ADVOCATING FOR THE ADVOCATE: IDENTIFYING, PREVENTING & RECOVERING FROM SECONDARY TRAUMA

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Advocating for the Advocate:
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The preamble to the American Bar Association's Model Rules of Professional Conduct admonishes lawyers to be advocates and assert the position of their clients. [1] This requires a lawyer to be competent, prompt, and diligent in all client matters.[2] These rules further suggest that it is the lawyer's responsibility to uphold the legal process while seeking to further the public's understanding and confidence in the law.[3] As such, attorneys are to exemplify ideals of public service within the legal profession.[4] Rule 1.1 of the ABA Rules notes that a lawyer must provide competent representation, while Rule 1.4 outlines procedures for communication in the client-lawyer relationship. [5] It is important to consider the ways in which being an advocate for one's client has a long term impact on the lawyer providing this rigorous representation. In many circumstances, the outcome is positive for both the attorney and client. However, it is equally important to understand the ways in which serving the needs of a client can inadvertently cause psychological harm to the attorney. This is particularly the case for attorneys involved in cases that consist of traumatizing events.

Ojelade defines trauma as a threat to the safety and security of one's self, family, and community. [6] This broad definition of trauma enables individuals serving in advocacy roles to recognize the ways in which they are impacted by the experiences of those who are simultaneously clients and members of their shared community. Responsible for playing a role in the preservation of society, lawyers do not simply serve as advocates asserting the position of their clients. [7] Instead, they are altered by the experiences of these clients and the information that they must hold confidential. [8] Thus, lawyers are impacted by the client's traumatic experiences and are at risk for developing Secondary Trauma. The concept of Secondary Trauma is also referred to as Compassion Fatigue and describes the experiences of many individuals exposed to traumatic events as a result of their work. Attorneys, healthcare providers, safety professionals, and even psychologists have been shown to develop psychological symptoms as a result to repeated exposure to traumatic events that occur to others they serve.

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[1] MRPC Preamble [2]
[2] Id. At [4]
[3] Id. At [5,6]
[4] Id. At [7]
[5] Id. At [1.1, 1.4]
[6] Ojelade, I. (2016). Sacred Journey: A Workbook for Healing Trauma. *The Clemency Project 2014*. Washington DC.
[7] Id. At [13]
[8] Id. At [1.6]

The research literature suggests that attorneys who are exposed to traumatic client information are at increased risk for developing depressive, anxious, substance abuse, and sub-threshold PTSD symptoms. [9] Ojelade notes that when seeking to address these or other Western defined mental health problems, people are four times more likely to seek out alternative healing methods. These healing modalities may be utilized in place of or as an adjunct to counseling. [10] As such, Ojelade notes the importance of understanding the ways in which clients recognize, define, and engage the healing process. [11] This is particularly the case for professionals impacted by traumatic information as a result of their work. In their role, attorneys can benefit from psycho-education regarding the identification and prevention of Secondary Trauma. For those who prefer to integrate alternative healing methods in the counseling process, psychologists assist in identifying safe and effective methods to bridge the two interventions. This enables those experiencing Secondary Trauma to integrate Western-based counseling with meditation, yoga, energy work, symbolism, spiritual interventions, and more.

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Theory

Use of Ifá as a Means of Addressing Mental Health Concerns Among African American Clients

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African Americans underuse counseling services because of factors such as cultural mistrust, stigma, and culturally incongruent treatment interventions. As a result, this population relies on informal healing networks. The foundations of these networks have been outlined within the professional literature. However, limited attention has been given to the indigenous healing methods used by African Americans in lieu of counseling. This article explores the conceptual, diagnostic, and treatment strategies of the indigenous healing system, Yorùbá-based Ifá.

Studies suggest that African Americans experience mental health concerns at the same rate as other Americans (Constantine, Myers, & Kindaichi, 2004). However, this population tends to underutilize available counseling services (Buser, 2009). Several studies examine treatment utilization patterns and the causes for poor treatment adherence among this population (Jackson et al., 2007; Sussman, 2004). Authors identify a number of potential barriers to successful treatment including cultural mistrust (Whaley, 2001), stigma regarding mental illness, racism within the therapeutic exchange (Parham, 2002), and treatment modalities failing to address the cultural values and worldview of the client (Duran, Firehammer, & Gonzalez, 2008; Myers et al., 2005).

In part, because of the aforementioned barriers, African Americans often rely on informal networks of support in lieu of seeking counseling (Harley & Dillard, 2005; Parham, 2002). These networks typically include family and community resources, religious leaders, and indigenous healers (Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004). In fact, African Americans are more likely to seek religious or spiritual experiences rather than admit to mental health concerns (Harley & Dillard, 2005). Spiritual and mental health concerns are often viewed as interconnected; therefore, religious institutions have an extensive history of providing both spiritual guidance and counseling services (Harley & Dillard, 2005). Within the African American community, indigenous African spiritual systems also have a long history of providing mental health services (Clarke, 2004). In fact, African Americans may rely on indigenous African spirituality as an alternative to Western forms of counseling (Boyd-Franklin, 2003). Although the scholarly literature has explored the therapeutic use of religion, little attention has been given to African-based spiritual systems used by African Americans as a mental health intervention (Boyd-Franklin, 2003; Constantine et al., 2004).

To assist counselors in increasing their level of cultural competency, this article explores historical factors prompting African Americans to choose African-based spiritual systems when addressing mental health concerns. Specifically, an overview of Yorùbá-based Ifá is presented. This article places [AU2] specific focus on Ifá because it is the largest indigenous African spiritual system practiced outside of its country of origin (K. Abimbola, 2006; Falola & Genova, 2005). Ifá and its diasporic manifestations are currently followed by an estimated 100 million people worldwide (K. Abimbola, 2006). Diasporic manifestations of Ifá include Candomble in Brazil, Santeria in Puerto Rico, Lucumi in Cuba, Shango in Trinidad, and Yorùbá within the United States (K. Abimbola, 2006; Falola & Childs, 2004). Scholars additionally note the increasing popularity of Ifá among African Americans as a healing modality (Boyd-Franklin, 2003; Clarke, 2004; Falola & Genova, 2004).

Finally, the conceptual, diagnostic, and treatment practices of Ifá are reviewed. Understanding this information will result in counselors gaining a broader knowledge base from which to work with African American Ifá adherents. This will enable clinicians to provide intervention strategies consistent with the client's beliefs regarding the etiology and treatment of mental health concerns. Providing culturally congruent interventions can result in improved treatment adherence among this population.

Factors Influencing Selection of Indigenous African Spirituality as a Healing Modality

Sussman (2004) suggested that historical, social, and cultural variables influence the culturally constructed health care systems developed by members of a particular society. These

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cultural healing systems include collectively held knowledge and beliefs regarding the cause, manifestation, and mitigation of mental health concerns among members of that group. Scholars posit that many Western intervention strategies fail to consider historical factors or the worldview of the client (Duran et al., 2008; Sussman, 2004). This approach toward care can result in the therapist misinterpreting a client's low treatment adherence as resistance rather than a culturally constructed means of managing and healing mental health concerns. However, within Western counseling, there is a growing trend toward the delivery of culturally competent counseling services (Constantine et al., 2004; Myers et al., 2005). This approach includes an examination of historical, social, and cultural variables influencing the client's worldview and treatment utilization patterns. The following example outlines the ways in which historical, social, and cultural variables influenced the use of Ifá as a mental health intervention among African American clients.

Historical Interactions Within the American Mental Health Care System

Historically within the mental health field, African Americans have been misdiagnosed and improperly treated for psychological concerns (Harley & Dillard, 2005; Parham, 2002). Studies suggest that African Americans are disproportionately diagnosed with psychotic disorders (Neighbors, Trierweiler, Ford, & Muroff, 2003; Trierweiler, Muroff, & Jackson, 2005) and underdiagnosed and inadequately treated for mood disorders (Jackson et al., 2007; Trierweiler et al., 2005). The authors further suggested that racial profiling in the therapeutic exchange has historically resulted in African-descended people being characterized as hypersensitive regarding issues of race, unable to meaningfully engage in counseling (Moodley & West, 2005; Parham, 2002), and excessively paranoid (Whaley, 2001). Such characterizations of African Americans by mental health professionals have resulted in members of this population being apprehensive toward engaging in treatment and may account for lower mental health utilization rates. Furthermore, these factors provide a context within which to understand treatment-seeking patterns among this group.

Affirmation of an African Identity

The efforts of Black nationalists and cultural anthropologists in the early part of the 20th century also affected treatment-seeking patterns among African Americans. These two groups ignited an interest in those who sought to reclaim their African cultural and spiritual heritage (Clarke, 2004). African-based spiritual systems brought to America by immigrant practitioners of Santeria, Candomble, and Vodou redefined religious practices (Falola & Childs, 2004). Some students of these African cosmologies sought to use African-derived religions as a tool for political organization and social empowerment. Adherence to African-based spiritual systems became an affirmation of Black nationalist ideology and of African cultural identity (Clarke, 2004). This affirmation of a political and ethnic identity, coupled with a historical distrust of Western mental health care, meant that adherents of African-based spiritual systems began relying on indigenous healers to address mental health concerns.

Cultural Congruency of Treatment Approaches

In addition to historical patterns of racism within the mental health field and efforts to reclaim a lost cultural heritage, writers suggest that indigenous healing strategies appeal to the values, beliefs, and worldview of many African Americans (Harley & Dillard, 2005; Parham, 2002). Indigenous healing methods are defined as those interventions developed and used by individuals of a particular society (Constantine et al., 2004; Yeh et al., 2004). Within indigenous African healing concepts, mental, physical, and spiritual well-being are integrated. This approach encourages familial and community interconnectedness, key values within the African American community (Parham, 2002). Mental health concerns are managed via holistic approaches addressing mind-body-spirit connections, in addition to kinship bonds that extend beyond biological relations (Boyd-Franklin, 2003). One of the most common indigenous African healing systems used within the Americas and Caribbean is the Yorùbá-based system of Ifá (K. Abimbola, 2006).

Ifá in the African Diaspora

Although *Yorùbá* more accurately describes the language spoken by people occupying the southwestern region of Nigeria, parts of Benin and Togo, the term has become a moniker representing the group's indigenous spiritual practices within the United States (Clarke, 2004; Falola & Genova, 2005). A more accurate descriptor is Ifá (K. Abimbola, 2006). Like many words in the Yorùbá language, the term *Ifá* has multiple meanings. In addition to denoting the spiritual practice, the word is used to identify a spiritual divinity, the divination process (communication with supernatural forces), and the sacred body of knowledge (Ifá Sacred Literary Corpus) used by priests of the tradition (W. Abimbola, 1997).

During the introductory stages of Ifá in America, African Americans primarily adhered to versions of the spiritual system that syncretized or blended Ifá with Catholicism. Later, devotees (adherents to the spiritual system) who adopted a Black nationalist ideology attempted to remove the African religion from its Catholic shield (Clarke, 2004). Recently, a new generation of African American devotees has emerged. This group follows orthodox Ifá teachings through initiation and ritual practices as observed by devotees in current day Nigeria (Clarke, 2004). Distinctions among Ifá practitioners

still exist within the United States; however, this is not unusual since regional variations of the spiritual system are also found throughout Nigeria (Falola & Childs, 2004).

Ifá as a Mental Health Intervention

Ifá devotees often seek the services of a priest to address problems described as mental health concerns in Western counseling (Boyd-Franklin, 2003; Elebuibon, 2000). These individuals may use a pluralist approach toward healing, which includes seeing both a priest and Western-trained therapist for the same issue (Sussman, 2004). A full overview of Ifá spiritual practices is beyond the scope of this article. However, the summary outlined as follows assists readers in understanding how the etiology, diagnosis, and treatment of Western-defined mental health concerns are conceptualized within this spiritual system.

Etiology of Mental Health Concerns Within the Spiritual System of Ifá

Within Ifá, mental health is not typically distinguished from physical or spiritual well-being (K. Abimbola, 2006; Elebuibon, 2000). With this approach, a set of culturally established beliefs and values defining emotional and behavioral norms are applied to recognize an individual as being ill. Through violation of these cultural norms, an individual may be labeled as *sick* rather than *healthy* (Sussman, 2004). Within Ifá, these violations are not labeled as mental health concerns, although the emotional and behavioral presentation can be consistent with Western conceptualizations outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR*; American Psychiatric Association [APA], 2000). For the purposes of clarity, violations of cultural norms are labeled as *mental health concerns* for the remainder of this article. This is not meant to suggest that such a clear distinction exists within Ifá, rather it is to assist the reader in understanding this complex system of culturally shaped beliefs regarding the cause, diagnosis, and management of what, from a Western perspective, would be viewed as mental health concerns.

Ifá practitioners believe that mental health concerns emanate from three sources: (a) supernatural forces, (b) natural causes, and (c) personal choice (identified as Ori and Iwa Pele). When mental health concerns arise in an individual, a priest is consulted to determine the source of the problem and to obtain an appropriate prescriptive remedy (K. Abimbola, 2006).

Supernatural Forces

Belief in supernatural forces causing illness is a widespread concept throughout the world (Sussman, 2004). Ifá devotees believe that anxious, depressive, and more severe psychotic symptoms may originate from supernatural forces (Prince, 2004). Resulting symptoms include alterations in behavior, speech, affect, and perceptual reality. Social relationships are also adversely affected. Ifá devotees believe that humans activate most negative supernatural forces, resulting in psychosomatic and other mental health concerns (Elebuibon, 2000). For instance, one person can create supernatural problems for another individual by wishing bad experiences on him or her, spreading harmful gossip, or by engaging in negative magic designed to hurt the person (Falola & Genova, 2005). For instance, a client exhibiting symptoms of depression may be told by an Ifá priest (through communicating with supernatural forces) that one source of her or his ailment is a friend who is spreading negative gossip.

Failure to propitiate or offenses against one's ancestors and other divinities can also trigger consequences resulting in mental health concerns (K. Abimbola, 2006; Adekson, 2003; Prince, 2004). This is often the case when a child experiences ongoing behavioral difficulties such as hyperactivity or social withdrawal after the death of a parent. In such a case, the priest determines how the spirit of the deceased parent can be appeased in order to alleviate the child's symptoms (Prince, 2004).

Natural Causes

According to Odejide's (1979) seminal work, Ifá devotees perceive two natural causes of mental health concerns: use of mind-altering substances and eating foods taboo or restricted for that individual (Elebuibon, 2000). In Ifá, substance use is recognized as causing mental health concerns paralleling those outlined in the abuse and dependence categories of the *DSM-IV-TR* (APA, 2000; Odejide, 1979). For instance, symptoms of cannabis dependence are attributed to the consumption of marijuana rather than supernatural forces.

Noncompliance with dietary restrictions is also believed to result in mental health concerns. These restrictions are identified when problems arise for a client or can be predetermined during a spiritual ceremony (Elebuibon, 2000). Consultation with a priest can result in the client being advised to make dietary changes, and this includes the addition or elimination of certain foods in order to regain or sustain optimum health (Elebuibon, 2000).

Personal Choice

The Yorùbá worldview emphasizes the notion of personal responsibility for one's own choices (K. Abimbola, 2006). Although the majority of mental health concerns are perceived as emanating from sources outside the individual, personal choice is also believed to affect one's well-being (Prince, 2004). The concepts of Ori and Iwa Pele illustrate this point.

Ori. In the Yorùbá language, the concept of Ori has multiple meanings. Ori refers to the physical head and a spiritual entity (K. Abimbola, 2006). When the term is used to represent the spiritual entity, it can be loosely compared with a guardian spirit influencing human behavior (Elebuibon, 2000). Ifá devotees believe that each person chooses an Ori before being born. It is believed that the individual's choice of Ori affects the quality

of one's life. A client who is constantly facing difficulties in life can be perceived as having chosen a poor Ori. Adequately caring for one's Ori is used as a preventative measure against mental health concerns (Falola & Genova, 2005).

Iwa Pele. Maintaining Iwa Pele (good character) is also considered an important tool in the maintenance or restoration of mental health (Elebuibon, 2000). *Iwa* is roughly translated as character or the essence of being. *Pele* is translated to mean gentle or good (Falola & Genova, 2005). The term *Iwa Pele* is therefore translated in English as good character. Ifá devotees believe that individuals who forgo Iwa Pele risk developing mental health concerns (K. Abimbola, 2006). In Yorùbá theology, sacrifice must be coupled with good character in order for a devotee's concerns to be resolved (K. Abimbola, 2006). Therefore, a client seeking to address mental health concerns may be counseled to make character improvements (Elebuibon, 2000). For example, rather than prescribing a spiritual intervention, a priest may advise parents to make improvements in their own character (behavior) in order to resolve their child's behavior problems.

Labeling and Diagnosis

Indigenous healers tend to address the gamut of human dysfunction from a holistic orientation (Constantine et al., 2004). Priests are consulted for a variety of issues without specifically separating out mental health concerns. This holistic approach generally eliminates the need for mental health labeling categories. The introduction of Western psychological methods into Nigeria brought about the practice of distinguishing and labeling mental health concerns as separate from other conditions. At least one author makes limited labeling categorizations for acute psychotic disorders in the Yorùbá language (Odejide, 1979). *Were,* disease of the mind, is similar to a diagnosis of schizophrenia in the *DSM-IV-TR* (APA, 2000; Odejide, 1979). Symptoms of Were include poor appearance and hygiene, disorganized speech patterns, and auditory and visual hallucinations. However, the etiology of the illness differs from Western psychology. The origins of Were are described as being caused by malevolent supernatural forces. Another diagnosis that parallels Western categories is *Were Abga.* This is similar to a diagnosis of dementia in Western mental health (Odejide, 1979). Although these few labels exist, priests generally emphasize the etiology of a problem rather than classification of the symptoms. Therefore, extensive information regarding symptom indicators or standardized intervention protocols does not exist.

In Ifá, diagnosis of mental health concerns begins with a violation of cultural norms, resulting in impairment of social relationships (Adekson, 2003; Prince, 2004). Once a problem is identified, a priest is sought out to determine its source and a prescriptive remedy. The priest uses the spiritual system of Ifá as a diagnostic tool through the process of divination (Falola & Genova, 2005). Divination is a method of connecting with supernatural forces to obtain information regarding the cause and treatment of the problem (K. Abimbola, 2006; Boyd-Franklin, 2003). The client seeking divination does not reveal the problem to the priest. This helps to ensure that the resulting information is not influenced by the subjective opinion of the diviner (K. Abimbola, 2006; Prince, 2004). The client is provided an object on which to pray quietly, returning it when finished. A series of invocations are performed opening the lines of communication between the priest and the supernatural world. The priest casts the divining tools (shells or seeds) until a set of four binary symbols are obtained. These symbols relate to specific chapters of the Ifá Sacred Literary Corpus (i.e., sacred text; Falola & Genova, 2005). The priest explains the message in the chapter by relating relevant stories and proverbs to the client. In the process, the etiology of the problem is ascertained, the client's questions are answered, and the intervention is prescribed.

Treatment

When mental health concerns arise, Ifá devotees typically use interventions prescribed through divination to alleviate the issue (K. Abimbola, 2006). Priests treat clients through a variety of methods, including spiritual baths, talismans (healing symbols), chanting Odu Ifá—The Sacred Ifá Literary Corpus, and sacrifice (Prince, 2004). Use of these intervention strategies is a method of healing the symptoms, while also addressing the underlying spiritual problem (K. Abimbola, 2006). Family members of the client often participate in therapeutic healing ceremonies, assisting with the administration of prescribed Ifá medications and helping to maintain special dietary restrictions (Boyd-Franklin, 2003; Vontress, 1991).

Spiritual Baths

Water is used in spiritual baths prepared with medicinal herbs for a variety of client concerns. Spiritual baths are often prescribed for clients with concerns believed to be the result of a curse (Oyelade, 1997). Clients experiencing psychotic symptoms are also given spiritual baths using a medicinal soap and sponge. In preparation of the bath, a priest recites specific prayers relevant to the client's presenting concern onto the mixture. The bath is then given to the client who is instructed in its use.

Talismans

Another intervention tool used by priests to ameliorate or guard against negative forces is a talisman or charm (Falola & Genova, 2005). Talismans are small medicinal pouches prepared specifically for the client. A talisman is worn on the body or displayed in a distinct area within the home (K. Abimbola, 2006). Some are worn for healing and others are used to ward off malevolent spirits, manage behavioral concerns of children, or provide luck during pregnancy (Elebuibon, 2000). For people experiencing acute mental health concerns,

talismans are also used as a sedative (Oyelade, 1997). Making talismans is a highly specialized field requiring additional instruction beyond the normal priest training.

Chanting Odu Ifá—The Sacred Ifá Literary Corpus

The Sacred Ifá Literary Corpus is a knowledge base composed of 256 chapters known as Odu (Falola & Genova, 2005). These chapters contain solutions to problems encountered in daily living and are used to express advice during divination. This body of knowledge is composed of stories, proverbs, and metaphors used for divination, in addition to being a therapeutic intervention (K. Abimbola, 2006). As an intervention, verses relevant to the client's concerns are chanted to invoke the medicinal properties embodied in the words (Falola & Genova, 2005). In Nigeria, when a client experiences mental health concerns, a group of Ifá priests gathers to chant Odus that return the person to a state of well-being. Chanting verses from the Ifá Sacred Literary Corpus for healing is primarily used in Nigeria and with less frequency throughout the diaspora because devotees have a more limited knowledge of the Yorùbá language (K. Abimbola, 2006).

Sacrifice

Among the Yorùbá, the act of sacrifice is considered an integral link in the relationship between the physical and spiritual worlds (Clarke, 2004; Falola & Genova, 2005). The process of sacrifice entails giving up or forgoing something in order to gain positive changes in one's life (K. Abimbola, 2006). People perform sacrifices in order to continue receiving blessings from benevolent divinities and to remove and keep away destructive malevolent forces (Elebuibon, 2000). Ifá devotees believe that sacrifice must be performed for individuals to achieve success in personal endeavors. Sacrifices include personal commitments (e.g., time, money, and individual belongings), plants, herbs, and cooked foods. Ceremonial sacrifice is also used as an intervention on a more limited basis in Nigeria than in the diaspora (W. Abimbola, 1997). Once the sacrifice is received, the devotee's concerns are considered spiritually resolved. Devotees believe that failure to complete a prescribed sacrifice results in additional problems for the client (Elebuibon, 2000).

Illustrative Case Example

Today, adherents of indigenous spiritual systems often consult with their spiritual leader when addressing mental health concerns (Boyd-Franklin, 2003; Sussman, 2004). This holds true among a growing number of African Americans drawn to indigenous healing systems and in particular Ifá (K. Abimbola, 2006; Clarke, 2004). Considering that clients may use Ifá in conjunction with Western interventions, counselors would benefit from understanding the conceptual framework underlying this healing modality (Yeh et al., 2002). It is also necessary for counselors to form therapeutic alliances with indigenous healers, incorporating knowledge gained from these practitioners into the counseling session. The following case provides an illustrative example.

The Case of Ade Cotton

Ade Cotton is an 8-year-old African American boy referred to counseling by his pediatrician. Mr. Cotton, Ade's father, expressed concern that his son has experienced attention difficulties, poor academic performance, and a failure to maintain peer relationships in school. During the intake session, Ade appeared visibly anxious. Mr. Cotton is an engineer who noted raising Ade alone after his wife died 6 years earlier. He became concerned after Ade's second-grade teacher suggested that he be evaluated by the school's psychologist. Mr. Cotton discussed his concerns with Ade's pediatrician, who suggested a counselor specializing in working with children. [AU3]

Intake

Although Mr. Cotton did not indicate any religious preference on his initial paperwork, the counselor followed up by asking about interactions with a spiritual community and prior use of indigenous healers. Mr. Cotton discussed his previous use of Ifá priests when addressing personal concerns. Boyd-Franklin (2003) noted that many African Americans treat religion and spirituality as separate concepts; therefore, counselors should ask clarifying follow-up questions. Counselors should also consider that individuals use the services of an Ifá priest without being a devotee. Therefore, the counselor should ask whether the client has used the services of an indigenous healer, received divination, or participated in spiritual rituals.

Etiology of the Problem

During the initial interview, the counselor maintained awareness of her own Western training influencing her assessment. The counselor considered how her own conceptualization of Ade's concerns was informed by her theoretical orientation and how that differed from his father's. She asked Mr. Cotton to share his beliefs regarding the origins of Ade's concerns. Mr. Cotton conceptualized his son's problems as being linked to the death of his mother.

Diagnosis

The counselor shared her assessment that Ade could benefit from psychodiagnostic testing by the school psychologist. She also noted Mr. Cotton's interest in pursuing divination from an Ifá priest. The two agreed that divination should occur first and coincide with family therapy. However, Mr. Cotton did not have access to a local Ifá priest. The counselor had established relationships with local priests, the child's school counselor, and school psychologist. She assisted the family in coordinating care for Ade.

The counselor made initial contact with the Ifá priest, having obtained a release of information. The counselor and the priest had a long-standing professional relationship, which

included a mutually signed nondisclosure confidentiality agreement. Ade and his father made an appointment to receive divination. The Ifá priest identified the origins of Ade's problems as a need for him to engage in activities in remembrance of his mother (e.g., propitiation of one's ancestors). The priest also counseled Mr. Cook on a need to set clearer boundaries and change his rigid disposition toward Ade (e.g., change in dad's behavior—Iwa Pele).

Intervention

The priest provided Ade with a spiritual bath to use daily for 1 week. She also prescribed activities that Ade and his father were to complete weekly in remembrance of his mother. After discussing the results of the divination, the counselor worked with Mr. Cotton to establish clear boundaries and soften his interpersonal style with Ade. The counselor also encouraged Mr. Cotton to monitor Ade's academic progress through regular contact with his teacher and school counselor. The two agreed to continue monitoring Ade for 6 months before reconsidering a referral to the school psychologist.

Within this illustrative case example, family participation in healing activities is highlighted. However, the choice to embrace a non-Western religion can cause conflict within families (Adekson, 2003; Boyd-Franklin, 2003). This may mean that family members decline to take part in healing activities or pressure clients to discontinue participation in Ifá. When treating an Ifá devotee, clinicians should evaluate family dynamics assessing for stressors in this area.

Conclusion

It is important for counselors to consider the underlying historical, social, and cultural variables that shape a client's beliefs regarding illness etiology, diagnosis, and intervention. Although the professional literature has begun to explore the use of indigenous healing modalities, little attention has been given to African Americans seeking these services (Moodley & West, 2005; Myers et al., 2005). The growing popularity of such healing modalities necessitates that counselors become better equipped to deliver services consistent with the client's beliefs (K. Abimbola, 2006; Boyd-Franklin, 2003). Considering that little is known about Ifá within the counseling field, future research should focus on understanding the ways in which priests of this spiritual system conceptualize and treat Western-defined mental health concerns. This will enable counselors to better comprehend the factors compelling some African Americans to seek this healing system either exclusively or in conjunction with Western mental health care.

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03Author Query List JCD Fall 11 Ojelade

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Use of Indigenous African Healing Practices as a Mental Health Intervention

Ifetayo I. Ojelade[1], Kenja McCray[2], Joel Meyers[3], and Jeffrey Ashby[3]

Abstract

The current study used a qualitative design informed by indigenous research methodologies to describe how indigenous African healers and their clients address Western-defined mental health problems. Healers for this study included Orìsà priests initiated within the Yorùbá-based system of Ifá. Two research questions guided this inquiry: (1) How do Orìsà priests and their clients conceptualize issues and concerns associated with mental health problems in Western psychology (2) What methods and techniques do Orìsà priests and their clients use to address issues and concerns associated with mental health problems in Western psychology? Data were collected during semistructured individual interviews with Orìsà priests in a three-phase model. The study also included focus groups with informants who sought the services of Orìsà priests. A combined total of 18 interviews were conducted that included 22 separate respondents residing within the southeastern United States. The following steps were employed to enhance methodological rigor: (1) bracketing of assumptions by the research team members, (2) use of a reflexive journal, (3) member checking, and (4) an audit trail. Data analysis consisted of a recursive process divided into

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multiple steps including codebook development, code application, and data analysis. Three major themes emerged from the data: (1) Conceptualization of Mental Health Problems as Spiritual Matters, (2) Origins of Mental Health Problems, and (3) Addressing Mental Health Problems. Results of this study indicate that respondents primarily conceptualize mental health problems as spiritual matters and seek to address these concerns with an Orìsà priest first. Practice and research implications for psychologists are discussed.

Keywords
indigenous healing, African spirituality, Yorùbá, Ifá

In the United States, people of African descent have prevalence rates of mental health problems that are similar to the general population (Neighbors, Caldwell, Williams, Nesse, Taylor, Bullard, Torres, & Jackson, 2007). Despite similar incidence rates, African Americans are underrepresented in the utilization of mental health services. When deciding to seek services, African Americans are overrepresented in accessing emergency hospital care (Parham, 2002), failure to return after the first session (Jackson, Neighbors, Torres, Martin, Williams, & Baser, 2007; Sussman, 2004; Williams, Ketring, & Salts, 2005), and premature termination (Williams, Ketring, & Salts, 2005). Researchers have outlined barriers to successful treatment, including cultural mistrust (Whaley, 2001), stigma regarding mental illness, racism within the therapeutic exchange (Graham, 2005), and treatment modalities that fail to address the cultural values and worldview of the client (Myers Obasi, Jefferson, Anderson, Godfrey, & Purnell, 2005).

Considering these barriers to treatment, scholars have identified the tendency of African Americans to rely on informal networks of social support rather than seek formal mental health care (Parham, 2002). These networks may include family, community members, friends, religious leaders, and indigenous healers. The cultural and historical foundations of these support systems have been outlined within the professional literature (Myers et al., 2005). However, limited attention has been given to the exploration of indigenous healing methods utilized by African Americans.

Like many people of color, African Americans may wish to use indigenous healing methods as an adjunct to, or in place of, Western psychotherapy (Constantine, Myers, & Kindaichi, 2004). Utilization of such healing modalities may be indicative of an affirmation of cultural heritage or historical concerns regarding stigma, racism, and treatment strategies inconsistent with the cultural values and worldview of this population (Gielen, Fish, & Draguns,

2004). For these reasons, African Americans may limit their help seeking to indigenous African healers or may seek the services of practitioners from both fields (Graham, 2005). Considering these treatment utilization patterns, psychologists would benefit from understanding the ways in which indigenous healers and their clients recognize, interpret, and deal with issues characterized by Western psychology as mental health problems. Gaining this knowledge will enable helping professionals strengthen their level of multicultural competence when working with clients who use such methods.

Indigenous Healing Methods

Indigenous healing approaches are more commonly used than allopathic (Western biomedical) methods (Gielen et al., 2004). Indigenous healing is defined as "helping beliefs and strategies that originate within a culture or society and that are designed for treating the members of a given cultural group" (Constantine et al., 2004, p. 111). For people of African ancestry, indigenous healing includes values, beliefs, and a worldview that recognizes a connection between mind, body, and spirit (Obasi, Flores, & James-Myers, 2009). Therefore, Western-defined mental health problems are addressed by healers through approaches that take into account all three aspects of the client. Intervention strategies can incorporate orality (mental), ritual (physical), and divination (spiritual), all of which represent healing beliefs originating from and designed to treat this cultural group (Myers et al., 2005). These interventions incorporate culturally congruent practices that are reflective of the worldview of African people (Obasi et al., 2009).

Concepts of indigenous healing have been previously articulated in the theoretical underpinnings of African psychology. Prior authors note that this theoretical orientation emanates from a worldview that interprets psychological experiences as a dynamic interdependence between the person, community, and spirit world (Grills, 2004; Parham, 2002). As a result, an individual's actions and psychological functioning are believed to have an impact on the living, deceased, and yet unborn. There is the belief that a person is always part of and connected to both the living and spiritual worlds even beyond physical death of the body. Prior authors have offered empirical support for the concept of the African worldview (Obasi et al., 2009). Further understanding how this theoretical framework informs indigenous healing modalities and treatment seeking patterns among African Americans can prove useful to psychologists.

Culturally Congruent Intervention Strategies

Mental health systems are culturally constructed entities composed of the knowledge, beliefs, and skills of a particular society (Gielen et al., 2004). All

cultural groups have a nosology (illness classification system), etiology (beliefs concerning the cause of illness), diagnosis (identification and labeling), and prognosis (expected outcome) system. Scholars suggest that Western-based approaches applied across different ethnic groups fail to address the specific beliefs and practices reflective of each population (Gielen et al., 2004; Myers, 2003; Parham, 2002). In fact, authors suggest that treatment adherence among African Americans is lower when underlying beliefs regarding illness etiology, treatability, and curability are ignored (Obasi et al., 2009; Sussman, 2004). Culturally congruent interventions that consider these factors address these concerns.

Noting the paucity of culturally congruent models, previous writers attempted to fill the void by creating African-centered interventions (Gregory & Harper, 2001; Van Dyk & Nefale, 2005). Other researchers used specific elements of the African worldview to strengthen existing strategies (Graham, 2005; L. Jackson, Gregory, & Davis, 2004). However, the literature is absent of studies examining clients who use indigenous African and Western therapeutic methods concurrently. This idea is potentially important because some clients may prefer interventions that use both indigenous African and Western healing modalities simultaneously (Graham, 2005).

Ifá and Indigenous Healing

One of the most common indigenous healing methods used throughout the Americas and the Caribbean is the Yorùbá spiritual system or Ifá. It is estimated that 100 million people throughout the world practice Ifá or its diasporic manifestations (Abimbola, 2006). Diasporic manifestations of Ifá have been described as the various spiritual traditions throughout the Caribbean and Americas and include Candomble in Brazil, Santeria in Puerto Rico, Lucumi in Cuba, Vodou in Haiti, Shango in Trinidad, and Yorùbá in the United States (Falola & Genova, 2005). These traditions were brought from southwestern Nigeria by enslaved Africans transported to the Americas and the Caribbean (Falola & Genova, 2005). Healers of this spiritual system are typically referred to as Orìsà priests. Previous writers have identified the use of indigenous healing practices in psychotherapy among religious practitioners of Santeria (Baez & Hernandez, 2001; Martinez-Tabos & Albizu, 2005) and Candomble (Prandi, 2000). However, few scholarly articles exist on Orìsà priests and their clients' conceptualization of issues and concerns described by Western-based approaches as mental health problems (Ojelade, McCray, Ashby, & Meyers, 2011).

It should be noted that within Ifá, clear distinctions between mental, physical, and spiritual well-being generally do not exist (Abimbola, 2006; Elebuibon, 2000). However, for the remainder of this article the term *mental health problem* is used to broadly define diagnosable (mood, anxious, substance-related, and

psychotic disorders) and nondiagnosable (marital problems, stress management, and emotional dysregulation) issues and concerns that are conceptualized and treated by Western trained psychologists. This is not meant to suggest that a clear distinction exists within the spiritual system or among study respondents; rather it is to assist the reader in understanding this inquiry.

Study Rationale

There is little in the literature to guide psychologists who work with clients seeking the services of an Orìsà priest. The purpose of this study is to describe how Orìsà priests and their clients conceptualize issues and concerns described by Western psychology as mental health problems. It further examines the healing methods used by respondents. This study included women and men initiated into the priesthood of a particular Orìsà or deity. Clients are defined as individuals who sought the services of an Orìsà priest. Western definitions of mental health problems include undiagnosable and diagnosable conditions defined by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., American Psychiatric Association, 2013). Two research questions guided this inquiry:

Research Question 1: How do Orìsà priests and their clients conceptualize issues and concerns associated with mental health problems in Western psychology?
Research Question 1: What methods and techniques do Orìsà priests and their clients use to address issues and concerns associated with mental health problems in Western psychology?

Method

The current study utilized qualitative methodology with a phenomenological approach to understand meaning making (Creswell, 1998). Such methods enable researchers to understand the subjective worldviews and experiences of diverse populations (Meyers, Truscott, Meyers, Varjas, & Collins, 2009; Suzuki, Ahluwalia, Mattis, & Quizon, 2005). This study is additionally informed by indigenous research methodologies (IRMs) that guided the design, interpretation of the data, and identification of investigator assumptions and biases (Denzin, Lincoln, & Smith, 2008). This study received institutional review board approval through the university of the principal investigator (PI).

Participants

Participants were 22 adults (12 women, 10 men) ranging in age from 30 to 83 years. All participants were of African ancestry (1 Caribbean, 1 Nigerian, and 20

American born). All participants reported a current residence in Georgia. Religious upbringing reported by participants included 18 Christians, 1 Muslim, 2 Ifá, and 1 no religious upbringing. Current religious practices of participants included 15 Ifá, 3 Akan, 1 Eve, 1 Bambara, and 2 no religious practices. Participants reported the following educational levels: 2 PhD, 11 master's, 6 bachelor's, 1 MD, and 2 some college. Four participants were initiated and trained as Orìsà priests (3 American-born women, 1 Nigerian-born man). The remaining 18 were individuals who had sought the services of an Orìsà priest at least three times.

Research Team

The PI is a woman of African ancestry whose various layers of her cultural identity (mother, daughter, psychologist, and researcher) are shaped by an African-centered worldview. The current inquiry was designed for emancipatory transformation and thus influenced by the cultural lens of the PI (Denzin & Lincoln, 2005; Morrow, 2005; Ponterotto, 2005). Researcher bias included the belief that indigenous healing practices are efficacious. To guard against and measure PI bias and to serve as a validity check, a reflexive journal was kept and debriefing with a subject matter expert occurred after each interview (Denzin & Lincoln, 2005; Morrow, 2005). The journal served as an additional data source, and debriefing sessions were intended to identify explanations requiring clarification, unexpected responses, consistencies, and inconsistencies across participants.

The core research team consisted of the PI, research assistant, and a research support team. A cultural informant was also utilized to facilitate contact with and interpretation of the culture within Ifá (Denzin et al., 2008; Miles & Huberman, 1994; Suzuki et al., 2005). Different from other qualitative methods, this individual played a prominent role in assisting the PI in the study design, recruitment of individuals, and interpretation of the findings. Prior to the commencement of the study, team members participated in a training conducted by the PI that included investigation procedures, bracketing biases, and methods for resolving disagreements.

Procedures

Recruitment methods included the use of a cultural informant and community outreach (Denzin et al., 2008; Suzuki et al., 2005). This cultural informant was previously known to the PI through prior fieldwork in the area. Individuals (priests, Ifà adherents, scholars, community members) were informed about the study and asked to assist in telling others. The PI screened interested respondents by phone to determine suitability (three visits to seek the services of an

Orìsà priest) for the study. Informed consent outlining the confidential nature of participation and basic demographic data were obtained from each participant.

An interview guide (see the appendix) consisting of open-ended questions was developed by the research team using specific input from the cultural informant. Emphasis was placed on the needs and benefits of the research for the community being studied (Denzin et al., 2008). The PI conducted semistructured individual interviews with four priests in a three-phase model for a total of 12 interviews (Creswell, 1998). Three focus groups (6 participants per group) were also conducted with individuals who had sought the services of an Orìsà priest. Each focus group met two times for a total of 6 interviews. All interviews included time to share personal experiences regarding participation in Ifá and ranged from 60 to 150 minutes in length. Alternating focus group and priest interviews were conducted during a 6-week period with each successive interview being 1 week apart. Recursive methods were used so participants could be asked to clarify or expand on their answers from prior interviews (Denzin & Lincoln, 2005). Saturation was reached after 12 interviews. The PI chose to conduct the remaining interviews as a validity check. Overall, a combined total of 18 interviews were conducted and included 22 separate respondents.

Qualitative Content Analysis

All interviews were audiotaped, transcribed verbatim, and stored on a password-protected computer. Content analysis consisted of a recursive process divided into multiple steps to help strengthen methodological rigor and study verification procedures. The three-part process included (1) codebook development, (2) code application, and (3) content analysis (Denzin & Lincoln, 2005).

Codebook development. Development of the codebook occurred in eight steps and involved an iterative process of identifying and defining the codes. The initial codebook was developed after one individual and two focus group interviews were completed using the following steps. (1) Two trained members of the research team independently coded each transcript, generating a list of inductive codes using an open-coding process. (2) The two team members then met with the PI to discuss the inductive codes, define the meaning of each category, resolve differences, and outline rules for identifying phrases as exemplars of each and to make suggestions for new codes. (3) Subsequent interviews were then coded using this version of the codebook. The codebook was revised using Steps 1 to 3 after each interview set concluded. (4) The codebook and transcripts were sent out to all participants (Lincoln & Guba, 2005; Morrow, 2005). The researcher made two attempts to elicit

respondent feedback approximately 14 days apart. Fifteen out of the 22 participants provided feedback after two requests. The cultural informant also provided feedback after reviewing each transcript and the codebook. (5) Participants' feedback was then discussed by two team members and the PI for integration into the codebook. (6) For the final codebook, two team members of the research team independently reviewed a draft developed using the reiterative process in Steps 1 to 5. Through a constant comparative method, these two team members redefined and merged codes. (7) Team members then met with the PI to finalize definitions and examples for each category in the codebook. (8) The final codebook was used to recode all transcripts (code application) and the reflexive journal.

Code application. In order to guard against rater bias, individuals coding the transcripts were not involved in the data collection process. After the development of the initial codebook, two trained team members worked together on the initial and final coding of the transcripts. During the initial phase, the pair independently coded the transcript and then met with the PI to compare coding, resolve differences, and calculate interrater agreement. A third team member served as an auditor, randomly picking transcripts to code and comparing the results with the original coding. In an effort to avoid misinterpreting the significance of a particular category, reviewers recorded its presence or absence, rather than the frequency of occurrence. Passages with agreements consisted of those in which the same code is assigned and disagreements with different codes or one reviewer assigning a code. Interrater agreement was determined for each session by dividing the numbers of agreements by the total number of codes (agreements + disagreements). The reliability rate for Round 1 ranged between 85% and 92% and for the final round between 90% and 93% (Miles & Huberman, 1994).

Qualitative content analysis. The PI and assistant analyzed the transcripts for themes and subthemes relevant to the conceptualization and treatment of mental health problems as defined by Western psychology. The following steps were employed: (1) The data were entered with labeled codes into a master spreadsheet. (2) The PI and assistant reviewed the data by code to indentify themes/subthemes (horizontalization). Through constant comparative methods, seven themes and 10 subthemes were identified (Denzin & Lincoln, 2005). Next, cross-case analysis was used to identify consistencies and inconsistencies across participants (Morrow, 2005). (3) The PI sought feedback from a subject matter expert and the cultural informant. The feedback was then utilized to reanalyze the data and further collapse the themes/subthemes (Denzin & Lincoln, 2005). (4) The PI and assistant met to agree on the further collapsed themes. (5) The PI

Table 1. Theme/Subtheme Definitions.

Theme 1: Conceptualization of Mental Health Problems as Spiritual Matters	
Definition: Participants' conceptualization of mental health problems.	
Theme 1 Subtheme:	Subtheme Definition:
Transgenerational Transmission	Methods used by families to pass down their conceptualization of spirituality.
Theme 2: Origins of Mental Health Problems	
Definition: Beliefs regarding the origins of mental health problems.	
Theme 2 Subthemes:	Subtheme Definition:
Western Socialization	Westernization as being a source of mental health problems.
Spiritual Forces	Respondents' belief that supernatural forces are a source of mental health problems.
Theme 3: Addressing Mental Health Problems	
Definition: Methods and techniques used to resolve mental health problems.	
Theme 3 Subthemes:	Subtheme Definitions:
Personal Resources	Interventions used to personally manage mental health problems.
The Divination Process	The process of seeking the services of an Orìsà priest.
Referrals	Orìsà priests referring clients to Western therapy.
Western Therapy	Accessing Western mental health services.

identified a theme/subtheme as relevant to the study if it answered at least one of the two research questions. (6) Themes/subthemes not answering the research questions were eliminated, leaving a total of three themes and 7 subthemes.

Findings

Systematic qualitative content analysis initially revealed seven content categories emerging from the interviewee responses. These categories were further collapsed to reveal three major themes that address the ways respondents conceptualize and treat mental health problems. The three major themes are presented in Table 1 (i.e., Theme 1: *The Conceptualization of Mental Health Problems as Spiritual Matters*, Theme 2: *The Origins of Mental Health Problems*, and Theme 3: *Addressing Mental Health Problems*). The results are presented by defining each theme/subtheme and through the use of illustrative quotes. These quotes present a thick description in the respondent's own voice (Morrow, 2005). To assist readers in understanding the integrated content analysis, participants are identified as Priest 1 to 4, Woman 1 to 9, and Man 1 to 9. Bracketing is used to help clarify the meaning of a particular passage as needed.

Theme 1: Conceptualization of Mental Health Problems as Spiritual Matters

All participants described mental health problems as signaling the presence of a spiritual matter needing to be addressed. Western diagnosable conditions such as mood, anxiety, substance use, and psychotic disorders were discussed as having a spiritual basis. Nondiagnosable problems typically treated by Western psychologists, such as marital problems, stress management, parenting concerns, and emotional dysregulation, were also characterized in this manner. For example, Man 6 stated,

> If I have a [mental health] problem, I understand that it is not [because of] a reality that I can see with my eyes or [can] think through. I understand that there are [spiritual] forces working on other planes of existence.

For Man 6 and other participants, spiritual matters were defined as any occurrence affected by supernatural forces.

Twenty-one out of 22 participants described an individual's ability to see and/or hear phenomena that others cannot as an interaction with the spirit world. Respondents described either personal or family member experiences with these types of interactions. Study participants noted that these interactions are not necessarily indicators of mental health problems. In this next example, Priest 1 shared his thoughts about a man responding to external stimuli and talking to himself on the train:

> In Africa, he would not have been declared mentally ill. If it were in Africa and [he] were initiated to an Orìsà (process of becoming a priest) and began to walk in the ways of that Orìsà [serve in the role of a priest], that particular behavior which looks unacceptable, would begin to mellow down and that person would be much better.

The priest described this man's problem as indicative of a spiritual matter. This sharply contrasts with Western conceptualizations of this behavior being indicative of psychotic symptoms. Of particular interest is that all participants noted beliefs consistent with the priest's conceptualization. However, as discussed in Theme 2, respondents additionally indicated a belief in organic mental illness.

Transgenerational Transmission of Spiritual Beliefs. Three coding categories reflected how beliefs regarding spiritual matters are transmitted to younger generations. Participant responses suggested that transgenerational transmission occurred in early childhood through (1) the imposition of a behavioral code

of conduct and (2) observation of family members' responses to interactions with the deceased. Individual and focus group interviews further suggested that this information was conveyed primarily through female family members, typically not explained to young children, and not subject to clarifying questions.

Behavioral code of conduct. A total of 18 participants reported adhering to a behavioral code of conduct without explanation of the purpose or meaning. The remaining 4 did not mention these experiences. For those whose responses fit into this category, these events taught the respondent how to conceptualize what is "normal" and considered a spiritual matter. For example, Man 3 described multiple behavioral codes of conduct from his early childhood. He said, "I remember old people telling us, walk around [dust devils], don't step through them, don't split the pole, and when people are moving into a house with a baby, throw a broom in, to sweep out the bad spirits." Respondents noted that although these behavioral parameters were imposed, no one explained the reasons for engaging in these activities. However, these experiences helped shape the respondents' interactions with the unseen spiritual world.

Interactions with the deceased. Twenty-one participants discussed childhood experiences in which interactions with the deceased were described as normal by adults. No one explained to the child how these interactions were possible. For example, Woman 2 discussed her grandmother's interactions with deceased family members:

> My grandma [would say], "my mom was walking down the hall last night. She told me to tell you to study hard, because you got to get your education." . . . [Woman 2 says,] they talk about it like it's normal to sit at the table and say . . . "your great-granddaddy" (who has been dead for 50 years) . . . "He told me to tell you."

In the above quote, the grandmother never explained how it was possible for her to interact with her deceased mother. In fact, when Woman 2 attempted to ask her grandmother a follow-up question, she was ignored. Other participants also described being ignored or more forcefully chastised for asking clarifying questions. In this next quote, Woman 5 described her family's reaction to her interaction with a deceased cousin at 12 years of age.

> My cousin's husband passed away. . . . And he came to me . . . I was in the bed with his wife and he gave me a message [to] put their daughter in the bed with

> them. . . . When [my cousin] woke up the next morning, she [asked], "Why did you put (child's name) in the bed?" I said, "Because (deceased husband) told me to, I don't know" Everybody went crazy . . . The whole family went crazy. My grandmother, the Baptist one, you know she's hard-core Baptist, pulled me to the side and said, "You have this special gift. Not everybody in our family has it. When you get older, you will see how to work with [it]." . . . But, I was scared because I didn't understand it.

In all, responses of family members to these events transmitted three messages: (1) Seeing and speaking with the deceased is a spiritual experience. (2) These interactions are normal. (3) It is not acceptable to ask clarifying questions regarding these experiences.

Theme 2: The Origins of Mental Health Problems

Four coding categories were combined to reflect the ways that respondents conceptualize the etiology of Western-defined mental health problems. Content analysis revealed two subthemes describing the sources of these problems: (1) *Western Socialization* and (2) *Spiritual Forces*. Individual and focus group responses also indicated that all interviewees acknowledged the existence of organic mental health problems.

Western Socialization. Twenty participants described Western socialization as adversely impacting the psychological well-being of people of African ancestry. Interviewees defined this as the process of being systematically taught to adopt an identity that is inconsistent with one's own African cultural heritage. Woman 9 provided the following response during a discussion on Western socialization.

> A lot of the [mental health] problems we [African Americans] encounter is because we are still dealing with our own Western socialization. . . . So, until we can free ourselves and free our minds [become less Westernized] . . . We will still be [experiencing mental illness].

Spiritual Forces. All twenty-two respondents discussed a belief in spiritual forces as a source of mental health problems. In fact, content analysis suggested that study respondents primarily conceptualized mental health problems as originating from spiritual sources. A total of three categories were identified as illustrative examples of spiritual forces impacting ones mental health: (1) negative interactions with others, (2) individual behavior, and (3) ancestral veneration.

Negative interactions with others. Twenty-one out of 22 respondents noted that one's mental well-being could be adversely impacted by harmful spiritual forces triggered by other individuals. For example, respondents stated that engaging in negative behaviors toward someone (e.g., displaying negative affect, gossip, unreciprocated taking, or wishing harm toward someone) can trigger harmful spiritual forces that impact the recipient's mental health. The important distinction here is that engaging in negative behaviors such as gossip can cause mental health problems for another person, rather than for the individual executing the behavior. In the following quote, Woman 8 attributed her experience with suicidal ideation to the negative behavior of her mother-in-law:

> This energy . . . sought me [out]. This very negative energy was using my mother-in-law, to destroy me. I mean, I had tried to kill myself. So, all this was very much a part of what was going on in the spiritual realm for me.

Individual behavior. In contrast, 16 respondents discussed ways that individuals can engage in behaviors that adversely impact their own mental well-being (e.g., failure to maintain a positive spiritual regime, ignore spiritual guidance, or unaddressed spiritual matters). In the next quote, Man 1 identified his failure to maintain a positive spiritual regime as the source of his increased levels of stress:

> I was told that I need to commit myself (to a spiritual regime) . . . [which will] help me be less stressed. . . . And a lot of times, I've let stress persuade or guide me away from what I'm supposed to be doing. And when I do that, I have problems. Stress is an Ajogun, a negative (spiritual) force, and that negative force takes me away from what I'm doing (my spiritual regime). It's [stress is] like, take off your protection . . . and the situation gets worse.

Ancestral veneration. All participants noted the belief that failing to acknowledge or honor one's ancestors leads to mental health problems. For example, Woman 2 described her father's problems as resulting from his failure to honor the memory of his deceased mother. In the following quote, she listened to his request for assistance in managing the relationship with his deceased mother.

> My father was like, "Oh please help me, I had an uneasy relationship with my mother before, but now that she's passed away, it's worse." And he was like, "I don't know what to do." And I said I can probably help with that.

The father described the quality of the relationship with his mother as having declined since her death. The father's perception of having an ongoing relationship with his deceased mother was consistent with 21 of 22 respondents,

suggesting that these types of interactions are viewed as possible. The daughter's belief that her father's problems were the result of his failure to engage in ancestral veneration (of his deceased mother) was also consistent with other respondents.

Theme 3: Addressing Mental Health Problems

Within this theme, a total of eight coding categories were combined through the content analysis process to reflect the methods and techniques utilized by participants to address mental health problems. This resulted in four subthemes emerging to describe the intervention process: (1) *Personal Resources*, (2) *The Divination Process*, (3) *Referrals*, and (4) *Western Therapy*.

Personal Resources. All respondents used multiple interventions prior to seeking the services of a healing specialist. This included coping strategies such as prayer, meditation, martial arts, spiritual cleansings, African dance, and drumming. Social support systems used by respondents included family, friends, organizational and spiritual communities. Speaking with family or community elders was reported as a coping strategy used by all focus group members. For example, Man 5 sought advice regarding his marital separation and resulting depressive symptoms from a respected community elder. The ambivalence he felt regarding whether or not to dissolve the marriage prompted him to seek advice from this elder. All study respondents reported similar experiences in which they sought the counsel of a trusted elder when experiencing Western-defined mental health problems. Feeling in need of additional support, Man 5 went on to seek the services of an Orìsà priest and Western-trained therapist. In fact, when accessing healing services, 16 of the 18 focus group respondents utilized a pluralist approach of multiple healing modalities to address a single issue.

When discussing the process of seeking help for her marital difficulties, Woman 1 said, "Not only did we get divination and sit with elders, we also went to a marriage counselor." In contrast, two participants sought the services of Orìsà priests without accessing Western-trained therapists. For example, when asked whether he would consider going to Western-trained psychologist, Man 6 responded, "Why would [I] consult somebody that is not a traditional healer?"

The Divination Process. Divination is the process of a respondent seeking the services of an Orìsà priest that include diagnostic and intervention strategies. All respondents described divination as a tool utilized by priests to communicate with the spiritual world. This enables the Orìsà priest to

diagnose and treat the client's problems. Woman 1 provided this description of divination:

> Ifá or Merindilogun [types of divination systems] is not a fortune-teller device. It's not like a crystal ball [or] Tarot cards. . . . It's actually a communication with God. You're having a conversation with God.

Presenting concerns. Focus group participants reported seeking divination for various concerns including major life decisions (the naming of a child, career choice, maintenance and development of relationships); physical health (heart conditions and blood clots), social interactions (marital difficulties, child rearing, transgenerational problems), and Western-defined diagnosable and nondiagnosable mental health problems. Orìsà priests provided similar examples of their clients' presenting concerns. For example, Priest 2 detailed her current client load:

> I have a couple of health cases, I have one sister who's got some mental issues she's dealing with . . . everybody else is money, love, and luck. Everybody wants money and everybody wants love. . . . I don't work for people trying to go after anybody else's husband . . . most of the time [I] do things to increase people's luck, or . . . to find a love of their own . . . [and] some people want peace.

All focus group members reported seeking the services of an Orìsà priest when experiencing Western-defined mental health problems. When asked to explain why he sought the services of an Orìsà priest instead of treatment from a Western-trained psychologist, Man 6 responded, "I think there's something that is inherently healing on a spiritual level that a psychologist would not be able to help me with, like an Orìsà priest would." Furthermore, participants conveyed the belief that most mental health problems are spiritual in origin and therefore must be addressed through divination and the prescribed spiritual intervention.

Diagnosis. Orìsà priests utilize divination as a diagnostic tool. All Orìsà priests noted that they are not initially told the reason that the client is seeking assistance. This practice was described as a method for avoiding bias and allowing the spiritual message to be directly relayed to the client. Priest 1 provided the following response when discussing the initial divination process:

> When a person comes to me for help, what [I] do first of all is divine; [I] don't want to know the story of the person as yet. Let him or her tell his or her story

> to Ifá first (indicating the person's handling of the sacred divining objects rather than talking).

Participants said that this method helped to reduce the likelihood of subjective interpretation of the message by the diviner. After a series of prayers and handling of the objects used for divination, the priest performs a series of rituals enabling him to identify the symbol (*Odu*) corresponding to the Sacred Ifá Literary Corpus (sacred text). Priest 1 described the importance of obtaining an Odu, "Everything flows from the Odu that we see . . . Once we know an Odu, then we will proceed from there by telling stories." These stories are believed to contain messages for identifying the appropriate remedy to resolve the client's problems.

Intervention. Participant responses indicated that resolution of the client's problem can include sacrifices (the giving up of one thing to achieve something else) prescribed in the divination. Sacrifices can be spiritual (participation in rituals) or behavioral (alteration of poor character, volunteering of time, preparation of food, gifting of money). In fact, all respondents describe sacrifice as a primary factor for resolving the client's problem. All participants stated that obtaining divination without the performance of a prescribed sacrifice would not resolve the issue. Priest 2 described sacrifice in this way:

> You are going to have success [resolution of the problem] if you perform a sacrifice . . Be it time, money, or some energy life force. The fact that you go clean up the ile [spiritual house] or donate clothes . . . It's how you help balance the karmic energy.

Referrals. Three of four Orìsà priests discussed an ongoing practice of referring clients to Western-trained psychologists. The one remaining priest stated that he would not make any such referrals. Priests outlined two reasons for making referrals: (1) severe presenting problems and (2) boundaries of competency. In the following quote, Priest 2 discussed her practice of encouraging clients to seek Western therapy for some problems:

> I try to get people to understand that it is not weak to get help if you need it, there is all sorts of help. We [need to] get our spiritual self aligned with our physical self…and if there is anything going on mentally that they need help with, (like) something that happened in the past . . I know . . . an African minded, Black psychologist to send them to.

Severe presenting problems. When clients presented with suicidal ideation, substance use disorders, or sexual trauma, three priests reported a practice of providing the needed spiritual interventions and then referring the individual to a Western-trained therapist. Each priest noted a lack of training in Western psychological interventions. In the following quote, Priest 3 discussed her treatment of rape survivors:

> I've had people tell me they were raped . . . and they've been to therapy, and it didn't work. [I said], well that's probably because you didn't stay in therapy long enough and you need to go back . . . I can deal with the issue that brought them to the mat [to get divination], but I can't deal with their father raping them, or their cousin raping them when they were four. That is not something that I am qualified to heal, that's something that you really need to go sit on a couch (get counseling) for.

Boundaries of competence. All priests discussed practicing within their boundaries of competence. This extended to treating clients experiencing suicidal ideation or other conditions outside of the priest's experience and expertise. For example, although Priest 4 described herself as trained and competent to deal with the spiritual problems resulting from trauma, she distinguished between her training and that of a Western-trained psychologist.

> Some people were traumatized as a child; sexual abuse, physical abuse, or emotional abuse, and they had years of trauma . . . some karma might lead them to me as a priest to clear out. . . . But I can't help fix that trauma for them. They need to be able to sit with someone who knows how to speak and articulate their trauma in ways they can accept it and start to heal it.

Western Therapy. Nineteen participants described Western therapy as useful for addressing mental health problems. Study participants generally communicated positive views regarding Western therapy. However, all of the participants reported a preference toward seeking the services of an Orìsà priest first when addressing mental health problems. Orìsà priests also noted the tendency of their clients to seek divination in order to address mental health problems prior to being treated by a Western-trained psychologist. All priests noted their lack of training in Western psychological interventions.

Woman 1 discussed her belief that all African Americans can benefit from Western therapy. She said, "It's not a question of if African people need therapy, it's for how much and for how long." Priest 1 disagreed with the idea of anyone using Western therapy, stating, "That's the one part of Western medicine that [I am] convinced is not effective. [I] don't think they (Western psychology) know much as far as mental health is concerned."

When addressing mental health problems, participants identified a variety of reasons for seeking the services of a Western-trained psychologist, including limited access to Orìsà priests, finances, and a desire for additional support. Limited access to a priest with whom respondents had established a working alliance was identified as the primary factor for individuals to instead seek Western therapy. In the following quote, Woman 3 discusses her choice to see a psychiatrist, despite her preference for addressing her anxious and depressive symptoms by visiting an Orìsà priest:

> I didn't have someone I could go to and I was like, I have to graduate . . . I didn't have someone to do an . . . Ori ceremony or spiritual bath [interventions performed by the priest]. So, I went to a doctor, because at the time, I did have insurance. They gave me . . . Xanax . . . then they gave me Paxil . . . . I was going crazy. Generally, I would go to my priest . . . but I had lost touch [with him]. So, I went to the doctor . . . I took [the pills] for 2 months, and it was enough to chill me out . . . and once the semester was over . . . I could really go back to a spiritual sense of praying and taking care of myself.

A total of 16 out of 18 focus group members and three out of four priests had previously sought Western therapy. Overall, respondents provided mixed reviews of the experience. Therapists who attended to the client's spiritual beliefs and cultural identity were described as helpful. For example, Woman 1 described her experience with a marriage therapist having no knowledge of African spirituality:

> She was an African American lady; she didn't understand none of what we were talking about. She was taking notes, she said, I need to write some of this down, ReAfrikanization, Orìsà, Vodou, spirits, ancestors . . . [If my husband said] my main issue with my wife is that she refuses to ReAfrikanize . . . She would be like, what? So, she couldn't help us on none of that stuff, but she did help us stay together.

Woman 1 went on to say that although the therapist did not understand the concepts discussed by the couple, she displayed a genuine interest in allowing them to process their beliefs within the session.

Respondents described unsuccessful counseling sessions with therapists who failed to address the client's spiritual beliefs, did not establish a therapeutic alliance, or used biblical references without the client's consent. Man 5 shared the following unhelpful experience with a Western-trained therapist:

> I went to [a therapist and] I didn't open up . . . at the time, I just needed someone to talk to. But, [we] did not get into spirituality. I did mention some things and

> it wasn't paid much attention to. And that's probably why it didn't seem to work out.

Based on prior bad experiences, most male participants expressed discomfort with psychologists who lack an understanding of African-based spiritual concepts as demonstrated in the following reflection:

> I have been to a psychologist before, but I would not go to another psychologist that does not understand Orìsà worship. They need to have the ability to say, "For that, you need to go to [an] Orìsà priest, or for that, you have to go to your shrine (consecrated alter)."

Discussion

Every group has a culturally constructed lens through which collectively held beliefs, values, and social norms shape the way its members conceptualize and interact with the world (Sussman, 2004). Consistent with IRM, the investigators of the current inquiry attempted to present the discussion from the cultural lens of its respondents. This is done to facilitate understanding of the way Orìsà priests and their clients conceptualize and address Western defined mental health problems. It additionally enables the Ifá community to directly utilize the research findings as a tool for their spiritual adherents. Understanding this information from the cultural lens of the participants can assist psychologists in broadening their depth of competency when working with this population and others who make use of indigenous African healing modalities.

The Impact of Culture on the Conceptualization of Mental Health Problems

Sussman (2004) suggests that cultural norms shape the way individuals convey, interpret, and treat illness. This cultural lens defines the way individuals label themselves and others as sick as opposed to healthy. Although the results of this inquiry were presented in three distinct categories, the interaction between the themes is consistent with this assertion. Study respondents described mental health care utilization patterns that were directly influenced by their cultural and spiritual beliefs. Figure 1 illustrates the interaction between respondents' beliefs regarding the etiology, conceptualization, and treatment of mental health problems. The figure highlights the importance of psychologists understanding how a client's beliefs affect treatment seeking and utilization patterns. Western-trained psychologists who fail to understand this may offer intervention strategies that are culturally inconsistent, adversely affecting treatment adherence.

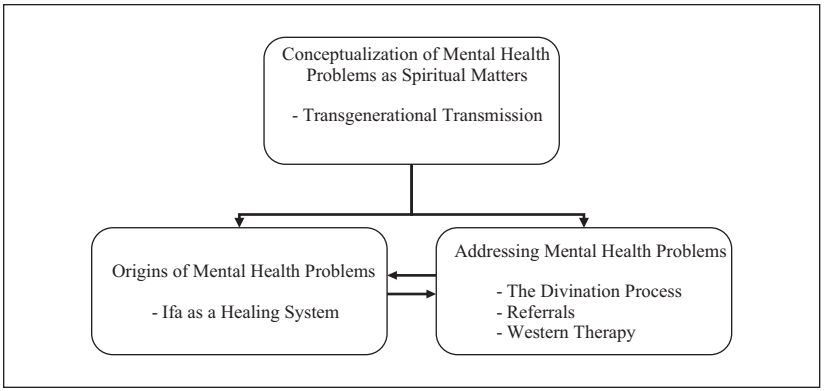

Figure 1. Interactions between the conceptualization, etiology, and treatment of mental health problems.

Conceptualization of Western-Defined Psychotic Symptoms

Results of this study indicated that conceptualizations regarding spirituality are passed down primarily by female family members in early childhood, typically without explanation. Participants reported that these spiritual beliefs later influenced how they conceptualized and treated Western defined mental health problems. For example, most participants learned that seeing/hearing phenomena that others do not is a normal experience. Participants maintained this belief as adults, viewing such interactions as spiritually based rather than a sign of mental illness. Early exposure to these beliefs helped participants embrace similar concepts within Ifá, which are consistent with concepts articulated by Grills (2004) in her description of African psychology.

The nonclinical aspects of seeing and hearing phenomena others cannot have not been studied among African Americans. However, researchers have identified disproportionate rates of schizophrenia and other psychotic symptoms diagnosed among this group (Arnold et al., 2004; Whaley, 2001). Whaley attributes this disparity to the misinterpretation of African American's cultural mistrust for clinically significant symptoms of paranoia. He asserts the existence of nonclinical paranoia, resulting from African-descended people's historical and contemporary experiences with racism. Extending Whaley's findings, this inquiry suggests nonclinical indicators of seeing/hearing phenomena others cannot. For example, almost all respondents reported personal or family experiences consistent with this experience. It is important to understand how such events influence a

client's endorsement of Western-defined psychotic symptoms. Psychologists failing to understand this cultural phenomenon may erroneously diagnose a client as experiencing Western-defined psychotic symptoms.

The Origins of Mental Health Problems

Respondents conceptualized mental health problems as emanating from three sources: Western socialization, underlying spiritual matters, and organic factors. Through divination, it is possible to determine the exact source of the problem. According to respondents, similar symptoms exhibited by different people do not necessarily have the same cause. This again suggests that only through divination is the origin the problem identified.

Western socialization has been identified by some scholars as adversely affecting the mental health of people with African ancestry (Graham, 2005; Parham, 2002). This concept is outlined by African psychology theorists, suggesting that being one's authentic self free from distortion promotes well-being, while embracing inconsistent values leads to illness (Grills, 2002; Parham, 2002). Study findings offer support for this concept. Respondents identified the value conflicts between African and Western worldviews as a stressor, triggering interpersonal conflicts, anxiety, depression, and other mental health problems. However, unlike prior researchers who have identified Western socialization as a primary source of mental health problems, respondents viewed the majority of these problems as indicators of underlying spiritual matters.

A number of authors have noted that spirituality is one of the most salient values within an African worldview (Graham, 2005; Obasi et al., 2009; Parham, 2002). African Americans have long been described as retaining the belief that the material and spiritual world affect one another (Boyd-Franklin, 2006). Results of the current study suggest that respondents hold similar beliefs regarding the impact of spiritual forces on their lives. Overall, mental health problems were conceptualized as spiritual matters. Therefore, interventions needed to have an impact on the spiritual origin of the problem. The results of this study offer support for Elebuibon's (2000) assertion that observable symptoms (mental health problems) are indicators of concerns that need to be addressed spiritually.

Respondents also acknowledged the existence of clinically significant psychotic symptoms resulting from organic mental illness. This is an important finding since there is little within the current literature to suggest that people who believe in the spiritual causes of mental health problems also acknowledge the possibility of organic mental illness (Gielen et al., 2004). Respondents were asked how one could distinguish between organic mental

illness and normal interactions with the deceased. The consensus was that divination conducted by an Orìsà priest is the most reliable method for making this distinction.

Addressing Mental Health Problems

In multiethnic societies, individuals may adopt a pluralist approach toward healing, influenced by their own cultural values and historical interactions with other groups (Sussman, 2005). Pluralist approaches toward healing consist of using multiple resources to address a single problem. Consistent with prior researchers' findings, the majority of respondents reported a similar approach toward mental health care, influenced by both their cultural/spiritual beliefs and interactions with Western culture (Gielen et al., 2004; Myers et al., 2005). Thus far, the literature is absent of information regarding the specific approach toward mental health care that Ifá adherents utilize. The findings of this study indicate that a pluralist approach toward healing is accomplished in four steps: (1) self-care, (2) seeking social support, (3) seeking the services of an Orìsà priest, and (4) seeking the services of a Western-trained psychologist. However, these steps are not fixed. In the latter two steps, respondents noted a preference for first seeing an Orìsà priest. Lack of access to a priest and limited financial resources could result in the client seeing a Western-trained psychologist instead.

Methods utilized by participants to address mental health problems include the use of social networks, martial arts, prayer, African dance, drumming, services of an Orìsà priest, and Western psychological interventions. Consistent with prior findings, focus group members primarily utilized informal social networks for healing (Myers et al., 2005; Parham, 2002). Priests reported seeing clients for a broad range of mental health problems, including mood, traumatic, suicidal, and substance-related disorders. This finding is consistent with prior authors who note a tendency of indigenous healers to treat Western-defined mental health problems (Gielen et al., 2004; Myers et al., 2005). Although participants' discussed the ability of an Orìsà priest to address these issues, Ifá was not perceived as a "fix all." The priests noted the limits of their training and competency, making referrals as needed.

In areas within one's competency, the Orìsà priests used divination (communication with spiritual forces) as a diagnostic tool. The results of this study indicate that use of divination is aligned with respondents' beliefs that interventions must alter the spiritual world in order to affect change in the physical realm for the client. Through divination, the etiology and intervention needed are determined. The respondents' assertion that the client need not disclose the problem prior to divination is consistent with prior authors' descriptions of the divination process (Abimbola, 2006; Elebuibon, 2000).

Significant differences existed between the American-born and Nigerian-born priest. These differences may be a function of age, national origin, and length of time as a priest. One significant difference occurred in the priests' willingness to refer to Western-trained psychologists. The American-born priests noted a willingness to refer and their own personal experiences with Western therapy. On the other hand, the Nigerian-born priest had no experience with psychologists and was not willing to refer. This priest also had the most seniority and was over 80 years in age. The next most senior priest had over 30 years of experience but was born in the United States and was under 50 years in age. It is reasonable to infer that these differences influenced the priests' perceptions of personal competency and willingness to interact with Western-trained psychologists.

Implications for Counseling

Cultural competency standards compel psychologists to understand the client's worldview in order to deliver appropriate treatment services. Considering the specific cultural nuances of the African worldview, graduate programs should seek to train emerging psychologists in methods of assessing worldview, collaborating with indigenous healers, and distinguishing between clinically significant concerns and nonpsychotic symptoms. Practicing psychologists can engage in specific steps to raise their level of cultural competency by first engaging in appropriate assessment practices, referring to indigenous healers when appropriate, and avoiding attempts to conduct interventions without the requisite training.

Culturally appropriate assessment begins with the psychologist gaining knowledge of the factors influencing a client's beliefs regarding the etiology, manifestation, and mitigation of Western-defined mental health problems. Gaining information regarding the client's worldview can be accomplished by conducting a clinical interview with broad depth and scope. The findings of this study suggest that this includes attending to the client's spiritual beliefs. This is consistent with prior findings suggesting that an integral part of an African worldview is one's connection to the divine (Obasi et al., 2009). Respondents reported more positive treatment outcomes with Western-trained psychologists when this occurred. Having clients fill out paperwork listing religious affiliation with minimal follow-up may be insufficient for gathering such data. Boyd-Franklin (2003) asserts that religion and spirituality may be treated as separate concepts among clients of African ancestry. Therefore, questions focusing exclusively on religious preferences may be ignored on intake paperwork by clients. Reframing such questions to ask for religious and/or spiritual preferences can help to capture more relevant data.

Furthermore, similar to respondents in this study, clients may visit an Orìsà priest and not be a practitioner of the spiritual system. Therefore, it is important for psychologists to inquire whether the client has ever utilized the services of an indigenous healer. Follow-up questions to determine the reasons a client chose to seek the services of an indigenous healer and a Western-trained therapist can also prove useful.

Once information regarding the client's spiritual practices is gathered, the clinician can begin inquiring about what beliefs the client holds with regard to the origins and treatment of mental health problems. Gathering this information will help the clinician to engage in collaborative treatment planning with the client and refer to an indigenous healer as appropriate. This does not suggest that clinicians should refrain from providing psychoeducation to clients as needed; rather, it suggests that therapists seek to educate as well as be educated in the therapeutic process. Results of this study indicated that clinicians who employed Western interventions without considering the worldview of the client experienced low buy-in, poor treatment adherence, and premature session termination, especially among male clients.

Psychologists should also caution against assuming that gathering information regarding spiritual beliefs automatically conveys a level of competency within Ifá. Similar to Western psychologists, extensive training is required to become an Orìsà priest. Thus, one cannot simply integrate interventions within a therapeutic practice without the requisite training. Instead, psychologists can use this information to expand their knowledge base regarding the tools utilized by their clients to address mental health concerns.

Limitations and Future Research Implications

Although all priests interviewed for this study are of African ancestry, three were reared in the United States and one in Nigeria. Divergent cultural practices among these two countries may have resulted in perceptual differences of mental health problems among priests. For example, the priests reared within the United States generally held positive views of Western-trained psychologists and reported a practice of making client referrals. The priest from Nigeria did not share this view and did not make referrals.

Furthermore, the educational level of study respondents is more advanced than that of the general population. Although not necessarily unusual for U.S.-based Ifá adherents, this factor should be considered as having impacted the current study. Replication of this study with a larger sample size considering the country of origin of the priests and educational levels of all respondents may yield different results.

Although efforts were made in this study to guard against the insertion of bias emanating from Western inquiry methods, the methodological approach to this investigation should be considered as having affected these results. Explaining non-Western concepts using Western terminology presents unique challenges when reporting findings. For this reason, future studies should seek to utilize methods that preserve the cultural integrity of the spiritual system. Researchers can accomplish this by expanding the use of interpretive methods consistent with IRMs (Denzin et al., 2008).

Considering that indigenous healing practices are increasingly popular, continued research is needed (Myers et al., 2005). Respondents described Ifá as a holistic system able to address mental, physical, and spiritual problems. However, three priests reported making referrals to Western-trained psychologists. Future research should seek to understand why these referrals are made if Ifá is believed to be a holistic healing modality. In addition, study designs that include psychologists, Orìsà priests, and their clients can prove useful in helping clinicians understand how these healers can better work together when treating clients who utilize indigenous African healing modalities.

Appendix

Sample Interview Questions.

Interview session	Questions
Interview 1 (training and experience)	1. How does a person become a priest? 2. Tell me about your training as an Orìsà priest. 3. What kinds of things do you learn? 4. Describe in as much detail as possible what happens when a person comes to you for help.
Interview 2 (defining mental health/ imbalance)	1. What are some of the causes of problems people come to you for help with? 2. Describe a healthy person. 3. How do you know if a person has a problem that needs to be addressed? 4. Are there times when you would suggest that someone seek help from a Western-trained mental health worker?
Interview 3 (intervention strategies and techniques)	1. Describe the types of problems people have when they come to see you. 2. Tell me what takes place in a typical session with a client. 3. Do you have specific strategies or techniques that you use to help clients?

(continued)

Appendix (continued)

Interview session	Questions
Focus Group 1 (experience seeking services of a priest and defining mental health/ imbalance)	1. Tell me the reasons that you seek the services of an Orìsà priest? 2. What happens when you go to see the Orìsà priests? 3. How did the priest find out what was going on with you? 4. What did you think was going on with you prior to seeing the priest?
Focus Group 2	1. How do you know when your issue has been resolved? 2. Are there times when you need to return to the priest for the same issue? 3. Did you ever consider going to someone else other than the Orìsà priest to assist with your concern? 4. Discuss the reasons you chose to visit the priest rather than other resources. 5. Have you considered seeing the priest and another resource for the same issue simultaneously? 6. What are your beliefs about health? 7. What are your beliefs about a lack of healthy balance?

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