because I am a Christian. I could bring in pastors in that sense.
However, even with pastors I am selective because there is that barrier on how I deal with the
African Independent Churches. I think it is because as a counselor sometimes your values override
your objectivity.”

Others reported that people in Botswana “are ashamed of their culture and, therefore, they
would not want to be seen to be associating with indigenous cultural practices,” remarked one
participant. There was a general belief that most people who visit indigenous healers, especially the
educated, or those in high social strata do so under the cloak of darkness because they do not want to
be associated with these cultural practices. Commenting on this behavior one participant shared this
with me:

People visit indigenous healers at night, and they do not want others to know they go there,
hence they would go around 9.00pm. You would be surprised that even those whom you would
not expect would visit healers. You would find them at night because they want to avoid
people seeing them. For example, people of high social status and even those in the medical
field such as nurses or those responsible for dissemination of information about health issues
and programs consult healers. These people believe in the help provided by the healers.
Other attitudinal issues that emerged can be associated with general limited knowledge and understanding of counseling among potential beneficiaries of counseling services. Some statements made by participants indicated that some people who perceive Western-based counseling as a foreign concept of handling issues. As one participant reported:

The concept of counseling is still not clear to most people in Botswana, hence many people always refer to it as, ‘Dilo tsa lona tse tsa sekgoa’ [i.e., this stuff of yours from the Western world]. Not many people know what the role of a counselor is. There is need for counselors to be aware of the societies in which their clients live in. What their customs are? How these customs have an impact on people on a daily basis? What influences their choices and decisions? What is important to them? And even things they find in the work place.

Policy dimensions and lack of institutionalization of cultural practices. Government policies and the lack of formalization of cultural practices and structures into the mainstream delivery of counseling services were barriers to utilizing these practices. This response seems to sum it all: “The current work setting for counselors is restrictive because it focuses on acquiring a medical report even for things that have nothing to do with medical issues.” The other major issue has to do with recognition of indigenous cultural practices. As noted by one participant, “Although the institution might be aware that the student is getting help from an indigenous healer, the parent has to ask a medical doctor to write something stating that the client is still unfit instead of getting the report from the healer. This is because healers are not recognized by the system.”

Summary

This chapter presented the research findings for the interview data of the study. The chapter included demographic characteristics of the participants. Participants’ responses to questions were summarized; among the areas covered were cultural structures used by counselors, how to handle
clients’ beliefs and worldviews, views about indigenous healing methods and practitioners, and challenges and barriers faced by counselors in utilizing indigenous cultural practices and structures. While the participants believed that cultural practices and structures are important in counseling, they had mixed feelings concerning working with indigenous healers. The data revealed that most participants tended to involve family members of the client for a variety of reasons, including creating a social support system for the client, for consultation on behavioral issues, for mediation, and for facilitation of referral to other services. The chapter also discussed some of the ways in which participants handled clients’ beliefs and worldviews. These ways included respecting the client’s beliefs and worldview, using the client’s beliefs and worldview to explore the problem, and referring to other services. However, participants seemed to have difficulty in handling cultural beliefs of clients, and expressed that it was difficult to handle the beliefs entrenched in indigenous culture and cosmology. Lack of knowledge on indigenous cultural practices, limited exposure to indigenous methods, inadequate training in handling cultural issues and the deficiencies in counselor education curriculum, and negative attitudes towards indigenous cultural practices and healing structures were identified as some of the barriers to utilization of these practices by counselors. The last part is chapter is a summary.
CHAPTER V
DISCUSSION AND RECOMMENDATIONS

This chapter provides a discussion and recommendations of the study. The first part of the chapter gives an overview of the study: the problem and purpose, research questions, and method and data analyses. The discussion of results is divided into the following headings: cultural practices and structures, handling cultural beliefs of clients, perceptions of indigenous methods and practitioners, and barriers and challenges in utilizing indigenous practices and structures. The chapter also presents recommendations and implications for policy formulation, curriculum design, counseling practice and theory, and recommendations for further research. The last part of the chapter discusses the hypotheses generated from the study.

Overview of the Study

The Problem and Purpose of the Study

This study, carried out within the backdrop of widespread discussions and the staggering evidence of the failures of the Western interventions on HIV/AIDS prevention and control programs, investigates ways and extent to which counselors in Botswana utilize indigenous cultural practices and structures during counseling. Furthermore, contemporary experience with the HIV/AIDS prevention programs in Botswana has revealed that current intervention strategies that do not incorporate indigenous cultural practices and local knowledge systems proved ineffective and inappropriate. In addition, incorporating the best of indigenous cultural practices and healing systems, and local knowledge systems ensures congruence of the current Western approaches with the cultural setting of many non-western cultures has been highlighted by several studies in the area of health. In spite of all these new developments, there is still little evidence attesting to the collaboration between counselors and indigenous cultural systems in Botswana. The primary purpose of this study was to identify and to examine the extent to which Professional counselors in
Botswana use and incorporate the indigenous cultural practices and structures during counseling. The intended general focus of the study was to find ways in which Professional counselors offer counseling. More specifically the study addressed the following questions:

1. What indigenous cultural practices and structures professional counselors in Botswana utilize?
2. What indigenous structures do counselors utilize in their practice?
3. How do counselors utilize indigenous cultural practices and structures?
4. How do you handle some of the cultural beliefs upheld by your clients?
5. What are your views about indigenous healing methods?
6. To what extent do you use the cultural practices and structures in counseling?
7. What are some of the issues and challenges you face when you utilize some of the cultural practices and structures?

Methodology and Data Analysis

This applied research, using in-depth interviews and content analysis, examined the ways and the extent to which counselors in Botswana incorporate indigenous cultural practices and structures. I used a maximum variation purposeful sampling procedure to select 30 counselors from different work settings. I conducted the interviews between the months of July 22 through September 26, 2006. A semi-structured interview guide was used in collecting data while audio taping was the main method of recording the interviews. The interview guide comprised seven main open-ended questions, which solicited information on the participants’ ideas, beliefs, attitudes, and information about the utilization of indigenous cultural practices and structures they used in counseling. The use of multiple gathering methods would yield valuable data on the interrelationships and interconnectedness of the issues explored in this study. I would recommend multiple data collection
strategies for in-depth exploration of issues associated with a systems perspective for a study of this nature. Each interview was approximately an hour and a half, and was later transcribed and coded. After transcribing and coding of the data, content analysis was the procedure for analyzing data. There was verbatim transcription for all interviews before coding and category construction. Reporting the results included, among other things, the use of descriptive narrative and direct quotations from interview statements.

Discussion of the Results

The following is a discussion of the results as they related to the interview data. The section is divided into the following headings: cultural practices and structures utilized by participants, handling cultural beliefs of clients, perceptions of indigenous methods and practitioners, and barriers and challenges in utilizing indigenous practices and structures.

Cultural Practices and Structures Utilized by Counselors

Generally, participants expressed difficulties in identifying specific indigenous cultural practices they utilized during counseling. This difficulty to identify specific practices could be due to a number of factors. First, is that although counselors in Botswana might have taken courses aimed at sensitizing them about the importance of culture in counseling, there is a possibility that there is a disconnect between what they learned during training and the context within which they operate. Further, the multicultural courses they may have taken during their training might have not addressed the unique cultural features of Botswana society. One needs to examine the theoretical assumptions and materials of these courses to establish whether they fit very easily within the Botswana social context. Of great importance, is to review the illustrations and cases cited during training, to determine their usefulness and appropriateness for a predominantly collectivistic cultural setting such as that of Botswana. Second, is that the counselor training programs might have not
addressed some of the negative views counselors might have about the indigenous cultural practices. In particular, there is need to investigate the views that counselors uphold on the indigenous cultural practices that have suffered years of denigration under the cloaks of “civilization” and Western cultural domination. Third, is that the influence of the colonial legacy, missionary teachings, and Western education may have a significant impact on the views counselors have about indigenous Botswana cultural practices. I believe that these negative views have resulted in counselors shying away from the cultural practices and methods because this influence made them believe that their ways were inferior to those of Western origin. Unfortunately, this perception about the cultural practices was reflective of the Eurocentric attitudes that continue to influence interventions in many parts of Africa.

Further, the study showed that participants found it difficult associating with indigenous healing practices. While some participants attributed this to their Christian religious background, it was also evident that their personal values and societal expectations of the educated person’s behavior had significant influence on their tendency to shy away from cultural practices. The literature review (e.g., Akosah-Sarpong, 2001; Hartland, 1904; Said, 1968; Salole, 1992) has revealed that educated Africans have sometimes found it difficult to associate with their indigenous practices and ways of living. The general perception is that the educated African somehow feels ashamed of his or her cultural repertoire and shuns or rejects anything that is associated with his or her indigenous culture (Salole, 1992). As Akosah-Sarpong has observed, Western education alienated the young from their core African traditional values, and that some Africans look down upon shrines used for initiation rites.

Like their educated counterparts in other parts of Africa, counselors in Botswana are likely to have difficulty associating with indigenous Botswana practices. As noted in earlier discussions, this
could be reflective of the negative impact of the colonial legacy, the messages against indigenous
cultural practices, and the governmental and institutional policies pertaining to the utilization of
cultural methods. The subtlety of the introjections of Western values, and the pervasive negative
self-identity and self-image that most former colonial Africa has, continues to influence people’s
views on how to address the psychosocial problems and development challenges faced by
communities. These views reflect a mindset that creates a sense of inadequacy and a constant search
to try to match the standards of the Western society without even examining their appropriateness
and the cultural context. For the counselor to be effective in Botswana setting he or she should strive
for congruence, have a positive self-identity, and address his or her own views about concerning the
cultural context.

There are numerous writers (e.g., Fanon, 1967; Mphahlele, 1962) who have written about how
educated Africans, living in a society entrenched in African beliefs, struggle to deal with the
contradictions created by racial domination and subjugation. The contradictions constitute a struggle
to reconcile the conflicting principles based on individualistic and collectivistic principles and views
about the world. How does the professional counselor emphasize two divergent value systems; one
emphasizing the individual and the other basing its interventions of collective perspective? This
makes the whole issue of incorporating the indigenous cultural practices as part of intervention
strategies, very complex. For example, how can one expect a counselor whose training puts the
individual at the core of therapy, to automatically, without any significant reorientation and
retraining, to respond appropriately in cultural setting where the “collective” determines the
outcome of one’s wellbeing. I believe that the assumption that the counselor would apply what they
have learned using a view of human behavior and ways of understanding based on theoretical and
philosophical frameworks from their clients is flawed. Such an approach to training that does not
match the experiences and worldview of the beneficiaries of the interventions has proved to fail. We
seen with various development interventions in Africa, where there has been failures of development
programs and responses to the problems faced by communities because the training of those
responsible for addressing the problems were not based on local understanding of the issues and
realities.

There is also limited understanding on how indigenous cultural methods and Western
approaches to counseling could be integrated. There is evidence of bias towards Western-based
interventions. This bias could be a reflection of the belief in the supremacy of Western interventions.
The general tendency is to try to have indigenous structures and practices incorporated into Western-
based structures instead of interfacing and using the most effective from each system. For example,
counselors expect healers to come to them rather than them going to the healers. During the
interviews, participants complained that the healers do not come to them or whenever they are
invited. As one participant observed, there is no instance when an ambulance has rushed a patient to
the healers, even for problems where they have superior knowledge and skill in handling. All these
reflect the inherent belief in the superiority of Western-based strategies. Integration cannot be
effective as long as there is an imposition of one standards of practice on the other.

There are indications from the data that limited knowledge about incorporating these practices
and structures into counseling may limit the use of these practices. This finding has far-reaching
implications for counselor education. This suggest a need to expose counselor trainees to the cultural
practices and healing systems that exist in the communities they would serve upon completion of
their training. Apart from having limited exposure about indigenous cultural practices, counselors
lack skills on how to use cultural practices in counseling. Counselor education programs should pay
attention to cultural issues and find ways of helping trainees deal with the cultural conflicts and
contradictions deeply entrenched within postcolonial Botswana society. How can counselor educators prepare counselors to deal with their own strong convictions against cultural beliefs? How do they make their training culturally appropriate and responsive to the complex realities of the African experience, which is characterized by the blend of cultures, that is, that of the indigenous peoples and that of the Western society? There is need for counselors to learn ways in which they can help clients handle the conflicting cultural experiences and worldviews.

There is an urgent need to engage in a dialogue and a public discourse integration of cultural practices and healing systems. A public discourse among the professional counselors and indigenous healers would help close the gaps in collaboration and cooperation between professional counseling and indigenous healing in Botswana. However, such a discourse, informed by indigenous knowledge and the different that contribute to the negative attitudes towards indigenous cultural practices, need to get to the root cause of lack of collaboration. This would include dealing with the deeply entrenched beliefs and attitudes that make it difficult for people to talk openly about using certain cultural practices particularly those denigrated by the cloaks of ‘civilization’ and religious dogmas. Why should a client be uncomfortable to openly talk to a counselor about seeing a healer? What makes it difficult for a counselor to facilitate referral to an indigenous healer who may have expertise in handling some of the complex beliefs that clients sometimes present? Why should an institution or school require a medical doctor’s report from a client who received treatment from an indigenous healer? Responses to such questions would illuminate some of the issues concerning indigenous cultural interventions and Western methods. In addition, it is also important to examine the intricate relationships that exist within all these elements of human experience, and the perceptions associated with cultural practices and methods.
The data revealed that a majority of participants normally involved family members of the client in a variety of ways. This included soliciting the participation of family members to provide social support to the client, to act as a monitoring mechanism, to ensure security and safety, to maintain continuity and adherence to behaviors agreed upon, for consultation, and to facilitate mediation and referral on those issues outside the purview of counselors. It is worth noting that the extended family network remains an important support system and counselors ought to help their clients reconnect with other family members for security, compassion, and care. As reported in the literature (e.g., Foster, 2002; Salole, 1992; Tshitswana, 2003; Turnbill, 1971) the extended family in most African societies will remain one main source of support, caring, and security.

Despite the onslaught on the extended family network, many people in Botswana continue to rely on close relatives in times of distress and whenever in need of compassion and care. For instance, most of the AIDS patients in Botswana have ended up under the care of family members through the home-based care system. Counselors in Botswana face the challenge of ensuring that the gap created by the breakdown in the extended family system does not widen. Most poignantly, considering the limited number of trained counselors in Botswana, it is befitting to argue that family has been, and will always be, an invaluable partner with counselors in handling behavioral problems, in mediating during disputes, monitoring behavior, and in facilitating referral to sources of help outside the institutionalized systems of care. Notwithstanding the challenges faced by family today, counselors in Botswana have the opportunity to learn effective ways of utilizing family systems and their functionaries in promoting professional counseling and culturally appropriate interventions.

Unlike professional counselors, family members are easily accessible and available to clients. These members remain a vital source of comfort and a primary source of help particularly in
communities where professional counselors are not available. One important role of the counselor in Botswana is to assist the client with the reestablishment of the broken or dysfunctional relations with their family of origin as well as other filial functionaries. Where such reestablishment is not possible, helping the client to access the social groups such as religious organizations that offer social support and compassion would be valuable.

Having an effective social support system around is likely to reduce chances of loneliness and depression, and may help the client reconnect with others and have a sense of belonging. Some writers (e.g., Berg, 2003; Bertalanffy, 1975; Bronfrenbrenner, 1979; Hewson, 1998; Patton, 2002) have highlighted the importance of interconnectedness and interrelatedness as determinants of wellbeing and harmony in an individual’s life. This emphasizes the importance of helping the clients to reconnect with their families, communities, and other resources around them in order to create harmony and balance. Counselors have to continue to strive to help clients establish social relationships that are more positive and fulfilling. As noted by Staugård (1985), effective resolution to the problem would require restoring a balance between the individuals and their surroundings. As shown in the literature, lack of closeness to others and the disconnection with the environment may cause psychological distress. Counselors may need to strive to breakdown all the barriers that make it difficult for their clients to connect with their environment, which in this case includes the social, cultural, physical, and spiritual or religious.

It would be helpful for training programs to pay attention to helping counselors learn effective ways of engaging families, and advocate for the promotion of interventions that emphasize people’s harmony with their environment as a means of creating a balanced life. It is clear from studies on indigenous methods of healing that any disconnection with the environment results in disturbances in one’s harmony and life in general. Put in another way, if there is any disturbance in one’s
connection with the cultural environment there is a possibility of cultural conflicts that may sometimes create problems for the individual. On the other hand, if an individual’s physical environment is affected they may have their life disrupted. In indigenous healing, for example, if a client came to the healer and said that their home has been bewitched or that there are some evil forces, generally part of the intervention would include treating the home environment. The treatment could involve directing the client to go and perform a certain ritual or the healer could visit the home to perform some ceremony or do something to eliminate the perceived forces. To deal with the client and leave out the environment is like “washing the dishes and then put them back into dirty water and expect them to be clean”. Helping the client to regain control and confidence to deal with vulnerabilities would not just require engaging in exploration of the feelings and thoughts, but would involve even removing that which is a perceived source of discomfort. If the client believes that there is a spell cast on them, how do you address it without using methods that the client believes would do away with it? All these reflect the need for counselors to pay attention to all aspects of a client’s life since all the elements of their life are interrelated and interconnected.

Healing systems is one indigenous cultural structure that counselors have seemed to have difficulties using directly. Although this structure featured consistently particularly when participants discussed clients’ belief systems and spiritual matters, none of the participants declared that they liaise or collaborate with the healing structures in assisting their clients. Invariably, within the school system or institutions counselors generally facilitate supporting the students’ release from school so that they continue with school after addressing the problem. A majority of participants disclosed their lack of knowledge and limited understanding of the operations of indigenous healers. They often described the healers as secretive and mysterious. Some participants attributed the pervasive misconceptions and apparent misunderstanding of the healing practices and systems to
their lack of exposure about indigenous cultural practices and indigenous intervention systems. Others have argued that government policies and the current counseling practices were major factors influencing the lack of utilization of cultural practices and healing systems in counseling.

Despite their positive views about the indigenous healers’ holistic approach to client’s problems and their perceived superiority in handling religious and spiritual matters, participants harbored misgivings about engaging healers as part of their referral system and consultation network. Most participants attributed their mixed feelings to their Christian religious background and the discomfort created by the perceived mystery and secrecy of indigenous healers. Numerous writers (e.g., Amanze, 1997; Dembow & Thebe, 2006; Hartland, 1904; Kealotswe, 1995; Salole, 1992; Sillery, 1954; Simmons, 1962; Staugård, 1985) have discussed the role missionaries have played in generating negative attitudes towards indigenous cultural practices. It is clear from the study that the negative perception of indigenous culture and healing practices continues even today. As reported in the data, some participants cited being a Christian as a major reason for finding it difficult to work with indigenous healers.

While some studies (e.g., Levers, 2006a; Liddell, Barrett, & Baydell, 2004; Subrick, 2006) have noted that to leave out healers in prevention programs would be futile, there is still a huge challenge of finding ways of dealing with the negative impact of the perceptions people have about indigenous cultural practices. Considering that indigenous cultural beliefs and healing practices continue to be part of Botswana society, it is imperative that counselors appreciate and understand the value systems and beliefs of clients.

Paying attention to these dimensions of life is central to holistic approach to counseling. A number of writers (e.g., Berg, 2003; Hewson, 1998; Staugård, 1985) have discussed the holistic approach as an important aspect of bringing about harmony and balance in the life of the individual.
This approach emphasizes the need to focus on the whole person, not just one aspect of their life. Unlike healers, counselors do not provide any tangibles (e.g., amulets, or protective medicine, etc), or prescribe rituals particular for those who seek help because they feel vulnerable. Whenever individuals or families feel vulnerable, they seek interventions that offer something tangible that can protect them or address their vulnerabilities. This could include something they can take along as protection or something they can use to deal with the problem. Counselors have to find ways in which they can meet the cultural expectations of their clients.

Many people in Botswana will continue to seek help from healers for their health and psychosocial needs. Clients tend to utilize more than one service. For example, it is possible for a client to consult a diviner, spiritual healer, and a counselor simultaneously. It is important to note that within the Botswana cultural context treatment is sort from a variety of sources. This has to do with verification of the diagnosis, and an attempt to get a second opinion on the cause of illness or the problem. Sometimes even some members of spiritual healing churches may seek the opinion of the indigenous healer. There are instances when relatives have sneaked in some traditional medicine or materials from a spiritual healer to a patient, especially when there are no observable signs of improvement. One of the commonly reported problems has been the complication created by the improper combinations of indigenous medicines and Western medicines. Some participants reported that most clients would not reveal that they are seeing a healer when they come for counseling because they feel that counselors would not appreciate or understand the cultural issues and realities they are dealing with. Participants observed that clients believe that Western-based counseling approaches do not address beliefs associated with cultural beliefs that healers normally deal with. As long as clients feel that their cultural beliefs are not addressed during counseling they will continue
seek help from indigenous healing systems. The study showed that many clients utilize the services of healers than those of counselors.

How to Handle Cultural Beliefs of Clients

Among the common clients’ beliefs identified by participants are witchcraft, spirit possession, influence of ancestors, having a ‘calling’ to become a diviner, or to practice healing, bad luck as a cause of misfortune and failure in life, and prayer as a way of addressing a problem. However, responses suggested that the belief in witchcraft remains the most pervasive in Botswana society. Literature (e.g., Aceves, 1974; Amanze, 2002; Bloomhill, 1962; Middleton, 1967) is replete with discussions of witchcraft as a perceived cause of illness among different parts of the world. There is also evidence from research that we must understand beliefs such as those associated with witchcraft within a social context. Counselors in Botswana deal with many clients who feel that there are always malevolent forces that continuously working against them.

It is also evident from the data that most counselors in Botswana find it difficult to handle cases that associated with cultural belief systems, spiritual inclinations, and general supernatural manifestations. They attribute this difficulty to the limited cultural exposure and the culturally inappropriate training they received. The failure to make breakthroughs in most of the cases connected to belief systems resulted in premature termination, or clients choosing not to return for future sessions. However, we must understand this failure within the context of a struggle that counselors are going through in trying to address these culturally entrenched belief systems using techniques and approaches grounded in “modern science” and Western psychology. Such approaches would be incompatible with explaining reality from the metaphysical realm. It would be difficult for a client guided by the religious-spiritual spheres to connect with a counselor whose training and approach to a problem rejects certain worldviews as irrational and unscientific.
Among the identified approaches to handling clients’ beliefs and worldviews were that the counselor must: always respect clients’ beliefs and worldviews; utilize the client’s belief system to explore the problem; and seek immediate referral to other resources. The data reveals that counselors in Botswana strongly believe that it is important for a counselor to respect and to appreciate the beliefs and worldviews of the client. The study cautioned against discrediting, dismissing the client’s beliefs as unscientific, or even trying to reshape the client’s worldview. The general position was that counselors ought to understand ‘where the client is coming from’. The suggestion is that as long as there is no harm caused, a counselor should not temper with the beliefs or action of the client, especially if it yields positive results. While this study shows that respecting the client’s beliefs and worldviews is an important aspect for counseling clients in Botswana, the challenge is on reconciling counselors’ personal values and strong religious beliefs with those of clients who may adhere to beliefs grounded on indigenous culture and worldview.

Most participants believed that focusing on a client’s beliefs is very important because religion pervades every aspect of life in Botswana society. Nonetheless, spending time trying to help a client change their beliefs would be futile and counterproductive. Counselors in Botswana may have to learn more about the cultural beliefs, values, customs, and the general worldviews of their potential clients in order to respond effectively and appropriately to their clients’ needs. They must be culturally grounded and be responsive to the belief systems and the psychosocial problems associated with Batswana’s religious worldviews. Due to limited skills in handling beliefs and indigenous worldviews of Batswana, most participants referred their clients to other service providers. While most participants had misgivings referring their clients to indigenous healers, there were those who expressed that they were comfortable dealing with clients who espoused Christian beliefs because such clients shared their worldviews and values.
Although counselors in Botswana might have grown up in communities where these beliefs about witchcraft, ancestors, and collectivistic worldviews, it may be difficult to reconcile the non-Christian clients’ beliefs with their own Christian belief systems. Most importantly, counselors may struggle with the dilemma of meeting the society’s expectations about educated people concerning these beliefs, and to appreciate the impact of the general attitude towards the indigenous cultural beliefs. It is very clear that the Eurocentric views about healers in Botswana still influence the way Batswana view indigenous healers. For most people, the mention of a healer connotes the “witchdoctor”, a term that healers were branded with during the colonial era. This label has erroneously applied to all indigenous practitioners involved in healing systems to be witchdoctors. Surprisingly, the moment you mention the term ‘indigenous cultural practices’ most respondents automatically focused on indigenous Setswana doctors. The other major challenge has to do with the general perception that these indigenous practitioners are a homogenous group and all are capable of causing harm.

Perceptions of Indigenous Methods and Practitioners

There are significant differences in perceptions counselors have about indigenous methods and Western-based approaches to counseling. These differences had to do with the focus of the therapy, the location where therapy takes place, the time and duration of therapy, the qualities of the therapist, and the approaches to diagnosis and intervention strategies. The common view is that, unlike professional counselors, healers focus on all aspects of the life of the client such as the personal, social, physical setting, and spiritual and/or religious dimensions. There is also a strong belief that counselors leave out the spiritual issues and focus mainly on one aspect of a person’s problem. The view is that the client’s physical and social environments play a crucial role in ensuring efficacy of the treatment. The perception is that healers do not treat clients as if they were
separate from their social and physical environments. It was evident from the interview responses that the therapist should pay attention to the client’s environment. To treat a client and then sending them back to an ailing environment that might be contributing to the distress is not productive. To address the client’s environment the healer visits the home of the client to perform some ceremony or ritual to eliminate the perceived cause of distress. The general opinion is that counselors had no capacity to attend to the perceived insidious threats to the client. The study revealed that counselors focus on reshaping the clients’ worldview, or spend most of time dealing with the client’s perception of reality. As a result, clients still have to consult a healer to address some of the issues, which they might feel, were left unattended to by a counselor.

The place where therapy takes place and the paraphernalia associated with the intervention have a significant influence. The widespread opinion is that the setting used by an indigenous healer is homely, welcoming, and is imbued with the potential to invoke some kind of ‘presence’ that creates an atmosphere conducive for a therapeutic encounter that evokes positive feelings. Concomitant with such a setting is the power associated with the regalia and other paraphernalia the indigenous healer uses in creating a therapeutic atmosphere. As reported in the literature (e.g., Bloomhill, 1962; Hewson, 1998) the healer’s regalia and paraphernalia do contribute to the therapeutic environment. In her description of healer’s ceremonial dress, Hewson (1998) has highlighted the regalia’s effects on the healing process. She argued that the healer’s clothing and adornments signify particular healing skills, and together with the healing instruments, they give client access to the healing power. Among the paraphernalia used are the tangibles, concrete, take-with-you materials or prescribed services and rituals for the client to do in order to address the problem particularly where there is fear of malevolent forces working against him or her.
One of the frequently cited criticisms of Western-based counseling was that it is time-driven, businesslike, focuses on paperwork, and in the process misses the human element. Several participants in the study referred to both the duration of counseling and the time limits as working against the cultural expectations of clients in Botswana. One example that stuck out was that counselors knock off at a certain time of the day, or are not available during certain days while the client may need assistance during that period. Yet, the healer is always available and easily accessible (UNAIDS, 2000), without time restrictions and time limits. The other one had to do with ensuring that the session is done within the set time limit to have the next appointment.

Concerning the differences in diagnosis, participants identified, among other things, the healer’s skill in diagnosing issues that go beyond the scientific realm yet counselors were viewed as limited to empirical, scientific understanding of human behavior. The observation during the study was that counselors do not delve into issues of faith and the spiritual aspects of humans. The other difference was that the healer always attends to the “why me part”, which demands soliciting the religious and spiritual realms of human understanding, and that the healer is imbued with predictive skills and the ability to go beyond observable phenomena as well as pays attention to nonverbal cues and demeanor. I believe that one of the most important thing counselors could do is to find ways of meeting the expectations of clients concerning the approach and response to the “why question.”

**Barriers to Utilizing Indigenous Cultural Practices and Structures**

Among the factors identified through the study is that many counselors may have limited experience on indigenous cultural practices due to counselor education curriculum deficiencies, inadequate training on how to respond in a culturally appropriate manner, and the negative influence associated with the perceptions people have about indigenous cultural practices and structures. The limited knowledge and the lack of understanding of the cultural practices and methods is a major
barrier to utilizing indigenous practices and methods in counseling. Furthermore, the lack of exposure and the limited grounding in the cultural practices lead to misconceptions and misunderstanding about indigenous cultural practices. To address this problem, counselor education programs ought to incorporate indigenous local knowledge and cultural beliefs and practices of Batswana. Internship and practicum experiences must provide opportunities for counselor trainees to interact with indigenous practitioners, participate in community rituals and activities of the communities where they will work upon completion of their training. The lack of participation in community ceremonies and rituals, and the over-reliance on office-based counseling are some of the barriers to exposure to the culture and experiences of the clients. For some counselors, language barrier makes it difficult to work with clients who are not fluent in the official languages. On the other hand, the lack of information about indigenous practitioners can be a limiting factor for collaboration and access to the indigenous practices and systems. Counselors need to seek information about indigenous practices and healing systems in their communities. The lopsided nature of the communication between counselors and indigenous practitioners, and the perceived superiority of Western interventions pose a serious challenge to effective dialogue and collaboration between indigenous practitioners and counselors.

Another significant issue associated with the utilization of indigenous cultural practices is the limited training and culturally inappropriate preparation of counselors who work in non-western settings such as Botswana. The challenge arises when working with clients’ belief systems and the culturally laden expectations and worldviews that some clients in Botswana have. Training does not adequately prepare counselors in Botswana to deal with religious and spiritual manifestations not commonly found in the Western world. Most counselor education materials do not provide illustrations and examples that are not on Batswana culture and social context. Considering the
blended social context of Botswana, it would be useful to have training that blends the Western and indigenous methods of counseling.

Attitudinal factors and conflicting belief systems are barriers to utilization of culturally appropriate interventions. Counselors have difficulty liaising with healers because that would work against their Christian religious convictions. Influenced by missionaries during the colonial period in Africa, most Christian teachings are incompatible with practices such as ancestor veneration and other indigenous cultural practices of Batswana. Sometimes these conflicting beliefs have led to tensions between parents and their children who may choose to embrace evangelical groups that have continued to find bases in Botswana society. These conflicting beliefs may cause so much rift and tensions in the family. Counselors sometimes deal with such religious conflicts between parents and their children. The lack of formal recognition of indigenous cultural practices and healing systems by institutions and the different policy formulation bodies such as government, need serious consideration.

To embrace indigenous cultural practices is one of the positive steps that counselors can take to facilitate a more fruitful dialogue with other service providers. Literature has shown that to incorporate indigenous cultural practices and the local knowledge systems lead to the success of any intervention. While cooperation and collaboration with indigenous practitioners may improve communication among service providers, it is also likely to reduce the inherent suspicion and the current problems that have been associated with the failure of contemporary interventions that ignore cultural practices. Reports have shown that whenever program developers left out indigenous practitioners and the local knowledge systems, there are serious setbacks and limitations.

Although counselors may have positive views about the potential benefits for collaboration with indigenous practitioners, several barriers to establishing a fruitful working relationship between
counselors and indigenous practitioners exist. These barriers seemed to reflect personal influences, societal and cultural issues that exist in Botswana society. The effects of missionary teaching and the continued conflicting religious beliefs that portray indigenous cultural practices negatively have serious implications on how counselors view Batswana’s cultural ways and indigenous practices. The challenge, therefore, is how counselors in Botswana can provide counseling without considering the sociocultural context of their clients. Secondly, if counselors choose to ignore liaising with indigenous practitioners they are likely to face the same problems that those in health sector experienced in the past decade. Studies (e.g., Levers, 2006b; Subrick, 2006) about Botswana, have noted the pitfalls of overlooking the impact of culture on the intervention programs and strategies. These studies have emphasized the need to incorporate local knowledge systems and the healing practices of Batswana into the intervention strategies.

Considering the nature of Botswana society, characterized by blending of belief systems and worldviews that are influenced by Western-based education, Christianity and indigenous religious practices, and technological advancement, counselors may have to come up with culturally grounded methods and strategies that respond to this blended system and mixed experiences. Counseling based on philosophical principles that do not reflect this blended cultural milieu may find little favor from many potential clients whose expectations are influenced by this complex cultural and social setting. If cultural expectations of clients have a bearing on their responses to the proposed interventions and outcomes, then it is imperative to examine the perceptions clients in Botswana have about counseling. Counselors ought to realize that the decision to seek certain types of interventions is not due only to the costs and access issues but a result of assumptions and expectations clients have about the cause of the distress, or the need and the perceived appropriateness of the treatments (Kearney, 1979). We may also argue that if healers are easily accessible, available, and affordable.
(UNAIDS, 2000; Dembow & Thebe, 2006), and do meet the expectations of personalized care that is culturally appropriate, holistic, and always involving client’s family, then counselors need to strive to tailor their services to meet the needs and expectations of their clients too. Failure to do so is likely to lead to many clients continue to rely mainly on the indigenous healing systems for their mental and psychosocial concerns and issues.

Counselors would have to embrace tenets of the indigenous cultural practices in a bid to become culturally relevant and to minimize the current ineffective wholesale transplanting of prepackaged alien intervention models, some of which are inappropriate to Botswana’s cultural and social setting. There may be a need to come up strategies that are suitable for a large proportion of the generally collectivistic Botswana society. To embrace some of the practices and interventions Batswana continue to use may enhance the stature and image of Western-based counseling within this hugely and uniquely different collectivistic social context. Whereas many counselors in Botswana rely solely on their Western-based training, many are struggling with ways in which they can make their training fit this cultural context that is different from the one described by the materials they use, and the focus of the training they went through. The study shows that counselors perceive significant differences between Western approaches they use and the indigenous methods. While they seem to view indigenous methods positively on a number of fronts, they struggle to reconcile the teachings influenced by the legacy of Christian missionaries and the negative impact colonialism has had on many African peoples. In spite of the belief that indigenous practitioners are holistic in their approach, they pay more attention to the client, they use a homely, welcoming setting that has a conducive atmosphere, and are skilled in handling issues beyond the scientific realm, most counselors find it difficult to embrace their practices. Counselors are not tapping on these positive practices to enhance their effectiveness and professional influence in the community.
Counselors need to consider the nature of Botswana society, characterized by Western cultural values and indigenous Botswana social norms and values. As Leung (2003) has noted, there is a need for a paradigm shift to recognize that indigenous practices and models are important to the development of global counseling. Imposition of alien models of care and approaches to mainstream counseling has proved inappropriate in responding to the experiences and concerns of non-western cultures. Interfacing of the elements and strategies of Western and indigenous systems (Lefley, 2001) would yield positive results. Counselors in Botswana need to examine their beliefs, values, and attitudes to establish the impact these have on their counseling.

Recommendations and Implications

The results may have some significant implications for policy formulation, counselor education curriculum planning, counseling practice and theory, and further research. It is evident from this study that there is need for a shift in paradigm and to have counselors learn new ways that would enhance their effectiveness and influence in Botswana society. This shift would help counselors find an anchor for their professional role in the communities they serve in Botswana. The following discussion explores some of the implications and recommendations derived from this study.

Policy Formulation

Education institutions and schools should review some of their current policies regarding cultural practices and healing systems. This would require addressing issues such as lack of recognition of the healing practices that many Batswana continue to rely on for their psychosocial needs and concerns. There is need to incorporate those indigenous intervention strategies that have proved efficacious. Current policies for institutions and organizations are not conducive for the effective collaboration between counselors and indigenous practitioners who, without doubt, continue to be a formidable resource for a majority of Batswana. Numerous studies (e.g., Liddell,
Barrett, Bydawell, 2004; Levers, 2006b; Subrick, 2006; UNAIDS 2000, 2007) have reported the benefits of effective collaboration between indigenous healing systems and the contemporary systems of care. These studies have documented the problems associated with ignoring indigenous healing structures in providing care. The continued existence of indigenous cultural healing practices and their ability to attract many clients has serious implications for counseling in Botswana. This means that counselors have to contend with their power and influence on many fronts, and that counselors cannot continue to ignore the benefits of collaborating with indigenous healers in improving counseling as well as reducing the problems created by the current status quo.

*Counselor Education Curriculum Design*

There is need to reexamine counselor education programs and curricular to ensure that they incorporated indigenous cultural practices and healing systems. This may also require the introduction of cultural studies to facilitate more exposure and understanding of the issues associated with beliefs, customs, and worldviews of Batswana. This also calls for the reorientation of counselor training in Botswana and the realigning of the practicum and internship experiences to include placement and shadowing some of the indigenous practitioners. More interaction between counselors and healers is likely to reduce suspicion and enhance communication.

The review of the current training materials, books, and illustrations would improve application of the learning experiences by counselors. The incorporation of philosophical and theoretical foundations of counseling that reflect the Botswana sociocultural context is of utmost importance. The use of indigenous psychologies and the ways of understanding human nature and behavior modification in counselor education is critical.

Counselor education curriculum in Botswana must help trainees to learn about the indigenous healing systems, to understand local knowledge systems and the different cultural practices and
customs of Batswana. Trainees would benefit from learning about theories of causation within Botswana context and the influences of culture, belief systems and worldview of clients on counselor effectiveness. Curriculum review to incorporate knowledge of the cultural structures, Botswana laws and policies, and the ethical issues germane to Botswana culture would help improve counselor education curriculum in Botswana. Counselor educators may have to encourage counselor trainees to collect information and to research in indigenous cultural practices and healing systems. It is clear from research and the current study that religion in Africa plays a significant role in people’s views about the world and how people respond to issues that affect them. Therefore, learning about the religious practices and beliefs of Batswana would help counselors appreciate the influence of their own religious beliefs in counseling.

Counseling Practice and Theory

Wolcott (2001) has acknowledged that “drawing theoretical implications is an important facet of the research process, and the advancement of theoretical knowledge is a reasonable expectation for the effort” (p. 77). From this study, we can draw a number of theoretical implications. First, there would be need to establish collaboration between professional counselors and indigenous practitioners as a way of influencing the necessary changes and perceptions expected to improve the delivery of counseling. Counselors can initiate a two-way collaboration that should include, among other things, dialogue and a public discourse through conferences, workshops, sharing of resources, and regular participation in community ceremonies and public rituals. Second, counselors may have to adopt approaches that fit the social context, and respond effectively to the psychological, physical, emotional, and spiritual needs of clients in Botswana. The third is that the incorporation of indigenous African psychology and knowledge systems to generate new theoretical orientations that reflect the worldviews and belief systems of clients in Botswana is essential. Counseling can no
longer just rely on Western philosophical thought and understanding of human behavior when addressing culture-specific issues of Batswana. Counselors in Botswana would benefit from striving to utilize the indigenous cultural practices in their counseling.

**Recommendations for Further Research**

There are several recommendations identified for further research in Botswana. More research on culturally appropriate methods of handling issues such as witchcraft, spirit possession, influence of ancestors, and other cultural manifestations such as trance would benefit counseling in Botswana. Many counselors seem to encounter difficulties when faced with these religious phenomena. There is need to study indigenous psychology and the cosmological forces that seem to play a significant part in influencing perceptions of reality and causation. In addition, the lack of knowledge about the Western-based services offered by the formalized systems of help may have influenced the perceptions people have about counseling.

Counselors have to initiate more research investigating culturally appropriate approaches and interventions. Counselor belief systems and views about indigenous cultural practices seem to have significant influence on responses and intervention strategies they use. This study has revealed that counselors had difficulty using indigenous practices and collaborating with healers because doing so would be counter to their Christian religious convictions. The study also showed that some institutional factors, societal influence and the contradictory expectations, attitudinal factors, inadequate and inappropriate training, and lack of exposure and grounding in handling cultural issues are areas that require more investigation. Institutions and government must commission studies on the influence of religious teachings, belief systems and values on addressing clients’ needs and concerns. Because very little is known about some of the factors that contribute to low utilization of counseling services in Botswana, encouraging more studies in this area would benefit
counseling in Botswana. Many people continue to seek help for psychosocial and related issues from faith healing centers and spiritual healing churches, and indigenous healers despite counseling services available to them. What is it that these groups provide which continues to attract large numbers to use their services yet very few people use the services of counselors? What can counselors learn from these groups’ practices to enhance their services? Further research on the expectations clients have about counseling would be valuable.

This study may act as a stimulus to more research and dialogue on possible collaboration between counseling and healing systems. There is need to investigate the impact of barriers to using culturally appropriate interventions in counseling. Further research on this topic may generate more data on the possible influences of counselors’ religious background and personal values on the utilization of indigenous healing systems in counseling.

Hypotheses Generated

From the results obtained in this study, we can generate a number of hypotheses. First, it is hypothesized that there is a significant relationship between the counselor’s selection of intervention strategies and his or her religious background. As counselors in Botswana make choices about how to intervene or where to refer the client for therapy they find it difficult to send a client to an indigenous healer because that would be against their religious conviction to associate with healers.

Second, it is hypothesized that counselors who use a holistic approach to counseling are more effective. In most collectivistic societies, interconnectedness, interrelatedness, and interdependence are critical elements that influence clients’ responses to therapy, and their expectations of the outcomes.

Third, it is hypothesized that where counselor education focuses on personal development, addressing the self-image and introjections of alien values, graduates of counseling programs are
more effective and culturally responsive. Self-identity plays a critical role in facilitating change in others. A counselor who has a negative view of his or her culture and that of the client is likely to have a negative impact on the client.

Fourth, the colonial legacy, religious teachings, and cultural domination have a significant influence on the attitudes of counselors towards indigenous cultural practices and structures in Botswana.
References


Hartland, E. S. (1904). *Popular studies in mythology romance and folklore: What is it and what is the good of it?* London: David Nutt.


Nkomazana, F. (2002). Some evidence of belief in the One True God among the Batswana before the missionaries. BOLESWA occasional papers in Theology and Religion. God, 1(9), 51-60. University of Botswana: Author


magical medicine: Traditional healing today (pp. 53-67). Durham & London: Duke University Press.


Appendices
Appendix A

Request for Permission to Conduct Research in Botswana
The Permanent Secretary  
Ministry of Education  
Private Bag 005  
Gaborone  
Dear Sir/Madam,

REQUEST PERMISSION TO CONDUCT RESEARCH IN BOTSWANA

I am currently a PhD candidate in counselor education and supervision in Duquesne University in Pittsburgh, Pennsylvania, USA. Counselors in Botswana are identified to participate in a research project focusing on the ways and extent to which incorporate and utilize indigenous cultural practices and structures in delivering their services. This letter therefore serves as request for authorization for me to conduct research interviews in urban, rural, and other major centers.

The information collected through during this study will remain confidential and will be used for the sole purpose of this study. In addition, the information will be disposed of in accordance with rules and regulations governing disposal of research data as required by the federal laws of the United States of America and Botswana laws.

After the study is completed, I intend to share the findings in accordance with statutory regulations governing dissemination of research in Botswana, which include, depositing copies of the report at the user ministry and/or affiliated body, University of Botswana (Research and Development office), Botswana National Archives and Records Services, and Botswana National Libraries Services (BNLS).

Attached are copies of the Research Permit Application Form, Research abstract proposal, and Curriculum Vitae. Both my email address and fax are included in the address above. Thank you for your assistance.

Yours sincerely,

________________________
Dan-Bush Bhusumane
Appendix B

Letter of Transmittal
LETTER OF TRANSMITTAL

Dear colleague,

I am currently a PhD candidate in counselor education and supervision in Duquesne University in Pittsburgh, Pennsylvania, USA. As part of this research project that is for the fulfillment of the requirements for the PhD in Counselor Education and Supervision, I am studying the ways and extent to which counselors in Botswana utilize indigenous cultural practices and structures. I invite you to participate in this important study.

Your have been selected through a purposeful sampling procedure from a list of counselors in Botswana and I sincerely request your cooperation in participating in an interview. The interview takes about an hour and I assure you that all information and your identity will be safeguarded, to ensure confidentiality and will be used only for the purpose of this study. No personal information collected during the study will be available to anyone at any time. If you would like a summary of the findings mailed to you at the end of the study, please send me your name and address in a separate stamped, self-addressed envelope.

I enclosed a stamped, self-addressed envelope so that you may return a signed consent form to me by the date indicated on the form. Should you have any questions regarding any aspect of the study please feel free to contact me at this number or by email shown, above. Your participation will contribute to our understanding of the issues of cultural relevance, utilization of indigenous cultural practices and structures in counseling. Thank you very much for your assistance in this project.

Yours sincerely,

________________________

Dan-Bush Bhusumane
Appendix C

Permission to Conduct Research
To: Dan-Bush Bhusumane  
University of Botswana  
Private bag 0022  
Gaborone

RE: PERMISSION TO CONDUCT RESEARCH

We acknowledge receipt of your application to conduct research that will:

➢ Identify and examine the extent to which counsellors in Botswana incorporate and utilize the indigenous cultural practices and structures in their services and programs.

You are granted permission to conduct your research entitled:

Examine the ways and extent to which counsellors in Botswana utilize the cultural practices and structures.

This permit is valid until 30 December 2006. You are reminded to submit a copy of your final report to the Ministry of Education, Botswana

Thank you,

M.L. Phiri
For Permanent Secretary
Appendix D

Semi-structured Interview Guide
Semi-structured Interview Guide

1. Identify and discuss indigenous cultural practices and structures professional counselors in Botswana utilize.

2. What indigenous structures do counselors utilize in their practice?

3. How do counselors utilize indigenous cultural practices and structures?

4. How do you handle some of the cultural beliefs upheld by your clients?

5. What are your views about indigenous healing methods?

6. To what extent do you use the cultural practices and structures in counseling?

7. Identify and discuss some of the issues and challenges you face when you utilize some of the cultural practices and structures.
Appendix E

Consent to Participate in a Research Study
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Examining the ways and extent to which counselors in Botswana are utilizing indigenous cultural practices and structures

INVESTIGATOR: Dan-Bush Bhusumane
102 Briaridge Dr. Apt# M
Turtle Creek, PA 15145
Tel# 412-452-1623
E-mail: Danbushnet@yahoo.com

ADVISOR: Lisa Lopez Levers, PhD
Counseling, Psychology, & Special Education
School of Education
Duquesne University
600 Forbes Avenue
Pittsburgh, PA 15828
Tel# 412-396-1871
E-mail: levers@duq.edu

SOURCE OF SUPPORT: This study is being conducted in partial fulfillment of the requirements for the doctoral degree in Counselor Education and Supervision at Duquesne University.

PURPOSE: Your name has been selected through a purposive sampling procedure from a list of counselors in Botswana. You are being asked to participate in a research project that seeks to investigate the ways and extent to which counselors in Botswana incorporate and utilize indigenous cultural practices and structures. In addition to participating in approximately two hours focus group, you will be asked to allow me to interview you for an hour.

The interviews and focus group sessions will be audiotaped and transcribed. You will have the opportunity to check the interview transcription for accuracy. These are the only requests that will be made of you.
RISKS AND BENEFITS: There are no perceived risks in participating in this study. Should you choose to withdraw from the study at any time you are free to do so and this will not affect your future professional relationship with the researcher or University of Botswana.

Your participation will contribute to the current knowledge on how counselors can incorporate the best of the indigenous cultural practices into the support systems and structures. Further, your contribution will help counselors in Botswana keep counseling culturally relevant, become sensitive to and complementary of the cultural values and practices thus making counseling services congruent with the emerging helping services in Botswana. If you are interested in the findings of this study please send a stamped, self-addressed envelope.

COMPENSATION: There will be no financial gains in participating in this study. However, participation in the study will require no monetary cost to you. An envelope is provided for return of your response to the investigator.

CONFIDENTIALITY: I assure you that all information and your identity will be safeguarded, to ensure confidentiality and will be used only for the purpose of this study. No personal information will be shared with anyone at any time. When transcribing audiotapes, all identifiers, of you, your agency, and anyone you talk about will be deleted or disguised.

A code number shall be assigned to all those who have been selected. This shall be done for purposes of anonymity. All names of the respondents and the code will be recorded separately in a confidential file. This would facilitate sampling for the Focus groups.

A form for respondents to indicate their willingness to participate in a personal interview schedule and/or Focus group will be included together with the initial contact letter.

All written materials and consent forms will be stored in a locked file in the researcher's office at the University of Botswana and destroyed five years after the completion of the study.
Preserving the information for minimum of five years is in accordance with the current guidelines for researchers, as provided by federal law of the United States of America. Your response(s) will only appear in transcriptions. By signing the consent form (participant’s signature for focus group), I also pledge not to discuss any information disclosed during the focus group with anyone outside the group since this will be a violation of confidentiality of other members of the group.

**RIGHT TO WITHDRAW:** You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time and your data will be automatically be excluded from the analysis and destroyed.

**SUMMARY OF RESULTS:** A summary of the results of this research will be supplied to you, at no cost, upon request.

**VOLUNTARY CONSENT:** I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project. I understand that should I have any further questions about my participation in this study, I may call Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board (412-396-6326) in the United States of America.

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<td>Researcher's Signature</td>
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