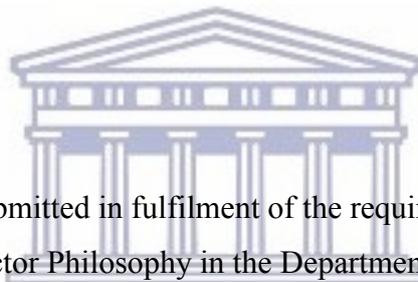


**SPIRITUALITY AND SOCIAL WORK
IN THE NAMIBIAN MENTAL HEALTH PRACTICE:
GUIDELINES FOR SOCIAL WORKERS**

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A thesis submitted in fulfilment of the requirements for
the degree of Doctor Philosophy in the Department of Social Work,

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WESTERN CAPE

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ABSTRACT

The aim of the study was to develop guidelines for social workers to be spiritually sensitive in their mental health practice. Spirituality in Namibia is an important part of the culture of the individuals that are served by social workers, as well as other caring professionals. For many, spirituality influences how they perceive their world. Spirituality is an important strength for individuals to manage their life challenges and for Namibians living with mental illness, spirituality is a source of comfort and strength during the recovery treatment process.

However, the researcher determined that there is scant literature on the conceptualisation and utilisation of spirituality in the Namibian social work context and specifically among social work professionals' practice with mentally-ill patients. Consequently, case studies were conducted to explore how Namibian social workers understand and utilise spirituality in their mental health practice, with the aim to develop guidelines for the practice.

The research process was conducted in two phases. Phase one focussed on information-gathering through a scoping review, as well as two case studies through in-depth individual interviews. After the completion of the first phase of analysis, the data from the scoping review and the interviews were shared with the participants for the development of the guidelines.

Phase two comprised two 1-day workshops for the purpose of developing guidelines for practice. The draft guidelines developed in the first 1-day workshop were forwarded for review to African experts in spirituality and social work from the University of the Witwatersrand and the Nelson Mandela University.

The research participants for both the in-depth individual interviews and the workshops were social work practitioners who were or had been employed at the two mental health hospitals in Namibia. A purposive, non-probability sampling method was employed to select the participants for the research sample.

Spiritually-sensitive social work that deals with mentally ill patients involves the understanding of more than one concept and dimension; therefore, it cannot be explained and interpreted by one single theory due to the different components it entails. Consequently, the

researcher had to employ an integrated way of exploring the phenomenon. Thus, a Conceptual Framework was selected. Four theories, namely, the Ecosystem Theory, Person Centred Approach, Afrocentric Perspective, and lastly, the Strength Perspective were observed to fulfil complementary roles in the comprehension of spirituality and social work in the African context of mental illness.



KEY WORDS

Spirituality

Spiritually sensitive social work

Mental illness

Guidelines

Namibia



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LIST OF ABBREVIATIONS

- AIDS - Acquired Immune Deficiency Syndrome
- ATP - African Technology Policy
- ATPS - African Technology Policy Studies
- BA - Bachelor of Arts
- DSM - Diagnostic and Statistical Manual of Mental Disorders
- HIV - Human immunodeficiency virus
- IASSW - International Association of Schools of Social Work
- IFSW - International Federation of Social Workers
- LCSW - Licensed Clinical Social Worker
- PCA - Person Centred Approach
- USA - United States of America
- WHO - World Health Organisation



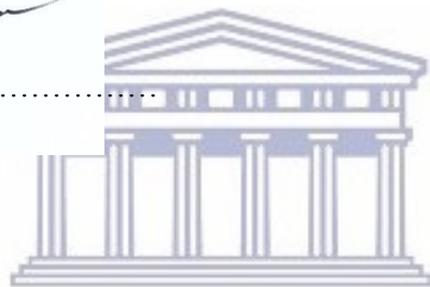
DECLARATION

I declare that *Spirituality and social work in the Namibian mental health practice: Guidelines for social workers* is my own work, that it has not been submitted for any degree or examination to any other university, and that all the sources I have used have been indicated and acknowledged by complete references.

Name: Zeldah U. Rukambe

Date: May 2019

Signature:.....



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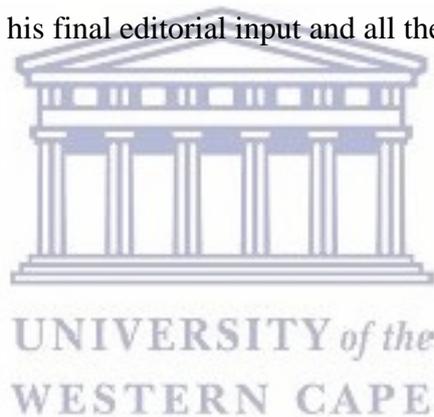


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CHAPTER ONE

INTRODUCTION

1.1. Background and rationale

In this chapter, the researcher presents an overview of the Namibian context in which this current research was conducted. The research background and rationale, context, overview of spirituality and mental health in Namibia, research setting, problem statement, research questions, aim, objectives and methodology are also discussed. This chapter is concluded by the significance of the study and the organisation of the complete thesis.

Namibia is a country with diverse spiritual practices (Buys & Nambala, 2003). In addition, social workers themselves embrace diverse worldviews as well as spiritual beliefs and practices. Therefore, spiritual diversity in Namibia could be a challenge to social work practice in Namibia, and the researcher argues that the focus should be on enhancing spiritually sensitive social work with clients, who may stem from diverse spiritual backgrounds that are contrary to or in conflict with those of the social workers providing the service. This is particularly vital with mentally ill patients whose worldview may be influenced by their defined spirituality.

Understanding spirituality in Namibia as well as its relationship to mental illnesses, therefore, becomes important as spiritual as well as mental illness realities are perceived differently in different cultures (Bartholomew, 2015; 2016; Vranckx, 1999). While there is a conceptual difference in the notion of spirituality, for many Namibians spirituality occurs within the context of religion, which also has a cultural dimension (Kgatla & Park, 2015). Mental illness treatment is a domain of social work that should offer culturally relevant services to persons with mental illnesses, as well as their significant others. As a Namibian social worker, the researcher's clinical practice and teaching experiences support the relevance of culture, tradition and religion in the lives of students, and more importantly, in the lives of clients.

Additionally, the medical multi-disciplinary teams of service providers are potentially influenced by spirituality, which in turn affects how service providers assess and provide interventions for their mentally ill patients, who seek treatment. In Namibia, many ethnic groups believe that being be-witched, or experiencing disconnect between a self and ancestors, prompts the onset of mental illness (Bartholomew, 2015), which could be one

reason why most patients in mental health settings insist on the inclusion of spirituality in their treatment processes (Sullivan, 1999; An interview conducted on September 17, 2015, with R. Dipura, Namibian social worker). To address this need, the mental hospital in Windhoek, Namibia incorporated spiritual aspects in their patients' assessment and treatment processes (An interview conducted on September 17, 2015, with L. Maparura, Namibian medical social worker). Various studies reveal that many clients view spirituality as a strength to cope with their life's challenges; however, not much has been achieved in terms of equipping social workers to become knowledgeable about spiritually-sensitive social work practice for the benefit of their clients (Bhagwan, 2010a; Mabvurira, 2016). The context of this current study is discussed next. Much can be expressed about the Namibian history; however, for the purpose of this study, only a brief discussion is presented to understand spirituality in Namibia in the context of the Namibian history.

1.2. The context of the study

1.2.1. A brief overview of the Namibian colonial history

Before exploring Namibian colonialism, it is worth mentioning that Namibia was part of the African countries before they were colonised and divided, or partitioned, by their colonisers. The Scramble for Africa (1880 to 1900) was a period of rapid colonisation of the African continent by European powers (Boddy-Evans, 2018) due to the economic, social, and military evolution that Europe was experiencing (South African History Online, 2015). European industries needed raw materials due to the civil wars that were raging in their countries; therefore, the British and their fellows came to Africa in search of raw materials such as cotton, ivory, gold, copper, timber, ground nuts for lubricating machines, palm oil, and vegetables, to meet the demand of their industries (South African History Online, 2015; Boddy-Evans, 2015). Consequently, the colonisation of African countries commenced. Zambia, Zimbabwe, South Africa and Namibia as countries that were rich in minerals were strongly scrambled for and divided. Namibia's neighbour in the South (South Africa) was colonised by the Dutch, North East (Zimbabwe) by the English, and in the North (Angola) by the Portuguese (Boddy-Evans, 2017).

The colonisation of Namibia started in the form of missionary work by the English and Germans, after which the Europeans started to monopolise trade in the country (Jauch, Edwards & Cupido, 2011; Baker, 2011). The interest of the Germans in Namibia intensified

and consequently in 1884, Namibia was established as a German colony and named German South West Africa (Baker, 2011). Germany's colonisation brought conflicts followed by great resistance by Namibians, as the Germans were seizing control of the country by force that was particularly focussed on taking possession of the land (Baker, 2011). The German colonialism lasted from 1884-1915, with a huge impact on the social, cultural, and traditional forms of social organisation (Jauch, Edwards & Cupido, 2011). The Namibian leaders, being ultra conservative, would not sign, or agree to treaties with the Germans, which resulted in violence and mass murder by the Germans (Baker, 2011). German traders swayed some chiefs to sell their land, inappropriately, or confiscated land by force (Gann & Duignan, 1977; Bley, 1971).

Eventually, after losing World War 1, Germany was forced to surrender all its colonies (Baker, 2011). White South African settlers were offered significant incentives to settle in Namibia, and measures were enacted to force Black Africans into becoming a cheap source of labour for the settler community (Jauch, Edwards & Cupido, 2011). The English colonial South African government formally entrenched segregation, applying its apartheid model in Namibia (Jauch, Edwards & Cupido, 2011). As South African involvement increased, the South African government was granted an administrative mandate to prepare German South West Africa for independence (Baker, 2011). The name of the country was changed to South West Africa, with South Africa continuing to enforce its mandates, including the introduction of unfavourable taxes (disadvantaging Black people), as well as the race discriminatory laws (received with resistance), reinforcing the role of Black South West Africans as subservient to White South West Africans (Baker, 2011; Jauch, Edwards & Cupido, 2011). After 75 years of colonial struggle, on 21 March 1990, Namibia gained its independence from South Africa (Baker, 2011), under a democratic multi-party constitution (Green, 2017).

1.2.2. Missionaries' work brought colonisation

As mentioned earlier, colonisation started when Europe wanted to access the minerals in Africa; however, the point of entry was in the form of missionary work by European missionaries. They dominated, oppressed, tyrannised and persecuted Africans, not only economically and politically, but also socially, culturally, as well as spiritually, with their dominant policies and social structures, practices, and religion (Rahaman, Yeazdani, & Mahmud, 2017). The minds of the Namibians were also colonised. Some Namibians believed

that the missionaries brought about colonisation (Jauch, Edwards & Cupido; Baker, 2011), as after the missionaries arrived in Namibia, an increase of forceful trading commenced (Horn, 2008; Baker, 2011). The London Missionary Society established the first foreign mission at Blydeverwacht in 1805, in the south of Namibia, followed by the Wesleyan Missionary Society in 1820, and from 1840 onward, the Rhenish Mission took over the work of the London Missionary Society (Horn, 2008). The Rhenish missionaries were soon followed by the Finnish Lutheran missionaries in the north (Horn, 2008). The Catholic and Anglican Churches also started their missions among the Ovambo people in the second half of the nineteenth century (Horn, 2008), while the Reformed churches became very influential under the South African colonial period (Horn, 2008).

It is important to discuss the Namibian history in the context of the missionary work as some Namibians are of the opinion that Christianity was introduced through the missionaries, which affected their spirituality, traditions and cultures (Jauch, Edwards & Cupido, 2011). The missionary work not only introduced Christianity, but also Western education, which involved literacy and the mastery of a European language that became the condition for entry into the modern sector (Rahaman, Yeazdani & Mahmud, 2017). Missionaries not only converted Africans from their traditional religions to the Christian religion, but also indoctrinated the Africans with Western values (Rahaman, Yeazdani & Mahmud, 2017). Missionaries, through their Christian Western teaching, challenged the traditional belief systems of the Africans and promoted the diffusion of new ideas and modes of life; in particular, it sought to impose monogamy and the nuclear family as the norm (Rahaman, Yeazdani & Mahmud, 2017). Traditional and cultural practices were very strong before the colonisation of Namibia, including the bond with extended family, as well as ancestral worship; however, it has changed significantly over the last century (Buys & Nambala, 2003). The Namibian people who were strong in ancestral worship, including the Herero and the Ovambo, were largely Christianised, and consequently, they lost their dependency on ancestral worship (Buys & Nambala, 2003; Malan, 1995). This shift came into being, due to the introduction of the Christian religion by missionaries to Namibia, which led to many religious practices, including the combination of the practice of both Western and traditional religions (Malan, 1995).

Some Herero people for example, continued to neglect and eventually ceased to maintain the traditional ritual fire, after migrating to the city. They gradually found life in modern society

sufficiently integrated to abandon these practices altogether, in favour of a modern lifestyle (Buys & Nambala, 2003). However, some Namibians still choose to practice both the Christian religion and tradition religion, while others practice one, or the other. Despite the invasion by the Christian religion, some Namibians still regard their ancestors as the *living-dead*, whom they believe to be mediators between God and the living (Buys & Nambala, 2003). In addition, they believe that these ancestral spirits chastise, through sickness and affliction, those who fail to honour them, or disregard tribal traditions (Buys & Nambala, 2003), which could be the reason why some choose to continue with the practice of their traditional religion only, or along with the Christian religion. Currently, approximately 80% of Namibians regard themselves as Christians.

1.2.3. The country

Namibia, officially known as the Republic of Namibia, is located on the south-western coast of Africa. It shares borders with Angola to the north, Zambia to the northeast, Botswana to the east, South Africa to the south, as well as southeast, and the Atlantic Ocean to the west. It ranges from arid in the north to desert on the coast and in the east (Green, 2017). The capital of the country is Windhoek. The only two mental hospitals in Namibia are situated in Windhoek and Oshakati, the distance between the two hospitals being 715 kilometres.

1.2.4. The people of Namibia: Ethnic and linguistic composition

About 85-87 % of Namibians are Black African. Namibia has eleven ethnic groups. The largest ethnic group is the Ovambo (49.8%), who live mostly in the north of the country, as well as in towns throughout Namibia. Other ethnic groups include Kavango (9.3%), Damara (7.5%), Herero (7.5%), White (6.4%), Nama (4.8%) Caprivian (3.7%), San (2.9%), Coloureds (4.1%) and Basters (2.5%) (United Nations [UN], 2017a; Green, 2017; United Nations [UN], 2017b). There are eight major languages spoken in Namibia, with English as the national language, although it is the home language of only approximately 3% of the population (Green, 2017; United Nations [UN], 2017b).

1.3. An overview of spirituality in Namibia

Based on the afore-mentioned regarding the Namibian people, it appears that Namibia is characterised by a culturally and ethnically diversified, small population of approximately 2.59 million (Namibia Statistics Agency, 2018). In addition, Namibian ethnic groups

comprise more than thirty different tribes, each with their unique language and cultural heritage that influence their spirituality. In this current study, the discussion of spirituality in Namibia might not have included all the contexts; therefore, each individual group, community, ethnic and tribe's spirituality should be explored further in future studies.

1.3.1. Spirituality and religion in Namibia

In Namibia, most people practice their spirituality in some form of religion, or in traditional practices. Before discussing spirituality in Namibia, it is important to understand the relationship between spirituality and religion. A detailed discussion on the conceptualisation of spirituality is presented in Chapter 2, which is the Literature review.

Spirituality and religion can be perceived as intertwined (Hodge, 2001); however, Canda and Furman (2010) explain that religion involves the patterning of spiritual beliefs and practices in specific social institutions, with community support and traditions maintained over time. The difference between spirituality and religion is that spirituality is a broader and more comprehensive term than religion as religion is associated more with institutions such as denominational affiliations and organised belief systems that promote participation in a faith (Cascio, 1998; Canda & Furman, 2010). Individuals may express spirituality via religious or non-religious forms. For example, embracing a higher power to deal with life challenges is a form of spirituality which can be expressed in a church with other believers or individually at any unorganised place (Canda & Furman, 2010).

However, Baloyi (2008) has a contrary view, from the African perspective. Baloyi (2008) asserts that spirituality and religion are deeply embedded in people's traditions, based on specific social ecologies; therefore, it is impossible to comprehend people's *psychology* and *psychotherapy*, unless such an understanding is situated within their culture, religion, and spirituality. Similarly, Bhagwan (2010b) states that religion and spirituality are inter-related yet distinct facets of the human experience. Their interrelation can be explained by assuming that if people are religious, they are spiritual; however, they are also distinct from one another in the sense that people can be spiritual without being religious. In the following section, an overview of spirituality as practiced in Namibia is presented.

Although Namibia is a secular state as indicated by the Constitution of The Republic of

Namibia (RNM, 1990) which allows for freedom of religion (Buys & Nambala, 2003), most Namibians' spirituality conceives the universe as having been created by a Supreme Being, known to them as God (Buys & Nambala, 2003; Malan, 1995). Some Namibians refer to themselves as Christians, which accounts for 80-90% of the population, with at least 50% identifying as Lutherans, and indigenous religions account for 10% to 20% (Buys & Nambala, 2003; Malan, 1995; Green, 2017; UN, 2017a; 2017b). The largest Christian group is the Lutheran Church, which grew out of the work of the Finnish Evangelical Lutheran Mission (Green, 2017). The next largest Christian group is the Roman Catholics, while most other Christian denominations, including the Dutch Reform, Methodists, Evangelical Baptists, Pentecostals, and Seventh Day Adventists, can also be found. Other religions, practiced in the country include, Judaism, Islam, Buddhism, Baha'i Faith and atheist attendance (Malan, 1995; Buys & Nambala, 2003; Green, 2017). In Namibia, some ethnic tribes practice indigenous religions which are also referred to as traditional beliefs and practices (Buys & Nambala, 2003; Malan, 1995). Traditional beliefs in Namibia are highly diverse, and include various ethnic beliefs such as belief in a supreme creator, belief in spirits, belief in the dead (known as ancestral worship), belief in the use of witchcraft, as well as belief in traditional healing (Buys & Nambala, 2003; Malan, 1995; Bartholomew, 2015; Kgatla & Park, 2015). It is also worth mentioning that some of those who practice an indigenous religion also practice Christianity (Kgatla & Park, 2015).

Therefore, despite the introduction of Christianity, some Namibians still regard their ancestors as influential in their lives. Due to the patriarchal belief system that is dominant in most African religions, females cannot be ancestors. The *ancestors* therefore refer to male elders who have died. They are regarded as the *living-dead* (Mbiti, 1969), and they are believed to be mediators between the Ultimate God and the living (Buys & Nambala, 2003). In addition, it is believed that these ancestral spirits chastise those who fail to honour them, and disregard tribal traditions (Buys & Nambala, 2003). The fear of being punished could be a reason why some Namibians chose to continue practicing their traditional religion as well as the Christian religion. Therefore, as previously mentioned, spirituality in Namibia is diverse, and each person's spirituality is perceived and practiced differently, given the diversity of the ethnic groups. Some practice spirituality through various religions, while others practice spirituality without necessarily referring to any form of religion.

In the following section, the researcher offers an overview of mental health in Namibia. A

detailed discussion of the Western and African perspectives on mental health, including the Diagnostic and Statistical Manual of Mental Disorders (DSM), is presented in Chapter 2, the Literature review.

1.4. An overview of mental health in Namibia

Mental health refers to our cognitive, behavioural, and emotional wellbeing, which also means an absence of a mental disorder (Nordqvist, 2017). While mental illness refers to any disease or condition that influences an individual's moods, as well as the way s/he thinks, behaves, and/or relates to others and his/her surroundings (Mayo Clinic, 2015; Health Direct, 2018; WHO, 2012; 2018)). From a Western perspective, mental illnesses are classified by the DSM, which is a classification system for mental illnesses, according to symptoms presented by the patient (Kawa & Giordano, 2012; Jimenez, 1988; Pilgrim & Rogers, 1993). The DSM is used by clinicians, psychiatric researchers, and social scientists for different purposes; however, its main purpose is to provide an assessment and classification of the various mental disorders (Kawa & Giordano, 2012; Van Rensburg, Poggenpoel, Myburg & Szabo, 2012; Judras, 2017). The DSM, currently in its 5th edition, was created in 1952, in the United States of America, and it claims that mental disorders are bio-medically oriented, and therefore, should be described and explained bio-medically. Another view maintains that the DSM was created as a standard manual because mental illnesses were uniformly manifesting, and affected people universally (Agbayani-Siewert, Takeuchi & Pangan, 1999; Jutras, 2017; Kawa & Giordano, 2012).

In the general African perspective, although not the perspective of all the Namibians, some Namibians have a cultural belief that mental illness can be explained and healed by spiritual leaders, including traditional healers. These healers have their own diagnoses of the causes of mental illness, which include, being *God-given*, witchcraft, curse, hereditary, spirit possession, poisoning in a dream, broken relationship or disrespect of elders and/or ancestors, evil eye, and sorcery (Patel, 1995; Bartholomew, 2015; Vranckx, 1999).

In Namibia, the multi-professionals, namely the psychiatrists, psychologists and social workers working in the two mental hospitals, are trained in Western theories that explain behaviour and treatment, within the DSM framework. The DSM framework highlights the alcohol-and-substance-abuse induced prevalence of post-traumatic stress disorder (PTSD),

schizophrenia, suicidal ideation, bipolar, domestic violence related psychological distress, as well as psychological symptoms and behaviours related to HIV/AIDS, which are some of the mental illnesses prevailing in Namibia (Feinstein, 2002). Western trained programmes may not align with, or acknowledge Namibians' indigenous beliefs of how mental illness are perceived and treated, if these traditions and culture, which form their spirituality, are not explored (Bartholomew, 2016). A detailed discussion on the Western and African perspectives on mental illness and treatments are presented in Chapter 2, the Literature review.

1.5. Research setting

The research setting was in Windhoek, the capital city of Namibia, where most of the social workers in mental health practice are employed, and also in Oshakati, which is 715km away from Windhoek. Mental Health services are available at the Windhoek Mental Health Care Centre in central Namibia, Windhoek, and the Oshakati Psychiatric Ward in northern Namibia. Access to mental health services and follow-ups therefore, could be a challenge for those who live in the remote rural areas. The Windhoek Mental Health Care Centre is a subdivision of the Windhoek Central Hospital. This centre provides outpatient and inpatient services to adults and children, with a bed capacity of 200; 120 in the general psychiatry unit, and 80 in the forensic psychiatry unit. Both the general psychiatry unit and forensic unit treat mentally ill patients, but the forensic unit treat patients who have committed crimes and are a danger to the community. The Windhoek Mental Health Care Centre has the full range of professionals, namely, psychiatrists, medical doctors, psychiatric nurses, clinical psychologists, social workers, occupational therapists, cleaners, kitchen staff, as well as security officers. Mental health forms part of the primary health care system; however, the treatment of severe mental disorders is not available at the primary level. Generally, treatment is available at the two hospitals (Windhoek Central hospital and Oshakati State hospital), but follow-up of discharged psychiatric patients is offered at all health care facilities country wide.

1.6. Problem statement

The current study explored spirituality and social work in mental health settings in Namibia, specifically as mental illnesses compared to other social problems in Africa are perceived and understood by many Africans as a sickness that manifests physically due to spiritual factors

(Bartholomew, 2015). Therefore, many mentally ill patients desire that their spirituality be considered in their healing process. Therefore, the DSM-IV and DMS-V as further discussed in Chapter two considered religion and spirituality as part of culture (Prusak, 2016), thus, introduced the category “Religious or Spiritual Problem” in the DSM-IV and this was further retained in the DSM-5 (American Psychiatric Association (APA), 2013). Consequently, clinicians including social workers are ethically obliged to assist the patient in such a way which takes into account the cultural, religious and spiritual contexts (Prusak, 2016). Therefore, the researcher aimed to develop guidelines, in this current study, for social workers to be spiritually sensitive to their patients’ spiritual needs in their mental health practice and settings. In an interview conducted on 17 September 2015 with R. Dipura, a Namibian medical social worker at a mental hospital, it was mentioned that most Namibian mentally ill patients consider spirituality as an important part of their lives, and that this significantly impacts their illness, mental illness and healing process in a positive manner. This confirms the findings by D’ Souza (2002), who surveyed 79 patients diagnosed with mental illness in Australia. This survey determined that 70% of the patients surveyed rated spirituality as important in their lives, while 67% reported that spirituality helped them to cope with their psychological pain. Additionally, 69% reported that their spiritual needs should be considered by the health care providers who were treating their mental illness (D’ Souza, 2002). Similarly, in other studies, many individuals suffering from serious mental illnesses wanted their spiritual beliefs, values and practices considered and included in their overall treatment planning and healing process (Baetz, Griffin, Bowen & Marcoux, 2004; Coyle, 2001). A cross-sectional study with 442 Licensed Clinical Social Workers (LCSWs) in the USA revealed that only 13% took a graduate course on spirituality and social work (Oxhandle, Parrish, Torres & Achenbaum, 2015). The study further revealed that the LCSWs displayed positive attitudes, high levels of self-efficacy, and perceived the integration of clients’ religion and spirituality in clinical practice as feasible; however, they reported low levels of engagement in the integration of their clients’ spiritual beliefs into practice (Oxhandle *et al.*, 2015).

In Namibia, prior to the current study, no such related study exists for social workers; therefore, the low level of engagement in the integration of the clients’ spiritual beliefs into practice can be linked to the fact that social workers have no proper guidelines, skills, or knowledge to deal with their clients’ spiritual dimensions, which confirms findings by Canda, Nakashima and Furman (2004). In an interview conducted on 17 September 2015 with R.

Tromp, a Namibian chief medical social worker at the mental hospital, it was mentioned that many Namibian social workers in mental health practice do not consider the use of spirituality in their clinical practice because of a lack of guidelines for practice. Moreover, in Namibia and other African countries such as Zimbabwe, there is a dearth of social work research that explores spirituality and social work in mental health practice (Mabvurira & Nyanguru, 2013). Mabvurira and Nyanguru (2013) highlight the lack of guidelines, skills and knowledge for the utilisation of spirituality in social work practice because the social work curricula in most Zimbabwean universities, both at undergraduate and post graduate levels, do not include spirituality, neither does the Council of Social Workers of Zimbabwe mandate social workers to apply spiritual sensitivity in their service provision. Similarly, a study conducted in South Africa revealed no reference to knowledge and skills related to spirituality in the Bachelor, Masters, and PhD social work programmes (Bhagwan, 2010a). Namibia is no exception, as no such studies was ever conducted in the country. Anecdotally, while spirituality is perceived as a viable strength for many people, generally, as well as a coping mechanism for mental health problems, the Namibian social work literature and education remains silent on the utilisation of spirituality in clinical practice. In consideration of this problem statement, the researcher aimed to develop guidelines for social workers for them to be spiritually sensitive in their mental health practice.

1.7. Research questions

- What research exists on spirituality and social work in Africa?
- How is spirituality conceptualised in social work practice in the Namibian context?
- How do social workers utilise spirituality in mental health settings?
- What guidelines are needed in mental health settings for social workers to be spiritually sensitive in their practice?

1.8. Research aim

The aim of this current study was to develop guidelines for spiritually-sensitive social work in mental health practice.

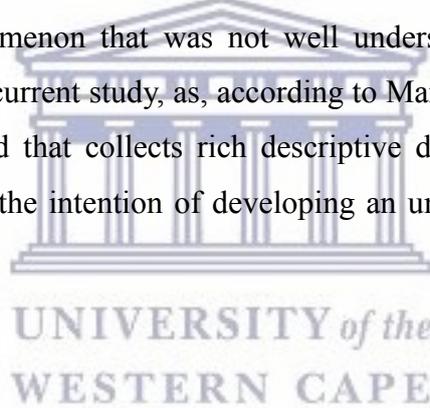
1.9. Research objectives

Several objectives were set for the current study:

1. To explore research on spirituality and social work in Africa by means of a scoping review;
2. To conceptualise spirituality in social work in the Namibian context;
3. To explore and understand Namibian social workers' utilisation of spirituality in their mental health practice; and.
4. To develop guidelines in the mental health settings for social workers to be spiritually sensitive in their practice.

1.10. Research methodology

The researcher made use of the interpretive ontological paradigm (Angen, 2000) as the aim was to fathom the meaning and understanding of spirituality in mental health social work practice from the participants. In addition, the focus was on acquiring an in-depth understanding about a phenomenon that was not well understood. A *qualitative research approach* was chosen for the current study, as, according to Maree (2007, p. 50), “Qualitative research is a research method that collects rich descriptive data in respect of a particular phenomenon or context with the intention of developing an understanding of what is being studied.”



1.10.1. Research design

Research design refers to the entire process of research, ranging from conceptualising a problem, to drafting research questions, data collection methods, analysis, interpretation and report writing (Creswell, 2012).

1.10.2. Research process

The research process was conducted in two phases, with phase one comprising data collection through a scoping review and a case study. Phase two facilitated two 1-day workshops, with the purpose of developing guidelines for practice.

1.10.2.1. Phase 1: Data collection process

- **Stage 1: Scoping Review:** To explore research on spirituality and social work in Africa by searching through databases for African studies conducted on spirituality and social work between 2006 and 2016).

- **Stage 2: Case Studies:** Individual interviews to explore the conceptualisation of spirituality in social work in the Namibian context as well as the utilisation of spirituality in their mental health practice with social workers who were currently or previously employed at two mental health facilities in Namibia.

1.10.2.2. Phase 2: Development of guidelines in two 1-day workshops

After completion of the first phase of data gathering, the data from the scoping review as well as the interviews were analysed and shared with the participants to extract key data for the development of guidelines in two 1-day workshops. Healy's (2015) framework was used to guide the development of the guidelines with the participants. The workshops were conducted over two days, and they were approximately one month apart, focusing on the following:

- **Day 1:** Based on the research data gathered from the scoping review and the interviews, relevant theory/ies, approaches and perspectives that supported spiritually-sensitive social work were presented and confirmed, including social work values, as well as ethical principles that could guide spiritually-sensitive social work. In addition, essential skills that could be employed when considering spiritually-sensitive social work were identified. This information formed the draft guidelines which were forwarded to two relevant experts from the University of the Witwatersrand and the Nelson Mandela University, respectively, for review as well as feedback.
- **Day 2:** After the draft guidelines from the first workshop were returned from the experts, with their comments, another workshop was held to review, modify and finalise the guidelines to the Namibian social work context.

1.11. Significance of the study

During the course of this current study, the researcher determined that in Namibia there is a lack of empirically-based social work practice literature involving spirituality, or spiritually-sensitive social work. This current research was aimed at producing social work knowledge and guidelines which specifically explore spirituality in mental health in the Namibian context for social work practice, as well as for researchers. In addition, the conceptualisation of spirituality in social work in the Namibian context for effective clinical practice in mental health was also explored.

1.12. Organisation of the thesis

Chapter 1 comprises the background and rationale, context, overview of spirituality and mental health in Namibia, the research setting, problem statement, research questions, aim, objective, methodology and the significance of the study.

Chapter 2 includes the literature review of spirituality and spiritually-sensitive social work in the mental health context.

Chapter 3 encompasses the conceptual framework employed in this research study.

Chapter 4 comprises the research design and methodology for the data collection and data analysis processes, as well as the ethical considerations adhered to in this current research study.

Chapter 5 contains the execution of the scoping review, as well as the analysis, findings and discussion of the findings.

Chapter 6 includes the execution of the case study by means of in-depth, one-on-one, semi-structured interviews, including data collection, data analysis, findings, discussion of the findings, and interpretation of the data that were collected. The themes that emerged from the raw data, according to their categories, are presented in Chapter 6.

Chapter 7 incorporates the guidelines for social workers in mental health settings to incorporate spirituality into their practice, formulated based on the data collected from the participants in the interviews, workshop discussions, as well as relevant input from experts on the subject matter, and guided by Healy's Dynamic model.

Chapter 8 contains the main findings, conclusions, recommendations, as well as the limitations of the current study.

CHAPTER TWO

LITERATURE REVIEW – SPIRITUALITY AND SPIRITUALLY-SENSITIVE SOCIAL WORK

2.1. Introduction

In this chapter, the researcher explores the existing literature related to the research topic, specifically, spirituality and spiritually-sensitive social work in the mental health settings. This literature review is essential as it guides the researcher to focus on the selected topic as well as the existing, relevant studies that other researchers have conducted (Creswell, 1994; Creswell, 2012). De Vos, Strydom, Fouché and Delport (2006) assert that a literature review is a search for the existing, available body of knowledge, which would help researchers to ascertain how other scholars have investigated the research problem under scrutiny.

2.2. Spirituality

The concept of spirituality in the profession of social work is relevant as social workers should seek to address the person that is in need holistically. Social workers and healthcare professionals who understand and appreciate this holistic approach ensure better interconnectedness of the psychosocial, physical, social, emotional, spiritual and cultural realms in their treatment processes with their patients (Govier, 2000; Callister, 2004). The researcher, therefore, discusses the definition of spirituality from a Western perspective first, and subsequently, from an African perspective.

2.2.1. Understanding the concept of spirituality from a Western perspective

It is important to note that many definitions exist for the concept of spirituality, and each definition is not absolute as it is defined in different contexts and people from diverse backgrounds (Roby & Maistry, 2010). Even in social work, the definition of spirituality is diverse as researchers/authors are influenced by their own backgrounds and belief systems. Hodge (2001, p. 204) states that “Spirituality is defined as a relationship with God, or whatever is held to be the Ultimate (for example, a set of sacred texts for Buddhists) that fosters a sense of meaning, purpose, and mission in life”. Additionally, Patel, Naik and Humphries (1998, p.11) define spirituality as “...the human search for personal meaning and mutually fulfilling relationships between people and the natural environment and between religious people and God...”

However, Derezotes (2006, p. 3) defines spirituality differently, describing it in a more general manner as follows: “Spirituality is a person’s desire for and expression of loving connection with everything; as the individual’s sense of connectedness, meaning, peace, consciousness, purpose, and service that develops across the life span”. It is different because it does not refer to any God, or an Ultimate being. Another simpler, yet general definition is by Moss (2005) who posits that, “Spirituality is what we do to give expression to our chosen worldview”. As can be gathered from these definitions, even if they were defined in the social work context, they would be diverse. The definitions of Hodge (2001) and Patel *et al.* (1998) are very directive and specific, yet their definitions exclude those who do not have a relationship with God or believe that there is a God, gods, or a higher Ultimate being (Senreich, 2013). In the contrary, the definitions of Derezotes (2006) and Moss (2005) could be perceived as too vague for social work education and practice. Therefore, anything could be spiritualised, which complicates social workers’ approaches in their work with their clients (Senreich, 2013).

In an attempt to find an inclusive definition for social work education and practice, Senreich (2013) prefers the definition of Canda and Furman (2010, p. 75) that:

Spirituality is a process of human life and development, focusing on the search or urge towards greater reality for a sense of meaning, purpose, morality and well-being; this search is in relation with oneself, other people, other beings, the universe, and ultimate reality, however understood (for example, in animistic, atheist, nontheistic, polytheistic, theistic, or other ways; orienting around centrally significant priorities; and engaging a sense of transcendence through an experience that is deeply profound, sacred, divine, or transpersonal.

Spirituality and religion can be perceived as intertwined; however, Canda and Furman (2010) explain that religion involves the patterning of spiritual beliefs and practices in specific social institutions, with community support and traditions maintained over time. The difference between spirituality and religion is that spirituality is a broader and more comprehensive term than religion, which is associated more with institutions such as denominational affiliations and organised belief systems that promote participation in a faith (Cascio, 1998; Canda & Furman, 2010).

Additionally, it can be said that religion is one of the means of fostering spirituality.

Individuals may express spirituality through religious, or non-religious, forms; for example, embracing a higher power to deal with life's challenges is a form of spirituality, which could be expressed in a church with other believers, or individually, at any given time and place (Canda & Furman, 2010).

There are diverse definitions of spirituality as noticed above, and some of them are open to anything, while others are confined to a particular relationship. What is understood by these definitions, from the Western perspective, is that they emphasise the search for meaning, purpose, peace, sense, wholeness and connections, or relationships. However, they are all helpful suggestions to spiritually-sensitive social workers as they possibly offer a sensitive attitude towards this aspect, and provide insights to the multiple dimensions of an individual's life. As mentioned earlier, spirituality is understood and experienced differently, given different backgrounds. Having discussed the definitions of spirituality from the Western perspective, it is important for the sake of spiritually-sensitive social workers in Africa, to explore the different understandings of spirituality in the African context.

2.2.2. Understanding the concept of spirituality from an African perspective

A study conducted by Nkomo (2016) with health care workers in South Africa included social workers and their perceptions of spirituality. The social workers, in their responses to the understanding of the concept of spirituality, expressed it as: "*Belief in God*"; "*Connecting with Supreme*"; "*Relationship with self*"; "*Holistic being, physical, emotional social and psychological*"; and "*Meaningful relationships: church, family or friends*". What is clear from these extracts is that the social workers understand spirituality as a connection with a religious being, as well as none religious relationships.

Mbuy-Beya (as cited in Abraham & Mbuy-Beya, 2013, p. 65), asserts that "Spirituality is what permits us to make sense of life; is the very center of the life and culture of the individual and community; it is a basic dimension of life, the soul of all culture; its essential element; it is life's motor in every aspect, be it technical, psychological, sociological, political, or artistic". Furthermore, Byaruhanga-Akiiki (1988, p. 15) defines spirituality as "a total life experience of a people such as their religious, social, political and economic sphere of life, their entire culture". These human dimensions, according to Byaruhanga-Akiiki (1988), are not separated from each other in Africa, but rather for many Africans, spirituality

is indivisibly linked to their fore-fathers, known as ancestors. The social workers' perceptions of spirituality in the study of Nkomo (2016) do not identify it as the core of their lives; however, studies by Abraham and Mbuy-Beya (2013), as well as Byaruhanga-Akiiki (1988) reveal spirituality as the core of life which affects every aspect of life. The difference is further noted in the definition of Byaruhanga-Akiiki (1988), with the emphasis on African spirituality being linked to African fore-fathers, also known as ancestors. Buys and Nambala (2003) concur with Byaruhanga-Akiiki (1988), by stating that ancestral worship is at the heart of most African spiritual experiences in Namibia. Diversity in the concept of spirituality in Africa is unavoidable because African people are diverse in ethnicity, race, traditions and cultures. However, the spirituality of all the people in Africa, or even in Namibia, is not necessarily linked to ancestral worship, or religion.

Unlike the Western perspective, according to Canda and Furman (2010), spirituality and religion are not intertwined, yet Baloyi (2008) holds contrary views, though the view is also from an African perspective. Baloyi (2008) asserts that spirituality and religion are deeply embedded in people's traditions and also on a specific social ecology, and as such, people's *psychology* and *psychotherapy* cannot be comprehended fully unless such understanding is situated within their culture, religion, and spirituality. Additionally, Mabvurira (2016) avers that there is no separation between spirituality and traditional African life. Given this importance of religion and spirituality to Africans, it can be argued that social work practice within the African context cannot be complete without the inclusion of a spiritual dimension (Baskin, 2002). In addition, Bhagwan (2010b) asserts that religion and spirituality are inter-related but also distinct facets of human experience. Their interrelation can be explained in that if an individual is religious, s/he is spiritual, and their distinction from one another as, since an individual can be spiritual without being religious. An example could be that some Namibians practice spirituality by engaging in traditional rituals such as consulting their ancestors, or witch-doctors, and/or religious practices, by being involved in church rites and activities. Alternatively, an individual can be spiritual without being religious, as some Namibians pursue a connection with nature, practice quiet times, and meditate on positive thoughts without attending a church service, or connecting with any religious activity.

Other contrary interpretations of the African perspectives on the concept of spirituality are proposed by Abraham and Mbuy-Beya (2013), Mabvurira (2016), as well as Byaruhanga-Akiiki (1988), who refer to spirituality as the core of life, which influences every aspect of

life, and it is not reflected in the Western perspective. Byaruhanga-Akiiki's (1988) definition emphasises that African spirituality is linked to the ancestors. Abraham and Mbuy-Beya (2013, p. 65) assert that spirituality is the very centre of life as well as the culture of the individual and community, which is not the case in the Western perspective. Additionally, the words *search for meaning* are not reflected in the African perspectives on spirituality. These highlighted differences in the understanding of the concept of spirituality are an indication that the Western and the African worldviews are different. However, even within the African perspective, diverse interpretations of the concept of spirituality are observed.

This discussion on spirituality highlights that the concept is complex due to the diversity in perspectives, backgrounds and socialisation. Therefore, spiritually-sensitive social workers should be aware of the different spiritual understandings and backgrounds in their work with clients for them to provide relevant, suitable and effective services, according to their clients' needs as perceived by their clients.

2.3. Spirituality and social work

2.3.1. History of Western social work

Spirituality and social work have existed ever since Jane Addams, one of the first pioneers of social work, in the early 1900s (Canda & Furman, 1999). The term *Social Work* first emerged in the United States of America, and its fundamental functions were initially based on the spiritual values of charity, communal responsibility, empathy, respect for human life, justice, care and support (Canda & Furman, 1999; Sheridan, 2003; Dwyer, 2010). Notably, these values are no different from contemporary social work values; however, the implementation thereof might be perceived differently as historical social work held more religious roots than contemporary social work (Loewenberg, 1988).

Fauri (1988), as well as Canda and Furman (1999), however, mention that between 1920 and 1970, social work separated from its spiritual roots, and progressed towards a secular orientation. This shift could have been because of global and societal change. Societal change replaced moral explanations of human problems with scientific explanations, and the social work profession started to rely on libertarian morality, secular humanism, and empiricism as the foundation for its ethics, values and practice approaches (Imre, 1984; Siporin, 1986). The profession has since developed in its sense of professionalisation and secularisation, based on

scientific models, which has led to the separation of spirituality from social work practice (Canda & Furman, 1999), with an expanded view that spirituality in social work is illogical, irrelevant and pathological (Russel, 1998).

2.3.2. Contemporary social work

Diverse social and health circumstances continue to prompt interest among social workers and other helping professions to provide more holistic services that integrate the religious and spiritual needs of those they serve (Coholic, 2012). In addition, practitioners including social workers, are required to honour the spiritual issues woven into the concerns that clients bring to practitioners (Mackernan, 2005; APA, 2013), given the inclusion of the religion and spirituality category in the DSM-5 as discussed in Chapter two. This prompt could be due to the discovery of the centrality of spirituality in human life (Mabvurira & Nyanguru, 2013). Thus, there is an emerging interest in how spirituality can be incorporated into social work practice (Mackernan, 2005; Crisp, 2008). The escalating interest in spirituality can further be observed in the increased numbers of publications and presentations on the topic of spirituality and social work (Canda & Furman, 2010). A study conducted by Bhagwan (2010 a) to explore the views of students with regards to the role of religion and spirituality in practice and the extent to which South African curricula considers religion and spirituality reveals a high level of religiosity or spirituality amongst students, and this is a gap in the curriculum on spirituality and support for its inclusion in social work education.. Other studies and publications on spirituality and social work include: Canda *et al.* (2004), Seinfeld (2012), Gray (2008), Carrington (2011), Sheridan (2009), Bhagwan (2011), Bhagwan (2013), and Mabvurira (2016), to mention but a few.

Researchers in the fields of spirituality and social work have developed from focusing on the relevance and role of spirituality in social work, to integrating spirituality into social work education and practice, in an ethical and spiritually-sensitive manner (Canda & Furman, 2010; Canda *et al.*, 2004; Mackernan, 2005). The increase in research and publications on the topic of spirituality and social work has rekindled recognition of the relevance of spirituality in social work (Sheridan, 2000). The issues that remain for discussion involve the application and integration of spirituality into social work education and practice, in an ethical and spiritually-sensitive manner (Canda & Furman, 2010; Sheridan, 2000; Mackernan, 2005; Bhagwan, 2010c, 2011, 2013; Mabvurira, 2016).

2.3.3. Spiritually-sensitive social work

To be spiritually sensitive as a social worker refers to the consideration of the client's spirituality as an essential aspect in the working relationship with the client. In addition, spiritually sensitive social workers seek to understand and accommodate their clients' perceptions on spirituality above their own, as a priority in addressing the client's problems (Van Hook, 2008).

Van Hook (2008) emphasises that in spiritually-sensitive social work it is accepted that spirituality is part of an individual's belief system, and therefore, a holistic perspective, in terms of assessments and interventions is attempted. Spiritually-sensitive social work explores the belief system, the meaning of such spiritual practice, as well as other spiritual dimensions, in order to understand and value the patient's spirituality. For example, when spiritually-sensitive social workers learn that a patient finds certain spiritual practices helpful in addressing problems, such social workers should consider exploring the meaning and purpose of such spiritual practices to the patient, as well as how their spirituality influences their behaviour. In addition, referring the patient to a chaplain, involving traditional healers when requested, allowing the patient to pray during counselling sessions, or establishing quiet rooms within the hospital for quiet times, are all ways of demonstrating being spiritually sensitive.

Canda and Furman (2010, p. 218) indicate that unlike secular social work, spiritually-sensitive social work surpasses embracing cultural and spiritual diversity, as part of the general ethical principles. Essentially, it involves appreciation and advocacy for clients' spiritual self-determination, in coping with life's unexplained challenges (Canda & Furman, 2010). Therefore, spiritually-sensitive social workers pay added attention to the client's spiritual aspects when deemed important to the client. Therefore, spiritually-sensitive social workers would not impose any form of spirituality or religion on the client, but identify what is salient for the client. However, it is also important to inform the client of any detrimental spiritual practice that might have a negative effect on their healing process, for example, a patient's belief in refusing medication could be detrimental to his/her healing process. Such actions should be performed with great awareness, to distinguish between the spiritual life and beliefs of the social worker, and that of the patient and his/her family (Van Hook, 2008). Consequently, paying added attention would include tending to the client's search for his/her life's meaning, purpose and sense of belonging.

Spiritually-sensitive social work is evident in Namibia, although Namibia is a secular state, as specified in the Namibian Constitution of 1990, which stipulates that, "...committed to these principles, have resolved to constitute the Republic of Namibia as a sovereign, secular, democratic and unitary State securing to all our citizens justice, liberty, equality and fraternity..." (RNM, 1990). Therefore, social work offered by the State is practiced as secular social work. The word *secular* refers to the absence of a particular religion, or religious framework (Holloway & Moss, 2010; Holden, 2002). This implies that social work in Namibia is practiced under no religious, or faith-based framework; however, it does not prevent secular social work from working with spiritual or religious clients. Namibian social workers are not trained to be spiritually sensitive; therefore, they lack the specialised knowledge and guidance. However, they practise spiritually-sensitive social work as guided by the social work profession's ethical principles and values.

2.3.3.1. Social work values and ethical principles for spiritually-sensitive social work

The mission of social work is rooted in a set of core values and ethics. The following is a discussion of social work values, in direct relation to ethical principles, in the context of spiritually-sensitive social work (Canda & Furman, 2010).

- ***Value: Service***

Ethical Principle: Social workers' primary goal is to help people in need, and to address social problems, by providing resources and benefits to people, to help them achieve their maximum potential.

Social workers should render service to all people in need of help and not discriminate against anyone, regardless of their diverse backgrounds (Schenck, Mbedzi, Qualinge, Schultz, Sekundu & Sesoko, 2015). Spiritually-sensitive social workers elevate service to others above self-interest, whenever necessary, and always seek mutually beneficial ways to provide the service (Canda & Furman, 2010). According to Nicholas, Rautenbach and Maistry (2010), this service is viewed as more important than the social worker's own interest. During service delivery, the social worker respects the client's right to decide, within the context of his/her abilities, as well as the social needs and problems experienced (Nicholas, Rautenbach & Maistry, 2010). Spiritually-sensitive social workers draw on their knowledge, values, and skills, to help people in need, which includes their material, biological, psychological, social, relational, and spiritual needs, according to the priorities and aspirations of the clients (Canda & Furman, 2010). When clients identify religious or

non-religious forms of spiritual support, including religious communities, spiritual support groups, and transcendent or sacred beings; these beliefs and related practices are respected by the social worker, and included in the intervention, as relevant preferences (Canda & Furman, 2010).

- ***Value: Social justice***

Ethical Principle: Social workers challenge social injustice.

Social workers should promote social justice as well as social fairness in their services by advocating on behalf of their clients, and linking them to other resources (Schenck *et al.*, 2015). Spiritually-sensitive social workers pursue social change, particularly with, as well as on behalf of vulnerable and oppressed individuals and groups (Canda & Furman, 2010). However, in a mental hospital, the spiritual needs of a patient with different or uncommon beliefs to other patients might be overlooked. Therefore, the spiritually-sensitive social worker advocates on behalf of such a patient, for his/her spiritual needs to be considered as well. The advocacy on behalf of individuals and cultural, or religious groups, who are the target of oppressive, discriminatory, as well as prejudicial attitudes, practices, and policies, because of their spiritual beliefs (Canda & Furman, 2010; Nicholas, Rautenbach & Maistry, 2010), is of particular concern. Spiritually-sensitive social workers strive to ensure access to vital information, services, and resources, especially regarding relevant spiritual support systems, equality of opportunity, and meaningful participation in decision making for all people (Canda & Furman, 2010).

- ***Value: Respect, dignity and worth of the person***

Ethical Principle: Social workers respect and enhance the inherent dignity and worth of the person.

Social workers should have respect for all human beings including respecting and enhancing the inherent dignity and worth of people (Schenck *et al.*, 2015), regardless of the different worldviews their clients may share. Spiritually sensitive social workers treat each individual in a caring and respectful manner, mindful of individual differences of cultural and ethnic diversity, religious and spiritual diversity, as well as all other forms of human variations (Schenck *et al.*, 2015; Canda & Furman, 2010). Social workers should at all times respect fundamental human rights and dignity, with special attention given to the individual's right to privacy, confidentiality, self-determination, and autonomy (Nicholas, Rautenbach & Maistry, 2010).

- **Value: Confidentiality**

Ethical Principle: Social workers should respect clients' right to privacy and confidentiality of their information and status

All people have the right to privacy; therefore, social workers should keep their clients' records as confidential as possible (Schenck *et al.*, 2015). Social workers in this context should be mindful and sensitive to their clients' form of spirituality, and although it may appear to be illogical in society, it should still be kept private and confidential (Schenck *et al.*, 2015). In the event that the social worker may need to share information with the supervisor, to solicit advice on a case, as well as solicit for support from colleagues, or from the multi-disciplinary team, the social worker must seek permission from the client, with an explanation about the need to share (Schenck *et al.*, 2015).

- **Value: Self determination**

Ethical Principle: Social worker acknowledges and promotes clients' need for self-determination

Social workers should regard the capacity of their clients and encourage them to believe in themselves, while reassuring them that they possess the expert knowledge about themselves, instead of outsiders (Schenck *et al.*, 2015). The social workers should foster their clients' self-actualisation, and allow them to rediscover who they are, as well as what is best for them (Schenck *et al.*, 2015).

Self-determination is relevant when a patient wishes to seek healing somewhere else, which may include traditional healers, or their ancestors. Spiritually-sensitive social workers acknowledge the responsibility of informing their clients about their right to self-determination, as well as assisting them to obtain appropriate services while encouraging them to know and believe in themselves (Schenck *et al.*, 2015). While the social workers should promote the patient's right to self-determination, it is also their responsibility to inform the patient of the obligations, and possible consequences of their decisions (Barsky, 2014); for example, decisions associated with services provided to them including religious and traditional rituals that they may choose. However, social workers may limit their clients' right to self-determination when in the social workers' professional judgment, the clients' actions, or potential actions pose a serious, foreseeable, and imminent risk to themselves or others (Barsky, 2014).

Spiritually-sensitive social workers promote their clients' socially responsible self-determination, thereby, assisting their clients to engage in clear moral and ethical decision-making, in a manner that respects the spiritual perspectives of their clients as well as the right of other people and communities to uphold their own self-determination (Canda & Furman, 2010).

- ***Value: Importance of human relations***

Ethical Principle: Social workers recognise the central importance of human relationships

Social workers are required to build professional relationships with their clients and communities (Schenck *et al.*, 2015). Social workers should work on fostering relationships with each of their clients, based on unconditional acceptance to the benefit of their clients. Social workers in general understand that the forging of relationships between and among people is an important vehicle for change (Canda & Furman, 2010). Social workers engage people as partners in the healing process which would include collaborations with religious and non-religious spiritual support systems that are relevant to their clients (Canda & Furman, 2010). Spiritually-sensitive social workers seek to strengthen relationships among people, specifically, to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organisations, and communities (Canda & Furman, 2010). Spiritually-sensitive social workers understand that many people believe in and claim to experience relationships with frightening, supernatural, divine, transcendent, or ultimate foundation aspects of reality. Therefore, when such beliefs and experiences are important to a patient, spiritually-sensitive social workers explore how their clients' relationships with these spiritual forces may influence their sense of well-being as well as the development of meaningful relationships with other people and nature (Canda & Furman, 2010).

- ***Value: Integrity***

Ethical Principle: Social workers behave in a trustworthy manner.

It is expected of social workers to be truthful and honest at all times. This integrity is also applicable to the future development of the science, training and practice of social work (Nicholas, Rautenbach & Maistry, 2010). Social workers are required to display integrity in order to service their clients and the community honestly and professionally (Schenck *et al.*, 2015). This implies that social workers have to be truthful and aware of their own belief systems, values, needs and limitations, as well as the effect these have on their work (Nicholas, Rautenbach & Maistry, 2010). In order to promote trust, spiritually-sensitive social

workers are open and honest about their moral, professional, religious, theoretical, ideological, political, cultural, as well as other assumptions of themselves and their organisations, which are useful to the helping process (Canda & Furman, 2010). Therefore spiritually-sensitive social workers should not be biased regarding the choice of or decision on spiritual support. Thus the social worker should allow the client to provide leadership without any interference.

- ***Value: Competence***

Ethical Principle: Social workers practice within their areas of competence and develop and enhance their professional expertise.

In order to maintain this competence, and to further develop it, social workers should strive for continuous training and development, implying that there has to be an attempt to expand the knowledge base of the profession (Nicholas, Rautenbach & Maistry, 2010); for example, expanding on relevant skills, specialized knowledge, theories, tools and techniques to facilitate change. Spiritually-sensitive social workers learn how to cooperate and collaborate with community-based spiritual support systems, helpers, and healers, in a culturally competent manner (Canda & Furman, 2010; Pulla, 2014). Spiritually-sensitive social workers should aspire to contribute to the knowledge base of the profession, especially regarding innovations in spiritually-sensitive social work practice, theory, policy, research, and education (Canda & Furman, 2010). Social workers are required to possess knowledge of human behaviour and development as well as the environment (social, biological, psychological, socio-structural, economic, political, cultural and spiritual) in which their clients live and interact (Pulla, 2014). The definition of social work by the IFSW further implies that social workers need to develop their multi-cultural knowledge, as well as be attentive to how such traditions, culture, beliefs, and religious practices influence their clients (Pulla, 2014).

- ***Value: Non-judgemental and acceptance***

Principle: Social workers should maintain a non-judgemental attitude towards patients whose spirituality is diverse

Social workers should value a person in his/her own right, without passing judgment, but rather portraying a non-judgmental attitude (Schenck *et al.*, 2015). Diversity in Namibia as well as the world is inevitable; therefore spiritually-sensitive social workers should maintain a non-judgmental attitude towards any patient who appears to be diverse by accepting and

tolerating the patient's worldview on spirituality and mental illness (Schenck *et al.*, 2015; Nicholas, Rautenbach & Maistry, 2010). When patients realize that they are not judged but rather accepted unconditionally, they will be more amenable to change, as well as more cooperative with the social workers in their working relationship (Holosko, Skinner & Robinson, 2008). Additionally, they will be more forthcoming about their spirituality and what it means to them.

From a Western perspective, it is easy to disconnect spirituality from religion, thereby making secular social work customary. However, from an African perspective, spirituality is mostly connected to people's religions and traditions, thereby making it difficult for social workers in Africa to consider their clients' spirituality without considering their religion and tradition. Baloyi (2008) asserts that spirituality and religion are deeply embedded in people's traditions, based on a specific social ecology, thus making it challenging to comprehend people's *psychology* and *psychotherapy*, unless such comprehension is situated within their culture, religion, and spirituality.

2.3.4. Social work in the African perspective

The term *Social work* initially emerged in Europe and America during the 1800s and 1900s (Canda & Furman, 1999); however, social work has existed in Africa even though it was not named as such. Before each country in Africa resumed the social welfare responsibility, social needs and social problems were dealt with by family and community, both immediate and extended (Rwomire & Raditlhokwa, 1996). The family at large, as well as the neighbours, shared communal responsibilities towards one another as there was no specialised cadre of workers to manage such social problems, even poverty and diseases (Rwomire & Raditlhokwa, 1996).

With colonisation and globalisation, not only did the societies in Africa change, but it introduced another form of *Social work* in South Africa, for the first time. This form of *Social work* was predominately for the benefit of the white ethnic group in need (Mwansa, 2010). South Africa was the first country to begin social work education and training in Africa during the 1920s; however, it was predominantly a profession for the White ethnic group (Sewpaul & Lombard, 2004). Subsequently, other African universities established departments to provide professional training in the field of Social work (Rwomire &

Raditlhokwa, 1996). *Social work* as a profession, although taught at the African universities, is Western oriented (Midgley, 1981; Macpherson & Midgley, 1987; Nicholas, Rautenbach, Maistry, 2010), as it was established during, and after the colonial era.

The problem with current social work education and practice in Africa, is that the basis of education and practice was developed in the West and implemented in Africa. The basis of social work education and practice in Africa is from western cultures and philosophies that focus on capitalism and individualism, and less on collectiveness, all of which are un-African precepts (Mabvurira, 2016). In addition, colonialism disconnected people from their originality, roots, language, collectiveness, as well as their own ways of thinking, feeling, and interacting with the world (Thiong'o, 1994; Tuhiwai Smith, 2012). It further destroyed existing social structures and systems of support through the introduction of capitalist economic structures (Chilisa & Tsheko, 2014; Rankopo & Osei-Hwedie, 2010). Gray, Kreitzer and Mupedziswa (2014) argue that due to these foreign influences, social work education and practice in Africa include very little theoretical knowledge about how to integrate the traditional cultures and support systems based on collective values with African social work education and practice.

In South Africa, as well as internationally, capitalism played an important role in social change and development (Schenck *et al.*, 2015). Consequently, there was an overflow of men for employment in urban areas, leaving their women and children vulnerable and unattended. Volunteer and faith-based organisations played a significant role in meeting the social needs of families before the development of social work as a profession (Schenck *et al.*, 2015).

The first university training was offered at the University of Cape Town in 1924 (Smith, 2014). Pioneers of social work education were Professor Bateson of the University of Cape Town (representing liberalism) and Professor Verwoerd of the University of Stellenbosch (representing Afrikaner nationalism) (Smith, 2014). Noteworthy is that Namibia was initially colonised by the Germans in 1884 till 1915, and subsequently, handed over to the South African government; thereby, inheriting the South African social work education.

As mentioned earlier, South African and Namibian social work were mostly influenced and developed by European methods of practice (Mabvurira, 2016; Schenck *et al.*, 2015; Gray *et al.*, 2014; Midgley, 2008). Even though the social work curriculum at the University of

Namibia is constantly changing, it still inclines towards the Western theories and approaches due to the lack of an African-based social work approach. Westernised social work serves as a good foundation and guide; however, it is not always effective in addressing African social problems (Mabvurira, 2016). Gray *et al.* (2014) criticised Westernised social work programmes and degrees for students studying in developing countries, using the same curricula as their Western counterparts, which foster individualism and professional imperialism. Social work training, research, and practice in Africa, primarily ought to be responsive to local realities in rural communities in which collectivist cultures and values struggle to survive, as well as in urban settings where collectivist values often remain deeply embedded in the population, in constant tension with neo-colonial economic realities (Ibrahima & Mattaini, 2017). For African social work interventions to be relevant and effective to African clients, social workers in Africa need to be sensitive to the African worldview when dealing with African clients because this worldview informs the way Africans clients relate to social problems, including mental illness (Thabede, 2008; Mabvurira, 2016). Literature reveals that western models of social work practice and research have failed to address the social problems that are specific to Africa, including rural poverty, inter-ethnic conflicts, land disputes, as well as HIV/AIDS, malaria, and other communicable diseases (Midgley, 1990, 2008; Osei-Hwedie & Rankopo, 2008; Rankopo & Osei-Hwedie, 2010). Therefore, it can be argued that social work in Africa might consider how it can become more relevant and effective to African clients.

2.3.5. Social work considerations in Africa

African literature suggests that social work educators and practitioners have to be more sensitive to the African worldview when dealing with African clients. Social work in Africa requires the development of culture-specific knowledge and practice (Gray & Coates, 2010). This implies that local, empirically-based knowledge should be developed to provide culturally sensitive, and appropriate solutions to particular contexts (Gray & Coates, 2010; Rankopo & Osei-Hwedie, 2010; Simonds & Christopher, 2013), instead of standardising, or replicating Western theories, concepts, and methods (Gray & Coates, 2010; Rankopo & Osei-Hwedie, 2010). Gray, Coates and Yellow Bird (2008) further move the discourse around *indigenisation* to cultural relevance, arguing that *indigenisation* is an outdated approach as it involves adapting imported ideas to fit local needs. What is preferable is a culturally appropriate approach which accesses values and practices that are culturally genuine, and

returns to cultural and spiritual roots to seek direction, while avoiding Western social work theory and practice (Ibrahima & Mattaini, 2017; Gray *et al.*, 2008).

If social work in Africa is to decolonise and indigenise itself, practitioners should have an understanding of African traditional religion and spirituality (Ibrahima & Mattaini, 2017; Mabvurira, 2016). African literature reiterates that for African social work to be relevant and effective, it should be built on an African World view which informs the way African clients relate to social problems, including mental illness (Thabede, 2008; Ross, 2010). Baloyi (2008) asserts that people in Africa lead and experience their lives steeped in certain spirituality domains, and these beliefs are guided by their traditional practices and rituals. In non-Western societies, particularly in Africa, people's lives are structured by spirituality and aesthetics (Matsinhe, 2007). Similarly, Africans are known to be driven and influenced by their individual traditions and culture, which also influence their worldview on the understanding of their social problems (Thabede, 2008). According to Van der Walt (1997), African reality exists and differs from Western reality, which generally ignores the spiritual as well as cultural dimension of phenomena, and focuses on the visible and measurable physical reality. In addition, for African people, the physical and non-physical are equally real, drawing knowledge from both to construct their social reality (Chilisa & Tsheko, 2014; Tuhiwai, 2012).

Therefore, *Western methodologies* which underpin most social work practices and scholarships, typically acknowledge what is perceivable by the five human senses, namely, taste, touch, sight, smell, and hearing, as legitimate evidence of knowledge, and dismiss the non-visible, such as gods or spirits (Chilisa & Tsheko, 2014; Matsinhe, 2007; Sillitoe & Marzano, 2009; Tuhiwai, 2012). In Western thought, supernatural causes are not considered to be feasible explanations for phenomena, while, in African thought, supernatural causes play an important role in explaining phenomena (Van der Walt, 1997). Therefore, a decolonisation of social work methodologies requires promoting and building genuine partnerships with existing community-based systems, including kinship care, neighbourhood associations, tribal associations, and religious fellowships (Ibrahima & Mattaini, 2017). For social work in Africa to be relevant and useful, decolonisation and re-orientation of the curricula, research methods, and practice approaches, which facilitate holistic and indigenous intervention, should be mandatory (Ibrahima & Mattaini, 2017). The process of decolonisation includes:

- Revising school curricula (Osei-Hwedie & Rankopo, 2008);
- Acknowledging and promoting indigenous knowledge, emphasising a culturally centred research design (Simonds & Christopher, 2013);
- Launching culturally relevant pilot programmes that are centred on the needs at grassroots level (Botes & Van Rensburg, 2000; Chilisa & Tsheko, 2014; Zakus & Lysack, 1998);
- Exploring different ways of knowing (Tuhiwai, 2012; Weaver, 1999); and
- Developing national and local scholarly journals that publish culturally relevant research (Gray *et al.*, 2008).

In addition, the decolonisation process could be facilitated further through the development of intra-continental exchange programmes for African faculty, and the promotion of genuine relationships between the global Southern and Western countries (Midgley, 2008). However, to decolonise social work in Africa, social workers in Africa are also required to be knowledgeable of their clients' spirituality, cultures and tradition.

2.4. Social work in Africa: Clients' culture and traditional beliefs

The belief systems of African clients, though diverse from client to client, inform their behaviours as well as the approaches to identify and deal with their life challenges (Thabede, 2008). The following four sections clarify some cultural beliefs, practiced by some of the clients in South Africa and Namibia.

2.4.1. Belief in a higher supernatural power/God

Most, but not all, African tribes, ethnic groups and cultures, believe in a higher supernatural power, Ultimate Being, and to some, God (Buys & Nambala, 2003, Mbiti, 1969). In addition, some Africans have adopted different mediators in their lives to mediate between themselves and God. Ancestors are regarded as mediators by many Africans. Some have adopted the Christian faith alone, while others have adopted the Christian faith without forsaking their indigenous belief in their ancestors (Buys & Nambala, 2003; Malan, 1995).

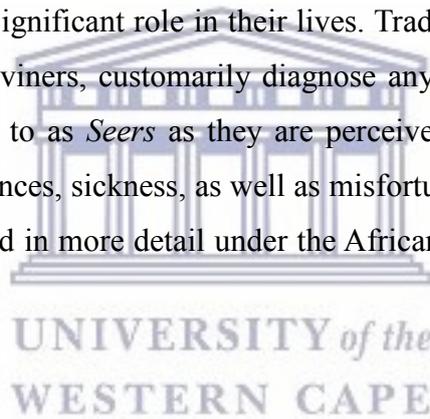
2.4.2. Belief in ancestors

Belief in ancestors is a belief in dead spirits of previous generations' forefathers, known as the *Living-dead* (Mbiti, 1969). The Ovaherero ethnic group in Namibia, as the Zulus in South

Africa, have a place for conducting prayers and rituals called *holy fire*, also known as *sacred fire* or *ancestral fire* (Immigration and Refugee Board of Canada [Nam 104027.E], 2012). This practice involves prayers and intercession to God by an appointed elder on behalf of others, through the ancestors, to deal with life's challenges, problems and traditional ceremonies. Holy fire ceremonies, reportedly, involve the use of ashes or water to purify the recipient against disorder, illness, or bad spirits (Immigration and refugee board of Canada [Nam 104027.E], 2012).

2.4.3. Belief in traditional healing

To most Africans, the belief in traditional healing embraces an understanding that bad situations are not regarded as merely natural but this is instead perceived as an external onslaught on the person, often caused by witchcraft, bad spirits, or even ancestors (Thabede, 2008). For social workers in Africa, this belief might be real or not, but to most African clients, it is real, and plays a significant role in their lives. Traditional healers, also known as herbalists, witchdoctors, or diviners, customarily diagnose any condition or problem (Ross, 2010). They are also referred to as *Seers* as they are perceived to see the causes of death, future incidents and circumstances, sickness, as well as misfortune (Ross, 2010). The work of a traditional healer is discussed in more detail under the African approaches to mental illness in section 2.8.



2.4.4. Animistic belief

This is the belief that the spirit of nature is found in certain mountains, hills, rivers, lakes, stones, trees, plants, animals and birds, which form part of the community of life (Ross, 2010). In Namibia, the Damara believe that their original ancestors emerged from a cleft rock; while the Herero and Ovambo people believe that their ancestors, as well as their livestock, emerged from the leadwood tree (*Combretum imberbe* or *omumborombonga* in Otjiherero). The people in the Kavango, Zambezi and South-Eastern Angolan regions (for example, the Mbukushu), however, believe that their ancestors, as well as all the other peoples, originated at the Tsodilo mountain in the extreme north-western corner of Botswana (Buys & Nambala, 2003; Malan, 1995). Therefore, it is important for social workers to be aware of the diverse beliefs in the Namibian community, as each belief might have a different influence on the behaviour of a particular client, followed by different rituals. As an example, the Kavango people might want to visit a specific mountain for spiritual and physical healing,

while the Hereros might want to eat leaves from certain trees for their spiritual and physical healing.

In the light of the above-mentioned African beliefs, the client has to feel really safe and respected by the social worker, to share his/her personal belief, which might be regarded as irrational by some. In addition, social workers have to be familiar and considerate of the traditional religious beliefs of their African clients in order to respond to the existential and spiritual aspects of the problems their clients may be experiencing (Thabede, 2008; Ross, 2010). The cultural and traditional beliefs of African clients, therefore, have implications for the African social work practice and education.

2.5. Implications on social work practice and education in Africa

Bhagwan's (2011) study that was conducted in South Africa with social work educators on the exploration of educators' perceptions, views and experiences of spirituality in pedagogy, revealed that spirituality should be integrated in the social work practice. In addition, the study revealed that while South African social work education embraces cultural diversity, a greater understanding of Africans is required, and therefore, should feature strongly in social work education. Bhagwan (2002) concurs that an understanding of spiritually grounded interventions which embrace traditional healing practices is important in working with traditional healers as much of the local population has moved towards using indigenous therapies in times of crisis. As emphasised earlier regarding the reality of witchcraft, traditional healing and ancestors in the lives of Africans, social workers need to acknowledge, and understand these practices by allowing these believers to follow their beliefs without passing judgment (Thabede, 2008; Ross, 2010). An example could include allowing the individual to attend cultural rituals, including witchcraft, traditional healing, and ancestral-worship, as part of the treatment plan, which implies that social workers should incorporate the African world view as a significant part of the knowledge base and practice, with current Western intervention theories and practices (Thabede, 2008). Social work education should also expose social work students to the individuals who would most likely be consulted to assist with clients' problems during the caring process, namely, family members, traditional healers, traditional leaders, pastors, elders, and neighbours, and not only Western-trained professionals. This early exposure would prepare graduates to know how to collaborate with them as sources of referral (Ross, 2010).

In the light of the above discussions, for social workers to be spiritually sensitive to deal with multi-cultural and multi-spiritual contexts, a decision to increase the development of African-based social work is required. As this current study explores the context of mental health settings, the discussion on social work and mental health is relevant. Social work and mental health in Namibia is based on Western education, therefore, it is vital to explore mental illness from a Western perspective, as well as an African perspective.

2.6. Mental illness from a Western perspective

Mental illness can affect anyone, even if it is perceived differently, in terms of context and culture. The Western perspective on mental illness was not much different from the African perspective until the 19th century, according to Agbayani-Siewert, Takeuchi and Pangan (1999). Before the 19th century, people who suffered from mental illness were regarded as *mad people*, as the concept, *mental illness*, did not exist then (Agbayani-Siewert *et al.*, 1999; Foerschner, 2010). *Mad people* were perceived to be the result of conflict with external supernatural phenomena, such as evil forces, as well as conflict with the deity (Jutras, 2017; Agbayani-Siewert *et al.*, 1999; Foerschner, 2010), which is similar to what most Africans still currently believe is the case. The approaches that were used to deal with such people were very harsh and inhumane as the afflicted were rejected by their own families, communities, as well as the state, and they would wander away, or be imprisoned (Agbayani-Siewert *et al.*, 1999; Foerschner, 2010). With modernisation in the United States of America, when an agricultural economy evolved to an industrial economy, the perception that mental illness was caused by supernatural forces shifted to individual moral blame (Agbayani-Siewert *et al.*, 1999, Jutras, 2017). In the late 18th century to the early 19th century, a psychodynamic perspective was developed by Freud, viewing mental illness as a product of the interplay of unresolved unconscious motives (Jutras, 2017; Foerschner, 2010), implying that the causes of mental illness shifted from being of an external nature to that of internal origin. This theory brought about a change of thought as mental illness started to be perceived as a disease and not as a result of supernatural forces, or individual morals (Jutras, 2017). Consequently, the need to systematically categorise mental illness, became necessary (Kawa & Giordano, 2012; Jutras, 2017).

Between the 19th and 20th centuries, psychiatry's perception of mental illness as a universal

phenomenon began evolving towards a scientific medical model of mental illness which explained mental illness scientifically (Jimenez, 1988; Pilgrim & Rogers, 1993). In 1952, a Diagnostic and Statistical Manual of Mental Disorders (DSM) was formulated (Kawa & Giordano, 2012; Judras, 2017). The DSM is used by clinicians, psychiatric researchers, as well as psychology and social scientists for different purposes; however, its main purpose is to provide a description, assessment and classification of different mental disorders (Kawa & Giordano, 2012; Van Rensburg, Poggenpoel, Myburg, Szabo, 2012; Judras, 2017). The DSM was created because mental disorders were perceived as being bio-medically oriented, and therefore, needed to be described and explained bio-medically. Another view was that a standard manual needed to be created because mental illnesses were manifesting uniformly, and affecting people universally (Agbayani-Siewert *et al.*, 1999, Jutras, 2017; Kawa & Giordano, 2012). The continuous amendments to the DSM, from DSM 1 to DSM 5, as updated in 2013, confirms that the DSM, indeed, could not fit all mental illnesses into a standard classification and assessment without considering multi-cultural factors including differential diagnosis of religion, spirituality and psychopathology when assessing mental disorders, as discussed next. (Turner, Lukoff, Barnhouse & Lu, 1995; Lukoff, Lu & Turner, 1998; Scott, Garver, Richards & Hathaway, 2003; Agbayani-Siewert *et al.*, 1999).

2.6.1 DSM-5 differential diagnosis of religious/spiritual problems and psychopathology

Religion and spirituality is regarded as important in the lives of those who are mentally ill (Baetz, Griffin, Bowen & Marcoux, 2004; Koenig, 2012) though religion and spiritual experiences have often been perceived as symptomatic of psychopathology by some clinicians (Lukoff, 2005). Nevertheless, the DSM-IV considered religion and spirituality as part of culture (Prusak, 2016), thus, introduced the category “Religious or Spiritual Problem” in the DSM-IV and this was further retained in the DSM-5 (American Psychiatric Association (APA), 2013). Again, this category was introduced due to increasing cultural sensitivity towards the issue of spiritual and religious experiences (St. Arnaud, & Cormier, 2017). Although the inclusion of religion and/or spirituality in psychotherapy may belong to the patient’s preferences, clinicians are ethically obliged to assist the patient in such a way which takes into account the cultural and religious context (Prusak, 2016).

The introduction of this category, also known as V-Code 62.89 has improved the likelihood of differential diagnosis between religion/spirituality and psychopathology/mental illnesses

(Prusak, 2016). Meaning that there is a differential diagnosis between religious and or spiritual problems from psychopathology that present spiritual content or psychopathological problems associated with religious and or spiritual problems (Prusak, 2016). The guidelines of the APA (2013) require clinicians to come up with a differential diagnosis between religious or spiritual problems that are unrelated to mental disorders and those that either co-occur with symptoms of such disorders (but with no causal relationship) or are factors which trigger or support an individual pathology. The following case example requires differential diagnosis; a patient with psychotic disorders presents with delusion of being a Higher Deity or receiving orders directly from the Higher Deity; A cultural bereavement, whereby a person deeply affected by death may experience being visited by the dead or yearning to restore a relationship with the dead. Such experiences can be diagnosed as having schizophrenic symptoms, while in that particular culture such experiences can be regarded as normal responses to their spirituality during the bereavement period. Prusak (2016) states that in each of these cases, the V-code 62.89 can be used and included in the diagnosis either (a) independently, (b) next to the diagnosis of a mental disorder or (c) within the diagnosis of the disorder if its symptoms have a religious or spiritual content. Similarly, the V-Code 62.89 can be used “when the focus of clinical attention is a religious or spiritual problem. Examples include distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values that may not necessarily be related to an organized church or religious institution” (APA, 2013, p. 725).

The DSM-5 thus, offers an expanded understanding of culture and its impact on diagnosis (Prusak, 2016). Furthermore, the inclusion of this category in the DSM has opened clinicians to the possibility of assessing religious and spiritual experiences as part of their psychological or psychiatric assessments without prejudging such experiences as inherently pathological (Johnson & Friedman, 2008; Menezes & Moreira-Almeida, 2010).

Mental illness as defined in Chapter one is any disease, or condition that influences an individual’s moods, as well as the way s/he thinks, behaves, and/or relates to others and his/her surroundings (Mayo Clinic, 2015; Health Direct, 2018; WHO, 2012; 2018). Mental illnesses include depression, anxiety disorders, bipolar disorder, schizophrenia, eating disorders and addictive behaviours (WHO, 2018). In most cases, the symptoms of mental illness could be managed by a multi-disciplinary team, including social workers, with

treatment that includes a combination of medications, counselling (psychotherapy), occupational therapy and psycho social interventions by social workers (Health Direct, 2018; WHO, 2012; 2018). However, the factors that contribute to mental illness may vary from person to person, given the social-cultural diversity in society, the community and groups.

2.6.2. Possible contributing factors to mental illness from a Western perspective

Multiple factors can contribute to mental illness, including:

- *Genetics*: Individuals whose parent/s has/have suffered from a mental illness maybe be susceptible, which implies that the parent/s may transmit the mental illness to their children through genes (Mayo Clinic, 2015; Health Direct, 2018; WHO, 2012; 2018). It is important to note that when a parent has suffered from a mental illness it is not conclusive that their offspring will suffer from a mental illness but rather that the offspring, more than likely, have a trigger to the mental illness, as it could be hereditary.
- *Biological*: Some mental illnesses develop as a result of an abnormal balance in the brain's chemicals called neuro-transmitters (Mayo Clinic, 2015; Health Direct, 2018; WHO, 2018). Factors such as brain damage due to a car accident or substance abuse can cause the brain chemicals to be out of balance, or not to work properly. Messages may get through the brain incorrectly leading to symptoms of mental illness (Mayo Clinic, 2015).
- *Psychological trauma*: Some mental illnesses may be triggered by psychological trauma, due to an incidence, such as severe emotional, physical, or sexual abuse; a significant early loss of a loved one, accidents, as well as being exposed to crime (Health Direct, 2018; WHO, 2018).
- *Social and environmental stressors*: Stressors such as severe poverty, sudden social changes, death or divorce, a broken family life, drastic job change, or schools, and substance abuse, may trigger a disorder in a person, who may be at risk of developing a mental illness (Mayo Clinic, 2015; Health Direct, 2018; WHO, 2012; 2018).
- *Personal factors*: An unhealthy lifestyle like alcohol and drug abuse as well as physical illnesses, like HIV/AIDS, may trigger a mental illness (Health Direct, 2018; WHO, 2012; 2018).

2.7. Mental illness from an African perspective

Mental health professionals practicing in Africa are Western trained; however, an understanding of mental illnesses in Africa is important, for effective and useful interventions with mentally ill patients. While in the Western perspective mental illnesses are mainly classified according to the DSM based on the identified symptoms and behaviours (not causes), in the African perspective traditional healers have their own ways of identifying and explaining the causes of mental illnesses (Patel, 1995). Their explanations include exogenous factors such as *God-given*, witchcraft, a curse, hereditary causes, spirit possession, poisoning in a dream, broken relationships and disrespect of elders, angered ancestors, evil eye and sorcery (Patel, 1995; Muchinako, Mabvurira & Chinyenze, 2013; Mabvurira, 2016). These concur with other African literature which asserts that disturbed or broken spirituality contributes to illnesses including mental illnesses (Sow, 1980). According to the African world view, an individual suffers from a mental illness because of conflicting and broken social relationships with either the macro-, micro- and/or meso-cosmos (Onyango, 2011). The macro-cosmos is the sphere, in which the Supernatural Being, also known to some as God, is experienced (Sow, 1980), therefore, a disturbed relation with God could contribute to physical or mental ill-health (Onyango, 2011). The micro-cosmos is the sphere in which the individual exists in the context of collectiveness and togetherness, while, the meso-cosmos is the sphere in which ancestors are experienced (Sow, 1980). Some Namibian ethnic groups, namely the Ovambo and Ovaherero, may develop some psychological distress due to disturbed relationships with their ancestors (Bartholomew, 2015; Kgatla & Park, 2015). It is believed that when an individual hears the ancestors or voices, s/he has to speak to the elders. This practice would involve an appointed elder who would pray and intercede to God or the supernatural on behalf of the individual hearing the voices through his/her ancestors, to deal with the identified problem. Failing to respond to and silence the voices of the ancestors would lead to ongoing voices being received from angered ancestors (Bartholomew, 2015).

Therefore, any conflict with relations, nucleus and extended family members, refers to conflict with the micro-cosmos, and conflictual relationships with ancestors refer to conflict with the meso-cosmos (Sow, 1980), which could lead to ill health, including mental illness (Onyango, 2011). Similarly, mental and physical illnesses could be caused by conflict between an individual and the ancestors, or a god, witches and spirits; however, they could also be attributed to natural causes or a breakdown in human relationships (Ross, 2010). In rural Kenya, human agency, namely, witchcraft, was initially identified as the cause of mental

illness, and when it persisted and remained incurable, despite the traditional healing, the supernatural, also known as God, was identified as the initiator, in whose hands the healing was perceived to be (Patel, 1995). Similarly, in Namibia, the Ovambo believe that being bewitched by other Ovambos or experiencing a disconnection with the ancestors prompts the onset of mental illness (Bartholomew, 2015). In addition, Kgatla and Park (2015) reveal that the belief that stealing from others, or touching other people's things, is another avenue through which an individual could be cursed to become mentally sick. Onyango (2011) asserts that the guilt and worry of not adhering to these cultural norms could cause mental and physical illness. From an African perspective, the cause of an illness or misfortune in many cases is due to factors that are external to the client; unlike Western views in which the responsibility and agency are located internally, within individuals (Thabede, 2008; Ross, 2010). These external causes are believed to have humans, and supernatural and ancestral spirits, as agents of diseases of various kinds (Onyango, 2011).

The African experience of psychological distress becomes abstracted from the individual and ascribed to an external force, weighing on and determining the maladaptive behaviours of the person, because the African belief is that mental illness is never a clinical problem (Bartholomew, 2015). The interconnectedness of the phenomenal world and spirituality are two major aspects of the African worldview that deal with ill health, and causes of ill health and healing (Kgathla & Park, 2015; Onyango, 2011). Similarly, according to Baloyi (2008), the spiritual dimension of the African understanding of reality is that *God* is always linked to all attempts to explain experience, including the healing of affected individuals. Baloyi (2008) further asserts that illness from an African perspective is perceived as a spiritual affliction manifesting itself in physical pain or sentimental discomfort, and healing can only be complete if both the spiritual and the physical aspects of the illness are treated. Therefore, as social workers in mental health settings, the integration of both African- and Western-trained approaches to mental illnesses have the potential of fostering relevant and effective treatment programmes with the likelihood of positive outcomes (Thabede, 2008; Ross, 2010).

Mufamadi (2009, p. 33) posits that the traditional way of healing addresses a human being holistically including the soul, the biological, moral, psychic, subconscious, spirit and physical, which has sustained many Africans for ages. Therefore, disregarding the traditional ways of healing or forms of health care would render treatment plans ineffective, irrelevant and incomplete. Shizha and Charema (2012, p. 62) aver that western medicine in isolation

cannot detect, prevent, solve, or treat the multiple aspects of spiritual, psychosocial and psychological illnesses; therefore, an integration of both Western and African traditional approaches is crucial.

2.8. African approaches to mental illness

As earlier mentioned, the African world view is that the cause of any illness or misfortune in many cases is the result of external causes and forces (Ross, 2010), with human, supernatural, and ancestral spirits as agents of diseases of various kinds (Onyango, 2011). In South Africa, when asked about their reasons for consulting traditional healers for healing, the responses have been as follows: *dissatisfaction with treatment received; traditional healers understand and have a close association with their cultural, religious and spiritual beliefs and practices; and traditional healers speak their language, spend time with them and provide culturally relevant explanations for their health conditions* (Ross, 2010, p. 47). In Namibia, even though the mental hospital and treatment is without charge, access is limited as there are only two mental hospitals in Namibia that are far from those in need of care. The people are aware of the hospital services and that counselling is available. Medication and injections are provided at the hospitals with scant explanations to patients regarding the reasons for the medication, while those treated for mental, or physical illnesses are barely informed of their diagnoses (Bartholomew, 2015). Consequently, patients prefer directive treatments or mostly externally oriented methods by their traditional healers because they believe in traditional healers and traditional rituals (ritual cleaning, enactment, sacrifices), and also receive explanations for their illnesses. However, internally oriented healing methods such as scarification, or making bodily incisions, aromatherapy, vomiting and purging, are also used but mostly for their perceived function of keeping evil spirits, witches, as well as bad luck away from their daily lives in the community (Meyer, Moore & Viljoen, 2003). Apart from Western medicine, it has been established that traditional medicine has several benefits including emotional and physical pain relief, through a shared and undoubted belief in the powers of the healer (Ross, 2010).

The African worldview maintains a holistic approach to healing that comprises spiritual, psychological and physical aspects of mental illness (Onyango, 2011). Similarly, Ross (2010), as well as Mufamadi (2009) posit that the treatment provided by healers other than Western trained healers is viewed as holistic because it targets the mind, body and soul of

patients in their families, communities and multi-cultural contexts. Most Africans have a different understanding of mental illness and its contributing factor, therefore, they also consider different methods of dealing with mental illnesses.

2.8.1. Physical methods

- **Dancing**

This involves interpersonal interactions like dancing with the patient around the fire at night to the beat of drums (Onyango, 2011). The activities usually involve only close members of the family and the patient may, or may not, join in the dance, depending on his/her condition. During African traditional healing ceremonies, the dynamics of human relationships in collaboration with the clients' significant others, are crucial for the healing (Onyango, 2011). According to Comaroff (1980), it is expected that these group activities of dancing would assist in reconstructing the client's physical, social and spiritual environments, as well as the building and restoration of broken relationships.

- **Herbal extracts**

Traditional healers use herbal extracts that are mixed with other liquids, during the healing ceremonies. Rauwolfia, which is rich in reserpine, is an example of a plant with psychiatric medicinal properties which has been used for the treatment of severe psychotic conditions since 1925 (African Technology Policy Studies Network [ATPS], 2013). This plant is found, as an ornamental plant, in many parts of Kenya and Tanzania, especially around the Mount Kilimanjaro area where it grows in the wild (ATPS, 2013). It is renowned for the treatment of *madness*, which is psychosis, regardless of the cause, or type (ATPS, 2013). The Ovaherero people in Namibia use a mixture of various herbs, ocean animals and fish, and a greasy substance called *inyamazani*, which is known as a traditional herb or root (Kgatla & Park, 2015). Traditional healers usually deposit a small portion onto charcoal and burn it. Subsequently, the *inyamazani* is inhaled as smoke. When it starts to smoke, the individual who is receiving treatment kneels down and inhales the smoke to chase the evil spirits away (Kgatla & Park, 2015).

In addition, herbal extracts are given to clients to drink, wash with, or sprinkle around in the house (Onyango, 2011). The knowledge of these herbs and ways to mix them is passed on to younger generations, who, after years of training, eventually become healers. The healers, customarily, make body incisions to administer the herbal treatments directly into the blood stream, according to Peltzer and Bless (1989).

2.8.2. Spiritual methods

- **Rituals**

Another approach to healing in the African worldview is the use of rituals. According to Mporu (2006), ritual enactment is one approach of traditional healers to cast away unwanted spirits that cause ill-health. For the Ovambo people in Namibia, at the start of the ritual, the healer makes a natural connection with the ancestors who have the ability to speak through the healers, while wearing specific clothes to facilitate this connection (Bartholomew, 2015). Rituals may differ among ethnic groups; however, the purpose is the same, which is, an attempt to maintain peace and harmony between the living and the spiritual world, especially the spirits of the ancestors who are believed to live on after death as well as still influence events in the living world (ATPS, 2013).

- **Cleansing**

In some cultures in Namibia, the close relatives gather in the village where a sheep is slaughtered. Subsequently, the patient is cleansed with the blood of the sheep to deliver him/her from pursuing evil spirits (Kgatla & Park, 2015). According to Onyango (2011), the cleansing treatment is performed to remove the causes of presenting problems, or ill health from inside or outside the body, as well as the environment of the patient. Besides cleansing, the burning of incense is used to drive away evil spirits from homes especially those of sick people (Onyango, 2011).

2.8.3. Psychological methods

- **Seeing and naming-counselling**

In contrast to the Western approach to healing, with the onus on the client to inform the healer/therapist of his/her reason for the appointment, in the African traditional healing approach, the healer names the problem and recommends the steps to follow in the healing process (Onyango, 2011). Therefore, the healer, who is also the seer/prophesier, identifies the problem, as revealed by the divinity, ancestors, or spirit consulted about the client's predicament, subsequently seeking confirmation from the client. In addition, the healer identifies the root cause or origin of the problem (where it comes from, and who is causing it). Negative events are explained and personifications are provided, followed by an initiation of the client to enter the treatment process (Onyango, 2011). In the naming process, the

ancestors of the client and the healer become part of the healing intervention in the world of the living (Onyango, 2011). Depending on the client's personal belief and spiritual conduct, even without much explanations from the healer, s/he may experience a decline in the symptoms, following a naming procedure; therefore, the act of naming could be considered therapeutic (Torrey, 1986).

- **Dreams**

Traditional Africans believe that dreams affect the daily lives of people in various ways, causing illness, or misfortunes at home, work, as well as in relationships (Onyango, 2011; Ross, 2010). The healers interpret the dreams and prescribe the treatment, or rituals to be performed, for the appeasement of the angry ancestors, or to cure the illness caused by the evil spirits (Onyango, 2011).

In summary, the approaches to healing, from an African perspective or worldview vary depending on the *state of debilitation*, or *symptom presentation* (Onyango, 2011). The healing approaches deal with presenting problems that vary from acute health, social, economic problems, and chronic health, to troubled spirits which require a holistic approach, including physical, spiritual and psychological methods (Onyango, 2011).

2.9. The importance of spirituality to mentally ill patients

Many patients, even in Western cultures, value attention to spirituality in their treatment plan. Those individuals suffering from serious mental illnesses would like their spiritual beliefs, values and practices to be considered and included in their overall treatment plan as well as recovery process (Baetz, Griffin, Bowen & Marcoux, 2004; Coyle, 2001). This is further confirmed by D' Souza (2002), who surveyed 79 patients diagnosed with mental illness in Australia and observed that 70% rated spirituality as very important in their lives, with 67% reporting that their spirituality helped them to cope with their psychological pain, and 69% reported that their spiritual needs should be considered by the health care providers who were treating their mental illness. The reasons for the importance of spirituality to mentally ill patients could be that it attaches meaning to their life challenges, offers them strength to cope with their circumstances, as well as hope in a hopeless physical condition (Saleebey, 1992b; Koenig, 2012).

2.9.1. Coping mechanism

Spirituality is a coping mechanism for many people who deal with emotional disorders, mental illness, and stress, in general (Puchalski, 2001; Koenig, 2012). An individual with a mental illness faces rejection, stigma, victimisation, and isolation by family members and society, while some lose their jobs because of their mental illness (An interview conducted on September 17, 2015, with R. Dipura, Namibian social worker). Therefore, patients adopt spirituality, for example, their beliefs, to cope with illness, pain, and life's stresses (Puchalski, 2001). Similarly, D' Souza's (2002) study in Australia observed that 67% of the respondents who regarded spirituality as important in their lives reported that their spirituality helped them cope with their psychological pain. Poor coping abilities adversely affect medical outcomes in terms of lengthening the hospital stay as well as increasing mortality (Koenig, 2012); while those who are spiritual tend to display a positive outlook and enjoy a better quality of life ((Puchalski, 2001).

2.9.2. Meaning and purpose

Spirituality offers a different viewpoint from which to make sense of life's challenges (Canda & Furman, 2010). Afflictions and other challenges are explained in the patients' cultural context; therefore, spirituality helps patients find meaning and purpose in their life experiences and challenges (Puchalski, 2001; D' Souza, 2002; Koenig, 2012).

2.9.3. Reduction of symptoms

Spirituality helps to reduce symptoms. As mentioned earlier, some African patients' personal beliefs and spiritual conduct may facilitate a reduction in symptoms following a naming procedure even without much explanations from the traditional healer (Torrey, 1986). Similarly, in the Western perspective it has been observed that spiritual commitment enhances recovery from illness and surgery, reduces symptoms for people with schizophrenia, depression and anxiety disorders, and lowers the rate of suicide and substance abuse (Puchalski, 2001; Young, 2012; Bellamy *et al.*, 2007; Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003; Koenig, McCullough & Larson, 2001; Plante & Sharma, 2001).

2.9.4. Contributes to the recovery process

Sullivan's (1992b) study of 40 adults with serious mental illnesses observed that spiritual beliefs were a critical factor in the recovery process of 48% of the sample. The participants

indicated that their spiritual beliefs had helped them to manage their problems and served as a means of social support in the form of attendance at religious gatherings (Walsh, 1995). In addition, spirituality encourages and enhances positive thinking as well as emotions such as awe, love, joy, hope, faith/trust, forgiveness, gratitude and compassion, which offer many mental and physical benefits (Puchalski, 2001; Canda & Furman, 2010; Holloway & Moss, 2010; Snyder & Lopez, 2007). Good feelings and emotions also have a good effect on the body as a whole, despite the challenges faced. They may act as signals for the body's immune and recuperative responses (Saleebey, 1996), as, when people believe that they can recover, according to their strongly held beliefs, their bodies often respond optimally (Puchalski, 2001; Saleebey, 1996). Therefore, given the importance of spirituality to mentally ill patients, social workers in mental health settings have particular roles to fulfil in fostering spiritually sensitive social work.

2.10. The roles of social workers in the mental health settings to foster spiritually sensitive social work

2.10.1. Assessment and exploration of the patient's spiritual perspective

To understand the patient's spiritual perspective, spiritual assessment becomes necessary (Koenig, 2012; Hodge, 2004; 2006). However, an assessment of the patient's spirituality becomes relevant only when the patient regards spirituality as an important aspect of his/her treatment plan because some patients might not want their spiritual perspectives incorporated. Therefore, talks around spirituality should be initiated by the patient and not the social worker (Bricker-Jenkins, 1992; Saleebey, 1992b). Alternatively, a patient might not be aware that s/he is allowed to talk about his/her spirituality; therefore, the social worker could also explore the patient's spirituality to help him/her speak freely. Should spirituality be pertinent, the social worker should ask the client to describe his/her spiritual perspective, how it developed since childhood, and how relevant it is to the current situation, as well as future possibilities for growth (Hodge, 2004; Koenig, 2012). Subsequently, the social worker should consider the spiritual and religious aspects of the patient's needs, strengths, resources, and goals, as well as the relevant aspects of his/her environment (Saleebey, 1996; Glickens, 2004; Kisthardt, 1992, Weick, 1992). Once the social worker knows what the patient's spiritual perspective or needs are, the social worker should explore it to gain a clearer understanding about it. The social worker should contact community leaders and traditional healers in the relevant tradition, and request information and personal stories about how this

spiritual perspective can offer aid, or resources that could be of direct, or indirect benefit to the patient (Ross, 2010).

2.10.2. Advocate

Social workers often represent, or speak on behalf of individuals, groups and communities, advocating for their rights (Schenck *et al.*, 2015). Particular attention is allocated to advocacy on behalf of individuals and cultural, or religious groups, who are the target of oppressive, discriminatory, and prejudicial attitudes, practices, and policies, because of their spiritual beliefs (Canda & Furman, 2010; Nicholas, Rautenbach & Maistry, 2010). In mental health settings, working in a multi-disciplinary team, spiritually sensitive social workers fulfil the role of advocate for the patients' spiritual needs to be considered in the treatment and recovery process, should a particular patient indicate the need for such consideration.

2.10.3. Referrer, linker, facilitator, educator

Social workers are not trained to be spiritual workers; therefore, it is not in their scope of practice to act as such. Should there be a need for the patient to be *linked* to his/her spiritual source for support and/or strength, the social worker should *facilitate* the appropriate *referral* to the spiritual source of help on behalf of the patient (Koenig, 2012; Schenck *et al.*, 2015; Nicholas, Rautenbach & Maistry, 2010), or include the spiritual leader as part of the multi-disciplinary team. This also implies calling in such support to come to the patient. Should a patient wish to connect to his/her ancestor, the social worker should consider the release of such a patient to travel to his/her homestead or village for such a traditional practice. However, before releasing the patient, the social worker should facilitate several *educational* meetings with the patient and the family to educate them on the illness as well as the importance of medication for the body, in addition to the traditional methods.

2.10.4. Counsellor

The social worker fulfils the role of a counsellor to assist individuals, groups, and communities to reach their psycho-social competence (Schenck *et al.*, 2015). In this role, the social worker explores the patient's spirituality to help him/her to speak freely, and further encourage the patient to believe in him/herself, while emphasising that s/he knows him/herself better than an outsider (Schenck *et al.*, 2015). During the counselling, the social worker fosters the patient's self-actualisation, and allows him/her to rediscover who s/he is, as well as what is best for him/her (Schenck *et al.*, 2015).

2.10.5. Mediator and negotiator

The social worker should resolve misunderstandings through mediation among the patient systems (Schenck *et al.*, 2015). In addition, the social worker should mediate between the patient and his/her family regarding the patient's treatment plan. The social worker should also negotiate between the patient's different systems to reach a workable consensus; for example, if the patient is suicidal, and one of the possible causes is family conflict. Finally, the social worker should mediate between all possible parties involved, and negotiate better and workable solutions in the interest of all parties.

2.11. Summary of the chapter

This chapter comprised the discussion on the understanding of the concept of spirituality, and the difference, as well as the link between spirituality and religion from Western and African perspectives. Spirituality and social work were also discussed by exploring Western as well as African perspectives. Similarly, mental illness and its approaches were explored from Western and African world views. The importance of spirituality to mentally ill patients and the role of spiritually sensitive social workers in mental health settings were presented. Therefore, in this chapter, the researcher highlighted the Western and African perspectives in the comprehension of spirituality, mental illness and social work practice. The main objective was for enlightening how social workers in Africa have to be considerate and sensitive to the African worldview on the subject matter, in order to render relevant and effective African-based social work services, to meet some African clients' needs, even though the social workers themselves may have been Western trained.

CHAPTER THREE

CONCEPTUAL FRAMEWORK

3.1. Introduction

In order to explain and interpret the phenomenon under study, the researcher employed a conceptual framework, rather than a theoretical framework for this current research project. A theoretical framework refers to the theory that a researcher selects to guide the research (Imenda, 2014; Maxwell, 2005), and includes theory application as well as a set of elements and principles drawn from one theory to explain a phenomenon (Imenda, 2014; Creswell, 2013). Spiritually-sensitive social work to deal with mentally ill patients involves the understanding of more than one concept and dimension; therefore, it cannot be explained and interpreted by one single theory due to the different components it entails. Consequently, the researcher had to employ an integrated way of exploring the phenomenon (Lier & Smith, 1999; Imenda, 2014; Creswell, 2013), and a conceptual framework was selected (Imenda, 2014). A conceptual framework is defined as an end result of integrated related concepts to explain and provide a broader understanding of the phenomenon under study (Imenda, 2014; McGaghie, Bordage & Shea, 2001).

Therefore, the researcher based this current research on a postmodernist interpretive framework to denote the study, specifically using social constructionism as the foundational framework for the study, while avoiding the modernistic medical model of explaining mental illness, and including Western as well as African perspectives of mental illness. A postmodernist belief in science generates a truth reality that is communicated by all humans which advocates that there is no ultimate truth but instead a socially constructed truth based on individuals' realities, worldviews, perceptions, and experiences (De Vos *et al.*, 2012). The basic principal of social constructionism is that knowledge is constructed through social interaction, and is the result of social processes (Gergen, 1995). Social constructionists maintain that no single objective perception or explanation of the world or reality is possible; instead, there are multiple belief systems and perspectives, multiple ways of viewing and explaining the world as influenced by an individual's own worldview, perceptions, values, cultures, contexts and experiences (Berger & Luckman, 1966). Additionally, social constructionism claims that reality is constructed through the use of language in interaction with others, and is primarily influenced by history, society and culture (Teater, 2015). Therefore, social construction, relative to the topic under scrutiny, can be illustrated in the

diverse perceptions of spirituality and mental illness. Namibian people have diverse spiritual and religious practices, which influence their construction of the realities of mental illness and the treatment thereof. Spirituality and religion help individuals to make sense of the world around them, and to provide explanations for mental illnesses, as well as the treatment thereof; thereby, constructing their own truth on the subject matter. These social constructions, therefore, shape individuals' reasoning, views, values, and behaviours. Consequently, in this current research, no ultimate theory, reality, or perspective can define them in a single approach as this study comprises multiple realities which need to be unpacked by multiple perspectives.

Schiele (2000) argues that no one theory is adequate to explain all human functioning. Therefore, the researcher selected theories based on the concepts that emerged from literature studies, including, searching for meaning and spirituality as strength. Four theories, namely, the Ecosystem Theory, Person Centred Approach, Afrocentric Perspective, and lastly, the Strength Perspective were observed to fulfil complementary roles in the comprehension of spirituality and social work in the African context of mental illness. Therefore, the manner in which these particular variables connect with each other within the various perspectives and approaches are discussed further in order to provide a broader understanding of spiritually-sensitive social work with mentally-ill patients. Prior to this discussion, an understanding of the concept of social work is essential as all the concepts and variables that are discussed form part of the fundamental components in social work practice.

3.2. Definition of social work

The International Federation of Social Worker's (IFSW) definition of social work adopted in 2000 states that the social work profession promotes social change, problem solving in human relationships, and empowerment, as well as the liberation of people, to enhance well-being. Utilising the theories of human behaviour and social systems, social work intervenes at the junctures where people interact with their environments. The principles of human rights and social justice are fundamental to social work (Virginia Commonwealth University Libraries Social Welfare History Project, 2016). The IFSW further states that social work practice, in addressing the barriers, inequities and injustices that exist in society, also responds to crises and emergencies, as well as everyday personal and social problems. Social work utilises a variety of skills, techniques, and activities, consistent with its holistic focus

(which includes physical, mental and spiritual dimensions), on persons and their environments (Virginia Commonwealth University Libraries Social Welfare History Project, 2016).

From the Social work definition above, the International Federation of Social Workers [IFSW] (Virginia Commonwealth University Libraries Social Welfare History Project, 2016) and the International Association of Schools of Social Work (IASSW, 2004) suggest that social workers should have knowledge of human behaviour and development, as well as the environment, including the social, biological, psychological, socio-structural, economic, political, cultural and spiritual environment, in which the clients reside, and with which they interact. In addition, the definition of Social work by the IFSW implies that social workers need to develop multi-cultural knowledge as well as how such traditions, cultures, beliefs, religions and practices affect their clients (Pulla, 2014).

The current study aimed to develop guidelines for social workers to be spiritually sensitive in their work with mentally ill patients in Africa. Therefore, including an Afrocentric perspective as part of this study's conceptual framework is essential in order to explore the African understanding and worldview, in underpinning the subject matter.

3.2.1. The Afrocentric perspective

Molefe Kete Asante is one of the pioneers of the Afrocentric perspective. The origin of an Afrocentric world view is found in traditional African history, before the advent of European and Arab influence (Mabvurira, 2016). The Afrocentric perspective implies that any phenomenon or situation is viewed from the perspective of the African person, based on African norms and values (Asante, 2003). Additionally, Afrocentrism is defined as a quality of perspective, or approach that is rooted in the cultural image and human interest of African people (Karenga, 1988, p. 404). According to Olaniyan (1992), the Afrocentric perspective is further viewed as an ethnocentric ideology which emphasises prominence of all things African, and attempts to grant Africans their rightful place in the world. An essential element of the Afrocentric perspective is that it recognises the centrality of spirituality in the lives of African people and serves as an alternative approach to understanding and analysing African communities (Mabvurira, 2016). The basic focus of the Afrocentric perspective is that Africans must define their reality, based on their worldview (Mabvurira, 2016).

3.2.1.1. Principles of the Afrocentric perspective

According to Williams (1993), the Afrocentric perspective has four values: the Afrocentric cosmology, the Afrocentric axiology, the Afrocentric ontology, and the Afrocentric epistemology.

- The Afrocentric cosmology refers to a world view that is the foundation of African thinking, beliefs, perceptions and values (Williams 1993; Mabvurira, 2016). For example, in the African region it is a way of life, and relates to culture and society, as they affect the worldview of the African people (Olupona, 2014, as cited in OUPblog: Oxford University Press's academic insights for the thinking world, 2014).
- The Afrocentric axiology is a value system that serves as the foundation for African beliefs (Williams, 1993). African cultures and values influence Africans' belief systems, which influence Africans' worldviews on issues, the patterning of their way of living, and identification and treatment of problems.
- The Afrocentric ontology emphasises Africans' collective identity, collective struggle and collective destiny (Williams, 1993), which also known as *ubuntu*. *Ubuntu* refers to "Africans as social beings that are in constant communion with one another in an environment where a human being is regarded as a human being only through his or her relationships to other human beings" (Tutu, 1997, as cited in Battle, 1997, pp. 39-43). Therefore, the *ubuntu* principle implies that an individual could suffer ill-health because of broken relationships, while s/he could be complete and healthy through the intervention of others. Broodryk (2002, p. 56) defines *ubuntu* "as an ancient African world-view, which is based on the primary values of intense humanness, caring, sharing, respect, compassion, and associated values, which ensure happy and qualitative human community life, in the spirit of the family". According to Mkhize (2003), *ubuntu* implies qualities such as warmth, empathy, understanding, communication, interaction, participation, reciprocation, harmony, a shared world-view and co-operation. Mbigi and Maree (1995) add that the *ubuntu* principle considers the African Collective Fingers, which implies that a hand perfectly represents the *ubuntu* concept, as it requires the collective co-operation of all fingers and the thumb to function optimally. According to Broodryk (2006), sympathy is important in *ubuntu*, and this is exercised when a problem befalls a community member.

- Afrocentric epistemology emphasises the importance of understanding African history, heritage, and culture, which knowledge helps people to develop to their fullest potential and achieve liberation (Mabvurira, 2016).
- By understanding the above-mentioned perspective, it is further important to understand that social workers are encouraged to address clients holistically (body, mind, spirit), as impacted by their environment.

3.2.2. Ecological Systems Perspective

The Ecological Systems Perspective, developed by Auerswald (1968), and further by Meyer (1976), emerged from the ecological ideas of DuBos (1972), and the general systems theory idea of von Bertalanffy (1967), both of which originated in biology (all cited in Greif & Lynch, 1983). The Ecological Systems Perspective assists social workers to understand their clients' systems in totality (Schenck *et al.*, 2015). In this perspective, the client's system is viewed as an entity that is in constant interaction with its environment, being influenced by, and also influencing the environment (Segal, Gerdes & Steiner, 2012). As stated in the definition of social work, social work should consider a holistic approach that includes physical, social, mental and spiritual dimensions of persons and their environments (Canadian Association of Social workers, 2012). Therefore, it is worth mentioning that the individual client should be seen as a system (Schenck *et al.*, 2015), as an individual has different human dimensions, namely, the physical, emotional, psychological and spiritual dimension. Should one dimension be affected, it will affect the other dimensions, and consequently, affect the client's reaction in certain circumstances.

Social work perceives the person as a holistic being, interacting with the environment (Schenck *et al.*, 2015). The Bio-Psycho-Social approach is in the Ecological Systems Perspective because it enables social workers to be considerate of other human contexts and dimensions in a holistic framework (Winkelman, 1999). The Bio-Psycho-Social approach maintains that the biological (effects of medication, body responses, and genetic elements), psychological (beliefs, thoughts, emotions, coping mechanisms, and behaviours), and social (socio-economical, socio-environmental, and cultural) factors, all fulfil significant roles in human functioning, in the context of the disease or illness (Ghaemi, 2011). This approach requires social workers to understand their patients' mental illness in a holistic way, and consequently, develop treatment plans, together with other multi-professions in mental health

settings (Ghaemi, 2011; Schenck *et al.*, 2015).

When addressing clients' circumstances and challenges including their spirituality, social workers should focus attention on the surrounding environment in which the client lives and is connected, which may have an effect on the client's circumstances (Schenck *et al.*, 2015; Winkelman, 1999). The individual is never in isolation; therefore, his/her human dimensions, relationships, family, community, social and spiritual spheres, cultural systems, as well as formal organisations are all systems that may affect, and influence a client's behaviour, and his/her worldview. The Ecological Systems Perspective maintains that as the individual's life interacts and is linked directly, and or indirectly, to such systems, the individual is influenced by them (Winkelman, 1999).

Therefore, the Ecological Systems Perspective requires spiritually-sensitive social workers to understand the multi-cultural systems in relation to the client's circumstances, behaviour and perceptions (Segal, Gerdes & Steiner, 2013). The Ecological Systems Perspective not only examines the range of sources from the systems that could be linked to the client's circumstances, but also the resources from the systems to assist with possible resolutions (Winkelman, 1999). In addition, this perspective helps African social workers in mental health settings to understand that their clients' mental illnesses are not individual or internal (Winkelman, 1999), instead, they are initiated externally in relationships with the broader environment, human and supernatural, as well as ancestral spirits (Winkelman, 1999; Onyango, 2011). This concurs with a statement in the literature review that the cause of an illness, or misfortune, in many cases, is due to factors which are external to the client (Thabede, 2008; Ross, 2010).

3.2.2.1. The main principle of the Ecosystems theory

- **Individual should be seen holistically**

Systems theories are based on the belief that individuals do not exist in isolation, but instead, grow and develop while interacting with their physical and social environments to form a complete whole (Teater, 2010; Hutchison, 2003). In social work, systems could constitute individuals, couples, families, communities, organisations, the society, or the world. Systems theories maintain that each system should be viewed as a unit, with several elements that make the system a functional whole, while each system should be viewed as being inter-

related, which could cause a change, or reaction in the main system. Social workers, when working with clients, should consider the bio-psycho-social-spiritual aspects of the client by investigating the physical and psychological functioning, social relationships, as well as community, or societal structures that affect the client (Teater, 2015). Similarly, every human being has a physical, emotional, psychological and spiritual dimension, and all these dimensions interact with each other, consequently, affecting the individual's functioning and reaction to certain circumstances (Schenck *et al.*, 2015).

3.2.2.2. Practice application of the Ecosystem theory

To understand the client and his/her problem comprehensively, the social worker should ensure that all the systems with which the client interact, are considered (Schenck *et al.*, 2015). Similarly, the Ecosystem theory is useful to develop a holistic view of persons-in-environment, to understand the client in his/her context (Hutchison, 2003). According to Teater (2015), the Ecosystem theory is primarily used in the assessment and intervention stages of social work practice during which the social worker assesses the client holistically by considering psychological, biological and social functioning, as well as assessing the interaction of other systems in the client's environment, particularly those that could be contributing to the presenting problem. When addressing the individual, the social worker may address the family system, community, traditional system, or even political systems as the focus for intervention (Teater, 2015).

3.2.3. Person-centred approach

The Person-centred approach, developed by Carl Roger (1940, as cited in Schenck *et al.*, 2015), was initially known as the Client-centred approach, with the client being in charge of the therapy, which leads to the client developing a greater understanding of self, self-exploration, and improved self-concepts (Seligman, 2006). Therefore, the focus is on the individual and his/her perceptions and experiences. The focus should be on the core conditions required for successful therapy such as ensuring that the therapist demonstrates respect and empathic understanding in a non-judgemental way, which is critical in the caring relationship (Seligman, 2006). These core conditions to respect and unconditionally accepting the mentally ill person are non-negotiable. The client's frame of reference and reality should always be at the centre of the interaction.

The goal of the Person-centred approach is to facilitate change within people through

fostering a safe and unconditional acceptance environment to empower the client to discover him/herself [referred to as client self-actualisation], and further decide whether s/he wants to change [referred to as client self-determination] (Schenck *et al.*, 2015; Eager, 2010). The goals of a social worker using this approach is to establish a warm and genuine relationship with the client as well as empower him/her to freely discuss, explore, develop and realise his/her inner self (Rogers 1992), as well as full potential (Holosko, Skinner & Robinson, 2008; Eager, 2010). Therefore, the role of the social worker is not to be the expert, the teacher, or the problem-solver, but rather a partner with the client, to achieve harmony with the client (Holosko, Skinner & Robinson, 2008; Eager, 2010).

The role of the teacher and the expert is assumed by the client in the social worker/client relationship (Streets, 2009). In the context of this current research, spiritually sensitive social workers would adopt this approach to assist their clients to discover themselves in relation to their spirituality. In the process of fostering a safe environment for the client to realise his/her full potential, the spiritually sensitive social worker is required to consider how the client identifies his/her problem/s and experiences, as well as solutions to his/her problems and needs, as perceived through the client's world view (Grobler, Schenck & Mbedzi, 2013), implying that spiritually sensitive social workers are required to exercise high regard for the client's self-determination, which is a central social work value with clients (Schenck *et al.*, 2015). Therefore, not considering the client's needs, wants, and request for spiritual integration in the caring process is a violation of the following two core values of the social work profession (Canda & Furman, 2010, p. 53-54):

- *Service and competence*: Social workers should rise above their personal interests to serve and benefit clients with needs as identified by the clients in a competent and knowledgeable manner.
- *Self-determination*: Social workers should respect the inherent dignity and worth of the client as well as be mindful of individual and cultural diversity, including spiritual diversity. According to Barsky (2014), social workers should inform clients about their right to self-determination, as well as their obligations, responsibilities, and possible consequences to their decision.

3.2.3.1. *The principles of the Person-centred approach*

The Person-centred approach is underpinned by eight principles; however, only the three

main ones which are relevant to the current study are discussed as they reflect the attitude of the therapist towards the client, namely, the therapist is congruent (consistent, genuine, authentic) with the client; the therapist provides the client with unconditional positive regard; and the therapist shows empathetic understanding towards the client (McLeod, 2008).

- **Congruence in counselling**

Congruence, also known as genuineness, requires the therapist to be authentic with the client, without deceit or pretence. A client-centred therapist needs to feel comfortable to share his/her feelings with the client. Not only will this contribute to a healthy and open therapist-client relationship, it will also provide the client with a model of good communication, and that it is safe and reasonable to be vulnerable (McLeod, 2008).

- **Unconditional positive regard**

The next Rogerian core principle is unconditional positive regard, which refers to the therapist's acceptance of, as well as respect and care for clients (Seligman, 2006). Unconditional positive regard is important because only in the presence of such regard will an individual be free to explore their perceptions without fear of being judged, or disregarded (Madoc-Jones, 2008; Seligman, 2006). Rogers (1940, as cited in McLeod, 2008) believes that for people to grow and reach their full potential, it is important for them to be valued personally. This refers to the therapist's deep, genuine, and unconditional caring, and attention for clients regardless of their worldview, or therapist-client differences.

- **Empathy**

Empathy is a skill used by person-centred therapists to demonstrate an understanding of the client's emotions (Seligman, 2006). The person-centred social worker attempts to become attuned to the client through empathy, and subsequently, reflects back to them what they are saying to develop and sharpen their understanding and appreciation of themselves (Madoc-Jones, 2008; McLeod, 2008; Rogers, 1992). Being empathetic is an important part of the person-centred counsellor's task.

3.2.3.2. Practice application of the Person-centred approach

- **Evolution of person-centred methods**

Therapists should position themselves to invest in the relationship with the client (Corey,

2005). This is fostered by having a genuine relationship with the client.

- **The role of assessment**

The role of assessing or identifying the problem is performed by the client according to his/her worldview. From a person-centred perspective, what matters is the client's self-assessment, as the best source of knowledge about the client is the actual client (Corey, 2005).

- **Areas of application**

The Person-centred approach has been used successfully on problems such as anxiety disorders, alcoholism, psychosomatic problems, agoraphobia, interpersonal difficulties, depression, cancer, and personality disorders (Corey, 2005).

The strengths perspective follows next, as spirituality is reflected in the current study and literature as a source of strength.

3.2.4. Strengths perspective

Throughout the history of social work, it was known as a caring and helping profession among other functions. The foundation of social work, in the past, was focused on problems and pathologies, as well as problem-solving models (Minuchin, Colapinto & Minuchin, 1998; Lawrence, 2004; Seligman & Darling, 2007). The Problem-solving model was adopted fervently through the medical model, between the 19th and 20th centuries, wherein the specialist, as the 'all knowing', executed the identification of the problem as well as the solution (Berg & Kelly, 2000). Such a model and approach overly focusses on diagnosis, deficits, labelling, and problems, was initially implemented in case management, as well as other areas of social work (Saleebey, 1996; Manthey, Knowles, Asher & Wahab, 2011), paying little, or no attention to the strengths a client may possess.

In 1980, at the University of Kansas' School of Social Welfare, social work practitioners, Weick, Rapp, Sullivan and Kisthardt (1980, as cited in Saleebey, 2008) initiated a new paradigm shift in the social work perspective, from problems to strengths. In 1989, Weick, Rapp, Sullivan and Kishardt (1989) further established the term, *strengths perspective*, to address a system, in which practitioners recognised the authority and resources a client possessed, in the client's frame of reference. The strengths-based approach was established to deal with the main problems faced in social work practice (Weick *et al.*, 1989; O'Hanlon &

Rowan, 2003), when applying the traditional problem-focused perspective in the mental health system on problems, such as individualising the problem of the client without considering the social context of the client (Schenck *et al.*, 2015). In addition, this move was necessary to deal with the client system that did not foster an opportunity for client-empowerment (Schenck *et al.*, 2015), but rather concentrated on the problem of the client. This client system relied on the social worker as the problem solver without allowing any exploration with clients to discover their ability to deal with their own problems (Schenck *et al.*, 2015; Weick *et al.*, 1989; O'Hanlon & Rowan, 2003).

3.2.4.1. Strengths perspective defined

The strengths perspective acknowledges an individual's strengths and abilities to cope with problems (Saleebey, 2003). Saleebey (1997, p. 6) suggests that individuals and groups "have vast, often untapped and frequently unappreciated reservoirs of physical, emotional, cognitive, interpersonal, social, and spiritual energies, resources and competencies". Clients who approach social workers and youth workers for assistance with problems are bigger than their problems (Early & GlenMaye, 2000), as they also have strengths and abilities that have allowed them to survive, if not thrive, in the face of the challenges they faced (Early & GlenMaye, 2000; Poertner & Ronnau, 1992; Saleebey, 1992b). The strengths approach maintains that human beings are capable of change (Saleebey, 2006; Caddell *et al.*, 2005), emphasising the individuals' efforts, achievements, positive contributions as perceived by the client as well as human strengths (Gardner & Toope, 2011).

In addition, the strengths perspective includes the client's attributes, coping skills and abilities in adversity, prior to, and in current successful life experiences, environmental resources, related cultural and social capacities, as well as willingness and determination to overcome difficulties (Glick, 2004). Glick (2004) places emphasis on discovering and utilising the client's strengths, particularly spiritual strengths, by motivating his/her potential positive and healthy behaviour, as well as intensifying his/her supportive network. Involving significant others, for example, community resources, family members, and support groups, in care management, could also have a positive effect in the patient's treatment process (Ryan & Carr, 2010).

3.2.4.2. Principles of the strengths perspective

The following are seven important principles of the strengths perspective (Saint-Jacques, Turcotte & Pouliot, 2009; Chapin, 1995; Early & GlenMaye, 2000; Kisthardt, 1992; Miley, O'Melia & DuBois, 2001; Poertner & Ronnau, 1992; Rapp, 1992; Saleebey, 1996; Sullivan & Rapp, 1994; Weick *et al.*, 1989):

- **People are perceived to possess strengths as well as the capacity to continue learning, growing and changing**

Every person has an inherent power (also characterised as a life force), transformational capacity, life energy, spirituality, regenerative potential, and healing power, which is a potent form of knowledge that could guide personal learning and growth, as well as social transformation (Kisthardt, 1992; Weick, 1992). Most people who are influenced by African spirituality believe that all human beings are created by a higher Supreme Being, referred to by some as God (Mbiti, 1969). To them, God is *in them*, and *with them*, to provide power and strength for daily living, and support in times of life challenges, sickness and trouble (Buys & Nambala, 2003; Mbiti, 1969). In addition to God, some also depend on their family members, community members, social groups, ancestors and spiritual leaders to unlock their inherent strength and power (Xie, 2013). Such support systems could also be regarded as additional strengths, besides the individual's inherent strength. According to Saleebey (1996), individuals and groups often have resources that are not identified or utilised, whether physical, emotional, cognitive, interpersonal, social, or spiritual energies and competencies. This principle could assist a spiritually sensitive social worker to draw from the clients' spirituality, and other strengths and resources that they may have, during the healing and recovery process. The clients' interpersonal relationships and/or spirituality may foster good morals and values in their lives which could also be used by the social worker to guide the clients' behaviour to be cooperative with the caring professionals as well as other patients in the mental hospital.

- **The focus of intervention is on the strengths and aspirations of people, rather than their pathologies**

According to Rhema (2016), what you magnify will take over your situation. Frequently service providers have focused on problems, deficits and pathologies (Chapin, 1995; Early & GlenMaye, 2000; Poertner & Ronnau, 1992; Saleebey, 1992c; Weick *et al.*, 1989); however, it should not be the main focus of intervention (Saleebey, 1996). This does not imply ignoring the challenges and problems, instead, they should be acknowledged, empowering what works

well, to disempower what does not (Saleebey, 1996; Miley, O'Melia & DuBois, 2001).

A focus on the problem was evident at the Windhoek State Hospital. The social workers could not do much for the patients due to the lack of staff; therefore, they assessed the patients' problems, and involved the doctors for medication, to try and resolve the problems, but, ultimately, the patients were re-admitted again. In such cases, the focus was on the problem and the pathology, not because they refused to employ interventions that embraced the strengths of the patients, but rather, because of the work load and their limited capacity. Such a challenge could render the interventions ineffective. Kisthardt (1992) suggests that interventions are much more effective when the clients' skills, beliefs, talents, gifts, interests, desires and uniqueness are appreciated, instead of being mired in the client's deficits. People in general cooperate and adapt better to change when they are involved, and their perspective is included in the design of the caring process, which includes how they believe the problem should be dealt with (Windesheim University of Applied Sciences, 2019). Therefore, the strengths perspective posits that people are motivated to use their capacity to change, when the focus is on their strengths (Clark, 1997; Saleebey, 1996; Weick *et al.*, 1989).

- **Communities and social environments are perceived to be filled with resources**

Communities and the social environment will always have something to offer as a facilitating resource, as the social environment provides important resources to everybody, not just clients (Sullivan, 1992a). A wide range of groups and institutions could provide support including family, friends, work, the church, sporting groups, support groups, peers, traditional leaders, influential people and local businesses. An extremely important source of strength is cultural support. Cultural approaches to healing may provide a source of revival and renewal of energies and possibilities. Cultural approaches to healing also provide inspiration and meaning for life (Saleeby, 1996).

A strengths-based approach encourages service providers including social workers in the mental health settings, to explore the full range of support available in a local community, instead of merely relying on their own strengths, and that of other professionals (Kisthardt, 1992; Poertner & Ronnau, 1992; Rapp, 1992). People learn from their trials and tribulations, and such a person could become as source of strength, inspiration and guidance to another person experiencing the same challenge (Saleeby, 1996). Clients' families and communities may be part of the resources that clients' rely on to develop their strengths (Saleeby, 2006). The kind of resources available in the community influences the health of clients living

within it (Health Engine, 2010). Living in a socio-economically deprived and underdeveloped community has a negative impact on the clients rather than strength (Health Engine, 2010).

- **Collaboration is central to the practitioner-client relationship, as primary and essential**

Unlike the problem-solving model in which the expert is the practitioner, in the strengths perspective the client is seen as the expert of their own circumstances (Bricker-Jenkins, 1992; Saleebey, 1996). The strengths-based approach focuses on “collaboration and partnership between social workers and clients” (Early & GlenMaye, 2000, p. 120); therefore, it will require humility on the side of the practitioner. This does not imply that the client dominates either, but rather, an equal collaborative partnership, in the best interest of the client.

- **Interventions are based on self-determination**

Social workers’ conception of people being experts of their own circumstances (Poertner & Ronnau, 1992; Saleebey, 1996; Sullivan & Rapp, 1994; Weick *et al.*, 1989) should be practical, and not merely by principle, but by allowing their clients to determine the form, direction, and substance of the intervention (Rapp, 1992, pp. 9 & 48). On the contrary, should the client’s self-determination be harmful, or place other lives in danger, his/her right to self-determination may be limited (Barsky, 2014). For example, if a client wants to take his/her medication with oil, as part of his spirituality, and not with water, as prescribed by the medical doctor, the social worker should carefully evaluate and consider this (including psycho-education) as well as the health consequences, if the doctor’s instructions are not followed correctly.

- **There is a commitment to empowerment**

Social workers should empower and equip individuals or groups to act on their own behalf, to achieve a greater measure of control over their lives and destinies (Sullivan & Rapp, 1994). Strength is also developed when people discover themselves and others as they struggle to overcome difficulties, which knowledge becomes a useful strength in the evolution of life (Saleeby, 1996). When social workers foster and develop their client’s self-actualisation as well as their strengths, including the individual’s capacity to act on his/her own behalf during the caring process, it is more likely that the solution will be sustained even in the absence of the social worker, with less relapses. Personal qualities and strengths often surface in the fires

of trauma, sickness, abuse and oppression (Saleebey, 1996). However, this will require the patient to be tolerant, and to draw from such personal qualities and strengths, which very well, might become the source of energy for successful intervention, even though the seed was sown in trouble and pain (Saleebey, 1996).

- **Problems are seen as the result of interactions between individuals, organisations, or structures, rather than deficits within individuals, organisations, or structures**

With the strengths perspective, problems are frequently the result of interactions between people, organisations or structures (Sullivan & Rapp, 1994). The African perspective is similar, as discussed in the literature review, as the cause of an illness/misfortune, in many cases, is perceived to be due to external factors related to the client with the symptoms (Onyango, 2011). This is unlike the Western perspective, in which the responsibility and agency are perceived to be located internally, within individuals (Thabede, 2008; Ross, 2010). Additionally, in the African perspective, these external causes have humans, and supernatural and ancestral spirits as agents of diseases of various kinds (Onyango, 2011).

3.2.4.3. Understanding Strengths perspectives in relation to reality of problems

The strengths perspective is concerned with resources, connections, skills, and gifts, instead of focusing on deficits, disease, labels, and problems (Gleason, 2007). In mental health settings, mental illnesses are real, and while being aware of the disorders as well as their effects on the patient, the wealth of strength from within and around the patient in need, should not to be repudiated (Saleebey, 1996). For example, the use of the strengths perspective while treating patients with multiple diagnoses should not be measured in disease oriented terms, like detoxification, harm-reduction, or symptom control, but rather in how far the strengths, potential, resources, trust, empathy, and competencies have been explored, developed and nurtured by the social worker, the clients, and their family members (Yip, 2003, p. 202). In Table 3.1, the contrasts of the strengths approach with conventional pathology-based approaches are illustrated (Saleebey, 1996).

Table 3.1: Comparison of pathology and strengths

Pathology	Strengths
Person is defined as a <i>case</i> ; symptoms add up to a diagnosis	Person is defined as unique; traits, talents, resources add up to strengths
Therapy is problem focused	Therapy is possibility focused
Personal accounts aid in the evocation of a diagnosis through reinterpretation by an expert	Personal accounts are the essential route to knowing and appreciating the person
Practitioner is sceptical of personal stories, rationalisations	Practitioner knows the person from inside out
Childhood trauma is the precursor or predictor of adult pathology	Childhood trauma is not predictive; it may weaken or strengthen the individual
Centrepiece of therapeutic work is the treatment plan devised by practitioner	Centrepiece of work is the aspirations of family, individual, or community
Practitioner is the expert on clients' lives	Individual, family, and or community are the experts
Possibilities for choice, control, commitment, and personal development are limited by pathology	Possibilities for choice, control, commitment, and personal development are open
Resources for work are knowledge and skills of the professional	Resources for work are the strengths, capacities, and adaptive skills of the individuals, family, and or community
Help is centred on reducing the effect of symptoms and the negative personal and social consequences of actions, emotions, thoughts, or relationships	Help is centred on the evolution of life, affirming and developing values and commitments, and making and finding membership in, or as a community

3.2.4.4. Strengths perspective in the current study context

The strengths perspective has been discussed and explained in detail to this point; however, the main recommendation of this perspective is that social workers should draw as much as possible from their clients' strengths, instead of being mired in their pathologies. In addition, the strength perspective was developed originally from mental health settings with the aim of

shifting from the problems-solving model, which focused on the problems and deficits of the patients, and designed solutions from the practitioner's point of view. The practitioners in mental health experienced the problem-solving model to be ineffective; therefore, the strengths perspective was developed.

It is worth mentioning that in the current study context, the research was also conducted in mental health settings. In addition, the research participants for the individual interviews and the workshops revealed that patients' spirituality was an important source of strength, which helped them to deal and cope with life's challenges and problems, including their illness. When the social workers were asked which theoretical approach was relevant to spiritually sensitive social work, they mentioned different approaches given the nature of the phenomenon. However, the strengths perspective was perceived as the umbrella approach, in the context of spiritually sensitive social work, especially in the Namibian context.

A person suffering a mental illness faces rejection, stigma, victimisation, and isolation by family members and society, with some even losing their jobs in the process (An interview conducted on September 17, 2015, with R. Dipura, Namibian social worker). However, the strengths perspective enables social workers in mental health settings to approach the patients with a positive attitude (Xu, 2015), which, in turn enhances their motivation and offers hope (Gray & Kabadaki, 2005; Xu, 2015). The strengths perspective opens doors for patients' growth, change, or increased effective coping, as it draws from other resources of the patients (Gray & Kabadaki, 2005; Xu, 2015). Patients with mental illnesses are often treated as outcasts by society, while the strengths perspective enables patients who often lack confidence and feel like failures when seeking services, to improve their self-esteem (Gray & Kabadaki, 2005; Xu, 2015). In addition, the strengths perspective enables social workers in mental health settings to uphold the individualisation value, even when dealing with patients in the same situation, or who were facing a similar problem (Gray & Kabadaki, 2005). The strengths perspective acknowledges and draws from resources within and around the client (Saleebey, 2002), which therefore guides social workers in mental health contexts to use their clients' spiritual coping resources, including their strongly-held beliefs that offer meaning to difficult life circumstances, and provide a sense of purpose (Gray & Kabadaki, 2005).

The findings of the current study suggest that spirituality is beneficial to people with severe mental illness, and in particular, daily spiritual experiences have been related to, and have

predicted an overall positive quality of life (Young, 2012). Systematic reviews of research literature have consistently reported that spiritual and religious involvement contribute to desirable mental outcomes such as: reducing symptoms for people with schizophrenia, depression and anxiety disorders, as well as lowering the rate of suicide and substance abuse (Young, 2012; Bellamy *et al.*, 2007; Corrigan *et al.*, 2003; Koenig, McCullough & Larson, 2001; Plante & Sharma, 2001). Sullivan's (1992b) study of 40 adults with serious mental illnesses observed that spiritual beliefs were a critical factor in the recovery process of 48% of the sample. The participants in that study indicated that their spiritual beliefs had helped them to work through their problems, and the attendance of religious functions served as a means of social support (Walsh, 1995). Similarly, D' Souza's (2002) study in Australia observed that 70% rated spirituality as very important in their lives, with 67% of that total reporting that their spirituality helped them to cope with their psychological pain.

Spirituality, therefore, is a coping mechanism for many people managing emotional disorders, mental illness, and stress in general (Koenig, 2012). In addition, the focus on spirituality reveals a wider range of possible support and resources to address the client's problem, and offers a different viewpoint from which to explain life's challenges (Canda & Furman, 2010). Patients regard spirituality as a strength and find purpose in their lives through spiritual connections with significant others for hope, strength and resources, to cope with the physical and psychological pain of their illnesses (D' Souza, 2002).

As spirituality is an important strength according to the literature above, the strengths perspective would be suitable to guide and encourage social workers to explore their clients' strengths and other resources, as perceived by their clients. The following discussion highlights spirituality as a wealth of strengths.

3.2.4.5. Beliefs and emotions as strengths

Spirituality and religious traditions reveal the strengths of people as they encourage and enhance positive emotions such as awe, love, joy, hope, faith/trust, forgiveness, gratitude and compassion, with many mental and physical benefits (Canda & Furman, 2010; Holloway & Moss, 2010; Snyder & Lopez, 2007). Additionally, forgiveness is a remedy for anger, hostility, and bitterness (Plante, 2008). Being able to let go of anger and perceived slights by others could result in positive mental and physical effects (Worthington, Berry & Parrott, 2001). Research reveals that those who tend to be grateful sleep better, are more optimistic,

more energetic, and maintain better interpersonal relationships (Emmons & McCullough, 2003). An individual's positive beliefs in his/her identity and condition play a significant role in his/her health maintenance and regeneration (Cousins, 1989). Therefore, for patients who are supported by positive beliefs and a supportive environment, the brain acts as a *health maintenance organisation* (Ornstein & Sobel, 1987). Positive effects may be defined as feelings or emotions that reflect pleasurable engagement with the environment, for example, interest, excitement, contentment, joy, engagement, love, and enthusiasm (Watson, 2000).

In addition, emotions have a profound effect on wellness and health as they may act as signals for the body's immune and recuperative responses (Saleebey, 1996). Therefore, it would appear that positive emotions could activate *the pharmacy within*, as well as embolden the application of reason in day-to-day life (Damasio, 1994; Ornstein & Sobel, 1987). When people believe that they can recover, or when they have a range of positive emotions about that prospect, in the context of their daily lives, their bodies often respond optimally (Saleebey, 1996). Similarly, positive emotions are key factors for well-being and quality of life, and have benefits beyond making people feel good in the moment, and actually broaden thoughts and behaviours (Brdar, 2011). Brdar (2011) adds that the results obtained in different settings using diverse methods and assessments have revealed that positive emotions are associated with cognitive strategies for reframing a situation, to perceive it in a more positive light such as optimism, hope, and finding meaning.

However, health professionals, including social workers in the mental health practice, should not only focus on the negative emotions such as anger, fear, anxiety, and sadness, but also on the strengths that emanate from positive emotions encouraged by spirituality. To enable social workers to do that, the strengths perspective is suitable. According to Baskin (2002), social work practice can only be considered holistic when the spiritual dimension is included; therefore, when social workers ignore the spiritual they are not responding to their clients holistically (Mabvurira & Nyanguru, 2013). Mabvurira and Nyanguru (2013) add that social workers, ideally need to focus on their clients' strengths. If a client values his/her spiritual strengths as a support to face problems and difficulties, the social work practitioner should consider incorporating a spiritual sensitive approach in the caring process within the guidelines of professional values and ethics (Canda & Furman, 2010). Derezotes (2006, p. 2) asserts that "since the spirit impacts everything" spirituality should be considered as

interconnected and inseparable from a bio-psychosocial approach to healing. Spirituality as a strength is lightened in relation to many social problems that practitioners encounter including psychological difficulties, substance abuse, marital and family problems, terminal illness, HIV and AIDS (Bhagwan, 2010b, Koenig, McCullough & Larson, 2001).

3.2.4.6. Critical evaluation of the strengths perspective in context

Some critics of the strengths perspective assert that people are set-up for disappointment when they are encouraged to believe that everything is possible, and in the event of failure, irrespective of the available strengths, they are disappointed (MacFarlane, 2006). Social workers in mental health should value patients' beliefs in the treatment and recovering process; however, they should also include medication as well because some patients refuse medication because of their personal beliefs. When healing does not occur according to their time frame and beliefs, it causes a tremendous setback.

3.2.4.7. Practice application of the strengths perspective

Client empowerment is central to social work practice (Cowger, 1994). Social workers in this setting could empower patients by ensuring that they are capable of making their own choices and decisions as well as guiding them through psycho-social-education about their medical condition and its prescribed medication. The role of a social worker therefore, is to nourish, encourage, assist, enable, support, stimulate the strengths in and around patients, to reveal their available strengths in their own environment, and to promote equity and justice at all levels of society (Cowger, 1994). In addition, social workers' roles in the strengths perspective include the following:

- Conducting a comprehensive assessment, including a spiritual assessment;
- Recognising and enhancing the personal strengths and resources of patients that will help them to find meaning and purpose for living, as well as to cope with their illnesses. These resources could emanate from the person in need, family, community support, according to what they realise will help;
- Helping patients to solve both interpersonal and environmental problems, according to their capacity, talents, and skills;
- Mobilising patients to adhere to the medical procedures in addition to their spiritual strengths or other resources (Tomaszewski, 2004; Saleebey, 2003).

In the current study, the manner in which particular variables connect with various

perspectives and approaches to create a broader understanding of spiritually sensitive social work with mentally ill patients are illustrated in Figure 3.1 below.

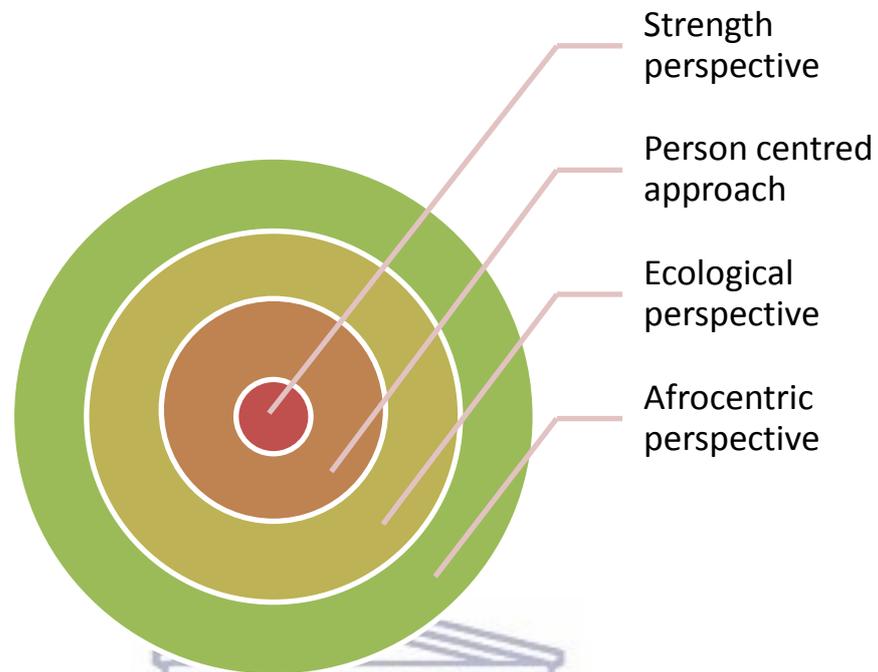


Figure 3.1: Variables connecting within various perspectives and approaches

3.3. The summary of the chapter

In this chapter, the researcher presented the conceptual framework by discussing the interrelated concepts to explain and provide a broader understanding of the phenomenon under study. In addition, the researcher explored four theories namely, the Ecosystem theory, Person-centred approach, Afrocentric perspective, and lastly the Strengths perspective. These interrelated theories were observed to fulfil complementary roles in the comprehension of spirituality and social work, regarding mental illness in the African context. The following chapter comprises the research design and methodology.

CHAPTER FOUR

RESEARCH DESIGN AND METHODOLOGY

4.1. Introduction

In this chapter, the researcher provides a description of the research design, the research methodology applied in data collection, the data analysis method, as well as the ethical considerations. For ease of referral, the researcher restates the research questions, and the aims and objectives of this current study.

4.2. Research questions

Research questions explicitly state what the researcher intends to investigate (Bryman, 2012). Similarly, according to Feldt (2010), a research question is an enquiry that the current research sets out to answer. The research questions provide the basis for the research, to guide the researcher in the investigation of the subject matter. Therefore, based on the subject matter, the researcher generated the following research questions to be answered by this research project:

- What research exists on spirituality and social work in Africa?
- How is spirituality conceptualised in a social work practice in the Namibian context?
- How do social workers utilise spirituality in the mental health settings?
- What guidelines are needed for social workers in the mental health settings to be spiritually sensitive in their practice?

4.3. Research aim

The aim of the study was to develop guidelines for social workers to be spiritually sensitive in their mental health practice.

4.4. Research Objectives

Several objectives were set for the study:

- To explore research on spirituality and social work in Africa by means of a scoping review;
- To conceptualise spirituality in social work in the Namibian context;

- To explore and understand Namibian social workers' utilisation of spirituality in their mental health practice; and
- To develop guidelines for social workers in the mental health settings for them to be spiritually sensitive in their practice.

4.5. Research methodology

The research method is a strategy of inquiry that moves from the underlying assumptions to the research design and data collection (De Vos *et al.*, 2012; Creswell, 2003; Creswell, 2013). Qualitative research is said to be interpretive by nature; therefore, this current study is underpinned by an interpretive paradigm as the ontological assumption. According to Creswell (2013), ontological assumption refers to the nature of realities and embraces multiple realities from multiple participants. In addition, with ontological assumptions, the researcher reports multiple perspectives as themes develop in the findings (Creswell, 2013). In the current research, the researcher sought to acquire knowledge and build guidelines from social workers' world views based on their multiple experiences, understandings and realities, regarding the conceptualisation of their own spirituality, and the use of spirituality in their work with mentally ill patients. A paradigm is a pattern or a set of legitimated assumptions as well as a design for gathering and interpreting data (De Vos *et al.*, 2012). Interpretive paradigmatic research seeks to explore perceptions, understandings and shared meanings as well as to develop insights into situations (Wellington, 2015). In addition, it seeks to produce knowledge by exploring and understanding the social world of the people being researched, focusing on their meanings and interpretations (Ritchie, Lewis, Nicholls & Ormston, 2013).

The interpretive paradigm in the context of this current study stresses the importance of understanding the social workers' understanding, as well as utilisation of spirituality in their own lives and in their work with mentally-ill patients. In the current study, the social workers shared their understanding of spirituality, how they embraced it, how spiritually sensitive they were in their work with mentally-ill patients, as well as how important spirituality was to their patients. Subsequently, the data collected from the social workers were thematically analysed followed by the interpretation and conclusions regarding their meaning (Creswell, 2003). Meanings were constructed from the individual interviews, and from the group interactions, during the two 1-day workshops (Nomlomo, 2007).

According to Maree (2007, p. 50), “Qualitative research is a research method that collects rich descriptive data in respect of a particular phenomenon or context with the intention of developing an understanding of what is being studied.” Qualitative research involves procuring insights from people regarding their experiences and sentiments of, as well as and perceptions on a specific issue in their natural settings (Flick, 2014). A qualitative approach is a generative form of inquiry (Ritchie & Spencer, 2002, p. 308) that uses varied instruments. In this current research, the researcher employed various qualitative approaches to collect data, namely, the scoping review, the individual, semi-structured interviews, and workshops.

4.6. Research design

A research design is a plan or a strategy that informs how the researcher will accomplish his/her research study (De Vos, Strydom, Fouché & Delpont, 2012). In the current study, the researcher made use of a scoping review as a first method of collecting data. A scoping review is a way of identifying key concepts that have been researched, or that underpin a research area (Peters, Godfrey, Khalil, McInerney, Parker & Soares 2015). The scoping review of this current study is discussed in Chapter 5.

Additionally, the researcher used a case study approach as the second method of collecting data. A case study is an in-depth study of a system (in this case the social workers in a mental health setting), based on data collection materials, situating this system, or case within its larger context or setting (Hoang-Kim *et al.*, 2014). In addition, a case study refers to the study of a case in action, the inquiry around an instance (Adelman et al., 1980, pp. 48-49), or the study of a specific instance that is frequently designed to illustrate a more general principle (Nisbet & Watt, 1984, p. 72). A case study can also be defined as a single instance of a bounded system (the case), such as a child, a clique, a class, a school, a community (Cohen, Manion & Morrison, 2000, p. 181), an event, a programme, or an activity (Creswell, 2003, p. 15).

Therefore, a case study potentially provides a rich and deep description of the case which is investigated within its natural setting, its complexity and its context, with the purpose of understanding it as much as possible (Punch, 2009). Through various data collection procedures, a case study provides the researcher with detailed information about a case. Baxter and Jack (2008, p. 546), as well as Yin (2003) assert that a case study should be

considered when: (a) the focus of the study is to answer how and why questions; (b) the behaviour of those involved in the study cannot be manipulated; (c) contextual conditions need to be covered because they are considered relevant to the phenomenon under study; or (d) the boundaries between the phenomenon and the context are unclear. Consequently, the case under scrutiny was the exploration of how social workers conceptualise spirituality in the Namibian social work context as well as how they utilise spirituality in their work with mentally ill patients.

Stake (2000) divides case studies into three groups:

- Intrinsic case studies that seek to understand the particular case - the case itself;
- Instrumental case studies that examine a case to gain insight into an issue or theory, which is to understand what is not obvious to the observer (Tellis, 1997, p. 1); and
- Collective case studies, or a group of individual studies aimed at gaining a fuller picture of an issue.

In the current study, a collective case study was employed. A collective case study is a study consisting of several cases in order to examine a “phenomenon, population, or general condition” (Stake, 2000, p. 437). Therefore, the collective case study in the current study was the social workers, who currently work, or had worked in mental health hospitals in Namibia, to explore their conceptualization of spirituality, as well as their utilization of spirituality in their social work practice, because the boundaries between the phenomenon and context (for example, spirituality and social work practice) were not clearly evident.

The collective case study design was selected to understand the phenomenon and gain meaningful insights (Stake, 2000; Desai, 2012). Similarly, a collective case study design provides a structure to gain insights into the issue of interest across settings as it allows comparison within and between cases (Adams, Jones, Lefmann, & Sheppard, 2014; Baxter & Jack (2008) Additionally, because case studies are considered a prime source of information, to enable the development of guidelines, and/or educational theory (Bassegy, 1999), the researcher employed the collective case study design for the purpose of developing guidelines for practice.

Finally, the researcher explored the development of guidelines for practice through two 1-day

workshops with the case study participants, as well as four 4th year interns. The first 1-day workshop involved developing the guidelines, and forwarding the draft guidelines to experts for reviewing. Approximately a month later, along with comments provided by the experts; the second 1-day workshop was conducted to finalise the guidelines.

4.7. Data collection and analysis process

The data were collected in two phases.

- **Phase one** comprised 2 stages: **Stage 1** - Scoping review; **Stage 2** - Case study for the conceptualisation and utilisation of spirituality in Namibian social work.
- **Phase two** comprised 2 stages: **Stage 1** - Facilitating a 1-day workshop to verify the collected data and developing draft guidelines for social work practice; **Stage 2** - Facilitating a 1-day workshop to confirm the guidelines.

4.7.1. Phase one: Data collection and analysis

4.7.1.1. Stage 1: Scoping review

Objective: To explore research on spirituality and social work in Africa.

The reason behind conducting a scoping review was to determine what previous studies had been published on spirituality and social work in Africa.

Inclusion criteria: Although much has been said internationally about spirituality and social work in the mental health practice, the focus of this current study was on an African worldview of spirituality and mental illness. Therefore, the researcher searched for African studies that had been conducted on spirituality and social work in the mental health practice, which should have been conducted within ten years prior to 2016. The outcome of the scoping review is discussed in Chapter 5.

Data Collection Tool: The following steps were followed in conducting the scoping review as outlined by Arksey and O'Malley (2005):

- **Step 1:** *Identifying the research question*
- **Step 2:** *Identifying relevant studies*
- **Step 3:** *Study selection*
- **Step 4:** *Charting the data*

- **Step 5: Collating, summarising and reporting the results**

These steps are explained in Chapter 5.

Data analysis: A simple descriptive evaluation of each study was presented in tabular format. The table also included the population under study, the interventions, and outcomes. The themes that emerged from the five articles are also discussed in Chapter 5.

4.7.1.2. Stage 2: Case Study

Objectives: The objective of the case study was to conduct individual interviews to explore the conceptualisation of spirituality in social work in the Namibian context, and to explore the Namibian social workers' utilisation of spirituality in their mental health practice.

Study population: A study population is a specific group from which the sample is selected (De Vos *et al.*, 2012). It is also referred to as a collection of all units of the study from whom the researcher expects to make specific analysis and conclusions (Welman, Kruger & Mitchel, 2007). The study population was all the social workers who were employed or previously, had been employed, in the two mental health hospitals of Namibia, namely, Windhoek and Oshakati, and who believed that spirituality was important in their lives as well as their clinical practice. It is worth mentioning that the population of social workers employed in mental health is generally small as only 4-5 social workers were currently employed at the mental health hospital in Windhoek, and two in Oshakati. For this reason, the researcher included those who had retired or resigned.

Sampling: Sampling is the process of selecting a relatively small number of cases from the social whole (Gray, Williamson, Karp & Dalphin, 2007). The sample featured a purposive non-probability group. Purposive sample according to Maree (2007, p. 79) implies that the participants are selected because of some defining characteristics which make them bearers of data required for the study. Padget (1998; 2008), similarly, states that purposive sampling is a deliberate process of selecting participants for a study based on their ability to provide necessary information. In a qualitative study, the focus is not on the number of participants, but rather on data saturation (Fusch & Ness, 2015). Therefore, this study sample size was anticipated to be between 10-15 social workers employed at mental hospitals in Namibia.

As the sample that was recruited through purposive sampling was not adequate, because at the time of conducting the research only 6-7 social workers were employed at the two

facilities under scrutiny, the researcher employed snowball sampling to augment the sample. Snowball sampling, according to Maree (2007), is a method that allows the researcher to approach participants with whom contact has already been made to penetrate their social networks for referrals to other participants who can potentially participate and contribute to the study aims and objectives, because they share some defining characteristics which render them holders of data needed for the study. The researcher, therefore, approached the recruited participants for names of possible and available social workers who had worked in the mental hospitals, and had either retired or resigned. Subsequently, the researcher approached those social workers to participate in the current study as well.

Inclusion criteria: The inclusion criteria for the selection of participants for the study were the following:

1. The prospective participant should be a qualified social worker with a BA social work degree;
2. The prospective participant should have an understanding of the meaning of spirituality in their own lives;
3. The prospective participant should be interested in building the knowledge of spirituality in social work;
4. The prospective participant should be available and willing to participate in this research;
5. The prospective participant should be working, or should have worked, in one of the two mental health hospitals (Windhoek and Oshakati); and
6. The prospective participant should be willing to be recorded.

It was easy to access the social workers employed at the mental hospital in Windhoek as the researcher had worked at the place before. The researcher approached the social workers individually to share the information sheet (Appendix C) that explained the purpose and process of the research study as well as the inclusion criteria. The researcher handed an information sheet to each of the potential research participants for their own perusal. It is worth mentioning that all selected participants met the inclusion criteria.

Sample size: Creswell's (2013, p. 157) position on sample size in qualitative studies is that the sample size depends on the qualitative design being used. The sample size is suggested to be between 8 and 12 members for the individual interviews (Crabtree & Miller, 1999). Given the complexity of the topic and the relative scant existing empirical research, the researcher

initially proposed to recruit 10 to 15 participants; however, only 9 could participate in the research, which was approximately the number initially suggested by Crabtree and Miller (1999).

Sample procedure: The researcher first visited the Windhoek mental hospital where the prospective participants were working to share the intentions of the research. The researcher then wrote a letter requesting permission to conduct the study to the relevant authority in the Ministry of Health and Social Services. The researcher was well received and permission was granted by the Permanent Secretary of the Ministry of Health and Social Services (Appendix B). Prospective research participants were approached by the researcher through face-to-face contact as well as by cellular phone to request their voluntary participation in the research process. Before the actual interviews, an interview schedule (Appendix F) was designed as an aid to guide the interview process. However, this guide needed to be tested, which is referred to as piloting in research.

Piloting the interview guide: A pilot study involves the testing of the study data collection tool and method, which implies getting started, practicing the interview questions, as well as receiving feedback (Griffie, 2005). Piloting is necessary as it can help to identify ambiguities, clarify the wording of the questions, and detect necessary additions or omissions (Mohd Noor, 2008).

Before the main study, the data collection instrument was piloted with two practicing medical social workers at the Windhoek Central hospital. These pilot study participants were medical social workers from the Windhoek Central hospital, and not social workers from the mental health settings as they were few in number, and earmarked to participate in the main study. Certain issues in the initial instrument were highlighted for amendment, and subsequently implemented (Michie *et al.*, 2005). The initial instrument is illustrated in Table 4.1.

Table 4.1: Initial interview guide

First Interview

1. Please describe your experiences of spirituality when you were growing up.
 - a. Describe what you think spirituality is in general
 - b. During your childhood, did you engage in spirituality practice – traditional and or church attendance etc.?
 - c. Please describe a time when you used those practices.
 - d. Please describe how you are utilising spirituality in your current life

Second Interview

2. When you hear the word spirituality, what does it mean to you as a social worker and how do you define it in the Namibian context?

Third Interview

3. Please describe a time when you decided that spirituality was an important aspect of your clinical practice with mental health patients.
 - a. Please describe a case that involved using spirituality as a part of your clinical practice in mental health.
 - b. Please describe a time when you realised your mental health client thought spirituality or religion was important
 - c. Please describe how you came to understand that spirituality would be an important treatment option?
 - d. Please describe your assessment process and how you decided the data warranted a spiritual approach?
 - e. Please describe how you determined that approach?

Initially, the interview guide allowed for three separate interviews; however, in the pilot study, it appeared that the social workers practically, could not avail themselves for three interviews due to their workload and other work commitments. Therefore, the researcher could not explore the phenomenon under scrutiny as in-depth was intended, and subsequently, incorporated all the questions for one round of interviews.

Main study data collection instrument and procedure: For the main study, the data were collected through in-depth, semi structured individual interviews. All interviews were audio recorded, after permission was granted by the participants. According to Kvale (2006, p. 481), in-depth, semi structured individual interviews “... attempt to understand the world from the subjects’ points of view and to unfold the meaning of their lived world. The

interviews give voice to common people, allowing them to freely present their life situations in their own words, and open for a close personal interaction between the researchers and their subjects” Therefore, the rationale behind the use of interviews was the researcher’s interest in exploring and understanding the participants’ worldview of spirituality in their personal life, as well as their social work practice. The data collection for these in-depth interviews was semi-structured to reveal the most relevant data, consistent with the research objectives. The interviews were organised around areas of particular interest while still allowing considerable flexibility in scope and depth (De Vos *et al.*, 2012), implying that the interviews were focused on how social workers were spiritually sensitive in their work with mentally ill patients. The researcher was also keen to probe the connection between spirituality and traditional beliefs, as it appeared to be an important aspect in their work with mentally ill patients. Initially, the plan was to conduct a series of interviews, but after the pilot study, as explained earlier, the researcher decided to conduct one interview with each participant. Although the social workers were interested in the subject and very enthusiastic to participate in the interviews, their workload did not allow the additional time. Each interview lasted between 45 minutes and 1 hour 45 minutes.

However, to some extent, adequate depth into the phenomenon under study was explored regarding spirituality, religion and tradition in the Namibian context. The participants expressed their spirituality as connected to their religion and tradition, not separated. Therefore, the researcher needed to employ probes to gain more clarity regarding the connection between spirituality and their religion, and/or tradition, as well as the meaning behind the connection. Even though the interviews reached data saturation by the 7th participant, the researcher continued until all 9 participants were interviewed to augment the views of the sample.

As mentioned earlier, the researcher was employed at the mental hospital, and had had prior interaction with the social workers there, which was helpful as it allowed the interviewer and the participants to develop a comfortable relationship, while still behaving objectively regarding their individual experiences in an appropriate context (Seidman, 1998). However, because of this, the researcher was prone to being biased. Therefore, the researcher staunchly attempted to maintain an impartial role to guard around bias. Concise Oxford Thesaurus (2007, p. 75) define bias as “showing partiality”, or showing an unfair preference for a person, place or thing. In the context of the current research, it implied that the researcher would display one-sidedness.

In the initial minutes of the interview, the researcher put the participants at ease by asking them to talk about their current spirituality (Siedman, 1998). This allowed the participants to provide salient stories about how they developed an understanding of spirituality. The researcher solicited stories regarding the various time markers related to spirituality, namely: their childhood and growing up; their personal experiences with spirituality; and the moment in their professional career when they started to utilise spirituality systematically in their social work interventions. Each participant, therefore, encountered a preliminary articulation of the concept of spirituality as well as its meaning in social work in Namibian context.

Subsequently, the researcher enquired about their professional conceptualisation of spirituality in their clinical practice. The interviews, ultimately, highlighted how spirituality was being utilised in mental health practice. In addition, the researcher provided many opportunities for both the interviewer and interviewee to understand the data by reflecting, probing and confirming what was said and implied by the participants (Lawlor & Mattingly, 2001; Rubin, 2000; Van der Merwe, 1999). Onwuegbuzie, Leech and Collins (2010) state that non-verbal communication can also be important to attain a deeper and shared meaning. Therefore, during each interview, the researcher paid attention to facial expressions as well as other body movements, quietness, and pauses. The recorded interviews were transcribed verbatim and used as part for the process of triangulation, along with the field notes (Tobin & Begleys, 2004, p. 393).

Table 4.2: The amended interview guide after the pilot study

Case study: Individual in-depth interview guide questions

Objective 2: To conceptualise spirituality in social work in the Namibian context.

1. Describe what you think spirituality is in general
2. During your childhood, did you engage in spirituality practice – traditional and or church attendance etc.?
3. Please describe a time when you used those practices.
4. Please describe how you are utilising spirituality in your current life
5. Is spirituality important for your life? If it is important, in what way?
6. When you hear the word spirituality, what does it mean to you as a social worker and how do you define it in the Namibian context?
7. Is there a different between spirituality and religion? let's discuss it

8. Can a person be spiritual without being religious?
9. Is there a different between a traditional person and a spiritual person?
10. Can a person be both traditional and religious?

Objective 3: To explore and understand Namibian social workers utilization of spirituality in their mental health practice.

1. What is your understanding of the relationship between spirituality and mental illness?
2. Is spirituality important to your patients in the mental health practice? If so how?
3. If spirituality is important to patients in mental health, what is the implication to the social work practice and profession?
4. Please describe a case that involved using spirituality as a part of your clinical practice in mental health.
5. What roles did you as a social worker play in dealing with this client who wish his/her spirituality be considered during the treatment process?
6. What essential skills did you consider in dealing with this case?
7. Which theoretical approach/model/perspective did you rely on in dealing with this spiritual sensitive case?
8. Please give any social work values and ethical principles that has guided you in your spiritual sensitive cases in your mental health practice
9. Please describe a time when you realized your mental health client thought of spirituality or religion was important to the client's treatment and recovery
10. How do you as a social worker determine that spirituality would be an important treatment option to be included in a particular case?
11. Do you follow any assessment process to determine that?
12. How do you deal with a client whose spirituality is detrimental/harmful to his treatment programme and recovery?
13. As a social worker, what will be your role in this case?

The researcher could not explore the subject as in-depth as intended because of the participants' availability constraints. Some interviews, as mentioned earlier, lasted 45 minutes to 1 hour, while others were between 1 hour and 1 hour and 45 minutes. However, each question was explored and to some extent, depth was reached as the research questions were answered and objectives were achieved.

Data analysis method and procedure for the individual interviews: Immediately after each interview, the recorded data were transcribed verbatim. According to Miles and Huberman (1994), researchers may use a simple two-level analysis method. This implies that the researcher can initiate the analysis based on the conceptual framework used in order to produce more inductive data, and the coding can shift from descriptive to more interpretative and inferential codes. The recorded data, therefore, was transcribed, analysed thematically, as well as through cross-case analysis.

Firstly, the analysis was done thematically by an independent coder for the purpose of unbiased quality assurance and data consistency check (Miles & Huberman, 1994). The data were analysed thematically, as guided by Rubin and Rubin (2005), Creswell (2014), Braun and Clarke (2006), as well as Miller (2007, p. 54). In addition, the researcher had field notes that were written down during the interviews which were also recorded. The field notes included information such as the interviewee's non-verbal communication, pauses, as well as experiences of the interviews, and the location of the interview. The field notes assisted the researcher in the preliminary data coding and interpretation (Gibbs, 2002). After reviewing all the data for each participant, a précis of each interview was created (Fullilove, 1998, as cited in Miller, 2007). An open coding process (Strauss & Corbin, 1998) was used in a descriptive manner to analyse the data. This editing approach (Crabtree & Miller, 1999) offered descriptive information and allowed for the development of thematic categories. As the transcripts were read, names or phrases that characterised the narrative were highlighted and used as code names. The constant comparative approach was used to determine whether the codes were consistent with the emergent themes and categories from the participant narratives (Strauss & Corbin, 1998).

Secondly, in addition to the thematic analysis, the researcher applied cross-case analysis. The codes from each participant's transcript were compared and contrasted with the other's, to determine whether agreement between the participant and the group occurred. Contradictory cases were identified and examined to determine the conditions under which the contradictory cases existed (Ryan & Bernard, 2003). For example, some stated that: *spiritual assessment is needed in the intake form*, while another said: *she wouldn't initiate a talk on spirituality unless the client brings it up*. In addition to the above analysis, the data were cross-analysed by comparing the cases. This approach forces researchers to search for the understated similarities and differences between cases, to enhance further understanding that was dormant (Eisenhardt, 1989). Cross-case searching methods enhance the probability that

the researcher will capture the novel findings that may exist in the data (Eisenhardt, 1989). After the completion of the first phase of analysis, the data from the scoping review as well as the interviews were integrated as preliminary guidelines and shared with the workshop participants for the purpose of developing the guidelines.

4.7.2. Phase 2: Development of guidelines

4.7.2.1. Stage 1: First 1-day workshop

The first 1-day workshop was conducted on the 17th of August 2017 for two hours. This was the only time that the social workers were able and willing to volunteer for the workshop. The venue was the Windhoek Central Hospital, Maternity Boardroom.

Objective: To develop guidelines for social workers in the mental health settings to be spiritually-sensitive in their practice.

Before the first workshop, the researcher consulted the study supervisor to be guided on the content and the format of the workshop. The participants who participated in the individual interviews were invited to participate in the workshop. Although they already agreed in phase one, their voluntary participation was once again confirmed. Therefore, the nine social workers who participated in the interviews also agreed to participate in the workshop. Additionally, the chief social worker requested that the researcher include students doing their internship at the hospitals as part of the workshop as she regarded the workshop as a learning experience for them. Consequently, four final year intern social workers placed at the mental hospital were also invited by the researcher to participate in the workshops. The total research participants who participated in the workshops, were, therefore, thirteen (13).

A workshop is defined as a gathering at which a group of people engage in study groups, discussion groups or seminar (Concise Oxford Thesaurus, 2007). Similarly, a workshop is a period of discussion or practical work on a particular subject in which a group of people share their knowledge or experience (Collins English Dictionary, 2018). The reason for the workshop was to triangulate data as well as gain a variety of insights since the views from the group of research participants were explored and clarified in ways that were not easily attained in the individual interview (Patton, 1999; Denzin, 1978; Lambert & Loiselle, 2008). It is worth mentioning that great interest was expressed in the topic which could be an indication of its importance to the social workers.

Proceedings: The researcher/facilitator was warmly welcomed while making a presentation on the objective of the workshop, the purpose of the guidelines, as well as the importance of spirituality in social work in general, before touching on the preliminary research findings as follows:

- Conceptualisation of spirituality within the context of Namibia and the dominant discourses;
- Relevant theory/ies, approaches and perspectives identified that supported spiritually-sensitive social work;
- Essential skills that should be considered and employed when considering spiritually-sensitive social work;
- Social work values and ethical principles that could guide spiritually-sensitive social work;
- Patients' assessments; and
- Detrimental aspects of spirituality.

Each theme above is discussed in the research findings. As each theme was presented, the participants, in groups of 4, were asked to discuss and record their views, whether they confirmed, amended, or contrasted with the preliminary research findings from phase 1. Regarding the conceptualisation of the term, *spirituality*, the group agreed on the concept, as conceptualised in phase 1, with one addition.

The guiding topics of group discussion were:

- Discuss and deliberate on the relevant theory/ies, approaches, perspectives guiding and supporting spiritually-sensitive social work;
- Social work values and ethical principles that guide spiritually-sensitive social work;
- Essential skills that should be considered and employed when considering a spiritually-sensitive social work, as well as the roles and skills to apply when the client's spirituality is detrimental to his/her treatment and recovery process.

Overall, the workshop participants displayed a keen interest in the topic, and they were particularly engaged. The group discussions as written by groups on the feedback forms (Appendix K), were later consolidated by the researcher, who was also the group facilitator.

After consolidating phase 1 and phase 2 first workshop data, guidelines were drafted, sent to two experts (social work lecturers at 2 universities in South Africa) for review and input. The experts' contributions were considered, which further directed the draft guidelines. Both experts displayed interest in the topic as they had conducted research on spirituality and social work, previously. These particular experts were selected from South Africa as there was no expert researcher in Namibia, who had conducted any research on spirituality in social work.

4.7.2.2. Stage 2: Second 1-day workshop

The second 1-day workshop took place a month after the 1st workshop, on the 4th of October 2017, and once again for two hours. The venue again was the Windhoek Central Hospital, Maternity Boardroom. Of the original group, 8 participants attended. Others wished to attend, but could not due to their workload at that point of time.

Objective: To continue with the development/finalisation of guidelines for practice, considering the contributions of the researcher, supervisor and experts.

Proceedings: The researcher/facilitator was warmly welcomed by the senior social worker and thanked everyone for coming. The researcher presented the draft guidelines and asked one of the group participants to read the data from the first workshop as consolidated by the researcher. Again, the researcher provided opportunities for everyone to understand the results as well as to examine and confirm checks for the internal consistency of the participants' data (Lawlor & Mattingly, 2001; Rubin, 2000; Van der Merwe, 1999).

Both the discussions of the first and second workshops were guided by Healy's (2015) Dynamic Model (Figure 4.1), to guide the development of the guidelines. The focus of the second workshop was to allow the group of participants to provide a more detailed discussion on the most relevant theories, values, roles and skills for application, as identified in Phase 1, and the first workshop, to ultimately select the most relevant ones for application in spiritually-sensitive social work. In addition, the group of participants needed to explain why and how the relevant theories, values, roles and skills were necessary and fitting. Notes from these discussions were captured and added to the development of the guidelines.

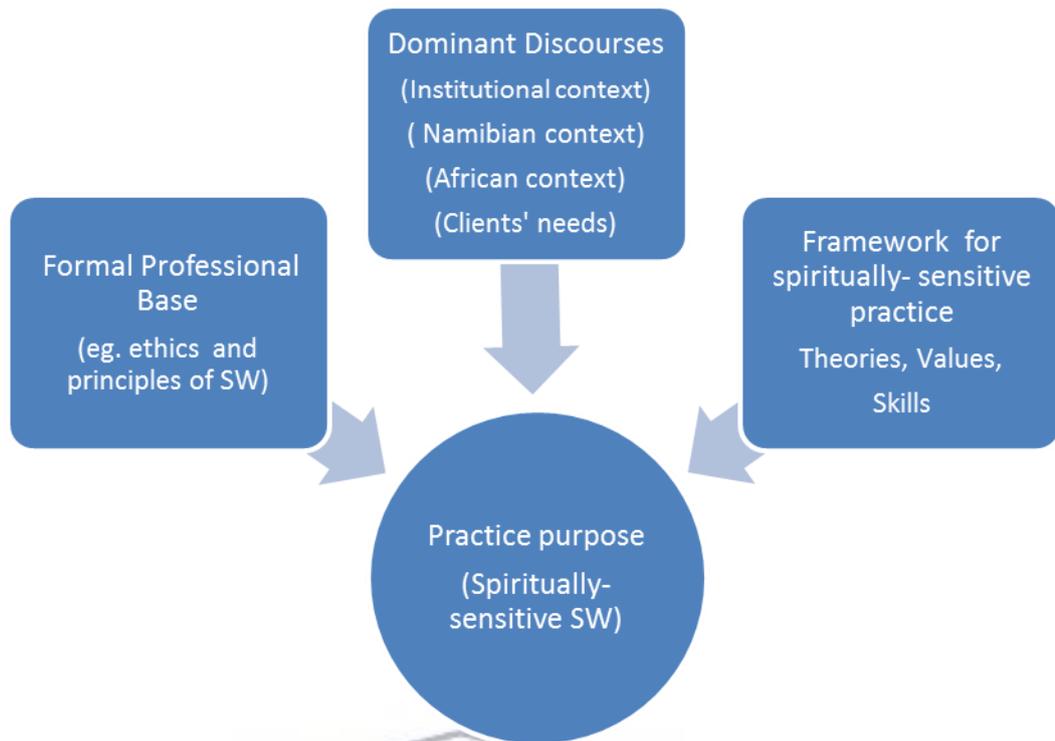


Figure 4.1: Healy's Dynamic Model: Adapted from Healy (2015)

Healy's (2015) Dynamic Model was used as it is concerned with the construction of social work practice and knowledge. It advocates that social workers are active participants in creating the context and framework through which to practice (Healy, 2015). The current study involved framing social work practice with spiritually-sensitive cases in mental health settings in the Namibian context; therefore, this model serves as a guide in developing a framework as well as guidelines for practice, given the particular context. The defined details of the developed guidelines are discussed in Chapter 7.

In summary, as guided by the above model, the researcher identified the following with the participants:

- **Dominant discourse:** The most significant outcome of the workshops was that social workers need to be better equipped, to be more spiritually sensitive to their clients' worldviews, because mentally-ill patients perceive spirituality as crucial to their healing and recovery process.
- **Formal professional base:** The researcher and the participants surveyed the ethical principles for the most relevant ones that applied to spiritually-sensitive social work.

- **Framework for practice:** The researcher and the participants identified relevant theories, skills, roles, and values for spiritual sensitive social work.
- **Practice purpose:** Social workers in mental health settings are required to be spiritually sensitive in their work with mentally-ill patients, who are adamant that their spirituality be considered in their treatment process.

4.8. Trustworthiness

The research quality was maintained by ensuring trustworthiness. Trustworthiness was achieved by considering the following:

- *Credibility:* Patton (1999, p. 1190) asserts that credibility depends on various techniques and methods of gathering high-quality data that are carefully analysed, with particular attention paid to issues of validity, reliability, and triangulation. Similarly, Baxter and Jack (2008) reveal that to ensure quality and credibility, integrated research methods can be considered in qualitative studies. In this study, therefore, data were collected through the scoping review, the individual interviews and workshops. The research participants in phase one and two were reminded that the process was voluntary, confidential and anonymous.
- *Dependability (reliability):* This relates to how research studies can be repeated (Shenton, 2004). For this reason, a detailed description of the data gathering process is provided.
- *Triangulation:* Triangulation refers to the use of multiple methods, or data sources, in qualitative research to develop a comprehensive understanding of phenomena (Patton, 1999). In addition, it refers to the use of multiple perceptions to clarify meaning, and for verifying the repeatability of an observation or interpretation (Stake, 2000, p. 454). Triangulation is also perceived as a means of widening and deepening a study (Hussein, 2009). Patton (1999, p. 1192) asserts that “the logic of triangulation is based on the premise that no single method ever adequately solves the problem of rival explanations. Because each method reveals different aspects of empirical reality, multiple methods of data collection and analysis provide more gist for the research mill.” As mentioned earlier, data were collected through multiple methods to ensure their validity and reliability, as well as credibility and trustworthiness (Rowley, 2002; Baxter & Jack, 2008; Patton, 1999). In addition, the data collected through the interviews were coded by an independent coder to ensure quality assurance and data triangulation.

4.9. Ethics statement

Ethical consideration is imperative when conducting social research. Ethical standards exist that researchers are obliged to follow for the sake of their participants' protection (Ary, Jacobs, Soresnen & Walker, 2014) As the researcher was interacting with human beings, ethical clearance was granted by the Senate Research committee of the University of the Western Cape (Appendix A), as well as the Ministry of Health and Social Services in Namibia (Appendix B). In addition, the researcher considered the issues regarding informed consent (Silverman, 2010), confidentiality and anonymity (Cohen, Manion & Morrison, 2007; Kvale & Brinkmann, 2009), and security (Boeija, 2010).

- *Informed consent*

Before the research study was launched, all research participants were informed about the purpose of the study as well as the research procedure. An information sheet (Appendix C) was handed to all the research participants including the workshop participants as well as a consent form (Appendix D). All the research participants, including the workshop participants, were requested to sign the consent form, voluntarily. The letter of informed consent confirmed their voluntary participation in the study, and they understood that they were free to withdraw their consent at any time without adverse consequences or loss of benefits. No reason for withdrawal was required.

- *Privacy and confidentiality*

The manner in which the data were collected was designed to ensure that no individuals could be identified. At no stage was any individual research participant revealed or communicated about to his/her management. Pseudonyms were used to ensure the anonymity and confidentiality of participants. The participants were also informed that the findings would be shared with all the relevant stakeholders. Regarding the workshop participants' confidentiality, the participants were given a confidentiality binding form (Appendix E) to sign, to ensure the confidentiality of the discussions during the workshops, by not disclosing the identity of other participants, or any aspects of their contributions to members outside of the group.

- *Further intervention required*

The researcher made provisions for further intervention should the participants be affected or negatively impacted by the study. However, no such service was needed as no

participant expressed the need.

4.10. Summary

In this chapter, the researcher discussed qualitative and interpretive research as employed under the ontological assumption. In addition, a collective case study design, as well as data collection through a scoping review, individual interviews and workshops, were discussed. Data analysed firstly through thematic, and secondly through cross-case analysis, were also discussed. Overall, detailed information about the research method and design, the paradigm that framed this current study, the data collection methods and process, data analysis, as well as ethical considerations were presented.



CHAPTER FIVE

PHASE ONE – STAGE 1: SCOPING REVIEW

5.1. Introduction

In this chapter, the researcher presents a detailed description of the scoping review, as well as the results thereof. According to Mays, Roberts and Popay (2001, p. 194), as well as Peters, Godfrey, Khalil, McInerney, Parker and Soares (2015), a scoping review is aimed at rapidly mapping the key concepts underpinning a research area, as well as the main available sources and types of evidence. In addition, a scoping review can be undertaken as a stand-alone project, especially, where an area is complex, or has not been previously reviewed comprehensively, (Mays, Roberts & Popay, 2001). A scoping review may also be undertaken as an exercise to summarise and disseminate research findings as well as identify research inadequacies (Peters *et al.*, 2015).

5.2. Background

The aim of the scoping review in this current study was to explore the existing research that was conducted on spirituality and social work in Africa. An increased interest about spirituality in social work has continued since 1980 till the present (Canda, 1997; Russel, 1998). The upsurge of interest is confirmed by the increased number of publications and presentations on the topic of spirituality and social work (Canda & Furman, 1999). A study conducted by Sheridan and Hemert (1999), on the role of religion and spirituality in social work education and practice revealed a general favourable stance towards it, as well as a relatively high endorsement and utilisation of spiritually oriented interventions with clients. Other studies and publications in spirituality and social work include, Joseph (1987), Derezotes (1995), Canda *et al.* (2004), Canda and Furman (2010), Seinfeld (2012), Gray (2008), Carrington (2011), as well as Sheridan (2009), to mention but a few. This increase in research and publications, generated a new understanding of the relevancy of spirituality in social work (Sheridan, 2000).

However, the increased research and publications in spirituality and social work has not occurred in Africa, particularly in Southern Africa. Literature in South Africa is sparse, with a few publications that championed the integration of spirituality into social work education (Bhagwan, 2010a; 2010b). In Namibia, and other African nations like Zimbabwe, there is a lack of social work research that explores spirituality and social work (Mabvurira &

Nyanguru, 2013), in fact, there is a general lack of research on African spirituality. Mabvurira and Nyangurure (2013) highlight the lack of guidelines, skills and knowledge for the utilisation of spirituality in social work practice, most probably due to the fact that the social work curricula in most Zimbabwean universities at undergraduate and postgraduate levels do not include any studies on spirituality. In addition, the Council of Social Workers of Zimbabwe does not mandate social workers in practice to be spiritually sensitive in their caring process. While, anecdotally, spirituality is considered a viable strength for people, generally, as well as for coping with mental health problems, the Namibian social work literature and education remains silent on spirituality in clinical practice. Therefore, because of this limitation, the researcher undertook a scoping review to explore research that has been conducted on spirituality and social work in Africa.

5.3. Inclusion criteria

The researcher examined African studies conducted on spirituality and social work between 2006 and 2016. Databases, such as, PsychLit, Ebscohost (Medline, Pubmed), Google Scholar, Science Direct, Sabinet, were scrutinised, focusing on published articles in peer-reviewed journals only, and excluding Master or Doctoral research theses, which, ultimately narrowed the search outcome to only five journal articles.

5.4. Data collection tool

The following steps were followed in conducting the scoping study, as outlined by Arksey and O'Malleys (2005):

- *Step 1: Identifying the research question: What domain needs to be explored?*

The researcher questions in this scoping review was, “What African studies have been conducted on spirituality and social work?”

- *Step 2: Identifying relevant studies*

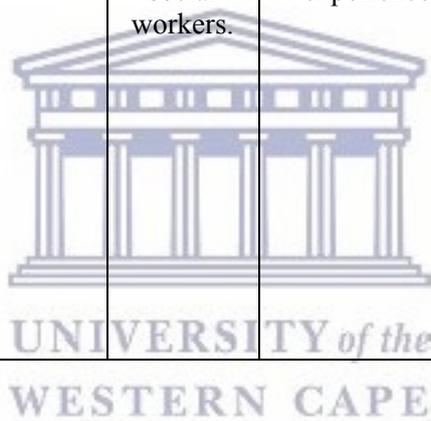
The researcher could only find five relevant studies, as indicated in Table 5.1, which confirms the lack of research done in this area.

Table 5.1: Data extraction form

Article details (References, Title, Vol No.)	Study method and design	Population and sample Size	Study aim	African worldview on spirituality and social Work, Or spirituality and practice	Study results	Field of study
<p>Bhagwan, R. (2010a). Spirituality in social work: Survey of students at South African Universities. <i>Social Work Education</i>, 29(2), 188-204.</p>	<p>Quantitative, Questionnaire Survey</p>	<p>The study was implemented through a survey with the population of final year social work students (N ¼ 714), at all universities in South Africa (N ¼ 21).</p>	<p>This study explores and highlights empirical research related to the inclusion of spirituality in training</p>	<p>Spirituality, particularly African Indigenous Religion, appears to be a dominant feature within SA society, education has not yet worked towards partnering with this dimension within its curricula. This leaves concern as to how current practitioners may be working effectively within the space of the client’s spiritual worldviews. Nevertheless, the study found significant support for its introduction into SA curricula.</p>	<p>The findings revealed high levels of religiosity or spirituality among students, a gap in the curriculum on spirituality and support for its inclusion in social work education.</p>	<p>Social work</p>
<p>Bhagwan, R. (2010c). Content areas for curriculum development: Spirituality and Social work. <i>Social Work/Maatskaplike Werk</i>, 46(3), 299-310</p>	<p>Qualitative study with students, through questionnaire</p>	<p>Final year social work students: N=342</p>	<p>Solely on the students’ levels of agreement on content areas for a course on spirituality and social work in South Africa.</p>	<p>It is important that issues of spirituality do not continue to remain separated from education. Without the appropriate knowledge and skills practitioners will remain unprepared to deal with the spiritual dimension in practice.</p>	<p>Students’ ranked “Religious and spiritual diversity” as a specific course content with 85%.</p>	<p>Social work</p>

<p>Bhagwan, R. (2011). Spirituality in Pedagogy: A qualitative study with educators. <i>Social Work/ Maatskaplike Werk</i>, 47(4), 511-520</p>	<p>Qualitative, individual interviews and focus group.</p>	<p>Six Schools of Social Work participated in this study. 17 interviews were held with 3 males and 14 females.</p>	<p>The aim was to deepen an understanding of educators' views about and experiences of spirituality at a personal level, in practice and in pedagogical processes.</p>	<p>There is a high need for Educators to be educated and trained on spirituality in social work education to be prepare to teach</p>	<p>This study was important as it illuminated the position of spirituality in social work pedagogy. While most educators in the sample experienced high levels of personal spirituality, spirituality remains on the distant horizon in education. Although most participants saw its relevance in education, based on the holistic paradigm, very few acknowledged giving it attention in pedagogy. However, it had received a voice in classroom discussions, and was interlinked, primarily, with diversity.</p>	<p>Social work</p>
<p>Bhagwan, R. (2013). Spirituality in social work in South Africa: Insights from a survey with academics. <i>International Social work</i>, 56(3), 276-289</p>	<p>Quantitative, National Survey</p>	<p>66 Educators from 16 Universities</p>	<p>To explore the view of the educators on spirituality in education and practice.</p>	<p>Little has yet been achieved to interweave the spiritual threads into the educational fabric</p>	<p>Indicating positive views on spirituality in social work education and practice.</p>	<p>Social work</p>

<p>Nkomo, T. S. (2016). Understanding of spirituality among healthcare professionals at Chris Hani Baragwanath Academic Hospital: A Social Work Perspective. <i>Ethno Med</i>, 10(1), 6-14</p>	<p>Qualitative research approach, with exploratory design obtained by conducting seven (7) focus groups with healthcare professionals.</p>	<p>More than 10 participants were present at each focus group</p>	<p>The aim of this study is to explore the impact of religion among healthcare professionals, including social workers.</p>	<p>Religion and spirituality are important in people's lives. Religion and spirituality enable individuals to explain and relate to their day-to-day activities and experiences.</p>	<p>The spirit plays an important role in coping, understanding and interpreting life experiences. A number of positive aspects of religion and spirituality were attributed to promoting resilience, productivity and job satisfaction of healthcare professionals in their working and personal lives. These aspects include prayer, meditation and ancestors. Religion and spirituality encourage good patient care. During illness, beliefs and Ubuntu</p>	<p>Social work</p>
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- *Step 3: Study selection*

The researcher selected African studies conducted on spirituality and social work from 2006 to 2016.

- *Step 4: Charting the data*

The journal articles selected were populated in Table 5.1, according to the suggestions by Arksey and O'Malley (2005).

- *Stage 5: Collating, summarising and reporting the results.*

All literature reviewed were recorded on a Data Extraction Form (Table 5.1), which provided the following information: *Article details (references, title, vol. no.); Study method and design; Population and sample size; Study aim; African worldview on spirituality and social work; Study results and Field of study.*

The key terms used to search for the relevant journal articles included: *African worldview of spirituality and social work*; *Spirituality*; and *Social work*.

5.5. Data analysis

The journal articles basically from two authors were analysed in the following themes.

5.5.1. Theme 1: Participants' spirituality

In Bhagwan's (2010a) study, although the sample primarily consisted of Black students, the majority of them professed to be followers of Christianity, instead of the African Traditional Religion. Religion in Africa is complex as well as multi-faceted, and while most Africans embrace Christianity, they live according to the teachings and practices of the African Traditional Religion. It is acknowledged that the African Traditional Religion is a combination of both religious and cultural contexts, from which most Black Christians originate, and live within (Bhagwan, 2002). It is possible that the reason behind not indicating the African Traditional Religion as their religion is because African spirituality is perceived as a way of life and part of their culture, rather than a direct expression of religion (Mbiti, 1975; Setiloane, 1986).

In Bhagwan's (2011) study, academics were asked about their personal experiences of spirituality. Some linked it to their personal life, while others linked it to their pedagogical role. A few educators (N=3) perceived spirituality as embedded in religion, and believed that spirituality flowed from religious norms and values. They described their daily experiences of spirituality as *the way you exercise your religion*, and through a *connection with God*. The majority of the sample, however, indicated a broader and more holistic understanding of spirituality as an experience beyond the confines of religion; echoing the sentiments of most.

In Nkomo's (2016) study, when social workers, among other healthcare professionals, were asked about their understanding of the concept of spirituality, they provided diverse answers, including: *"Belief in God"*; *"Connection with the Supreme"*; *"Relationship with self, holistic being, physical, emotional, social, and psychological"*; and a *"Meaningful relationship with the church, family, or friends"*.

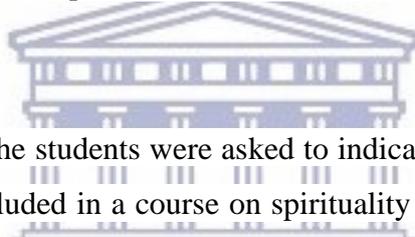
5.5.2. Theme 2: Spirituality in social work education

The study by Bhagwan (2010a) revealed a high level of spirituality among students, and

observed significant support for its introduction into the South African curricula. In order to investigate the relevance of the spiritual domain in education, the students were asked to consider the following rationales for its inclusion in curricula:

1. Religious as well as spiritual beliefs and practices are part of multi-cultural diversity. As such, social workers should acquire knowledge and skills in this area in order to work effectively with diverse client groups;
2. Spirituality is another dimension of human existence, and should be considered by social workers as part of the bio-psychosocial framework, currently used to understand human behaviour. Social work education should expand this framework to include the spiritual dimension.

Of the two rationales above, the participants showed greater support for the first one with 86%, and 67% for the second rationale. Similarly, in Bhagwan (2013), when academics were posed the same question, they also preferred the first rationale, with 92.4 %, and 89.4% for the second rationale.



In Bhagwan's (2010c) study, the students were asked to indicate which specific content area, in their opinion, should be included in a course on spirituality and social work. The students ranked "*Religious and spiritual diversity*" highest, with 85%. In Bhagwan's (2013) study with academics, there was greater support for religion and spirituality to be offered as a required course with 45.4% ($n = 30$); 9.1% ($n = 6$) voted that it should be a required course in the clinical track only; 39.4% ($n = 26$) voted that it should be offered as an elective; 4.5% were against it being offered at all; and 1.6% represented missing data. Bhagwan's (2011) study revealed that spirituality does have a presence in social work education; however, what remains to be determined is how educators could work towards threading it into the other dimensions of social work to complete the holistic approach. Similarly, Nkomo's (2016) study recommended that social workers and healthcare professionals have a course component on religion and spirituality in their curriculum, with the content comprising both Western and indigenous religious belief systems.

5.5.3. Theme three: Spirituality in social work practice

In Bhagwan's (2010a) study, the participants had a strong positive view of the role of religion and spirituality in practice, correlating with the strong positive role that religion and spirituality fulfil in the personal lives of the participants. The participants were asked to

indicate whether they had used spiritual interventions with clients, and whether they viewed these interventions as appropriate for social work practice. More than half of the sample reported using the following activities:

- gathering information on their clients' spiritual backgrounds;
- helping clients to reflect on their beliefs about loss, or difficult life situations;
- helping clients to consider ways that their spiritual beliefs/practices are helpful;
- referring clients to spiritual counsellors;
- recommending participation in a spiritual programme/activity;
- helping clients to clarify their religious or spiritual values; and
- praying privately for a client.

Between 30% and 50% indicated using the following:

- helping clients to consider ways in which their spiritual support systems are harmful;
- using or recommending religious or spiritual books or writings;
- recommending spiritual forgiveness, penance, or making amends;
- helping clients to consider the spiritual meaning of their current life situation;
- referring clients to a 12-step rehabilitation programme;
- using spiritual language;
- discussing the role of spiritual beliefs in relation to significant others, and
- sharing their own spiritual beliefs with clients.

Less than 30% of the sample used the following:

- assisting clients to reflect critically on spiritual beliefs;
- helping clients to consider ways in which their spiritual beliefs are harmful;
- recommending the use of a spiritual diary or journal;
- meditating with a client;
- helping clients to assess the spiritual meaning of dreams;
- touching clients for healing purposes; and
- helping clients to develop a ritual as a clinical intervention, and participating in clients' spiritual rituals as a clinical intervention.

Regarding the participants' views on the appropriateness of these interventions for practice, the study revealed a high level of congruence between the activities that the sample had used

and those that they believed to be appropriate for practice, as well as a high congruence between those least frequently used and those that they regarded as inappropriate for practice. This resonates with the findings in a USA study with practitioners (Canda & Furman, 1999). Although 43% believed that helping clients to develop rituals was appropriate, only 17% indicated using spiritual interventions in practice. The lack of knowledge about how to use spiritual interventions may account for these discrepancies. In Bhagwan (2011), while current South African social work pedagogy embraces cultural diversity and spirituality as manifested within cultures, this appears to be invisible. One participant from the study by Bhagwan (2011) articulated that African spirituality needed a stronger voice, as it underpins the lives of so many in South Africa; therefore, a greater understanding of it is critical to working effectively with clients, who hold this worldview. The second rationale revolves around spirituality as an integral component of the holistic perspective.

Educators who made this point said the following:

“spirituality cannot be disconnected from practice”,

“we teach the holistic perspective to students ... we need to consider a client’s particular spirituality”.

Bhagwan’s (2013) study with academics reveals a high rating that reflects a positive attitude towards spirituality in practice. Nkomo’s (2016) study recommends it to social workers in healthcare settings, to ensure that individuals seeking healthcare are not discriminated against because of their beliefs. Nkomo (2016) further asserts that it is important for social workers in healthcare settings to understand the religious ceremonies and rituals which are practiced by clients and patients in their working environment. This is critical in instances where service users or clients seek assistance from both religious and non-religious agencies. Social workers in healthcare settings should search for the strengths and positive aspects of African and Western beliefs, which might be of importance during the caring process. In this way, social workers could help their patients in a more relevant way which makes sense to them.

5.5.4. Theme four: Education and training in spirituality

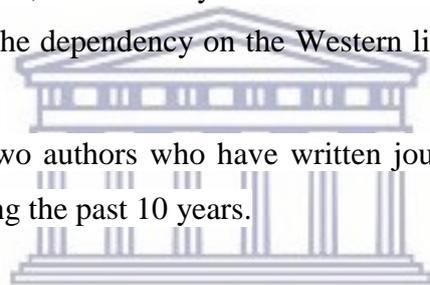
Based on Bhagwan’s (2013) study, about 50% of the educators indicated that spirituality had *never* been presented in their training. When asked to rate their satisfaction with the amount of content received on religion and spirituality during their education, 36.4% of the educators

expressed lower levels of satisfaction, 27.3% expressed satisfaction, while 25.8% expressed higher levels of satisfaction. Data were missing for 10.5% of the sample.

5.6. Identified research disparities

Based on the five journal articles reviewed, the following research disparities were identified by the researcher:

- The conceptualisation of the concept of spirituality is important to create an understanding in social work education and practice. Of these five studies, four did not conceptualise the concept of spirituality. The lack of the conceptualisation of spirituality confirms the limitation of literature on spirituality in the African context. Although the participants in Nkomo's (2016) study were asked to define spirituality, the study did not conclude with a working definition of spirituality for social work education and practice in Africa.
- Bhagwan's studies depended mostly on Western literature to define and discuss the concept of spirituality and religion, which may have overlooked the African worldview of spirituality and religion. The dependency on the Western literature was largely due to lack of literature in Africa.
- Actually, there are only two authors who have written journal articles on spirituality and social work in Africa during the past 10 years.



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5.7. Summary

This chapter comprised the results of the scoping review. The objective of this scoping review was to explore the research conducted on spirituality and social work in Africa. Few research journal articles were found, as only two authors had written journal articles on spirituality and social work in Africa during the past 10 years. Regarding the participants' spirituality, spirituality is experienced differently given diverse groups, namely, the students, academics, and healthcare workers, as revealed in Bhagwan (2002; 2010a; 2011) and Nkomo (2016). The scoping review revealed that the participants expressed greater support for the inclusion of spirituality in social work education. In addition, the scoping review revealed that a consideration for the clients' spirituality in practice was important; however, there was a lack of knowledge on how to use spiritual interventions. Regarding education and training in spirituality, the majority of the educators revealed that spirituality had *never* been presented in their training. Of these five studies, four did not explore the concept of spirituality. The lack of the conceptualisation of spirituality confirms the limitation of literature on spirituality in the African context. Bhagwan's studies, which are mostly reflected

in this scoping review, depended much on Western literature to define and discuss the concept of spirituality and religion, and may have overlooked the African worldview of understanding spirituality and religion. This also confirms the lack of African literature on spirituality and social work, creating a dependency on the Western literature. In the next chapter, the results of the semi-structured interviews are discussed.



CHAPTER SIX

PHASE ONE – STAGE 2: THE CASE STUDY

6.1. Introduction

The research results presented in this chapter reveal that spirituality is not only important in the lives of mentally-ill patients, but also in the lives of the social workers working in the mental health setting in Namibia. In this chapter, therefore, the researcher describes the participants' biographical, employment, and personal spirituality profiles in the form of tables, followed by a brief discussion of each. Subsequently, a summary of the themes, sub-themes and categories that emerged from the semi-structured interviews are introduced and discussed in detail.

Table 6.1: Participants' biographical profile

Gender: Female	8
Male	1
Total participants	N=9
Employment	
No. of social workers currently working in the mental hospital	3
No. of social workers who worked at the mental hospital, currently working in the hospital but not in the mental unit	2
No. of social workers who previously worked at the mental hospital, but currently working at other workplaces	4
N =	9

Social work has traditionally been known as more of a female occupation, than male. This is also reflected in Table 5.1. Not only is it reflected in this research, but also, generally, in the Windhoek Central State hospital. Even though in Namibia an increase of males occupying the social work profession is evident, Earle (2008, p. 130) states that, like many caring occupations, social work, even now, is viewed as an extension of what was perceived to be women's work in the community. In Table 6.1, the participants are identified as social

workers providing services in a mental hospital or who had been doing so at some stage. The reason for including those who had been involved in the mental hospital previously was because the current cohort of social workers in the mental hospital were few. Therefore, they were included in the current research because of their valuable experience with the mentally-ill patients.

Table 6.2: Participants’ employment profile

Participants	No of years as a social worker
P1	Between 1-5 years
P2	Between 1-5 years
P3	Between 1-5 years
P4	Between 10-20 years
P5	Between 1-5 years
P6	More than 20 years
P7	Between 1-5 years
P8	Between 10-20 years
P9	Between 1-5 years

As indicated in Table 6.2, only three of the participants had practised social work for longer than 10 years, while the other six had only been practising for 1 to 5 years. According to the Namibia Social Workers Association, as reported by *The Namibian News Paper* (Tjihenuna, 2015), social workers do not remain in one position for long periods as they are drawn to greener pastures, specifically the Ministry of Health and Social Services, under whose authority the mental hospital falls, as well as the Ministry of Gender Equality and Child Welfare. This could be one of the reasons why few social workers stay in one position for longer than 10 years, and more social workers are in practice for less than 5 years, before

seeking other career opportunities.

Table 6.3: Participants' personal spirituality profile

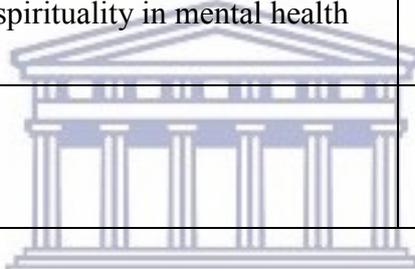
Participants	Description of personal spirituality
P1	<ul style="list-style-type: none"> • Engaged in a form of spirituality at childhood through Christian religion • Engaged in certain traditional practices that are not contravening with the Christian religion • Currently as a grown up, practices spirituality through the Christian religion
P2	<ul style="list-style-type: none"> • Engaged in a form of spirituality at childhood through both Christian religion and traditional practices • Currently as a grown up practices spirituality through Christian religion
P3	<ul style="list-style-type: none"> • Engaged in spirituality through both Christian and traditional religion at childhood • As a grown up, values and practices both the Christian and the traditional religion as the two cannot be separated
P4	<ul style="list-style-type: none"> • Engaged in spirituality at childhood through the Christian religion • Not practicing traditional religion • Currently as a grown up, childhood spirituality serves as a building block to current spirituality. Now practices spirituality meaningfully with deeper understanding
P5	<ul style="list-style-type: none"> • Engaged in spiritual practices through both the Christian and traditional religion • As a grown up, still values and practices both, as both are meaningful
P6	<ul style="list-style-type: none"> • Engaged in spiritual practices at childhood through the Christian religion • Never practiced traditional religion • Currently practices Christian religion
P7	<ul style="list-style-type: none"> • Engaged in spiritual practices at childhood through Christian religion • Currently still practices the Christian religion, however, not as strong as at childhood
P8	<ul style="list-style-type: none"> • Engaged in spiritual practices at childhood • Believes that evil spirits exist but dealt through Christian religion not traditional religion

	<ul style="list-style-type: none"> As a grown up, practices spirituality through the Christian religion, and by connecting to nature and the environment
P9	<ul style="list-style-type: none"> Engaged in spiritual practices through both the Christian religion and traditional religion at childhood. As a grown up, still practices both Christian and traditional religion

While spirituality can be practiced through religion or without religion (Canda & Furman, 2010), based on their spirituality profile, all the participants practiced their spirituality through either the Christian and/or traditional religions. The Christian religion, disseminated by the missionaries to Namibia, initiated the practise of both Western and Traditional religions (Malan, 1995), and to some extent, influenced indigenous people to forsake their traditional religion for the Christian religion, as discussed in Chapter 1. Christianity, as a religion, was not prominent in Namibia before colonialism; however, currently, it is a major force in society, and at times, it is in conflict with the indigenous tradition and culture.

Table 6.4: Summary of themes, sub-themes and categories

Themes	Sub-themes	Categories
Theme 1: Conceptualising spirituality	<p>Sub-theme 1.1: The term spirituality in general</p> <p>Sub-theme 1.2: Spirituality across religions</p> <p>Sub theme 1.3: Spirituality not necessarily linked to religion</p> <p>Sub-theme 1.4: Spirituality linked across religion and tradition</p> <p>Sub-theme 1.5: Spirituality in the Namibian context</p>	<p>Category 1.3.1: Distinct differences between spirituality and religion</p> <p>Category 1.4.1: Similarities and distinctions between spirituality and tradition</p>
Theme 2: Personal perceptions and experiences of spirituality	Sub-theme 2.1: The role of spirituality in personal life	
Theme 3: Spirituality in social work	Sub-theme 3.1: Case examples	

<p>Theme 4: Spirituality and mental health work by social workers</p>	<p>Sub-theme 4.1: The spiritual dimension in social work practice in the mental health field</p> <p>Sub-theme 4.2: Need for knowledge about the mental illness and spirituality</p> <p>Sub-theme 4.3: Clients' needs for inclusion of spirituality in mental health care</p> <p>Sub-theme 4.4: Relevant theories/approaches/perspectives/models to guide social work practice in mental health work</p> <p>Sub-theme 4.5: Values and ethical principles regarding social work practice in mental health work</p> <p>Sub-theme 4.6: Skills needed to include spirituality in mental health work</p>	<p>Category 4.3.1: Assessment of spiritual needs</p> <p>Category 4.5.1: When spiritual needs are detrimental to the well-being of the client</p>
<p>Theme 5: Challenges to be addressed</p>		

6.2. Discussion of the themes, sub-themes and categories

6.2.1. Theme 1: Conceptualising spirituality

In this theme, the conceptualisation of spirituality in social work in the Namibian context was explored by the participants. The definition of spirituality is not absolute, as it is defined differently in various contexts (Roby & Maistry, 2010). In the current study, it was evident that social workers have conceptualised spirituality from their various personal experiences as well as from their patients' diversity of beliefs and experiences. Due to the spiritual and cultural diversities in Namibia, the conceptualisation of the term *spirituality*, could be a challenge, as stated by some of the participants.

“Namibia is a diverse community and it can be difficult to make the Namibian conceptualisation of the challenge.”

“Now when it comes to the Namibian context, we have so many beliefs. Namibia is a country with diversity in cultures and all that with the different beliefs also.”

According to the participants' responses, when people in Namibia refer to *spirituality*, it is usually a challenge to have one definition of spirituality due to the diversified ethnic, traditional and religious groups. Spirituality is often conceptualised by discipline, culture and ideology (Mabvurira, 2016). According to Buys and Nambala (2003), it is hard to generalise the Namibian spirituality due to the fact that Namibia is characterised by a cultural and ethnic diversified population of over two million people. In addition, Namibian ethnic groups comprise more than thirty different tribes, each with their unique language and cultural heritage that influences their spirituality (Buys & Nambala, 2003).

Crisp (2008) asserts that contemporary scholarship which locates itself as being in the field of spirituality is very diverse in its definitions of spirituality. This could imply that there is no ultimate definition for spirituality, as it is experienced and perceived differently by people from differing origins. Therefore, it can be alleged that *spirituality* is an abstract term which lacks a definitive definition (Mabvurira, 2016). Having identified this challenge, the current research cannot claim to have exhausted the possibilities and thereby concluded a national understanding of *spirituality*, as *spirituality* is personal, and therefore, unique to every person. The researcher is of the opinion that further research should be conducted with various Namibian groups, to explore their conceptualisation of spirituality. In the current research, the conceptualisation of the term, *spirituality*, was drawn from five sub-themes.

6.2.1.1. Sub-theme 1.1: The term spirituality in general

According to Canda and Furman (2010, p. 75), spirituality is defined as, "...a process of human life and development, focusing on the search or urge towards greater reality for a sense of meaning, purpose, morality and well-being; this search is in relation with oneself, other people, other beings, the universe, and ultimate reality however understood (for example, in animistic, atheist, nontheistic, polytheistic, theistic, or other ways; orienting around centrally significant priorities; and engaging a sense of transcendence through an experience that is deeply profound, sacred, divine, or transpersonal)". Similarly, spirituality includes the recognition of a feeling or sense or belief that there is something greater than oneself, something more to being human than sensory experience, and that the greater whole of which people are part is cosmic or divine in nature (Spencer, 2012). Additionally, spirituality is distinguished from all other things human such as values, morals, and mental health, by its connection to that which is sacred, the transcendent. The transcendent is that which is outside of the self, and yet also within the self, and in Western traditions, "The

transcendent is God, Allah, HaShem, or a Higher Power in Western religious traditions, or to Brahman, manifestations of Brahman, Buddha, Dao, or ultimate truth/reality in Eastern traditions” (Koenig, 2012, p. 2).

It is worth mentioning that Koenig’s (2012) definition of spirituality does not include a connection to ancestors, while in the African context, spirituality is mostly viewed to include the connection with the ancestors. Indigenous African spirituality involves deeper human values, attitudes, beliefs, traditional practices and rituals, based on various African worldviews (Gumo , Gisege , Raballah, & Ouma, 2012; Baloyi, 2008). . During the interviews a participant explained the definition of spirituality as follows:

“I will define spirituality as one’s connection to either a deity or being connected to one’s ancestors. By deity I define that as either a god, or having (a) gods, because some believe in one god and some believe in multiple gods.”

Ancestral worship is at the heart of the African spiritual experience in Namibia, as confirmed by Buys and Nambala (2003). Due to participants’ diversified ethnical, traditional and religious backgrounds, diverse definitions were also noted in the current research. Some refer to spirituality as just a belief, whether in a Christian God or ancestors, as per the following direct quotation:

“I think spirituality is how you believe in things. You may be believing on the Christianity part, or on the traditional part, or both. That's how I believe, but it is not something to do with spirits, because even if you're a Christian, God is not a human being, He is Spirit. Our traditional, ancestors they are spirit. So that's how I see spirituality, it's your belief.”

Another participant explained:

“I believe and I can define spirituality as someone's belief, their belief, and their value, how do they value. And also maybe some norms attached to what they believe in and how they value whatever they believe in. To me that's spirituality.”

In contrast, other participants had contrary views as per the following extracts:

“...and spirituality for me, it’s not really so much linked to religion but it is just that space of your being, this wholeness that keeps you calm, content, the way you feel content and such. It can be many different things. It could be going to church, it could be going to your holy fire to ask for guidance, it could be taking a walk in the forest, going to the sea many different.”

“We are human beings and we have a spiritual part and it is not necessarily tied to religion, but it's that belief in an upper being.”

It is clear from the descriptions of the participants that some had already made the connection between religion and spirituality, which is discussed further in the next section.

6.2.1.2. Sub-theme 1.2: Spirituality across religion

In Africa, the terms *spirituality* and *religion* have often been used interchangeably (Mabvurira, 2016). Some of the participants considered separating spirituality from religion; therefore, for many the terms are perceived to be intertwined. Similarly, African spirituality simply acknowledges that beliefs and practices touch on and inform every facet of human life, and therefore African religion cannot be separated from the everyday or mundane (Olupona, 2015). However, some literature assert that a difference between spirituality and religion does exist because spirituality is a broader and more comprehensive term than religion, as religion is more associated with institutions and an organised belief system (Canda & Furman, 2010; Bergamo & White, 2016; Van Niekerk, 2018). Again, in the Namibian context, most people’s spirituality is embedded in their religion and tradition (Malan, 1995), and conforming to one without the other is virtually impossible.

One of the participants expressed the following:

“I think it’s very hard for you to be spiritual without being religious, because religion is intertwined with spirituality in the sense that you can’t physically see the people who you are actually communicating with...”

Here, the participant was referring to the ancestors or “Living-Dead” spirit. Another participant indicated the following:

“You will never be religious without involving spirituality. Spirituality and religion are interdependent. There is no way you can be one without the other.”

On the contrary, Canda and Furman (2010) have a different view, asserting that spirituality can be expressed with, as well as without religion, and that an individual can be spiritual without being religious. However, Baloyi (2008), writing from an African perspective, avers that spiritual belief is inextricably linked to people's religion, implying that African spirituality is inseparable from religion. Some participants further indicated that spirituality spreads across religion, as per the following extracts:

“There are a lot of people who are both religious and spiritual at the same time.”

“What I mean is there are different religions connected to spirituality, like in Christianity, we believe in just Jesus Christ as the Lord and Saviour. But then in other religions, they may believe in more than one god, like there may be a god of the wind, a god of life, a god of love and so on.”

Mabvurira (2016) and Koenig (2012) concur with the participants' views that spirituality is intertwined with religion. Koenig (2012) emphasises that spirituality includes both a search for the transcendent as well as the discovery of the transcendent, which therefore, involves traveling along the path that leads from non-consideration to questioning, to either staunch non-belief or belief, and if belief, then ultimately to devotion, and finally, surrender. However, the issue of spirituality not being linked religion has contrary views.

6.2.1.3. Sub-theme 1.3: Spirituality not necessarily linked to religion

On the contrary, even though most participants indicated that spirituality and religion are intertwined, some still maintained the probability of being spiritual without being religious. Canda and Furman (2010) assert that religion involves the patterning of spiritual beliefs and practices within specific social institutions, with community support and traditions, maintained over time.

- **Category 1.3.1. Distinct differences between spirituality and religion:** The difference between spirituality and religion is that spirituality is a broader and more comprehensive term than religion, as religion is more associated with institutions like denominational affiliations and organised belief systems that promote participation in a faith (Cascio, 1998; Canda & Furman, 2010; Bergamo & White, 2016).

People may express spirituality in religious, or non-religious forms. For example, embracing a higher power to deal with life's challenges is a form of spirituality, which could be

expressed in a church with other believers or individually in any place (Canda & Furman, 2010; Bergamo & White, 2016). Some participants stated the following:

“...And spirituality for me, it's not really so much linked to religion but it is just that space of your being this wholeness. That keeps you calm, content, the way you feel content and such. It can be many different things. It could be going to church, it could be going to your holy fire to ask for guidance, it could be taking a walk in the forest, going to the sea many different.”

“We are human beings and we have a spiritual part and it is not necessarily tied to religion, but it's that belief in an upper being.”

“I think spirituality for me it's my Christianity. For somebody else it might be something different, but for him he can say okay, this is my spirituality. Maybe I don't agree with that. But somehow I think everybody has some inner feeling that manifest maybe in a different way. Or they are not going to church, or they don't belong to a specific religion, but they still can have some spiritual experience.”

Some literature maintains that spirituality is defined only in terms of meaning or purpose in life and does not necessarily include a god, deity or a higher power (Crisp, 2008; Derezote, 2006).

6.2.1.4. Sub-theme 1.4: Spirituality linked across religion and tradition

In Namibia, as well as the rest of Africa, most people practice their spirituality as influenced by their religion, and/or by tradition and culture (Buys & Nambala, 2003; Mbiti, 1969; Gumo, Gisege, Raballah, & Ouma, 2012). Byaruhanga-Akiiki (1988, p. 15) defines *spirituality* as “a total life experience of a people such as their religious, social, political and economic sphere of life, their entire culture”. Baloyi (2008) further confirms that in Africa people lead and experience their lives based on certain spirituality, and these beliefs are guided by their traditional practices and rituals. Similarly, spirituality in Africa is one where an African is inserted into his/her traditional beliefs and practices through a well-defined system of rites of passage which make up a culture (Gumo, Gisege, Raballah, & Ouma, 2012). In this sense, *spiritual belief* is inextricably linked to people's religion, traditions and culture (Baloyi, 2008). One of the participants confirmed that spirituality and religion spread

to the individual's culture, particularly in Africa, as follows:

"I think Namibia is a bit of religion, and it's a bit probably our cultural practices also. I wonder whether there is a part of cultural practices also. It's not only religion, because some of us may believe, many times, in the Namibian stone, we would say no there is no such thing. And I cannot speak of a specific group, but from what I've encountered I think there could be some traditional, cultural part in it as well. Because some people would see spirituality also in that realm, and many would see it in the religious realm."

Some participants expressed the following:

"One could perhaps find some tradition in religion. And sometimes when we, even in the ordinary ones we are sitting and singing and there are drums, and we are singing and clapping hands and we are playing drums, it's a bit of tradition."

"Like at the funeral, like in some Oshiwambo cultures, they will perform certain rituals at the funeral, like to cleanse the family, or for the spirit of the dead person to come back. In Oshiwambo culture they actually take oil, an elder person in the family would like to bring some certain oil, maybe kept somewhere then she will my size people on their hands or their feet (here the participant mean the elder will apply special traditional oil on the hands of people who attended the funeral to prevent them dead). Yet again if you go to church, after doing that traditional cleansing or whatever, they will still go to church and ask for the pastor to pray for them that death should not happen in the family anymore and that God should protect them. Like in our church they will be called in front and the congregation pray"

Spirituality and religion are deeply embedded in traditions, based on a specific social ecology; therefore, it is impossible to fully comprehend individuals' *psychology* and *psychotherapy*, unless such an understanding is situated within their culture, religion, and spirituality (Baloyi, 2008; Mabvurira, 2016). Therefore, as supported by the literature (Malan, 1995; Buys & Nambala, 2003; Mbiti, 1969; Baloyi, 2008; Limb, Hodge, Ward, Alboroto & Larkin, 2018), the participants insisted that people *do* value and practice both religion and

tradition as per the following extracts:

“We don’t really separate (religion and tradition). Because we believe we came from our forefathers, then we can just shun them because they are dead. And we also believe that our forefathers were made by God.”

“But I can’t run away from a tradition, I believe in both because it’s all about your belief, not the pastor’s belief, my belief.”

“Because you can’t ignore the fact that you were born in a certain family, and you can’t ignore the fact that God created you and your family. So I value both.”

“People will make them contradictory, but in the reality is I have experienced and seeing, they don’t contradict. They want to separate them. This one is like this, this one is like this. They are both spirits. Only that the other one is this superior spirit, which made the other spirits. The God, the holy. And then there is the other one of our people died and they are spirits.”

Therefore, it appears that based on the above views, most participants believe, value and practice their spirituality and religion, even though they might consider that their spiritual practices are in conflict with their religious beliefs and practices. This reverts to the African worldview which values both traditional roots and religion (Mabvurira, 2016), as well as that many African people understand healing to be part of their religion, culture, and tradition (Morekwa, 2004).

However, Namibians still regard their ancestors as the ‘living-dead’, who are believed to be mediators between God and the living (Buys & Nambala, 2003). According to the participants, and confirmed in literature, ancestors are regarded as part of people’s spirituality as in their belief, ancestors are *alive* and still exert tremendous power over the living (Buys & Nambala, 2003; Malan, 1995; Mbiti, 1969), although they do not regard their ancestors as their *God*.

- **Category 1.4.1. Similarities between spirituality and tradition.** The participants indicated that there was not much difference between spirituality and tradition, as both were connections to the spiritual realm. This implies that social workers should be aware that their own spirituality might be different from their clients’ spirituality, particularly, if

their clients' spirituality was influenced by their traditions. Although many share Christianity as one religion, diverse traditions and beliefs are still practiced by various individuals and groups within the Christian religion and churches. Consequently, it is argued that each person's spirituality is unique to the person, and therefore, should be regarded as such by the social worker, as the following participants revealed:

"I think a traditional person somewhere somehow is also spiritual. He is not religious, he is spiritual."

"Because you are may be a traditional healer or doing things in a traditional way, it's not saying that you don't believe, or not attending to church services all going to meetings where people meet, specific religions are meeting. Because you will find a client in front of you. The client is spiritual, you are also spiritual, but your spirituality is different, their spirit is different in the sense that their spirituality is traditional. And they will say yes, what do you mean I am not spiritual? I am also spiritual. I believe in a god even though my god is not your god. And that's where they find their security."

"In that I would say yes a person can be considered spiritual, because in other words we also call, like for example a traditional healer, sometimes we refer to them as spiritual healers also, because of the connection that they have with this certain spirits."

"But there is a connection, like when you are traditional, they do have traditional healers for example. Those traditional healers. They have to worship to a certain god who actually give them the power now to do certain practices. Like for example if this lady was unable to give birth, they will worship to either the ancestors, that ancestors, my ancestors give me this power so I can make this woman to be able to give birth."

It is worth highlighting that based on the above quotations, ancestors were regarded by some as a source of strength to deal with difficult situations. Kisthardt (1992), Weick (1992), Saleebey (2006), as well as Glicken (2004) emphasise the importance of discovering and utilising the client's strengths in the caring process; therefore, they suggest that social workers consider exploring mentally ill patients' spirituality during the healing and recovery process as their spirituality was perceived to be a strength, and patients needed to develop

inner strength to survive and cope with afflictions. Additionally, besides the patients' perception of spirituality as a source of strength, religion and spirituality have been observed to be sources of resilience during adverse circumstances (Crawford, Brown & Bonham, 2006; Wong & Vinsky, 2008; Cascio, 2012).

6.2.1.5. Sub-theme 1.5: Spirituality in the Namibian context

Ancestral worship was the foundation of people's active spirituality in Namibia (Malan, 1995). Prior to the arrival of White people on the African continent, indigenous African people had their own way of worshipping God, which has assumed the umbrella name, African Traditional Religion (Mabvurira, 2016). As a result of colonialism, Africans have been victimised by cultural denigration, which manifested in all areas of life, including religion and spirituality (Schiele, 1996). Western thought, dominated by Christianity, created a hierarchical structure of world religions, implying that certain religions were inferior to others (Mabvurira, 2016). Consequently, Africans were coerced to regard and embrace Christianity and Islam, progressively, even though they did not completely lose their traditional beliefs (Mabvurira, 2016). In Namibia, the shift came through colonialism, firstly through missionary work, which introduced modernisation, forced urban migration, modern education and secularisation, in general (Malan, 1995). Therefore, even if *ancestral worship* is still highly regarded in the lives of many, it is not practiced as strongly as before colonialism and missionary work (Buys & Nambala, 2003; Malan, 1995). Currently, spirituality in Namibia has been observed to incline towards Christianity, given the influence of missionaries who arrived during the colonial period (Buys & Nambala, 2003). Consequently, this might have influenced people's conceptualisation of spirituality in Namibia. Namibia is known as a secular state; however, approximately 90% of Namibians profess to be Christians, with a large number actively practicing their religion through regular church attendance (Buys & Nambala, 2003).

Some participants indicated that spirituality in Namibia was mostly practiced through one religion or another; therefore, connecting spirituality to a god. The following extracts refer:

“Ok. In the Namibian context, since we have, we are mostly 90% Christians and we have 10% of other religions, I will say in that context it means that spirituality we view it as our connection to our God which we worship.”

“Seeing at the 90% Christianity, it shows that 90% of people in Namibia believe

that Christianity, they worship God, so that's their spiritual connection. And then for those other religions such as maybe Hindus, the Buddhists, they also have their own gods which they worship so I will say it's the connection that we have to our god."

"I think spirituality for me it's my Christianity. For somebody else it might be something different, but for him he can say okay, this is my spirituality. Maybe I don't agree with that. But somehow I think everybody has some inner feeling that manifest maybe in a different way. Or they are not going to church, or they don't belong to a specific religion, but they still can have some spiritual experience."

However, even though the Namibian population is regarded as 90% Christian, not all are religious, and some who claim to be Christian do not adhere to Christian values and morals. The following extracts refer:

"We cannot assume all people are religious in Namibia. There are some who are not and it will not fit them."

"...Not necessarily practicing Christian values. "But things that are happening in this country are so unchristian like. We have murders, we have rape, we have all... That's not what Christianity is all about. Yet we claim to be a Christian community."

As there is diversity in Namibian spirituality, there is also diversity among Christians. According to Buys and Nambala (2003), the constitution of Namibia allows for religious freedom as the country is a secular state, which makes spirituality in Namibia especially diverse. The largest Christian group in Namibia is the Lutheran Church that stemmed from the work of the Finnish Evangelical Lutheran Mission. The next largest is the Roman Catholic Church, and most other Christian denominations also exist. Other religions practiced in Namibia include Judaism, Islam, Buddhism, and the Baha'i Faith (Buys & Nambala, 2003). As mentioned, Christian religions in Namibia are diverse because some include traditional practices, whereas others nullify traditional practice. One participant stated the following:

"...Diverse and including traditional practices. I think Namibia is a bit of

religion, and it's a bit probably our cultural practices also. I wonder whether there is a part of cultural practices also. It's not only religion, because some of us may believe, many times, in the Namibian stone, we would say no there is no such thing. And I cannot speak of a specific group, but from what I've encountered I think there could be some traditional, cultural part in it as well. Because some people would see spirituality also in that realm, and many would see it in the religious realm."

In Namibia, some ethnic tribes practice indigenous religions, which is also referred to as traditional beliefs and practices (Buys & Nambala, 2003; Malan, 1995). Traditional beliefs in Namibia are quite diverse and include various ethnic beliefs which include: belief in a supreme creator; belief in spirits; belief in the dead, also known as ancestors; belief in the use of witchcraft, and belief in traditional healing (Buys & Nambala, 2003; Malan, 1995; Bartholomew, 2015; Kgatla & Park, 2015). It is also worth mentioning that some of those who practice an indigenous religion also practice the Christian religion (Kgatla & Park, 2015). Despite the invasion of the Christian religion, some Namibians still honour their ancestors.

6.2.2. Theme 2: Personal perceptions and experiences of spirituality

Exploring the participants' personal perceptions and experiences was not part of the aim and objectives of the current research. However, it was essential to establish self-awareness, regarding their own spirituality. Self-awareness and reflection have been described as important elements of professional development in social care practice (Mainemelis, Boyatzis & Kolb, 2002; Laming, 2009). Self-awareness is described as a process of self-discovery, albeit within different disciplines (Carper, 1978). Schön (1983) suggests that professionals could become more aware of their inherent knowledge, and learn from their experiences through the processes of self-reflection. Finlay (2008) asserts that self-reflection involves examining the assumptions of everyday practices and claims, of which practitioners become more self-aware when they evaluate their responses critically to everyday practice situations. According to Sheridan, Bullis, Adcock, Berlin and Miller (1992), self-awareness when related to the spiritual dimension, is being confident that interventions with a particular client or client group, can be performed effectively while sharing a diverse spirituality. For example, certain practitioners may be averse to accepting and respecting an individual's particular spirituality and, therefore, be conflicted to affirm and work with a client of diverse

spirituality (Sheridan *et al.*, 1992). Social workers' self-awareness, therefore, should highlight the behaviours that need to be modified, to not compromise their professional values and ethics regarding their clients' spiritual diversity as opposed to their own (Sheridan, 2009).

6.2.2.1. Sub-theme 2.1: The role of spirituality in the personal life of the social worker

Healthcare professionals, including social workers, need to be assisted to view spirituality as an effective tool in their endeavour to help themselves and their patients (Nkomo, 2016; Fanning, 2015). It could be argued, therefore, that spirituality is an important tool in the life of any human being, and in the current research context, in the lives of the social workers as well as their patients. Some participants regarded spirituality as a source of security, which adds meaning to their lives, and provides them with an identity to experience a sense of belonging. The following extracts refer:

“...it (spirituality) just gives you identity to know that you belong to the Christian family. You know that this sky did not just appear by signs, you know that somebody out there created the sky, you know there is a person there who, the supernatural person, who creates miracles. Because then you know you have a sense of identity, you know what family you belong to.”

“I mean before, I got to understand spiritual things, before I got to understand that there is God out there, I just used to live my life anyhow. I was like, I think the Bible also is some scriptures that talk about, don't be like lost sheep, sheep that just attend to themselves, I mean you should be a sheep that has a shepherd and, so you spiritually you have God. Jesus is like sort of you're like your leader he is the one taking care of you, that's why I regard him as my source of life, so life would be meaningless without that relationship, with my god, the god that I serve. It would be meaningless.”

“I would say it's important because I feel connected. Personally without spirituality I feel like I am on my own.”

Other participants asserted that without spirituality, life is meaningless. Literature explains that religion and spirituality are important to people because they enable individuals to explain and relate in their day-to-day life activities and experiences, whether professional or personal (Nkomo, 2016). According to Puchalski (2001), D' Souza (2002), Koenig (2012),

as well as Canda and Furman (2010), spirituality is highly regarded as it provides a sense of meaning and purpose to individual life experiences and challenges. The following participants regarded spirituality as an important aspect of their lives, for growth and development:

“I’m actually a very spiritual person, basing it on a Christianity. It’s a very important aspect of my life as the years went by, as I started beginning to grow, beginning to understand life, from a different perspective, I cannot say that I understand life fully yet because I’m still growing, but I mean I am an, almost, late adulthood now, so yes.. I’ve learned to discover that spirituality is surely the most important aspect of my life because, before anything happens in the physical realm, we have realms. Before anything happens in the physical realm, it had already happened in the spiritual realm. I believe that my life and other people’s lives no matter whether they believe or not, it’s more based on the spiritual aspect. Only that you can see it.”

“You know your spiritual life is really very, very important. Maybe it’s the most important aspect of your life. That you cannot start and a day without it. It’s a lifestyle. It’s the cornerstone of everything.”

Abraham and Mbuy-Beya (2013) and Byaruhanga-Akiiki (1988) refer to spirituality as the core of life that holds every aspect of life. This implies that spirituality is significant and necessary to the participants as it holds every area of their lives together, which cannot be ignored. Therefore, if spirituality is essential to social workers, then social workers should explore their clients’ spirituality.

Healthcare professionals, including social workers, in Nkomo’s (2016) study, described spirituality as their source of support in their daily activities. This support can be referred to as strength. Therefore, spirituality is a strength to health professionals as it provides them with meaning and purpose in their work with patients, which enhances better service to their patients (Nkomo, 2016; Fanning, 2015). In the current study, the participants articulated that spirituality gives them an inner source of strength, and helps them in their work with the patients, as the following extracts indicate:

“It’s just one or two sentences which you don’t share with the client but you have your own spirituality. Something that gives you strength for you to be able

to fulfil your tasks to the best of your abilities.”

“I also pray for strength also, so I can help the clients better.”

“I’m calling on my supernatural power be it God or what, to give me, to enlighten me, to give me guidance on how to deal with this clients. I will not say please let's hold hands and pray. But I would say my own prayer and say, I am stuck here, God, please help me. What do I do next, what do I say next?”

The participants above regarded spirituality as their source of strength, which is supported by Fanning (2015), Kisthardt (1992), Weick (1992), Saleebey (2006), as well as Glicken (2004). In addition, religion and spirituality have been regarded as sources of strength to be resilient during life’s adverse moments (Crawford *et al.*, 2006; Wong & Vinsky, 2008; Cascio, 2012), or when facing a demanding client. The following extract refers:

“Or this is the person that I may be the person I met in the previous encounter, the previous encounter did not go well. Now we are meeting again. Please help me, give me this calmness, and give me the ability to be able to control myself or to be. And that really helps. When a person comes in you are in a different state of mind.”

Spirituality helps individuals to respond to challenging people in an agreeable manner as it encourages and enhances positive emotions such as awe, love, joy, hope, faith/trust, forgiveness, gratitude and compassion, which also offers many mental and physical benefits (Canda & Furman, 2010; Hodge, 2004; Holloway & Moss, 2010; Seinfeld, 2012; Snyder & Lopez, 2007; Limb, Hodge, Ward, Alboroto & Larkin, 2018). Good feelings and emotions also have good effects on the body as a whole, despite the challenges faced in practice as a social worker. This implies that spirituality can promote mental and emotional health, as well as maturity in social workers, to assist them in dealing with challenging patients. Not only is spirituality a strength in the social workers’ professional lives, but, according to the following participants, spirituality also serves as a companion, as well as a pillar to lean on, no matter the human circumstances, or when forsaken by others, as the following participant revealed:

“I will say it’s a source of strength because I will, when nobody else is there, when everybody has turned their backs on you, you know, that you know God is always there for you no matter what situation you find yourself in, God will

always be there for you..”,

Another participant stated that spirituality generates growth and development:

“Spirituality does not just assist practitioners how to deal with clients, but also needed for personal and professional development, as indicated. Spirituality is really relevant, it’s really needed. Not just for our effective service delivery but also for you on personal, professional growth and development.”

Spirituality is an important tool in the life of any human being, especially social workers and their patients. Social workers have revealed that spirituality provides them with strength, resilience, guidance, abilities, calmness, hope, as well as love for their work with their patients (Mabvurira, 2016; Nkomo, 2016; Crawford *et al.*, 2006; Wong & Vinsky, 2008; Cascio, 2012; Canda & Furman, 2010, Hodge, 2004; Holloway & Moss, 2010, Seinfeld, 2012; Snyder & Lopez, 2007).

6.2.3. Theme 3: Spirituality and social work in mental health setting

Spirituality in social work is an unavoidable human aspect that is present in social work practice. Literature confirms that a disturbed spirituality contributes to illness, including mental illnesses (Ross, 2010; Sow, 1980; Onyango, 2011; Olupona, 2015), which implies that spirituality can be a strength, as well as a disturbance. From an African perspective, a person could suffer from mental illness because of conflicting and broken social relationships with either the micro, meso, and/or macro-cosmos (Onyango, 2011; Olupona, 2015). Micro-cosmos is the sphere in which individuals exist in a context of collectiveness and togetherness, while the meso-cosmos is the sphere in which ancestors are experienced (Sow, 1980). Macro-cosmos is the sphere in which God is experienced (Sow, 1980); therefore, a disturbed relationship with *God*, could contribute to physical or mental ill-health (Onyango, 2011, Olupona, 2015).

6.2.3.1. Sub-theme 3.1: Case examples

The participants shared how they coped with mental illness cases that involved spirituality. According to the cases below, disturbed spirituality, and/or conflicting social relationships may have contributed to patients’ mental illness (Ross, 2010). Consistent with the literature, mental and physical illness can be caused by conflict between an individual and the

ancestors, or a god, witch and spirit. Illness can also be attributed to natural causes, or a breakdown in human relationships (Ross, 2010, Mabvurira, 2016). Some participants revealed that patients have been admitted to the mental hospital presenting with mental disorders, and/or symptoms; however, they might not really be mental cases, but, instead, suffer from a disturbed spirituality which does not need medical intervention, as indicated in the following two cases:

“Quite a number of them. I remember when I just started here in 2014, there was a lady who had come, she was suicidal, she was depressed, because, I can’t remember exactly what happened between her and her boyfriend, but the boyfriend is a junior pastor, a but, at a later stage this guy’s spiritual mother, so-called spiritual mother, they are Christians apparently, but I understand, as we went deeper into the case we get to discover that these people are Christians, but they are also practicing witchcraft. That case did not even need medical intervention but she was admitted here. We just had to go deeper and find out, and speak, we invited this guy to come, we spoke and he started mistreating the girl and things like that. The spiritual mother, it’s not even her biological mother, it’s his spiritual mother, who is in Owamboland did not like this boy, I think she wanted her to marry somebody else. So she started tormenting this girl. She would say that she would see bones on her bed, physical bones. She will be strangled in bed while she is sleeping. She would hear a voice telling her to kill herself. She came here with psychotic symptoms, that even if the doctors evaluated her they saw that no, there is no mental illness here. So we had to call in this man (boyfriend to the patient), talk to him. He explained what was happening, and we really just had to focus more on the spirituality (of the patient), I’m not so sure whether they were sent for prayers, but she never came back here again. That was the first episode and she wanted probably stayed here for four days or for three days. Because those things disappeared the next day. Then she was gone she never came back again.”

From the case above, it appears that the patient’s boyfriend was approached for more information, as the social worker, along with other social workers, explored the patient’s spirituality. The boyfriend revealed what possibly was causing the patient’s spiritual disturbance, which was not necessarily a mental illness. It is possible that they (the patient

and the boyfriend) were subsequently referred to spiritual leaders, as the doctor could not determine any mental illness. Therefore, the social worker is required to explore and gain a deeper understanding of the patients' behaviour, as well as their social systems, and thereafter, refer them to a psychologist, before involving the spiritual leaders.

Additionally, in this case the spiritual mother who was regarded as the boyfriend's spiritual support, was believed to have caused the spiritual unrest in the patient. A spiritual source of support could be regarded by some as helpful to mental illness (D' Sousa, 2002; Puchalski, 2001; Koenig, 2012); however, in this case it could be regarded as the cause of the patient's mental health problem. Some spiritual sources of support can have oppressive or destructive consequences for the individual, as well as the wider community/society, both intended and unintended (Holloway & Moss, 2010).

As stated previously, the micro-cosmos is the sphere in which an individual exists in the context of collectiveness and togetherness (Onyango, 2011). In the second case below, a disturbed micro-cosmos social relationship occurred, which may have contributed to the patient's mental illness. The patient could be suffering from a mental illness for killing a fellow human being or because the family, who lost their loved one, had laid a curse on the individual who has killed their beloved one. Kgatla and Park (2015) reveal that killing, stealing from others, or touching other people's things is another avenue through which somebody can be cursed to become mentally sick.

The case below is about a man who had killed another person unintentionally. Subsequently, he asked his father, back home, to pay a cow to the relative of the deceased person he had killed, as failing to pay back the family, who had lost their love one could lead to mental unrest for the one who had killed. Traditionally, that would have been the expected response, as failing to do so, could invite a curse on the one who had killed, according to Kgatla and Park (2015). The following extract refers:

“This one who killed without knowing. I want to pay cows and my father must do this. I am wanting to do this. You see he is not in church. He is talking about... Tradition. I had to call in the father. I asked them over the phone, what did you do on this case, to the people whose relative was murdered? And then they told me, we did this, this, this. I said fine, I can't tell him. I want you to

come and tell him, because you may think I am lying or maybe I just wanted to calm down. So I want you to come then you explain to him whilst I am in.”

In the case above, as described earlier, the social workers insisted that the family of the patient who had killed a person come and speak to the patient to confirm that they had settled the payment to the family of the deceased, and bring peace to the patient. Therefore, to assist the mental recovery, the patient’s family needed to intervene traditionally by repaying the family of the deceased with cows.

In the cases below, the macro-cosmos relationship was disturbed. A disturbed relation with God can contribute to physical or mental ill-health (Onyango, 2011), because, generally in Namibia many people believe that God is the supreme creator of the world, of mankind, animals and plants (Buys & Nambala, 2003). Killing what God has created can be disturbing to someone who regards God as supreme.

“Because one patient was asking me, if a person kills, I know it’s bad, even in my tradition, killing is bad. And I asked him if you kill what will happen to you? You will be unfortunate in the rest of your life. Then I asked him, in your own culture, if you kill someone, what should you do? No you should pay. But to just highlight to you how connected his tradition and the church was; he said, will God forgive me? These people can forgive me, but will God forgive me? He is now worried about the forgiveness from God, not from people, they are paid. But will God forgive me? And he said this question he had it for more than 10 years. Asking himself, will God ever forgive me for what he did? Because he killed his own mother by mistake. So he was asking themselves actually every day. So you know when it comes to forgiveness. And the other question he asked, will my mother forgive me. I know she is dead, but will she forgive me. Now I was stuck, very much stuck. I just referred everything to the church people. And they managed to answer him. I don’t know the way they answered him. But it looks like he was content with the answer. That guy was aggressive. You would just wake up aggressive. And you wonder, didn’t he take his medication? What is wrong? But when all these things came, it’s like I was free to him, he was free to me. He saw me as a sister somehow. I don’t know. I asked him, is that the reason why you are always getting angry? He said yes, whenever those things come.

When I announced that no, we are going to have people will come to have a church service for you on Sundays. Those ones who are interested in going to church, you can join them at this time in the hall. I told them please don't force him. You will come when time comes. You will see him coming. And it happened like that. That's where it came out. He went and asked. Then they talked, they had almost a month of lecturing, teaching him. The sisters, from nowhere, they just started calling wanting to see him after 20 something years. Now, we call it spirituality. Because he had this guilty conscience about his mother. He did not know, will I be forgiven? Will my mother forgive me? The moment he just started talking about it, even those ones in the village, they felt the need to see him. From nowhere they wanted to see him. And they started visiting."

Apart from ensuring that patients receive their medication, social workers should listen attentively as well as explore and seek to understand the patient's spirituality in order to deal with patients' emotional and mental disturbances. As confirmed by literature, should spirituality be deemed necessary in the caring process, the social worker should consider the spiritual and religious aspects of the patient's needs, concerns, strengths, resources, and goals, as well as relevant aspects of the client's environment (Saleeby, 1996; Glickman, 2004; Kisthardt, 1992; Weick, 1992). The cases below are similar to the previous case regarding seeking forgiveness from their ultimate being, referred to as God, in order to be healed, or to find peace. If the social workers do not pay attention to their patients' spiritual concerns, healing might not be complete, as per the following extracts:

"I had a case of one patient. Okay he actually committed murder and he is now stable. He is recovering. He always thinks that I (referring to the client) will be punished by God for... Okay I (client) know I was sick when I committed the crime, but god will punish me for this crime. And he (client) will just sit, when he is just having a headache or a fever or something, he is still scared to die; no I (client) cannot die without a repenting. So since I (the social workers) am not a spiritual expert, I had to call in the pastor that he preferred because he has been there for more than 10 years. So I made an appointment with the pastor. Then the pastor came and he told him now about the importance of confession whatever, and the forgiveness part. And after that he (client) felt at peace. So later he can talk to me (social worker) to say, madam I'm now at peace. He

even started eating because I noticed he was not really eating. Like there was no inner peace.”

Another one said the following:

“There is a patient that was here for a long time and then he went, I (social worker) went, and it’s a female patient. When I created my time that we just have the time just to sit with the female patients to let them have a social talk for them to communicate and then laugh and talk. Later on she called and said, you know what, I need to talk to a pastor, and want, to report what I have done in the past. To confess my sins so that maybe I can be forgiven. Can you assist me to get the pastor? So I (social worker) was like, is it really supposed to be done like that. Since they are pastors that are coming every week and she is now asking for a pastor just to come and attend to her alone to confess. So I said okay, let me work on it I will come back to you. Later on I went to my supervisor and then I asked and they said we cannot deny that. As long as it is something that will not make the patient feel confused or what, but it’s just a matter of her confessing and get everything out of your mind to say that I have spoken to the man of God. I so I arranged for the pastor though it was really very difficult. Asking for these pastors they were saying that their schedule is too tight. But lastly, I got a pastor that came and attended to the patient and then she said thank you very much.”

Most, but not all African tribes, ethnic groups and cultures believe in a higher supernatural power, the Ultimate Being, or to some God (Buys & Nambala, 2003, Mbiti, 1969). In the cases above, the patients believed that they had offended their God, or contravened the law of their God, which states, *thou shall not kill*. Therefore, they believed in the need to make amends for the sake of their peace and health. This requires the social worker to be spiritually sensitive, and attentive to the patients’ needs, over and above the legal implications of a murder inquiry. Social workers should establish a trusting relationship with their patients, to enable the patients to be amenable, while the social worker is exploring, and enquiring what their needs are. This concurs with the principle of the Person Centred Approach, which emphasises that social workers should practice unconditional positive regard by accepting, respecting and caring about their clients (Seligman, 2006). Unconditional positive regard is important because only in the presence of such regard, will a client be truly free to explore

their perceptions (Madoc-Jones, 2008; Seligman, 2006), without fear of being judged or disregarded. The following extract was shared by a participant, regarding certain spiritual practices which could lead to mental illness or which can intervene with the medical recovery process:

“The boy was admitted and by then was also very confused. So this boy was very disruptive. He was into Satanism. In Satanism there is certain phases (rituals) that they must grow into, and that is how they are going to go through the hierarchy. And in one of these phases he had to offer the mother. So during that he stabbed the mother. So then he hurt her. Now, through that whole process we (social worker and the multi-disciplinary team) had to work with the child and the mother. So it’s that stage we called the mother in and, it was especially me and the matron at that stage. We called her (mother) in and she just started to vent. So she was talking about these things that happened to her, and what happened to the boy. So she felt very guilty, because she felt she was the mother of this child she should have seen what was going on. So there was a lot of guilt. There was a lot of blame. There was a lot of uncertainty. Where is my child heading to? There was a lot of anger. Even anger towards the centre because she felt we are not really tackling the problem. Although the boy was in the Ward, he (patient) tried several times to commit suicide. The mother, she wanted the child to be healed. So these demons must just go away. That is how she felt. So it was really very sad case to the point that on her requests, we called in somebody to pray for them. So we sort of moved on at the level where she was to attend to her needs. And then she asked also if this person cannot pray for the boy so that these demons can go away, which was allowed because she was really, she couldn't understand what was going on now. There was a time that the boy sort of, was a little bit calmer. He was here for a very long time. I think three months or five months. So it was very up and down up and down. There was always this ambivalence until one day when the boy walked out of the Ward and he killed himself. And then we had to start the process again with the mother. She was very angry with the hospital. She felt we left her without any help. We didn't see that the boy was gone and he was reacting on what was going on in his mind. So afterwards we had a long process with the mother. Especially with guilt and beliefs. Because later on you could see she was also

now saying “must I believe in God or is there still a God”. So we referred it back to the priest who assisted her here, and had the most contact after that. So I feel strongly that you must be very sensitive and on the level of the client. And react on the request of the client. You know sometimes people will say no, I'm not calling the priest. But that was her need at that point. So I think you must meet the person where he is. Even in spirituality.”

The approach of the social worker in the above extract is an example of the Person Centred Approach (PCA), as the social worker considered the client's needs and concerns by requesting the priest's involvement; although more could have been done in terms of the PCA to explore the meaning of the patient's Satanist beliefs, as Satanism was part of the patient's spirituality. The following case of another social worker reveals how an individual's spirituality can intervene in his/her medical recovery process:

“I remember I had a case at the rehabilitation ward. This is the ward for stable patients ready to go back into the community. So there was this patient that was doing well with the medication and was given recommended for discharge. Just to wake up one day that he stopped taking medication because he had a dream from his God that he cannot take his mental medication for the rest of his life. So I considered it very sensitive, because this person looked stable. He was not confused to say he was taking medication time. So we, I had to do the client education. What is it, what are the symptoms? So he later understood. We called in the doctor. Then I created a contract where he had to sign that I (referring to the patient) am taking my medication every morning. So that's how spirituality can sometimes intervene in people's minds.”

In this case, it appears that the patient refused to accept medication; however, the PCA requires that the social worker explores the patient's belief in his God, to decline medication as well as the meaning thereof. The aim of the Person Centred Approach is not to change the patient but to foster an environment that is safe, with unconditional acceptance and understanding, in order to enable the client to discover his/herself (known as client self-actualisation), while deciding whether s/he wants to change (known as client self-determination) his/her mind regarding accepting medication. In this case, by using this approach, the social worker's goal is to establish a warm and genuine relationship with the client, in order to encourage him/her to discuss, explore, develop and realise his/her inner self

(Rogers, 1951), as well as what the best practice would be to bring about healing and recovery.

The social workers in the current research considered their patients' spirituality; however, they should attend to their patients' spiritual needs individually, as they might be different from each other. One of the participants explained as follows:

“I can talk of many (patients) because there is a group which came to me. They were receiving a church service from this old priest, so they would come to my office, and one of them just mentioned, have you heard of this priest? Is this priest still alive? Then I said, what priest? This one who used to come here to pray for us. They all started laughing. Then I said, why are you laughing? He had only one sermon and luckily and fortunately the chief social worker had told me about that, and also I was in stitches just like they were. Then one of them said, we don't need those type of sermons, we need to pray, we need someone who can come here and pray for us. Because we normally just didn't impose things on them as I have told you. Imposing things on mentally sick patients is not very appropriate. At least they should come up with their (patients) ideas, or you just propose to them and then they will give you the answers. So that's where now we decided to approach the management and tell them. At least it's them (patients) who are requesting for that. And we felt they really need some spiritual guidance and all those things. And it really, to be very honest it really helped quite a lot. It changed most of the patient's behaviour. Whichever church they want to choose. You can't baptize them here. Just give them the word of God and help them. Yes.”

The patients as well as the literature revealed that spirituality needs to be incorporated in the healing process, where necessary (Koenig, 2012; D'Souza, 2002); however, it should be up to each individual patient to determine which type of spiritual practice is fitting for him/her. The following extract refers:

“That's also when we realized, one came to us and requested his Koran. He is Muslim, we didn't know we had a Muslim, and he came, I'm not a Christian, but I need my Bible, I know I can do my prayers alone, but you know I cannot bring my church people here. Can you please find me a Koran for Muslims? So now,

we knew now that we've got a Muslim and we have got these ones."

Regarding the above case, the social worker offered social justice to the patient by adhering to his wishes, regardless of how diverse it was from the other patients' beliefs. According to literature, advocacy should be performed on behalf of individuals and cultural or religious groups, who are the target of oppressive, discriminatory, and prejudicial attitudes, practices, and policies, because of their spiritual beliefs (Canda & Furman, 2010; Nicholas, Rautenbach & Maistry, 2010).

In the cases that the participants managed, they employed different social work roles, namely, educator, counsellor, linker, coordinator, facilitator, advocate, networker, referrer, to deal with cases involving spirituality. The following excerpts refer:

"And also you have the other role of you know, being a networker where you refer to this patient to, like if for example if it's Muslim you referred them to their Muslim leaders, if it's a Christian you also do the same also."

"I would say I played as a coordinator. I coordinated between the pastor and the patient. And the facilitator also of the session that is here is where you will meet."

"I think we were most all of all facilitators. And then we were able to allow her to vent it. Also try to into her life, to give her a little bit of security. To allow her to be angry, because she would come in and shout at us and then we need to calm her down. So it was wisdom and it was teamwork. I think that was the central thing."

Social workers are not trained to be spiritual workers; therefore, it is not in their scope of practice to act the part. Should the need of the patient involve being *linked* to his/her spiritual source, for support and/or strength, the social worker should *facilitate* appropriate *referrals* to the spiritual source of help for the patient (Koenig, 2012; Schenck *et al.*, 2015; Nicholas, Rautenbach & Maistry, 2010). This also implies calling in such support to come to the patient. Should a patient wish to connect to his/her ancestor, the social worker should consider releasing such a patient to travel to his/her homestead or village, for such a traditional practice. However, before releasing the patient, the social worker should facilitate several *educational* meetings (Nicholas, Rautenbach & Maistry, 2010; Schenck *et al.*, 2015)

with the patient, as well as the family, to educate them on the illness, and the importance of medication to the body, in addition to traditional methods.

From the cases discussed earlier, the social worker also plays the role of a counsellor, to provide support to individuals, groups, and communities, and assist them to reach their psycho-social competence (Schenck *et al.*, 2015). In this role, the social worker explores the patients' spirituality, to help them to speak freely, and further encourages them to believe in themselves, bearing in mind that they were more knowledgeable about themselves, than any outsider (Schenck *et al.*, 2015). During the counselling, the social worker draws on the clients' spiritual strengths, and further fosters their self-actualisation, allowing them to rediscover themselves, as well as what is best for them (Schenck *et al.*, 2015). The participants expressed the following, in terms of being a mediator and negotiator:

"I acted as a mediator to help them decide what to do."

The social worker resolves misunderstandings through mediation among the patient's systems (Schenck *et al.*, 2015). Therefore, the social worker can mediate between the patient and his/her family regarding the patient's treatment plan. In addition, the social worker can further negotiate between the patient's different systems to reach workable consensus; for example, if there are suicidal attempts by the patient and one of the possible causes is due to family conflict. The social worker can mediate among the possible parties involved, and negotiate a better and workable solution in the interest of all parties. Therefore, social workers represent and speak on behalf of individuals, groups and communities, advocating for their rights (Schenck *et al.*, 2015). The participants expressed the following regarding their role as advocates:

"The role I played there was advocate. I advocated for the client to the doctor because actually the doctor could not understand. The patient was doing well and is recommended to go home. So they wanted even to counsel his recommendation that this person should remain here. So I had to say just give you a second chance."

Particular concern is usually given to advocacy on behalf of individuals and cultural or religious groups, who are the target of oppressive, discriminatory, and prejudicial attitudes, practices, and policies because of their spiritual beliefs (Canda & Furman, 2010; Nicholas,

Rautenbach & Maistry, 2010). In mental health settings, working with a multi-disciplinary team, spiritually sensitive social workers should fulfil the role of advocate for patients' spiritual needs to be considered in the treatment and recovery process, should a particular patient indicate the need for such considerations.

Regarding all the cases discussed above, in order to understand the patient's spiritual aspects, spiritual assessment and exploration becomes necessary (Koenig, 2012; Hodge, 2004; 2006), even though there is no direct quotation from the participants. Social workers are often confronted with spiritually sensitive cases in their work with mentally ill patients; however, not all admitted cases are pure mental cases as some are due to being disturbed spirituality. Therefore, social workers are required to explore and understand the patient's spirituality, where necessary.

6.2.4. Theme 4: Spirituality and mental health work by social workers

This theme highlighted the perception of the participants that social workers in mental health practice needed to be knowledgeable of and sensitive towards spirituality and mental health, in order to work effectively. As mentioned previously, understanding how mental illness and mental health are conceptualised in the person's culture of origin is important (Australian Association of Social Workers, 2014).



6.2.4.1. Sub-theme 4.1: The spiritual dimension in social work practice in the mental health field

Canda (1989) asserts that religion affects clients significantly, and individuals possess spiritual needs that assist in providing an understanding of, as well as a purpose for life. Additionally, spirituality may be perceived as the intrapsychic dimension of human development in which individuals move towards connectedness and well-being (Derezotes, 1995; Limb, Hodge, Ward, Alboroto & Larkin, 2018). The participants in the current study considered spirituality as another human dimension that needed to be incorporated in the holistic approach of the treatment process, similar to addressing the biological and social human dimensions of the patient. The following excerpts refer:

“Ok. I think it will actually enhance the social work profession more, because

as social workers we are supposed to look at the holistic approach which includes the, the physical, the social, the emotional and also the spiritual part. So we can't actually say that we serving the patients without actually having that spiritual element there also. So it's much needed also."

"When we were being trained as social workers we were told that as a human being has many different dimensions of which one of them is the spiritual dimension. Of which others are the medical dimension, the physical dimension and so forth. So spirituality just happens to be one of the parts of a human being."

"If he is being attended to holistically to say he is being spirituality, medically and socially with relatives and support from the family. Then he will be attended to holistically. So for me to exclude spirituality it's not really a holistic approach."

Considering patients' spirituality in social work should not be strange as social work practice endeavours to address the individual holistically. As explained in the earlier discussions on the roles of social workers, to assess their clients' spirituality is not an easy task. Literature posits that in order to meet the needs of patients holistically, as well as assist them to make sense of their circumstances, spiritual healthcare should be considered as equally important as the physical, social and emotional dimensions (Nkomo, 2016). According to the Ecosystems Theory, an individual has various human dimensions, namely, physical, emotional, psychological and spiritual dimensions. When one dimension is affected, it affects the others, and eventually affects the individual's reaction in certain circumstances (Schenck *et al.*, 2015; Winkelman, 1999). Therefore, the concept of a holistic patient care approach requires that healthcare professionals understand the interconnectedness of the psychosocial, physical, social, emotional, spiritual and cultural realms, and treat their patients accordingly (Govier, 2000).

A contrary view from one of the participants alleged that including spirituality in counselling is not the primary role of social workers, unless it becomes necessary in the caring process. Besides, being spiritually sensitive as a social worker does not imply that counselling is spiritualised in its entirety (Passmore, 2003). Spiritual discourse should only be engaged in, when it is initiated, and regarded as a need by the patient (Passmore, 2003). The following

participant disclosed:

“And that’s why in my counselling sessions I use to avoid, until I get a sense of where this person stands around these issues. I would never come in with my Christian background. Not just in sessions, anywhere, you don't know who the person is. So for me what is important is the person before me. Sitting there in front of me or needs my help. Unless if that person comes in from the start with his perspective around god or whatever. And even if he say’s I don't believe in God that is his view. I’m not there is a pastor who is trying to convert someone into whatever I believe in. My role as a social worker is to focus on the person’s problem and how we could assist this person in becoming this whole, not the whole but to have the issues, the concerns addressed.”

The challenge, however, is how the social worker will know whether the client has a spiritual need or concern without exploring the client’s spirituality. The social worker’s judgment becomes complex, especially when the client’s spirituality is not symbolised. Therefore, using the ecosystem approach, the social worker should consider all human dimensions and the client’s systems which are constantly interacting with its environment, being influenced by, as well as influencing the environment (Segal, Gerdes & Steiner, 2012).

6.2.4.2. Sub-theme 4.2: Need for knowledge about the mental illness and spirituality

One of the social work values requires social workers to improve their knowledge in the areas of theory and practice (National Association of Social Workers [NASW], 2016; Chisom, 2015). The participants were often counselling patients with spiritual needs, therefore, knowledge related to spirituality is essential in order to address the patients’ challenges comprehensively and holistically. Carers should be prepared to respond to their clients’ spiritual needs as they would to other needs. However, according to Dudley and Helfgott (1990, p. 287), “Social workers cannot respond effectively without professional preparation”, implying that they require training and guidance on spirituality and social work, or on spiritually-sensitive social work. In the following extracts, the participants suggested the integration of spirituality into social work education:

“I feel that we all need to have a component of spirituality..... Sort of integrated into our training. Or if some of us have already received training, maybe to

have it as an extra sort of specialised kind of training, it's very important because it makes you understand a patient and other people better. I think in that way we will be able to render better services to all patients and their families.”

“Maybe the universities, the people that are developing the curriculum for social work students, maybe they should have a module on spirituality. Because I was not really taught. We were just told that people have different beliefs and you cannot judge them. It's their choices. But we need to determine the spiritual needs.”

“You use your own discretion. There is really nothing in our training that deals with spirituality.”

“Because it's not covered in our training.

“When we do it we don't really give it much thought that this is around spirituality.”

These participants' quotations are consistent with literature which maintains that, according to various studies, many clients view spirituality as a strength to cope with life's challenges; however, social workers are not trained sufficiently to be knowledgeable about spiritually-sensitive social work practice, for the benefit of their clients (Bhagwan, 2010a). Similarly, Yeo and Miller (2010) assert that social workers are not knowledgeable about the application of spirituality in conceptualisations, assessments and interventions, which may result in unintentional violations of the code of ethics. The findings of a study conducted by Bhagwan (2011) in South Africa on the exploration of social work educators' perceptions, views and experiences of spirituality in pedagogy, revealed that, while current South African pedagogy embraces cultural diversity, spirituality as manifested within cultures, appears invisible, which is one of the reasons for the consideration of spirituality in pedagogy and practice. Additionally, one participant in the study by Bhagwan (2011) articulated the need for African spirituality to be accorded a stronger voice, as it underpinned the lives of so many in South Africa, and a greater understanding thereof was crucial, to effectively address the issues of clients with this worldview. In the Namibian context, the social work curriculum at the University of Namibia, the only university in the country that offers social work studies, addresses cultural diversity; however, it does not necessarily address spirituality and social

work, or spiritually-sensitive social work. Therefore, social workers should endeavour to increase their education on religious and spiritual issues, so that they can be able to enter into informed dialogue with their clients, and offer them effective assistance (Nelson-Becker, 2005; Gumz, Wall & Grossman, 2003).

Competency is a value in social work that should be pursued with vigour (Chisom, 2015); therefore, social workers in mental health should strive to attain knowledge of mental health psychopathology (Chisom, 2015; Australian Association of Social Workers, 2014), which is a specialised field in social work. In the current research, the participants revealed their need for knowledge of, and practice in mental health and mental illnesses:

“And the orientation wasn’t there. You are just put there to work as a social worker in mental health. So you need to go in the research, what should I do when I’m working at mental health. And then it was, mostly trial and error.”

“Unfortunately, most of the social workers don’t know mental health.”

“....Not only is more psychosocial education needed to empower patients about mental illness, the social workers too in the field of mental health also need training in both spirituality and mental health in order to intervene effectively.”

For social work services to be relevant not only for the patients, but also for better cooperation in a multi-disciplinary team, knowledge and understanding of mental illnesses or disorders at different stages in life, on the overall mental health psychopathology, is essential (Australian Association of Social Workers, 2014; Chisom, 2015).

6.2.4.3. Sub-theme 4.3: Clients’ needs for inclusion of spirituality in mental health care

Many individuals suffering from serious mental illnesses want their spiritual beliefs, values and practices to be considered and included in their overall treatment planning and recovery process (Baetz, Griffin, Bowen & Marcoux, 2004; Coyle, 2001; Puchalski, 2001). The participants in the current study revealed that spirituality was very important to their patients as their patients requested it as indicated in the following extracts:

“It is very much important. It is very much important because we hear it, not maybe on a daily basis, but whenever we get in contact with them we hear them.”

We see that they are crying that they want who ever this pastor to come. They want this person to come you know. Like a few months ago also we had someone who was just also pressing on wanting to confess.”

“Then now because the patient is actually requesting for the spiritual part and I knew that’s okay, now in order to complete the holistic circle, this spiritual but also needs to be included there also. Because we can’t say that the patient is actually happy order covering, without all four areas being covered.”

“There are some patients who, would really, one would work with and you will be able to see that spirituality is important to them, because they are talking about it's, they are describing it.”

“You’ll find that some of them require, will start to request for prayers, they wanted you to bring somebody that can pray for them. Because they believe that, the higher authority is the one who will heal them, from this illness because some believe that you can drink your medication but also involve God in it.”

Many patients who are confronted with chronic or fatal conditions rely on spirituality and religion to cope (Büssing & Koenig, 2010). In Namibia, when an individual finds him/herself in severe trouble, *Kalunga* in Oshiwambo, and *Mukuru* in Otjiherero, meaning God, is the last hope and recourse (Buys & Nambala, 2003). Similarly, according to Baloyi (2008), the spiritual dimension of the African understanding of reality maintains that *God* is always linked to all attempts to explain experiences, including the healing of ailing individuals. Some Africans have a high regard for spirituality to deal with their mental illnesses as they believe that mental illness is never a clinical problem (Bartholomew, 2015), but that it is spiritually connected.

The participants in the current study revealed that acknowledging the inclusion of patients’ spirituality provides hope and motivation for them to commit to treatment and overcome difficulties. According to literature, spirituality and religious traditions reveal strengths in people, as it encourages and enhances positive emotions such as awe, love, joy, hope, faith/trust, forgiveness, gratitude and compassion, which also has many mental and physical benefits (Canda & Furman, 2010; Holloway & Moss, 2010; Snyder & Lopez 2007). This

could imply that patients supported by their spirituality have better emotional well-being, despite their conditions and dilemmas, and therefore, cooperate better during the treatment process. The following participants confirmed this as follows:

“So I saw that it actually helped the patients to actually get motivated to focus more on their treatment because so many patients had actually given up. They said, for example there at the forensic unit some patients have been there for more than twenty years. So they have actually given us more on the treatment, they have said I have been here for twenty years it looks like maybe I might not go, maybe I might not get cured. But through spirituality and talking about religion also, they have actually been more motivated now to focus more on the treatment.”

“Because they have because there is the patient who actually used to leave the treatment, saying that I totally give up I would rather die, but because of the spirituality now they have actually been motivated and they carried on going on with the treatment also.”

“I will say it is important, because it has actually helped some patients actually overcome some very difficult times.”

Once again, literature confirms that spirituality and religion are beneficial as they help to maintain self-esteem by providing a sense of meaning and emotional comfort (Mabvurira, 2016). Spirituality fosters a positive belief in an individual's life. When people believe that they could recover, they experience a range of positive emotions about the prospect in the context of their daily lives, and their bodies often respond optimally (Saleeby, 1996). The participants revealed that spirituality improved treatment outcomes of patients connected to spirituality:

“Because all of the lack of this religion or the spiritual support, you know support which they were receiving, some way actually having a relapses but for those patients were actually very much spiritual like that they will read the Bible, although they are sometimes where they can relapse but they were actually responding much better after the treatment.”

“On the other hand, when spiritual groups is in the centre you can see that the

people enjoy it, they like this, somebody is at least now listening to them all. Respecting them all. They have a feeling of belonging. And some of them, it helps them in the recovery process.”

“And really, we saw a change in some of our clients [after church services were included]. A definite change. Because suddenly on a Monday they were more calm some of them. Some of them came with a different approach towards their illnesses. Some of them were saying really we want these people to come in more. The people brought each of them Bible. Some people asked for a specific Bible in their specific language. So there was really some, there was a need which was never addressed before. So they, I think they sort of gave the anchor to some of the patients.”

It could be said that they received attention and acceptance through a spiritual source of support which contributed positively to their emotions. Positive beliefs fulfil a significant role in health maintenance and regeneration (Cousins, 1989). When patients are supported by positive beliefs as well as a supportive environment, the brain acts as a *health maintenance organisation* (Ornstein & Sobel, 1987), which contributes to a positive recovery. In addition, spirituality encourages and enhances positive thinking, as well as emotions like awe, love, joy, hope, faith/trust, forgiveness, gratitude and compassion, which also has many mental and physical benefits (Puchalski, 2001; Canda & Furman, 2010, Holloway & Moss, 2010; Snyder & Lopez 2007). Good feelings and emotions also have good effects on the body as a whole, despite the challenges faced as they may act as signals for the body's immune and recuperative responses (Saleebey, 1996).

- **Category 4.3.1. Assessment of possible causes of patient's mental illness:** Assessing the cause of the problem, whether it is pure mental illness and/or spiritually related, would assist in determining an effective treatment option. A participant expressed:

“The grandfather killed someone. Now this person the way he sometimes behaves, he behaves like that person was killed. So you say this has got something to do with spiritual things. The doctors give medication, but no improvement. And then you wonder, so is this real illness which can be controlled by this westernised medication or does this one need to be taken back to unresolved long back issues, and then we see how it goes. And having worked

in mental health, it has really worked. When you do your collateral, ask about the family background. We normally concentrate on family background when we go back. Because that family background will tell you, is this just simple illness which has just started, or it's something warning you or something caused by something. You know your grandfather did this this this. You need to go and do this this. Honestly you will see the person getting fine without drinking anything. But some of these things they don't even get better, then you know this one needs tablets."

This scenario is an excellent example of the African view that the cause of the mental illness or misfortune, in many cases, is external, as mentioned previously in the literature review chapter (Ross, 2010), and that these external causes have humans, supernatural and ancestral spirits as disease agents of various kinds (Onyango, 2011). Consequently, traditional healers become relevant in this regard (Mabvurira, 2016). Traditional healers and their patients prefer directive treatments or mostly externally oriented methods (for example, ritual cleaning, enactment, sacrifices) (Onyango, 2011, Mabvurira, 2016). Additionally, literature reveals that the incorporation of clients' spiritual, ethical and cultural beliefs into Western counselling, group and community work approaches, has the potential of fostering increased client investment in the healing process, and enhancing the likelihood of positive outcomes (Thabede, 2008; Ross, 2010).

Since not all patients will regard spirituality as important to their treatment and recovery process, exploring the patient's spirituality becomes relevant only when a patient regards spirituality as important to be considered in the caring processes. However, some participants suggested that the intake form should include a section that explores the patient's spirituality:

"If you look at the intake form, the intake form has got some things. It has a problem probably, especially if you also do some thorough investigation of the families functioning. You look at that also. And it's probably a matter of how much do we value it. Maybe I see you value the spirituality as very important. But then seeing how does that, what I am hearing, exploring it a bit deeper. What is the meaning for a client about spirituality? If they say I come Lutheran, what does it mean to be Lutheran? How does it feel being a Lutheran? May be relating it's probably to the problem."

“While I was working at the mental hospital we realized that we are attending to the person in a holistic way. But spirituality didn't feature. You know it was just in the medical team, the multidisciplinary team but there was no really attention given to spirituality.”

“Maybe if you consider developing some assessment tools to consider the spirituality needs of the client because at the moment you can't really know until the person comes to you wanting to kill himself or herself or something. But if there was a certain tool to guide you to say, or guidelines to say may be if you observe this or you see this, consider it as spiritual.”

The extract above reveals that it is important to consider the patient's spiritual needs and concerns in his/her treatment plan during the aiding process. In order to understand the patient's spiritual aspects, spiritual assessment becomes necessary (Koenig, 2012; Hodge, 2004; 2006; Limb, Hodge, Ward, Alboroto & Larkin (2018).

6.2.4.4. Sub-theme 4.4: Relevant theories/approaches/perspectives/models to guide social work practice in mental health work

Social work is a profession that is guided by theories and relevant approaches (Chisom, 2015). The participants indicated that they used different theories and approaches, often not even being aware of which one they were using. This could be observed from their facial expressions, and the way they paused when asked which theory they had used. Each participant used a different theory or mixed theories depending on the type of case as well as the issues involved in the case. Therefore, Schiele (2000) posits that no one theory is complete enough to explain all human functioning. The following theories were shared:

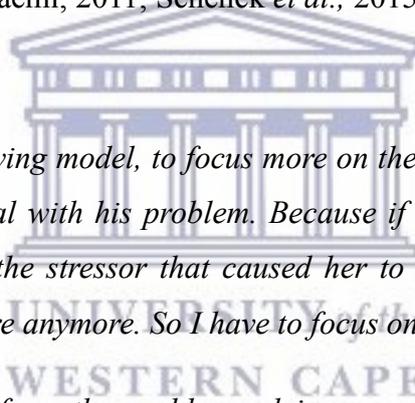
- *Bio-psycho-social model*

“Bio-psycho-social. That's the most appropriate one when you are in mental health. Because you know this person has got a physical illness. Social problems, psychological problems. So you need that theory so much, because you will be involved with everyone. So you can't just say the doctor or the psychiatrist will deal with it.”

Social work views the person as a holistic being interacting with the environment (Schenck *et*

al., 2015). The Bio-Psycho-Social approach is in the Ecosystems perspective, because it enables social workers to be considerate of other human systems and dimensions within the holistic framework (Winkelman, 1999). Social workers should consider the bio-psycho-social-spiritual aspects of the client by assessing their physical and psychological functioning, social relationships, and community, or societal structures that affect the client (Teater, 2015). All these dimensions interact with each other and consequently, impact the person's functioning and reaction to certain situations (Schenck *et al.*, 2015). The bio-psycho-social approach guides the social worker to consider that biological (effects of medication, body response, genetical elements), psychological (which entails beliefs, thoughts, emotions, coping mechanisms, and behaviours), and social (socio-economical, socio-environmental, and cultural) factors, all play a significant role in human functioning, in the context of disease or illness (Ghaemi, 2011). This approach requires social workers to understand their patients' mental illness in a holistic way, considering other human aspects as well as the environment of the patients' interaction (Ghaemi, 2011; Schenck *et al.*, 2015).

- *Problem-solving*



“I use the problem-solving model, to focus more on the problem at hand, to just help this patient to deal with his problem. Because if the problem was solved, the trigger, the issue, the stressor that caused her to be suicidal, the suicidal ideas would not be there anymore. So I have to focus on the problem.

“But starting, maybe from the problem-solving approach that we have been introduced to where we learn the various stages, steps. Because what I like about problem-solving they is possible alternatives. And then with alternatives we ask the client, the problem is identified and assessed and then alternatives. The client probably would say, my headman is an alternative, let's think of a second alternative. Let's think of a third alternative. And maybe with those ones, probably the person might then decide I'm going to my traditional healer, my traditional chief based on his perspective. Because he will make the ultimate decision.”

Social workers assist clients on how to apply a problem solving method so that they can develop their own solutions with the problem solving process, rather than telling clients what to do (Chisom, 2015). According to Min (2011), besides *observing* the problem to

solve, the social worker should *identify* the problem and its impact on the client, and consequently, *strive to solve* the client's problems by unlocking the clients' strengths and resources to cope with and overcome the problems, for life richness through the process of reducing problems.

- *Systems approach (including multi-disciplinary work)*

“The basic theory under which we as social workers operate is the, person in the environment, that you want to understand person, or the systems theory, I don't know if it's the ecological perspective. Where the person comes from. That really, you cannot look at the person in isolation. When we started and when we spoke about my own spirituality we said that this is how I was brought up. So when you meet with the client, a medical doctor focuses on the person, the psychologist perhaps, the occupational. But as the social worker you want to see the person in relation to his environment. And his environment means the next of kin, the support system, where you grew up from childhood. Nowadays we even say we should start looking from conception when the mother was pregnant. But from how the person grew up, where the person grew up. What was his foundation is that person? So you need to see the person in his totality and not necessarily as an individual. I think that is the systems perspective that has a foundation on our social work practice. In the mental health centre really you cannot be looking at the person and say, who the person is today is a result of where he or she is coming from. And especially the Ubuntu-ness. I am a black person, I have mostly worked with black clients. Our sense of community is very... In the black culture you are not an individual. In some cultures we even ask you, who are you? You don't say, I am so, you say I am the daughter of, and I come from... So people have an understanding. So if you say I am who, I said no, everything that person is exposed to. That forms the system that has the impact on. It's not just the family, it is the work, the school, the religions perhaps, persons of influence, the institutions, the hospitals. And that's the biggest theory that one, or at least I apply within the mental health set up.”

“Not only professional team members, you also need to the community, the family, the other agencies you know, the system network in order to render sufficient service to the patients.”

In addition to what has been reported about the Systems theory, literature further asserts that the Systems theory is essential because it helps the social worker to understand that the client's systems in totality, are in constant interaction with its environment, being influenced by, as well as influencing the environment (Segal, Gerdes & Steiner, 2012). Having discussed the theories above, it is also encouraging to note that the theory base for school social work is constantly developing through research (Australian Association of Social Workers, 2014), as no one theory will fit all cases.

6.2.4.5. Sub-theme 4.5: Values and ethical principles regarding social work practice in mental health work

Social work is guided by professional ethical principles and values (Kist-Ashman, 2013, Chisom, 2015). In addition, it was noted that the participants' personal spirituality, which was inclined towards Christianity, enhanced the application of social work values in their practice, as well as to value clients as fellow human beings, and attend to their needs with dignity, regardless of their background. The custom of the church strongly teaches that people should care for one another, while, simultaneously, social work advocates for the development and welfare of disadvantaged people in society (Mabvurira, 2016). The participants expressed the following too:

“As a social worker. It was a Christian college in Wellington. And one of the primary things that we learnt there and which I still apply in life, I tell my children also is that, every person is the making, the image of god is in every person. You know no matter what that person looked like or how bad he is. Somewhere somehow, and that is the way that I'm trying to speak about people you know. So you need to take your values further like with the respect, the dignity that people have. Even in my work you know.”

“And then you for your norms, your values around principles of Christianity or what the church dictates how its membership should behave. And those are basic principles, like caring for the poor, your neighbours, thou shalt not steal. Those basic principles. They are also societal norms basically but enshrined within the Christian values.” “Coming from the Christian background the Bible is very clear that we should help the poor. We should reach out to them. And that gives you so much gratification. Not in terms of monetary value of such, but as a human being doing well to others.”

Literature reveals that in the early 18th century, the social work profession was primarily shaped around Judeo-Christian notions of charity, justice, love, human respect, caring, compassion for the need and communal responsibility (Holloway & Moss, 2010). However, Canda and Furnam (1999) contend that there are spiritual elements embedded in social work values and practice. The inspiration to help others, therefore, seems to have developed as part of individual spirituality (Mabvurira, 2016). In Namibia, the Christian religion is the most dominant; therefore, some social workers' Christian norms and values still guide their conduct with their clients because in most cases they regard social work as their calling. Healthcare professionals, including social workers, aver that spirituality/religion provides a fulfilling experience in their calling (Nkomo, 2016). Regarding which values and ethical principles are relevant in their spiritually sensitive social work, the participants applied the following values:

- *Human dignity, uniqueness, non-judgement and respect*

“So in that sense what I mean is although some people may come and say that they are may be Muslims, and I am a Christian, does that now mean that I shouldn't help this person because we have different beliefs, that's not what it actually means. So if I look at the person as being someone who is actually unique, then I can actually be open and, you know this person also.”

“You know these are sick people, although mentally sick people, but the fact that they are human beings then they are supposed to be respected. You know the dignity of a human being cannot be taken away just because the person is mentally sick. We value that a lot.”

“It's not to be judgmental. Because if the patient is telling you that I have to stop this medication because it's an instruction from God, sometimes as a normal person you might think what is wrong with this person that there is a voice telling him to stop taking medication. So one does not need to be judgmental. You need to respect the person's dignity. Whether the person is mentally ill. Because sometimes we just tend to see, aah this person, even if I talk it's useless and you chase the person away. He might even commit suicide. There are cases where they have committed suicide after being ill-treated by the staff members.”

The participants revealed that spiritually sensitive social workers should respect people's fundamental human rights and dignity at all times, regardless of their mental health status or the circumstances they find themselves in, even when their spirituality does not make any sense. Social workers should have respect for human beings, including respecting the inherent dignity and worth of people (Schenck *et al.*, 2015; Chisom, 2015), regardless of which different worldview their clients may share. Spiritually sensitive social workers should treat each person in a caring and respectful manner, mindful of individual differences, or cultural and ethnic diversity, religious and spiritual diversity, as well as all other forms of human variation (Schenck *et al.*, 2015; Canda & Furman, 2010). Social workers should respect people's fundamental human rights and dignity at all times, with special attention given to the individual's right to privacy, confidentiality, self-determination and autonomy (Nicholas, Rautenbach & Maistry, 2010).

- *Objectivity and self-determination*

The social worker should respect the client's right to self-determination, which implies that the client's desire to make his/her own choices, including finding resolutions, takes priority (Mattice, 2014). In addition, self-determination infers that clients make independent decisions about their lives, while the social worker must assess and confirm that they have the capacity to determine what they want (Schenck *et al.*, 2015; Mattice, 2014). Social workers should promote the client's right to self-determination; however, social workers should be objective enough to provide the correct information and knowledge, and allow the patient to decide. This also implies that social workers should still remain objective by not imposing their beliefs or opinions when sharing information with the patient. The participants disclosed the following:

"We need to get to their level where they are able to understand what you are saying and still help them to make their own choices and their decisions. We help them to do that. We don't make it on their behalf. So it self-determination, diversity that we don't have to, we must not think alike. I being the professional and being in a position to know slightly better, should give the person the information whether good or wrong and person ultimately makes the decision of what he or she wants. Having an understanding of the pros and cons. So the values are really embrace diversity, believe in the self-determination of our

clients.”

“I remember when we were being trained social workers told, one of the ethics, that we actually use as a code of conduct, an oath, was that we should respect people’s determination, people’s individuality. So then when it comes to spirituality, as a social worker and not as me, not as a person individually, but as a social worker, that’s when one, the idea of people having different beliefs having different traditions different religions comes in.”

“In a way that I am objective, not also allowing my beliefs, my own personal beliefs to influence the counselling process all the helping relationship.”

Social workers should believe in the capacity of their clients and further encourage them to believe in themselves as well as convince them that they know themselves better than an outsider (Schenck *et al.*, 2015). The social worker should foster the client’s self-actualisation, and allow the client to rediscover who they are, and what is best for them (Schenck *et al.*, 2015).

Self-determination is relevant when a patient wishes to go somewhere else for healing, which may include going to a traditional healer or ancestors for healing. Spiritually-sensitive social workers acknowledge a responsibility to inform clients of their right to self-determination, help them to obtain appropriate services, and further encourage them to know and believe in themselves (Schenck *et al.*, 2015). As much as the social worker should foster the patient’s right to self-determination, it is also the responsibility of the social worker to inform the patient of the obligations and possible consequences to their decisions (Barsky, 2014), for example, decisions associated with services to be provided to them, including religious and traditional rituals that a patient might choose. Social workers may limit clients’ right to self-determination when, in the social workers’ professional judgment, the client’s actions or potential actions, pose a serious, foreseeable, and imminent risk to themselves or others (Barsky, 2014). According to literature, spiritually-sensitive social workers should promote the clients’ socially responsible self-determination, by assisting clients to engage in clear moral and ethical decision making, in a manner that respects the spiritual perspectives of clients, as well as the right of other people and communities to uphold their own self-determination (Canda & Furman, 2010).

- *Acceptance*

When patients realise that they are not judged but rather accepted unconditionally, they are more open to change, and co-operate better with the social worker in their working relationship (Holosko, Skinner & Robinson, 2008). In addition, they will be more inclined to speak freely about their spirituality as well as what it means to them. The following extract refers:

“Acceptance. I think that was the one that probably made me much easier to adjust. Because they want to be accepted. Because we are out there, the community out there stigmatizing and discriminating against our people with mental disorders. And if you make them feel accepted, they also don't show that aggressiveness or wanting to be attacking you.”

Diversity in Namibia as well as all over the world is inevitable. Spiritually-sensitive social workers, according to the participants, should maintain a non-judgmental attitude towards any patient by accepting and tolerating the patients' worldview on spirituality and mental illness. Acceptance also refers to the social worker's unconditional and positive regard towards the client, including respecting and caring about the clients (Seligman, 2006). Unconditional and positive regard is important because only in the presence of such regard will clients be truly free to explore their perceptions (Madoc-Jones, 2008; Seligman, 2006), without fear of being judged or disregarded. The social worker should accept the client with deep and genuine unconditional caring and attention, regardless of the client's worldview, or regardless of the differences between the social worker and the client (McLeod, 2008).

- *Honesty/Integrity/congruence*

Social workers are expected to be truthful and honest at all times, as well demonstrate integrity in order to service clients and the community honestly and professionally (Chisom, 2015; Nicholas, Rautenbach & Maistry, 2010; Schenck *et al.*, 2015). This further implies that social workers should be truthful and aware of their own belief systems, values, needs and limitations, as well as the effects these have on their work (Nicholas, Rautenbach & Maistry, 2010). Congruence, however, which is also referred to as genuineness, requires the therapist to be authentic, without deceit or pretence, with the client. A client-centred therapist needs to be comfortable to share his/her feelings with the client. Not only will this contribute to a healthy and open relationship between the therapist and client, it will also

provide the client with a model of good communication, and demonstrate that it is safe to be vulnerable (McLeod, 2008). A participant expressed the following:

“I think honesty is one of the things. Don’t pretend. Don’t make promises, especially to people with mental illness, or with family of people with mental illness. Don’t say everything will be okay because you know. I was, all my life I am trying to, in calm, but I will tell them okay these are now the signs and symptoms, or this is the way that things will go or this is what you can expect, you know. So that the people, because people believe that they come back to you. And say, okay what you have said it was true so now we can maybe go forward.”

In order to promote trust, spiritually-sensitive social workers should be open and honest about their moral, professional, religious, theoretical, ideological, political, cultural, as well as other assumptions of themselves and their organisations, that are useful to the helping process (Canda & Furman, 2010). Spiritually sensitive social workers should not be biased when choosing or deciding on spiritual support. The social worker should allow the patient to lead without interfering, which concurs with being objective.

- *Confidentiality*

All people have the right to confidentiality, which generally implies that whatever is communicated between a client and the counsellor remains between them, and cannot be disclosed to others without written permission from the client (National Association of Social Workers [NASW], Connecticut Chapter, 2019). In addition, confidentiality requires social workers to keep clients’ records private (Reamer, 2016; Nicholas, Rautenbach & Maistry, 2010; Schenck *et al.*, 2015). Social workers should at all times respect clients’ fundamental human rights and dignity, with special attention paid to their individual’s rights to privacy, confidentiality, self-determination and autonomy (Nicholas, Rautenbach & Maistry, 2010). A participant expressed the following:

“And confidentiality is something which is much important when it comes to mentally ill people. You know, at first I wondered, do they know what is confidentiality? They know, and they will tell you, social worker I want to tell you something, but if I hear it, I know it’s you. And they also, they do understand it, but they don’t know that it’s called confidentiality. We value that a lot because

even if others know that this person killed, they don't need to know why and how. It has got nothing to do with them."

Social workers in this context should be mindful and sensitive to their patients' type of spirituality, even when they appear to be illogical in society, and it should still be kept private and confidential, as everyone has a right to privacy (Schenck *et al.*, 2015, Canda & Furman, 2010). However, the client's right of confidentiality may be compromised, if s/he exhibits signs of being a danger to him/herself, or others (American Counselling Association, 2014; Mattice, 2016; Reamer, 2016; NASW, Connecticut Chapter, 2019). Should a client express any life-threatening inclinations towards another person or her/himself, the social worker has the right to disregard confidentiality, as the incidence can escalate to a matter of public safety (Reamer, 2016; Mattice, 2016). In the event that the social worker is constrained to share information regarding a case with the supervisor, to solicit advice and support from colleagues, or from the multi-disciplinary team, the social worker should seek permission from the client first, with an explanation of the need to share (Schenck *et al.*, 2015).

- **Category 4.5.1: When spirituality is detrimental to the well-being of the client**

Social workers need to acknowledge that not all spirituality and/or religious expressions are good in their human intent, but instead detrimental. Some may have oppressive or destructive consequences for the individual, as well as the wider community or society, both intentionally and unintentionally (Holloway & Moss, 2010). The participants revealed the best procedures they followed when their clients' spirituality was detrimental to their well-being, as per the following extracts:

Psycho-education to client, family and influential people

"But what we do as staff members here or as social workers, we try to educate, mobilize as much as is possible our patients as well is also involved with their family members. Educate them about the illness. So you bring it to the people's attention to make them aware that mental illness is real."

"Maybe it's education because sometimes the person does not really understand the reason why he is kept there or the reason why he is taking medication. You know they are forgetful because of their conditions. So you need to remind them now it's the... this is what you are suffering from because when you are there you need to know each client's illness, like how to handle this person. So I think

education is more important now and then.”

“And these village heads and Chiefs they would listen better if they use their own priest from their own. As a social worker I tell them, I first explain the diagnosis. Tell them the symptoms and the signs and you know tell them the medication that he is on, tablets or injection or what. And also highlight to them that he told me he believes in this this this. But with this illness he is having, if he doesn't take his medication, you can expect this this this will happen to him. So it's mainly like I would educate, I would intervene, it's like educating those influential people.”

Network with spiritual leaders, other professionals and family

“And let's say if the one that you said if the person said that I will take this medication with petrol. Then maybe I will evaluate to say that okay, maybe he needs psychological assistance. Then I will link the person with the right specialist. I will link the person with the psychologist to carry on with the person.”

“We try to involve the family, may be if there is any form of support, whether it's a family, girlfriend, a friend or somebody, if he has support. Because they are somehow don't even have support. They are rejected by everybody.”

A discussion on the relevant skills to be considered in spiritually sensitive social work, follows hereafter.

6.2.4.6. Sub-theme 4.6: Skills needed to include spirituality in mental health work

Apart from other social work skills, the participants referred to communication skills as essential in addressing a spiritually-sensitive case. Communication skills involve probing and allowing the patient to talk about his/her feelings, without fear of rejection or judgement (Seligman, 2006; McLeod, 2008). The researcher discusses some of the communication skills referred to in the following sections.

- **Active listening**

Some participants said the following:

“I will say one most important skill is active listening. As other patients [in a group session] are busy talking, you have to actively listen, and also you have to keep eye contact with everybody in the group in this sense that one person, for example a Muslim might say something and in the Christian might look very much hurt by what that person said, so if that moment you actually have to close the conversation and you allow other people to actually share their feelings and views on what was just said, and this other person also comes and explains the reasons why is to why they actually said that.”

“The essential skills to consider in cases like this it should be attentive listening, because this person will be talking sometimes nonstop, and you may just make your conclusion.”

“That’s what we use most of the time through the communication skills that apply, clarification, probing to get an understanding where this person is coming and where the person is going.”

- **Empathy**

Being empathetic enables good communication skills as it displays an understanding of the client’s emotions (Seligman, 2006). The person-centred social worker attempts to *tune* into the client through empathy and subsequently, reflects back to them what they are imparting, to allow them to develop and sharpen their understanding and appreciation of themselves (Madoc-Jones, 2008; McLeod, 2008; Rogers, 1992). Being empathetic is an important part of the task as person-centred counsellors follow with sensitivity what the client is communicating, and subsequently, reflect this information back to the client (McLeod, 2008). In mental health settings, communication and empathetic skills are essential for the social worker to establish a good professional working relationship with the person who has a mental illness or a disorder. As confirmed by literature, spiritually-sensitive social workers should listen respectfully to the patient, and provide an emotionally supportive setting while granting due regard to the person’s age and cultural background (Australian Association of Social Workers, 2014). Therefore, a spiritually-sensitive social worker should communicate mutually in the working relationship with his/her patient by using remarks that do not uphold or diminish a certain belief but instead he/she gathers and provides information in a way that respects the person’s experience, beliefs and feelings (Australian Association of Social

Workers, 2014).

6.2.5. Theme 5: Challenges to be addressed

The participants mentioned many challenges that need to be addressed in the mental health practice as discussed in the following sections.

6.2.5.1. Not following the medical plan 1

Patients often do not adhere to the medical plan and/or do not return for follow-up appointments:

“So it becomes really a challenge for you, you may follow up but it’s hard. Usually because with our follow-ups, we usually ask them to come back so we see how they are progressing. So now if the patient is not compliant, they are not obedient, it becomes really hard for you to manage this case.”

This challenge could be understood by acknowledging that African thought exists, and differs from Western thought, as Western thought generally ignores the spiritual and cultural dimension of phenomena, and focuses on the visible and measurable physical reality (Van der Walt, 1997). The patient’s compliance to the medication and/or follow-up appointments could be a challenge, especially, when the patient’s needs are not met according to their worldview, but rather dealt with from a clinical perspective. Such one-sided treatment plans become difficult to implement by the party who was not considered. African patients desire that their traditional approaches to healing also be considered, for example their traditional healers who are culturally closely regarded (Mabvurira, 2016). Traditional healers provide a client-centred and personalised health care that is culturally appropriate, holistic and tailor-made to meet the needs and expectations of their people (Mabvurira, 2016).

However, in Namibia, traditional healing is not recognised by the national health system nor is it incorporated in the health system, thereby, making it challenging to refer patients to traditional sources for healing. Nevertheless, people use their tradition healers. Even if traditional healers are not yet officially recognised as part of the multi-disciplinary team that provides help to patients, social workers still need to be sensitive to the African worldview when dealing with African clients because this worldview informs the way African clients relate to social problems, including mental illness (Thabede, 2008).

Social workers are encouraged to be spiritually sensitive in their work with clients, but it could be a challenge when working in a multi-disciplinary team as the other professionals in the team might not pay attention to the patient's spirituality. A participant expressed the following:

“It causes conflict sometimes between you and the other professionals. Because I know usually be psychologists and social workers a little bit more sensitive to these things, but the other professionals don't have time for these things”

“But like I mentioned earlier we work as a team here. There are some people, some of our colleagues who don't believe in spirituality. So at times, you just hold your hands together and let it be, let it slide. Advice the client to come back, I mean to go for prayers.”

This challenge should be addressed by social work education regarding how to work in a multi-disciplinary team whose members might not necessarily understand the importance of the client's spirituality. The social worker's role in this instance is to advocate on behalf of individuals and cultural or religious groups who are the target of oppressive, discriminatory, and prejudicial attitudes, practices, and policies, because of their spiritual beliefs (Canda & Furman, 2010; Nicholas, Rautenbach & Maistry, 2010). In mental health settings, working in a multi-disciplinary team, spiritually sensitive social workers should fulfil the role of an advocate, to advocate that patients' spiritual needs have to be considered in the treatment and recovery process, should a particular patient indicate the need for such consideration.

6.3. Summary

In this chapter, the researcher has dealt with the concept of spirituality and how it is defined in the Namibian context. The differences and relationships between spirituality, religion and tradition were necessary to discuss as most Africans' spirituality is directly or indirectly connected to religion and tradition. Spiritual diversity in Namibia is also highlighted. In this chapter, it was determined that not only was spirituality necessary in the lives of mentally ill patients, but also in the lives of the social workers, particularly, in their practice, as it guides, comforts, and provides strength. In addition, social workers in mental health practice are confronted with spiritually-sensitive cases which require specialised knowledge, training and guidance in spirituality and social work, or in spiritually-sensitive social work, in order to work effectively. However, the social workers, it was determined, appeared to have dealt with

their cases, guided by theories or approaches, skills, roles, and professional values, as deemed necessary. The findings also revealed that social workers need to acknowledge that not all spirituality and/or religious expressions are good in human intents, but they may be detrimental. Some may have oppressive or destructive consequences for the individual as well as the wider community.



CHAPTER SEVEN

PHASE TWO – STAGES 1 AND 2: GUIDELINES FOR SOCIAL WORKERS IN MENTAL HEALTH SETTINGS TO BE SPIRITUALLY-SENSITIVE IN THEIR PRACTICE

7.1. Introduction and rationale

This chapter includes the development of the guidelines, based on the research process followed, which includes the scoping review and the in-depth interviews with the social workers. According to the results of the study, and given the cultural context, mental ill patients and social workers in Namibia consider spirituality as important in the healing and recovery process of the mentally ill. Literature concurs that those individuals suffering from serious mental illnesses desire that their spiritual beliefs, values and practices be considered and included in their overall treatment planning and recovery process (Baetz *et al*, 2004; Coyle, 2001). Therefore, social workers in the mental health settings are required to explore and understand patients' spirituality during the helping process.

Addressing client's spirituality or being sensitive to the patient's spiritual needs during the helping process is a social work ethical consideration (Winkelman, 1999). Besides, should social workers overlook the spiritual dimension of people's lives, they may be missing an opportunity to help people construct holistic narratives that accurately fit their experiences (Holloway & Moss, 2010). Social workers who overlook patients' spirituality might miss multiple strengths that spirituality may offer to patients' healing and recovery process, because patients regard spirituality as their strength to healing and recovery as well as in dealing with their life challenges. D' Souza (2002) confirms that spirituality is regarded as a strength by patients as they find meaning in their lives through the spiritual connection with significant others, for hope, strength and resources to cope with the physical and psychological pain of the illness. Acknowledging clients' strength including spiritual strength in the helping process is considered beneficial in social work (Saleeby, 2006).

In Namibia, currently there is no empirically-based social work practice literature involving spirituality and social work or spiritually-sensitive social work, while in Africa only a few researchers have attempted to focus on spirituality and social work. Therefore, Namibian social workers in mental health practice are challenged with applying spiritual sensitivity in their work as no guidelines for practice exist. Consequently, the researcher, through the current study, attempted to develop guidelines for spiritually-sensitive social work in mental

health practice.

7.2. Protocol developmental process

Practice guidelines are a set of compiled and organised knowledge statements aimed at guiding practitioners to find, select, and use appropriately, the interventions that are most effective for a given task (Proctor & Rosen, 2003). Similarly, in the Concise Oxford Thesaurus (2007), guidelines are referred to as a set of instructions, directions, suggestions, and guiding principles, to guide an action. Therefore, the guidelines developed in the current study will not be the ultimate standard for practice, but rather a guide for possible direction. This is the first attempt at guidelines and could still be developed further. It is a working document that needs to be implemented and tested.

These guidelines were developed as part of the current completed research; therefore, the developmental process of the guidelines is explained in the research methodology and design chapter (Chapter 4). The content of these developed guidelines was based on the outcome of the current research, specifically from the relevant literature reviewed, the research participants' responses, the inputs of the two experts, and workshop discussions. The discussions on the completed research process as well as the subject of spirituality and social work in mental health practice in the Namibian context is found in the overall thesis. The aim of the research was to develop guidelines for social workers to utilise spirituality in their mental health practice. Therefore, these guidelines have been developed for social workers in the mental health settings in the Namibian context, to guide them on how to utilise spirituality in their practice; however, these guidelines should also be applicable in any other social work setting. Healy's (2005) Dynamic model was adopted to provide direction in the development of the guidelines, during the workshops.

7.3. Aim of the guidelines

The aim of the guidelines was to guide social workers on how to be spiritually-sensitive in their work with mentally ill patients. In the following section, the guidelines are presented and discussed, in detail, as guided by Healy's (2005) Dynamic model.

7.4. Formal professional base

The formal professional base include the working definitions, ethics and principles that

govern the social work practice. The most relevant ethical principles identified for Spiritually-Sensitive Social Work Practice (SSSWP) are further discussed later in the guidelines.

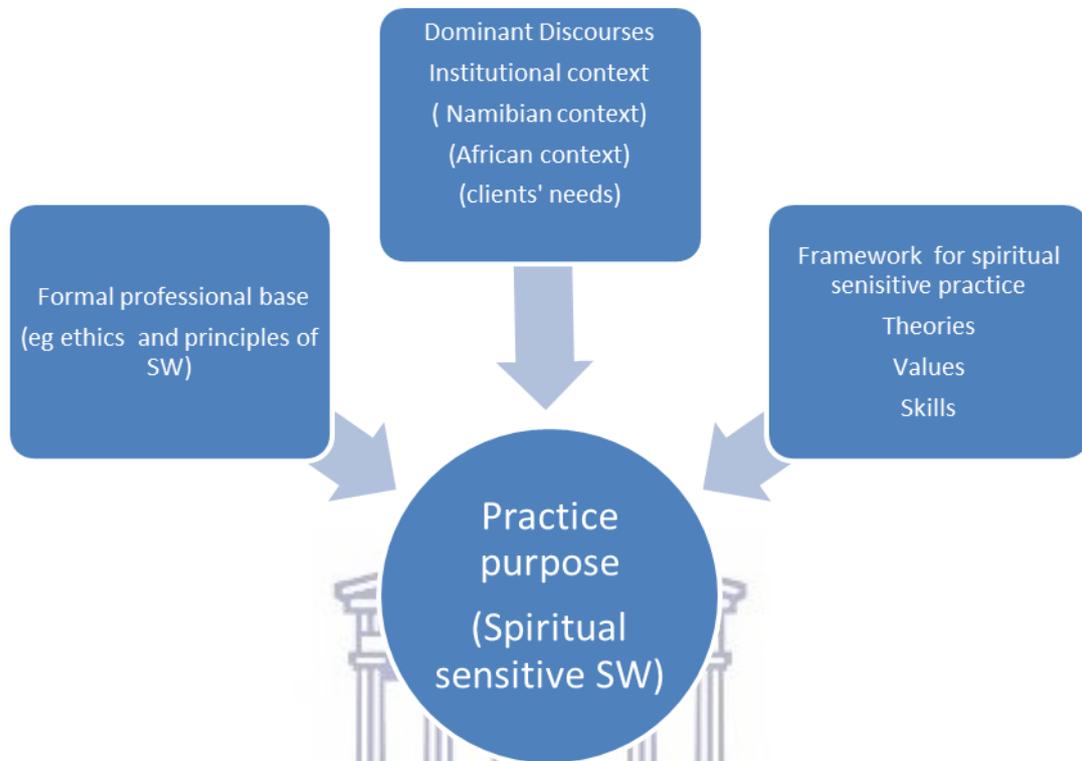


Figure 7.1: Healy's (2005) Dynamic model

7.4.1. Clarifying the concept of spirituality

The concept of spirituality in the profession of social work is relevant as social workers seek to address the person in need, holistically. Social workers and healthcare professionals, who understand and appreciate this holistic approach, ensure better inter-connectedness of the psychosocial, physical, social, emotional, spiritual and cultural realm in their treatment process with their patients (Govier, 2000; Callister, 2004). The definition of spirituality is very diverse, and therefore, not absolute as it is defined in various contexts (Crisp, 2008; Roby & Maisty, 2010). However, in an attempt at an inclusive definition for social work education and practice, Canda and Furman (2010, p. 75) suggest a working definition as follows:

Spirituality is a process of human life and development, focusing on the search or urge towards greater reality for a sense of meaning, purpose, morality and well-being; this search is in relation with oneself, other people, other beings, the universe, and ultimate reality

however understood (for example, in animistic, atheist, nontheistic, polytheistic, theistic, or other ways; orienting around centrally significant priorities; and engaging a sense of transcendence through an experience that is deeply profound, sacred, divine, or transpersonal).

Spirituality and religion can be perceived as interlinked; however, Canda and Furman (2010) further explain that religion involves the patterning of spiritual beliefs and practices within specific social institutions, with community support and traditions maintained over time. The difference between spirituality and religion is that spirituality is a broader and more comprehensive term than religion, as religion is associated more with institutions such as denominational affiliations and organised belief systems that promote participation in a faith (Cascio, 1998; Canda & Furman, 2010). People may express spirituality through religious or non-religious practices; for example, embracing a higher power to deal with life's challenges is the form of spirituality that can be expressed in a church with other believers or individually at any informal place (Canda & Furman, 2010). In the Namibian context, due to its spiritual and cultural diversities, conceptualisation of the term, *spirituality*, can be diverse, as well.

7.4.2. Conceptualisation of spirituality in the Namibian context

Spirituality in the Namibian context is perceived as a connection, a relationship, and an experience between an individual and fellow individuals, including elders, spiritual/traditional leaders (micro-cosmos), and/or between an individual and the dead/ancestor (meso-cosmos), and/or between an individual and the supernatural, deity/god (macro-cosmos). In addition, spirituality involves a belief system that might be diverse, and can change over time; however, it can also be viewed as a sense of wholeness. Spirituality in Namibia is influenced by people's tradition and religion; however, it is also practiced without any connection to a religion or particular tradition.

7.4.3. Social work values and ethical principles for spiritually-sensitive social work

Before seeking for an understanding of the social work values and ethical principles for spiritually-sensitive social work, it is important to reflect again on the global definition of social work (as in Chapter 3), because the values and ethical principles are the fundamental components in the social work practice. According to the global definition of social work by

the IFSW, *the social work profession promotes social change, problem solving in human relationships and the empowerment, as well as the liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. The principles of human rights and social justice are fundamental to social work.* The IFSW further states that, *social work practice, in addressing the barriers, inequities and injustices that exist in society, also responds to crises and emergencies as well as to everyday personal and social problems. Social work utilises a variety of skills, techniques, and activities, consistent with its holistic focus (which includes physical, mental and spiritual dimensions) on persons and their environments* (Virginia Commonwealth University Libraries Social Welfare History Project, 2016).

From the global social work definition above, the mission of social work is rooted in a set of core values and ethics. The following is a summary of social work values in direct relation to the ethical principles, in the context of spiritually-sensitive social work (Canda & Furman, 2010), and based on the data gathered from the research participants and the workshop discussions.

Value: Service

Ethical Principle: Social workers' primary goal is to help people in need and to address social problems

Spiritually sensitive social workers elevate service to others above self-interest, whenever necessary, and always seek mutually beneficial ways of service (Canda & Furman, 2010). During service delivery, the social worker has to respect the client's right to decide, in the context of his/her abilities, and the context of social needs and problems experienced (Nicholas, Rautenbach & Maistry, 2010). Spiritually sensitive social workers draw on their knowledge, values, and skills to help people in need, including their material, biological, psychological, social, relational, and spiritual needs, according to the priorities and aspirations of clients (Canda & Furman, 2010). When clients identify religious or non-religious forms of spiritual support, including religious communities, or spiritual support groups, and transcendent or sacred beings, these beliefs and related practices should be respected by the social worker, and included in the treatment approach, as relevant clients' preferences (Canda & Furman, 2010).

Value: Social justice

Ethical Principle: Social workers challenge social injustice.

In the mental hospital, the spiritual needs of a patient, who has a different belief or uncommon belief to other patients might be overlooked; therefore, the spiritually- sensitive social worker should advocate that such a patient's spiritual need is also considered. Spiritually sensitive social workers pursue social change, particularly with, and on behalf of vulnerable, oppressed individuals, and groups of people (Canda & Furman, 2010). Spiritually sensitive social workers strive to ensure access to needed information, services, and resources, especially from spiritual support systems relevant to their clients, equality of opportunity, and meaningful participation in decision making for all people (Canda & Furman, 2010).

Value: Respect, dignity and worth of the person

Ethical Principle: Social workers respect the inherent dignity and worth of the person.

Spiritually sensitive social workers treat each person in a caring and respectful manner, mindful of individual differences as well as cultural and ethnic diversity, religious and spiritual diversity, and all other forms of human variation (Canda & Furman, 2010). Social workers should at all times respect people's fundamental human rights and dignity, with special attention given to the individual's right to privacy, confidentiality, self-determination and autonomy (Nicholas, Rautenbach & Maistry, 2010).

Value: Confidentiality

Ethical Principle: Social workers should respect clients' right to privacy and confidentiality of their information and status

Social workers in this context should be mindful and sensitive to their patients' type of spirituality; even when it appears to be taboo in society, it should still be kept private and confidential. Sharing information with other colleagues should be purposeful, for example, soliciting advice about a case, for support from colleagues, or the multi-disciplinary team. The social workers should take reasonable steps to keep them informed of the need of confidentiality of the information they may acquire.

In the event of a threat to the safety, or interests of the patient or of others who may be affected by patient's behaviour, the social workers should take the necessary steps to inform appropriate third parties, even without the prior consent of the patient. When in doubt, it

would be wiser to seek professional guidance from the immediate supervisor.

Value: Self determination

Ethical Principle: Social worker acknowledges and promotes clients' need for self-determination

Spiritually-sensitive social workers acknowledge a responsibility to inform patients of their rights, and help them to obtain appropriate services. As much as the social worker should promote the patient's right to self-determination, it is also the responsibility of the social worker to inform the patient of obligations and possible consequences associated with services provided to them; for example, religious and traditional rituals that a patient may request. Spiritually-sensitive social workers should promote their clients' socially responsible self-determination; therefore, they should assist their clients to engage in clear moral and ethical decision making, in a manner that respects the spiritual perspectives of clients as well as the right of other people and communities, to uphold their own self-determination (Canda & Furman, 2010). Spiritually-sensitive social workers should engage in a process of dialogue with their patients and their families, or any other relevant support system to encourage mutual understanding, and mutually beneficial solutions to conflicts (Canda & Furman, 2010).

Value: Importance of human relations

Ethical Principle: Social workers recognise the central importance of human relationships

Social workers in general understand that relationships between people are important vehicles for change. Social workers engage people as partners in the helping process, including collaboration with religious and non-religious spiritual support systems that are relevant to their clients (Canda & Furman, 2010). Spiritually-sensitive social workers should seek to strengthen relationships between people, in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals [micro-cosmos], families, social groups, organisations, and communities [meso-cosmos], supernatural including deity, gods [macro-cosmos] (Canda & Furman, 2010). Spiritually-sensitive social workers understand that many people believe in, and claim to experience relationships with scary or supernatural aspects of reality, a transcendent, divine, or ultimate foundation of reality; therefore, when such beliefs and experiences are important to a patient, the social workers should explore how their clients' relationships with these spiritual forces may influence their sense of well-being, as well as the development of fulfilling relationships with other people and nature (Canda &

Furman, 2010).

Value: Integrity

Ethical Principle: Social workers behave in a trustworthy manner.

Social workers are expected to be truthful and honest at all times. They should be able to reflect on their own feelings and behaviour, and be true to themselves. Social workers have to be truthful and aware of their own belief systems, values, needs and limitations, as well as the effect these may have on their work (Nicholas, Rautenbach & Maistry, 2010). In order to promote trust, spiritually-sensitive social workers should be open and honest about the moral, professional, religious, theoretical, ideological, political, cultural, and other assumptions of themselves, and their organisations, which are useful to the treatment process (Canda & Furman, 2010). Spiritually-sensitive social workers should not be biased when choosing or deciding on spiritual support, as the patient should be allowed to lead without any interference from the social worker.

Value: Competence

Ethical Principle: Social workers practice within their areas of competence and develop and enhance their professional expertise.

In order to maintain this competence and to develop it further, social workers should strive for continuous training and development (Nicholas, Rautenbach, & Maistry, 2010). Spiritually sensitive social workers should learn how to cooperate and collaborate with community-based spiritual support systems, helpers, and healers, in a culturally competent manner (Canda & Furman, 2010). Spiritually-sensitive social workers should aspire to expand the knowledge base of the profession, especially innovations in spiritually-sensitive social work practice, theory, policy, research, and education (Canda & Furman, 2010). Spiritually-sensitive social workers should be culturally competent in order to follow appropriate ways in which the person can be assisted effectively, including collaboration with or referral to, spiritual or traditional leaders.

Value: Non-judgemental and acceptance

Ethical Principle: Social workers should maintain a non-judgemental attitude towards patients whose spirituality is diverse

Diversity in Namibia, as well as the rest of the world, is inevitable. Spiritually-sensitive social workers should maintain a non-judgmental attitude towards any patient, by listening in

order to understand the patient's worldview on spirituality and mental illness. When patients realise that they are not judged, but instead accepted as unique individuals, they would be more open to change and to co-operate better with the social worker in their working relationship.

7.5. Dominant discourses on spirituality and social work

The dominant discourses refer to ideas in circulation that everyone knows and talks about. Social workers should be equipped to be more spiritually sensitive to their clients. They should be able to understand their clients' worldview, as mentally ill patients (and probably other clients as well), and consider spirituality as important to their healing and recovery process. Additionally, the findings of this current research revealed that spirituality was not only important in the lives of the mentally ill patients, but also in the lives of the social workers working in the mental health setting in Namibia, as it supports them.

The three dominant discourses that highlight spirituality in social work practice are identified as follows:

- **Spiritually-sensitive social work:** Guidelines and knowledge of spirituality and social work is required because social workers are expected to consider the spiritual aspects of their clients in their social work practice, as an ethical principle to the benefit of their clients. The potential success in practice would be limited should the social workers choose to ignore their clients' spirituality (Wiedmeyer, 2013).
- **Holistic approach to be implemented:** The social work profession highly regards and encourages a holistic approach when attending to a client. From the social work definition in Chapter 3, the International Federation of Social Workers (IFSW, 2014) and the International Association of Schools of Social Work (IASSW, 2004) suggest that social workers should be required to possess knowledge of human behaviour and development, as well as the environment, such as social, biological, psychological, socio-structural, economic, political, cultural, and spiritual environment, in which clients find themselves and interact with (Pulla, 2014). The definition of social work by the IFSW further implies that social workers should be schooled in multi-cultural knowledge, as well as how such traditions, cultures, beliefs, and religious practices affect their clients (Pulla, 2014). In addition, Faver (1986) concurs that social work has subscribed to a holistic framework for a long time, and posits that the bio-

psychosocial-spiritual and environmental factors are inseparable. Therefore, practitioners who neglect the spiritual dimension are working against the ethics of this framework, and will miss opportunities for a complete assessment and treatment plan (Bhagwan, 2007; Derezotes, 2006).

- **African-centred paradigm:** Thabede (2008) states that social workers dealing with African clients/non-Western clients need to be aware of and sensitive to beliefs that identify African culture so that they are able to reach out to African clients, from the worldview of their clients, be it social, psychological or spiritual. What African clients believe informs both their behaviour as well as the rituals they engage in to address life's challenges (Thabede, 2008).

7.6. Framework for practice: Conceptual framework for spiritually-sensitive social work

Framework for practice refers to theories, values and skills required as a base for practice. Relevant theories, skills, roles, values for spiritually-sensitive social work were identified and they are discussed later in the guidelines. When dealing with mentally ill patients, spiritually-sensitive social work involves understanding more than one concept and dimension as it cannot be explained and interpreted from the perspective of one theory alone, due to the different components it entails. According to Lier and Smith (1999), Imenda (2014), as well as Creswell (2013), an integrated way of exploring the phenomenon may be required. Therefore, a Conceptual framework can be used instead of a theoretical framework (Imenda, 2014). A Conceptual framework is defined as an end result of integrated and related concepts to explain and provide a broader understanding of the subject matter (Imenda, 2014; McGaghie *et al.* 2001). The following are influential theories that as discussed in detail in Chapter 3, address particular variables which are integrated with each other in relation to the phenomenon:

- Ecosystems perspectives
- Person-centred approach
- Afrocentric perspective
- Strengths perspective

7.6.1. Roles of spiritually-sensitive social workers

- **Advocate**

Particular concern is given to advocacy on behalf of individuals and cultural or religious groups, who are the target of oppressive, discriminatory, and prejudicial attitudes, practices, and policies, because of their spiritual beliefs (Canda & Furman, 2010; Nicholas, Rautenbach & Maistry, 2010). In mental health settings, working with a multi-disciplinary team, spiritually-sensitive social workers should fulfil the role of advocate, to campaign for patients' spiritual needs to be considered in their treatment and recovery process, should a particular patient indicate the need for such consideration.

- **Referrer, broker/linker, facilitator, educator roles, as they integrate with each other**

Social workers are not trained to be spiritual workers; therefore, it is not in their scope of practice to act as such. Should a patient express the need to connect with his/her spiritual source, for support and/or strength, social workers should facilitate appropriate referrals to the spiritual source of support that the patient requests, which implies calling in such support to come to the patient. Should a patient wish to connect to his/her ancestor or community support, the social worker should consider linking or releasing such a patient to travel to his/her homestead or village for such community support or traditional practice. However, before releasing the patient, the social worker should facilitate several psycho-educational meetings with the patient as well as the family to educate them about the illness and the importance of medication to the body, in addition to traditional healing methods.

7.6.2. Skills for spiritually-sensitive social workers

Empathetic communication skills

All social work skills are essential and useful in any context of social work even in spiritually-sensitive social work. However, in the current study it was important to emphasise empathetic communication skills. In mental health settings, empathetic communication skills are essential for the social worker to establish a good professional working relationship with the person suffering from a mental illness or a disorder. In addition, communication and empathy encompasses understanding the importance of spirituality to the patient. When the client feels understood, the working relationship between the patient and social worker will be effective. Spiritually-sensitive social workers should listen respectfully to the patient and provide an emotionally supportive environment while showing due regard for the person's age and cultural background. Spiritually-sensitive social workers should communicate

mutually in the working relationship with their patients by using words that do not uphold or diminish a certain belief. Spiritually-sensitive social workers also gather and provide information in a manner that respects the individual's experience, beliefs and feelings.

7.7. Purpose for practice: Understanding of the patient's spiritual perspective

Social workers in mental health settings are required to be spiritually sensitive in their work with mentally ill patients because patients value spirituality as a strength, and prefer that it be considered in their treatment process. An understanding of the patient's spirituality becomes relevant only when the patient regards spirituality as an important aspect of his/her treatment plan which should be initiated by the patient and not the social worker. The social worker should only discuss issues around the spirituality when the patient broaches the subject. Should spirituality be important to the patient, the social worker should seek to understand it by asking the patient to describe his/her spiritual perspective, how it developed since childhood, and how it was relevant to the present situation, as well as future possibilities for growth. Subsequently, the social worker should consider the spiritual and religious aspects of the client's needs, strengths, resources, and goals, as well as relevant aspects of the client's environment.

7.7.1. Exploration of the patient's spiritual perspective

Once the social worker knows what the patient's spiritual perspective is, the social worker should explore it to obtain further understanding about it. They can contact community leaders in the relevant tradition to request information and personal stories about how this spiritual perspective offers help or resources that can be of direct or indirect benefit to the patient.

7.7.2. Spiritually-sensitive social work

Being spiritually sensitive as a social worker encompasses displaying consideration for the client's spirituality as an essential aspect of the working relationship. This further implies that spiritually-sensitive social workers should seek to understand and accommodate their clients' views on spirituality above their own, as a priority in addressing the clients' problems (Van Hook, 2008).

Van Hook (2008) emphasises that spiritually-sensitive social workers acknowledge that

spirituality is part of an individual's belief system, and therefore, make attempts for a holistic approach to assessments and interventions. Spiritually-sensitive social workers should explore the patients' belief systems and spiritual dimensions to understand their spirituality. When a spiritually-sensitive social worker ascertains that a patient finds certain spiritual practices helpful in addressing problems, such a social worker should consider ways, in conjunction with the patient, to assist him/her to incorporate spiritually-sensitive interventions to deal with a difficult life situation. Examples of these actions are: referring the patient to a chaplain; involving traditional healers at the patient's behest; allowing the client to pray during the counselling session; or establishing quiet rooms in the hospital setting for quiet times (Van Hook, 2008).

Canda and Furman (2010, p. 218) assert that unlike secular social work, "spiritually-sensitive social work goes beyond embracing cultural and spiritual diversity as part of general ethical principles". This concept is further expanded to appreciation and advocacy on behalf of the clients' spiritual self-determination, to coping with life's unexplained challenges (Canda & Furman, 2010). Therefore, spiritually-sensitive social workers pay attention to the client's spiritual views if deemed important to the client. Spiritually-sensitive social workers should not impose any sort of spirituality or religion on the client, but assess what is salient for the client. However, it remains the social workers' responsibility to bring to the attention of the client any detrimental spiritual practice that might have a negative effect on the client's healing process; for example, a patient's belief in not taking medication could be detrimental to his/her healing process. Such actions should be implemented with great awareness of the need to distinguish between the spiritual life and beliefs of the social worker, and that of the patient, and his/her family (Van Hook, 2008). Paying further attention includes tending to the client's search for his/her life's meaning, purpose and sense of belonging. During the initial stage of problem identification in the helping process, a spiritually-sensitive approach includes the client's spiritual assessment (Gray, 2006).

7.7.3. Main role players in the guidelines

The guidelines encourage social workers to be spiritually-sensitive in response to their mentally ill patients' spirituality. Therefore, social workers should, in turn, persuade the multi-disciplinary team to be sensitive to the patients' spiritual needs. However, as this is just a guide, social workers should continue to provide services to their patients within the

confines of their competencies, based on their education, training, supervisory experience, and relevant professional knowledge and skills. In the future, the guideline should be expanded to consider other multi-disciplinary team members.

7.8. Training section/ workshop

Before the implementation of these guidelines, training and orientation should be provided.

7.9. Continuous support, supervision and orientation

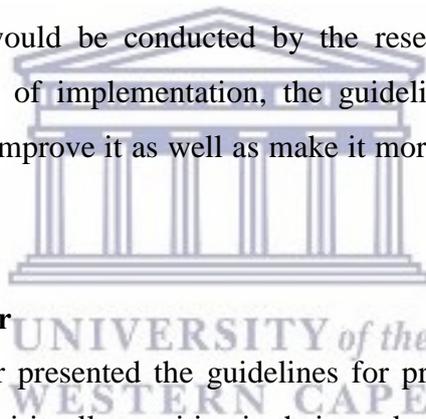
A forum should be established that would provide continuous orientation and support to the individuals who implement the guidelines. In addition, this platform should offer case debriefing and group supervision.

7.10. Sustainability

Monitoring and evaluation would be conducted by the researcher to ensure quality and sustainability. After a period of implementation, the guidelines should be reviewed and amended where necessary to improve it as well as make it more relevant and useful to social work education and practice.

7.11. Summary of the chapter

In this chapter, the researcher presented the guidelines for practice. The emphasis was on guiding social workers to be spiritually sensitive in their work with their mentally ill patients. The content of these guidelines were developed based on the findings of the current research, mainly from relevant literature that was reviewed, the research participants' responses, workshop discussions, and relevant experts on the subject matter as guided by Healy's (2005) Dynamic model.



CHAPTER EIGHT

SUMMARY OF THE FINDINGS, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

8.1. Introduction

In this chapter, the researcher summarises the findings according to the objectives of the current study. However, before proceeding with the summary, the researcher recaptures the problem statement, aim and objectives of the current study for the logical perspective. Subsequently, the researcher presents the conclusions, recommendations, and limitations of the study.

8.2. Statement of the problem

It appears that most Namibian mentally ill patients consider spirituality an important part of their lives as well as a significant positive influence on their illness and healing process (An interview conducted on September 17, 2015, with R. Dipura, Namibian social worker). This is further confirmed by D' Souza (2002), who surveyed 79 patients diagnosed with mental illness in Australia. The findings of D' Souza's (2002) survey revealed that 70% rated spirituality as very important in their lives, with 67% of this total reporting that their spirituality helped them to cope with their psychological pain, and 69% arguing that their spiritual needs should be taken into consideration by the health care providers treating their mental illnesses (D' Souza, 2002). Similarly, many other individuals suffering from serious mental illnesses insist that their spiritual beliefs, values and practices should be considered and included in their overall treatment planning and healing process (Baetz, Griffin, Bowen & Marcoux, 2004; Coyle, 2001).

A cross-sectional study with 442 Licensed Clinical Social Workers (LCSW's) in the USA revealed that only 13% completed a graduate course on spirituality and social work (Oxhandle *et al.*, 2015). That particular study further revealed that the LCSWs displayed positive attitudes, high levels of self-efficacy, and perceived the integration of clients' religion and spirituality in clinical practice as feasible but reported low levels of engagement in integrating clients' spiritual beliefs into practice (Oxhandle *et al.*, 2015).

In Namibia, no such related study exists for social workers. This low level of engagement in integrating clients' spiritual beliefs into practice can be linked to social workers not having

proper guidelines, skills and knowledge on how to deal with clients' spiritual dimensions as confirmed by Canda *et al.* (2004). Many Namibian social workers in mental health practice consider the use of spirituality in their clinical practice; however, there is a lack of guidelines for practice (An interview conducted on September 17, 2015, with R. Dipura, Namibian social worker). In Namibia as well as other African countries such as Zimbabwe, there is a lack of social work research that explores spirituality in social work, particularly in mental health practice (Mabvurira & Nyanguru, 2013). Mabvurira and Nyangurare (2013) argue that the lack of guidelines, skills and knowledge on the utilisation of spirituality in social work practice can be due to the fact that social work curricula in most Zimbabwean universities at both undergraduate and postgraduate levels do not include anything on spirituality, neither does the Council of Social Workers of Zimbabwe mandate social workers in practice to be spiritually sensitive in their interventions. Similarly, the findings of a study conducted in South Africa indicated no reference to knowledge and skills related to spirituality in the Bachelor, Master, and PhD social work programmes (Bhagwan, 2010a). Namibia is no exception, however, as no such studies have been conducted there. While, anecdotally, spirituality is understood to be a viable strength for people, generally, as well as to cope with mental health problems, Namibian social work literature and education remain silent on the utilisation of spirituality in clinical practice. In lieu of this problem statement, the researcher aimed to develop guidelines for spiritually-sensitive social work in mental health practice.



8.3. Research aim

The aim of the current study was to develop guidelines for spiritually-sensitive social work in mental health practice. Based on the findings, the aim of the study was achieved.

8.4. Research objectives

Based on the findings, the following objectives that were set for the current study, were also achieved.

- To explore research on spirituality and social work in Africa by means of a scoping review;
- To conceptualise spirituality in social work in the Namibian context;
- To explore and understand Namibian social workers' utilisation of spirituality in their mental health practice; and

- To develop guidelines for social workers in the mental health settings to be spiritually sensitive in their practice.

8.5. Summary of research findings

A summary of the findings in the current study is presented in relation to its objectives.

8.5.1. Objective 1: To explore research on spirituality and social work in Africa by means of a scoping review.

The objective was met through the scoping review which was used to determine what research had been conducted on spirituality and social work in Africa. The aim of a scoping review is the rapid mapping of the key concepts that underpin a research area, as well as the main sources and types of evidence available (Mays, Roberts & Popay, 2001, p. 194; Peters *et al.*, 2015).

8.5.1.1. Findings

- **Lack of publications on spirituality and social work in Africa:** Studies and publications on spirituality and social work in Africa is scant, specifically journal articles. In addition, literature in South Africa is sparse, with few publications that support the integration of spirituality into social development education (Bhagwan, 2010a, 2010b). In Namibia, currently, there is no research on social work and spirituality, as is the case in some other African nations such as Zimbabwe where there is also no research journal articles exploring spirituality and social work (Mabvurira & Nyanguru, 2013), although there is a PhD research conducted by Mabvurira (2016). Mabvurira and Nyangurare (2013), although not a journal article, highlight the lack of guidelines, skills and knowledge on the utilisation of spirituality in the social work practice.
- **Participants' spirituality is diverse:** Regarding the participants' spirituality, the scoping review revealed that spirituality is experienced differently, given diverse groups, such as the students, academics, and healthcare workers, as revealed in Bhagwan (2002; 2010a; 2011), and Nkomo (2016).
- **Greater support on the inclusion of spirituality in the social work practice and education:** The scoping review revealed that the participants displayed greater support for the inclusion of spirituality in social work education. The scoping review further revealed that considering the client's spirituality in social work practice is important;

however, social workers lack knowledge on how to apply spiritual interventions (Bhagwan, 2002; 2010a; 2011; 2013).

- **Lack of knowledge, education and training in spirituality by educators:** Regarding education and training in spirituality, the majority of the educators revealed that spirituality had '*never*' been presented in their training (Bhagwan, 2002; 2010a; 2011; 2013).
- **Lack of conceptualisation of spirituality in the African context:** Of the five studies reviewed in the scoping review (Bhagwan, 2002; 2010a; 2011; 2013; Nkomo, 2016), four did not conceptualise spirituality. The lack of the conceptualisation of spirituality confirms the limitation of literature on spirituality in the African context. Bhagwan's studies, mostly reflected in this scoping review, depended much on Western literature to define and discuss the concept of spirituality and religion, which may have overlooked the African worldview of spirituality and religion. This again confirms the lack of African literature on spirituality and social work, creating a dependency on Western literature.

8.5.2. Objective 2: To conceptualise spirituality in social work in the Namibian context.

This objective was met through the individual interviews with the participants, as well as through discussions with workshop participants.

8.5.2.1. Findings

It is important to note that the concept of spirituality is defined differently, and each definition is not absolute, as it is defined in various contexts, given diverse backgrounds (Roby & Maistry, 2010). Even in the social work context, the definition of spirituality is still diverse as each writer is influenced by his/her own background and belief system. Similarly, the diversity of the spirituality concept in Africa is unavoidable because African people are diverse in ethnicity and race, which add further diversity through their traditions and cultures. However, the spirituality of all people in Africa, especially Namibia, is not necessarily linked to ancestral worship or religion. The findings of the current research revealed that Namibian spirituality is diverse and practiced differently, given the diverse ethnic groups and their diverse perspectives. Some practice spirituality through diverse religions, while others practice spirituality without necessarily referring to a belief or referring to any form of religion.

Conceptualisation of spirituality in the Namibian context

The conceptualisation of spirituality in the current research was based on the research participants' responses. The research participants concluded that spirituality in the Namibian context is perceived as a connection, a relationship, or an experience between an individual and fellow individuals, including elders, spiritual/traditional leaders (micro-cosmos), and/or between an individual and the dead/ancestors (meso-cosmos), and/or between an individual and the supernatural deities/gods (macro-cosmos). Additionally, spirituality involves a belief system that can be diverse or that changes over time. Spirituality can also be perceived as a sense of wholeness.

8.5.3. Objective 3: To explore and understand Namibian social workers' utilisation of spirituality in their mental health practice.

This objective was met during the individual interviews with the participants, while discussing their cases.

8.5.3.1. Findings

The participants revealed that spirituality is very important to their patients, as more often than not, their patients initiated the narrative around spirituality. However, spirituality was considered necessary not only in the lives of mentally ill patients, but also in the lives of the social workers, particularly in their practice, as it guided, comforted and provided them strength and resilience. The participants considered spirituality as another dimension that needed to be incorporated in the holistic approach to the treatment process, exactly like addressing the biological, psychological and social human dimensions of the patient. A contrary view from one of the participants suggested that including spirituality in their counselling was not the social worker's primary role, unless it became a need in the helping process. As social workers, being spiritually sensitive does not imply that all counselling is spiritualised, instead, social workers should only engage in spiritual talk when it is initiated and regarded as a need by the patient. The findings further revealed that social workers in mental health practice are often confronted with mentally ill patients who are spiritually inclined, and therefore, require specialised knowledge, training and guidance in spirituality and social work, or in spiritually-sensitive social work for effective intervention. Additionally, as mental health is a specialised field in social work, the participants expressed their need of knowledge and practice in mental health and on mental illnesses. However, as social workers, they deal with their cases guided by relevant theories or approaches, skills, roles, and professional values, as was deemed necessary.

The findings further revealed that social workers should acknowledge that not all spirituality and/or religious expressions were good in their human intent, and these may be detrimental. Some may have oppressive or destructive consequences for the individual as well as the wider community. The participants indicated that there were other challenges to be addressed in mental health practice such as patients sometimes not adhering to the medical plan or not returning for follow-up appointments. These challenges can be understood, considering the presence of African thought, which differs from Western thought that generally ignores the spiritual and cultural dimension of phenomena, while focusing on the visible and measurable physical reality (Van der Walt, 1997).

8.5.4. Objective 4: To develop guidelines for social workers in the mental health settings to be spiritually sensitive in their practice.

This objective was met through the individual interviews and workshop discussions. The development of the guidelines was guided by the dynamic model of Healy (2005), as it concerns the construction of social work practice and knowledge. Healy (2005) acknowledges that social workers are active participants in creating the contexts and frameworks through which to practice. This current study involved framing social work practice in the interventions with spiritually-sensitive cases in mental health settings in the Namibian context; therefore, this model serves as a guide in developing a framework and guidelines for practice, the defined details of which were discussed in Chapter 7.

8.5.4.1. Findings

As guided by the above-mentioned model, the researcher identified with the participants regarding the *dominant discourse*. What emerged strongly was that social workers needed to be equipped with the appropriate skills to be more spiritually sensitive to clients as well as to be more accommodating of their worldviews, because mentally ill patients consider spirituality as important to their healing and recovery process. Regarding the *Formal Professional Base*, the researcher and participants focussed on the ethical principles that were most relevant to spiritually-sensitive social work. For the *Framework for practice*, relevant theories, skills, roles, and values for spiritually-sensitive social work were identified. *Practice Purpose*, suggested that social workers in the mental health settings had to be spiritually sensitive in their work with mentally ill patients.

8.6. Conclusions

- It was observed that practitioners felt under-prepared to respond to their clients' spirituality due to a lack of knowledge and guidelines, as well as the topic not being included in their training.
- In Namibia, no studies that explore spirituality and social work have been conducted; consequently, there is a lack of publications, training and knowledge, as well as guidelines on spirituality and social work in social work practice and education.
- There is a lack of African conceptualisation of spirituality.
- In Africa, spirituality is experienced and practiced differently by diverse groups.
- Spirituality in Namibia is diverse as it is influenced by people's diverse traditions and religions; however, it is also practiced without any connection to any religion or particular tradition.
- Spirituality is very important in the lives of patients as they constantly request that their spirituality be incorporated in treatment plans. Additionally, spirituality is necessary not only in the lives of mentally ill patients but also in the lives of social workers, particularly, in their practice, as it guides, comforts and provides strength. The findings further revealed that social workers in mental health practice are often confronted with spiritually-sensitive cases which require specialised knowledge, training and guidance in spirituality and social work as well as mental health and mental illnesses, or in spiritually-sensitive social work, to provide effective intervention.

8.7. Recommendations

For social work practice

- Based on the review of the views and the experiences of the participants in practice on the importance of spirituality in life, spirituality should be integrated into social work practice and education in order to be spiritually sensitive in social work practice.
- Spirituality is experienced diversely by different groups, in diverse contexts; therefore, social workers should be spiritually sensitive in Africa, and they should embrace spiritual diversity. In addition, social workers should expand their knowledge and understanding on their clients' African spirituality in order to deal with multi-cultural and multi-spiritual contexts.

- The process of self-reflection of spirituality in the lives of social workers should be considered an important tool for self-awareness.

For social work education

- Mental health is a specialised field in social work; therefore, social workers need specialised training and knowledge regarding mental health, mental illness, as well as the African approaches to mental illness.
- Based on the review of the views and experiences of the participants in pedagogy, spirituality should be integrated into social work education, with clear direction as to what the content should be.
- It is vital that social work education includes content regarding the African worldview on spirituality and social work, in order to prepare social workers to provide relevant services to their diverse African clients, with different ideological perspectives.

For researchers

- Additional funding is needed to sponsor research publications that explore spirituality and social work in Africa in order to increase publication in this research area.
- Future research should explore the conceptualisation of spirituality in Africa.
- Further research is required with social work academics and students regarding what the content of the course on social work and spirituality should entail.
- Additional research is required to explore when spirituality is detrimental in social work practice.

8.8. Limitations of the study

- Initially, the plan was to conduct a series of three individual interviews with the participants, for an in-depth investigation of spirituality. However, the researcher could not obtain additional relevant information as intended, because of the participants' unavailability. Nevertheless, each research question was answered, and to a greater extent, depth was reached, as all the objectives were met.
- During the scoping review, few journal articles on the subject of spirituality and social work in Africa were found, obliging the researcher to rely only on two authors, once more confirming the lack of publications that explore spirituality and social work in Africa.

- Even though the interviews reached data saturation by the 7th participant, the researcher continued until all 9 participants were interviewed, to augment the views of the sample. The sample size of 9 participants in the individual interviews could be regarded as a small sample, though a sample for individual interviews is suggested to be between 8 and 12 members (Crabtree & Miller, 1999). It is worth noting that given the complexity of the topic, and the relative scant of existing empirical research, the researcher initially proposed to recruit 10 to 15 participants; however, only 9 participants could participate in the research, which was approximately the number initially suggested by Crabtree and Miller (1999).
- The workshop given time was the only time that the social workers were able and willing to volunteer for the workshop. Thus, the workshop time could be noticed as short, though that particular workshop's objective was met, also, considering that the workshop was mainly to triangulate data that was already collected.

8.9. Reflection

Despite the time limitations, a particular issue that was relevant to the current research and which emerged strongly was the participants' expressions of spirituality, religion and tradition, as well as how they valued their religion and tradition as Africans. As a social worker, the researcher realised how Western social work education has limited the understanding of the relevance of indigenous tradition, religion, and cultural beliefs in dealing with social problems.

8.10. Conclusion of the thesis

Spirituality is an important element in the lives of Africans as it provides, among other benefits, meaning, purpose, hope, and strength to deal with different challenges in life, including dealing with mental illnesses. Therefore, social workers in Africa should be equipped, trained, and guided with decolonised social work education that is African-oriented, without disregarding the relevant Western social work education, thereby preparing social workers to be spiritually-sensitive to the African clients they serve.

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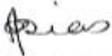
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APPENDICES

Appendix A: Ethics approval letter from the Research Ethics Committee (UWC)

 <p>UNIVERSITY of the WESTERN CAPE</p>	<p>OFFICE OF THE DIRECTOR: RESEARCH RESEARCH AND INNOVATION DIVISION</p>	<p>Private Bag X17, Bellville 7535 South Africa T: +27 21 959 2988/2948 F: +27 21 959 3170 E: research-ethics@uwc.ac.za www.uwc.ac.za</p>
<p>14 February 2017</p>		
<p>Mrs Z Rukambe Social Work Faculty of Community and Health Science</p>		
<p>Ethics Reference Number: HS17/1/18</p>		
<p>Project Title:</p>	<p>Spirituality and Social Work in the Namibian Mental Health Practice: Guidelines for social workers.</p>	
<p>Approval Period:</p>	<p>03 February 2017 – 03 February 2018</p>	
<p>I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.</p>		
<p>Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.</p>		
<p>The Committee must be informed of any serious adverse event and/or termination of the study.</p>		
		
<p><i>Ms Patricia Josias</i> Research Ethics Committee Officer University of the Western Cape</p>		
<p>PROVISIONAL REC NUMBER - 130416-049</p>		
<p>FROM HOPE TO ACTION THROUGH KNOWLEDGE</p>		

**Appendix B: Approval letter from the Ministry of Health and Social Services
(Namibia)**



REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: 061 – 203 2562
Fax: 061 – 222558
E-mail: hnangombe@gmail.com

OFFICE OF THE PERMANENT SECRETARY

Ref: 17/3/3

Enquiries: Ms. H. Nangombe

Date: 23 March 2017

Mrs. Zelda U. Rukambe
PO Box 61852
Katutura
Windhoek

Dear Mrs. Rukambe

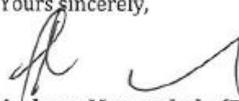
Re: Spirituality and Social work in the Namibian mental health practice: Guidelines for social workers

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
 - 3.1 The data to be collected must only be used for academic purpose;
 - 3.2 No other data should be collected other than the data stated in the proposal;
 - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;

5/1/2014

- 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
- 3.5 Preliminary findings to be submitted upon completion of the study;
- 3.6 Final report to be submitted upon completion of the study;
- 3.7 Separate permission should be sought from the Ministry for the publication of the findings.

Yours sincerely,


Andreas Mwoombola (Dr)
Permanent Secretary



"Health for All"

Appendix C: Information sheet



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2012 Fax: 27 21-9592845

E-mail: cschenck@uwc.ac.za

INFORMATION SHEET

Project Title: Spirituality and Social work in the Namibian mental health practice: Guidelines for social workers.

What is this study about?

This is a research study conducted by student, Zeldah U. Rukambe, from the University of the Western Cape. You are invited to voluntarily participate in the series of individual interviews and in the workshop because we would want to develop guidelines for social workers to utilize spirituality in their mental health practice. The discussions during this research process will assist us to build social work knowledge specifically exploring spirituality in mental health in the Namibian context for social work education, practice and researchers.

What will I be asked to do if I agree to participate?

You will be asked to participate in a three day individual interviews and further in a two day workshop to share your understanding and utilization of spirituality in your own lives and in your work with mental ill patients with the aim to develop guidelines. Semi-structured questions and a workshop guide around the subject of spirituality and social work in English, will guide the interview and workshop discussions.

Would my participation in this study be kept confidential?

I will do my best to keep your personal information confidential. To help protect you confidentiality, the information you provide will be totally private; no names will be used so there is no manner that you can be identified as a participant in this study. The information will be treated with anonymity and confidentiality. Your name will not be reflected on the transcribing or analyses of the data. The information obtained from this interview will be collated with the information from other completed interviews from other participants. Therefore, there will be no way to connect you to the study. This study will also use workshop discussions therefore the extent to which your identity will remain confidential is dependent on participants' in the

discussion group maintaining confidentiality.

This research project involves making audiotapes of you for better capturing of valuable data during the discussion. For quality assurance, trustworthiness and reliability, the University of Western Cape might need access to the tapes, other than that, under no circumstances will this tapes be out for other use not intended for. These tapes will be destroyed after use intended for.

What are the risks of this research?

All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

In Namibia, there is a lack of empirically based social work practice literature involving spirituality or spiritually sensitive-social work. This proposed research will produce social work knowledge and guidelines specifically exploring spirituality in mental health in the Namibian context for social work practice and researchers. The research will also bring forth conceptualization of spirituality in social work in the Namibian context for effective clinic practice in mental health.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify

What if I have questions?

This research is being conducted by Prof. C. Schenck at the Social Work Department at the University of the Western Cape. If you have any questions about the research study itself, please contact **Prof Schenck** at: **+27 21-959 2012 e-mail: cschenck@uwc.ac.za**

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof Catherine Schenck
Head of Department
University of the Western Cape
Private Bag X17
Bellville 7535
cschenck@uwc.ac.za

Prof José Frantz
Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535
chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Research Committee.



Appendix D: Individual interviews consent forms



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2012, Fax: 27 21-959 2845

E-mail: cschenck@uwc.ac.za

CONSENT FORM

Title of Research Project: Spirituality and Social work in the Namibian mental health practice: Guidelines for social workers.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name.....

Participant's signature.....

Date.....



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2012, Fax: 27 21-959 2845

E-mail: cschenck@uwc.ac.za

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Participant's name... Sylvia Maharukua

Participant's signature... [Signature]

Date... 06/04/2017

UNIVERSITY OF THE
WESTERN CAPE



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 2012, Fax: 27 21-959 2845
E-mail: cschenck@uwc.ac.za

CONSENT FORM

Title of Research Project: Spirituality and Social work in the Namibian mental health practice: Guidelines for social workers.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

Participant's name.....*Erika N. Kamwanka*
Participant's signature.....*[Handwritten Signature]*
Date: *18 April 2017*

UNIVERSITY of the
WESTERN CAPE



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Private Bag X 17, Bellville 7535, South Africa

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E-mail: cschenck@uwc.ac.za

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Participant's name... Abbott Kaulimbola

Participant's signature... [Signature]

Date... 18/4/2017



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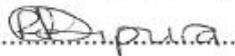
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 2012, Fax: 27 21-959 2845
E-mail: cschenck@uwc.ac.za

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Participant's name.....Rufaro D. Dipura

Participant's signature..........

Date.....19/4/2017



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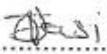
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Participant's name..... JENNIPIHER LIFASI

Participant's signature..... 

Date..... 21 APRIL 2017



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Participant's name.....*SL. TROMP*.....

Participant's signature.....*SL. Tromp*.....

Date.....*2017-04-21*.....



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Participant's name.....*Secilia Moshana*.....

Participant's signature.....*[Signature]*.....

Date.....*24/04/2017*.....



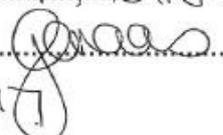
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Participant's name..... J. Ananas
Participant's signature..... 
Date..... 20.4.2017



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Participant's name.....*Emma Leonard*.....
Participant's signature.....*[Signature]*.....
Date...*25/04/2017*.....

Appendix E: Workshop group confidentiality binding forms



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WORKSHOP GROUP CONFIDENTIALITY BINDING FORM

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I agree to uphold the confidentiality of the discussions in the workshop group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.



Participant's name.....

Participant's signature.....

Date.....



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Participant's name Erike N. Kamwanka
Participant's signature [Handwritten Signature]
Date 18 April 2017



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Participant's name..... Rufaro D. Dipura
Participant's signature..... [Signature]
Date..... 19/4/2017



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Participant's name.....JENNIFER LIFASI.....

Participant's signature.....*JLifasi*.....

Date.....21 APRIL 2011.....



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Participant's name..... J. N. TROMP.....

Participant's signature..... J. N. TROMP.....

Date..... 2017-04-21.....



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Participant's name... Sylvia Muharukua

Participant's signature... 

Date... 06.04.2017



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Participant's name.....*Secilia Nlshana*.....

Participant's signature.....*[Signature]*.....

Date.....*24.04.2017*.....



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Participant's name: Selma Yusuf.....

Participant's signature: [Signature].....

Date: 24.10.17.....



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Participant's name.....Michelle v.d Merwe

Participant's signature.....

Date.....04/10/2017



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Participant's name..... Izaan D Diegaardt
Participant's signature..... [Signature]
Date..... 04/10/17



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Participant's name.....*Cynthia Kambona*.....

Participant's signature.....*Cynthia Kambona*.....

Date...*04/10/2017*...



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Participant's name.....*Rugave S. Zimunya*
Participant's signature.....*[Signature]*
Date.....*04.10.17*



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Participant's name..... *Changu C Ngandu*
Participant's signature..... *Ngandu*
Date..... *04/10/17*

Appendix F: Interview schedule

Interview schedule

Title of Research Project: Spirituality and Social work in the Namibian mental health practice: Guidelines for social workers.

Case studies: Individual in-depth interview questions

Objective 2: To conceptualize spirituality in social work in the Namibian context.

1. Describe what you think spirituality is in general
2. During your childhood, did you engage in spirituality practice – traditional and or church attendance etc?
3. Please describe a time when you used those practices.
4. Please describe how you are utilizing spirituality in your current life
5. Is spirituality important for your life? If it is important, in what way?
6. When you hear the word spirituality, what does it mean to you as a social worker and how do you define it in the Namibian context?
7. Is there a different between spirituality and religion? let's discuss it
8. Can a person be spiritual without being religious?
9. Is there a different between a traditional person and a spiritual person?
10. Can a person be both traditional and religious?

Objective 3: To explore and understand Namibian social workers utilization of spirituality in their mental health practice.

1. What is your understanding of the relationship between spirituality and mental illness?
2. Is spirituality important to your patients in the mental health practice?
If so how?

3. If spirituality is important to patients in mental health, what is the implication to the social work practice and profession?
4. Please describe a case that involved using spirituality as a part of your clinical practice in mental health.
5. What roles did you as a social worker play in dealing with this client who wish his/her spirituality be considered during the treatment process?
6. What essential skills did you consider in dealing with this case?
7. Which theoretical approach/model/perspective did you rely on in dealing with this spiritual sensitive case?
8. Please give any social work values and ethical principles that has guided you in your spiritual sensitive cases in your mental health practice
9. Please describe a time when you realized your mental health client thought of spirituality or religion was important to the client's treatment and recovery
10. How do you as a social worker determine that spirituality would be an important treatment option to be included in a particular case?
11. Do you follow any assessment process to determine that?
12. How do you deal with a client whose spirituality is detrimental/harmful to his treatment programme and recovery?
13. As a social worker, what will be your role in this case?

Appendix G: Workshop discussion guide

Workshop discussion guide

Objective 4: To develop guidelines for social workers in the mental health settings to incorporate spirituality in their practice.

Day 1: Based on the research data from phase one, the three dimensions of Healy model will be identified, and the following will also be established:

- Conceptualization of spirituality within the context of Namibia
- Relevant theory/ies, approaches and perspectives supporting spiritually sensitive-social work will be identified;
- Essential skills that one should consider employ when considering a spiritual sensitive- social work.
- Social work values and ethical principles that can guide the spiritually sensitive-social work;

Before finalization of the guidelines, the draft guidelines will be sent to African experts in spirituality and social work for review.

Day 2: After return from experts, another workshop will be held to review, modify and finalize the guidelines for spiritual sensitive social work in the Namibian context.

Appendix H: Summary of independent coding

Summary of independent coding

Dr M.A. van der Westhuizen
(DPhil in Social Work)

Date: 26 June 2017

Box 16
Huguenot College
Wellington
7656
Tel: 021-8731181
E-mail: mvdw@huguenote.com

Regarding: Independent coding: Spirituality and social work in the Namibian mental health practice: Guidelines for social workers by Ms Z. Rukambe

I hereby confirm that I acted as independent coder for the qualitative data obtained from the abovementioned research study. I made use of the framework for qualitative research by Tesch (1990) as described by Creswell (2009:186). Nine transcripts were analysed and data saturation was observed after 7 interviews.

I identified themes, sub-themes and categories and placed the relevant verbatim quotations from participants under each in my final report. Please note that, in an effort to integrate the data into a collective storyline and to protect the privacy of the participants, I combined the verbatim quotations under the relevant themes, sub-themes and categories with no reference to the individual participants. I also placed the data in the themes, sub-themes and categories under specific headings to indicate a possible storyline for each. Please note that some of the data overlap between themes, sub-themes and categories (for instance the role of spirituality in social work and personal experiences). In my opinion this confirms consistency and the repetition of information under different themes points to specific focus areas to be included in the guidelines.

In my opinion the findings assists the researcher to conceptualise and contextualise spirituality in social work-mental health field, describes how it is included in current services and identifies areas to be included in guidelines for practice.



Appendix I: Summary of the 1st Workshop: 17 August 2017



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Summary of the workshop on: Guidelines for social workers in the mental health settings to incorporate spirituality in their practice.

Date: 17 August 2017

Time: 14h-16h

Venue: Windhoek Central Hospital, Maternity Boardroom

Attendees: 13 participants- Medical Social workers and Final year intern Social workers
(Attendance register with contact details is attached)

Facilitator: Zelda Rukambe (Researcher)

Proceedings:

Introduction

The facilitator was warmly welcomed.

The facilitator made a presentation on the objective of the workshop and the purpose of the guidelines, before touching on the research findings as follows:

- Understanding Spirituality in social work
- Conceptualization of spirituality within the context of Namibia
- Relevant theory/ies, approaches and perspectives supporting spiritually sensitive-social work identified;
- Essential skills that one should consider employ when considering a spiritual sensitive-social work.
- Social work values and ethical principles that can guide the spiritually sensitive-social work;
- Patients' assessment
- Detrimental spirituality

Each point as above was given feedback on the research findings and a discussion followed. Due to time limit, participants were grouped and were asked to discuss and write on the relevant theoretical approaches, Social work values, skills, roles to be employed when dealing with a spiritually sensitive case (**feedback forms from groups' discussion is attached**).

Main Points:

Understanding Spirituality in social work

A brief understanding on spirituality as part of a holistic approach in social work practice was shared. Participants agreed the need to consider clients' spirituality and the importance of having guidelines to enhance knowledge on how to deal with spiritually sensitive cases.

Conceptualization of the term spirituality-Participants were in agreement with the content of the definition as defined by the research findings. An addition, they added to the term spirituality to include, "Spirituality can change over time as the belief system change".

Theoretical approaches: Social workers to use relevant theories they understand, and they must know the application thereof. Participants agreed on the relevant theories from the research findings and during their group discussion added others suitable theoretical approaches that can also be used depended on the nature of case and priority needs in the case.

Patients' assessment was not discussed due to time, however, they agreed the intake form to be revised.

Detrimental Spirituality: Regarding which role to play when spirituality is detrimental, research findings showed that, Social workers should do Bio-Psycho-education to teach and explain the importance of medication to the body healing and recovery, medication adherence and consequences of none adherence, especially to patients who do not want to take medication or who wish to take medication with contrary substances due to their spirituality. Social workers to consult with the patient's family members and the Patients' Spiritual leaders and the multi-disciplinary team. Participants agreed with that and added that a record of all the efforts and steps taken be kept for future reference.

Future training

As time could not allow, participants requested a follow up training for comprehensive knowledge and empowerment on spirituality and social work practice for effective practice.

Way forward

The facilitator explained that the guidelines will be drafted from the research findings and from the workshop findings, send to the experts for their input, and then back to the participants for a second workshop before it can be finalized.

Closure

The Social workers together with their supervisor expressed their gratitude and appreciation for the informative and eye opener workshop. Refreshments where served and enjoyed!!!

Appendix J: Attendance List of the 1st Workshop: 17 August 2017

1st workshop
Thursday
17/08/2017

CONTINUING PROFESSIONAL DEVELOPMENT (CPD) ACTIVITY
WINDHOEK CENTRAL HOSPITAL
MEDICAL SOCIAL SERVICES
ATTENDANCE LIST

DATE: 18.08.17
TOPIC: Spirituality in social work
PRESENTER: Zelata Kunzombe
TIME: 14 hrs
VENUE: OPD, CONFERENCE ROOM

NAME AND SURNAME	PROFESSION	HPCNA NUMBER	CONTACT NUMBER	SIGNATURE
Gynthia Hambona	Social work (Intern)		0816684932	<i>Gynthia</i>
Esperanza Amukwayo	Social worker	SWC 00544	0812474499	<i>Esperanza</i>
Isaac D Dorpoort	Social Work (Intern)		0813443334	<i>Isaac Dorpoort</i>
Ruome Shalem Zimunya	Social Work Intern		0816605556	<i>Ruome</i>
Changyu C Ngondulu	Social work (intern)		0812526185	<i>Changyu</i>
Mirelle vd Merwe	social work (intern)		0814493768	<i>Mirelle</i>
Selina van der Merwe	Social work (Intern)		0812320790	<i>Selina</i>
Jennifer Zifasi	Social worker	SWC 00640	0812236712	<i>Jennifer</i>
Ms Erika M. Kamundata	Social Worker	SWC 00417	0812045678	<i>Erika</i>
Ms. Sylvia Muhemkwa	Social worker	SWC 00778	0816605159	<i>Sylvia</i>

**CONTINUING PROFESSIONAL DEVELOPMENT (CPD) ACTIVITY
WINDHOEK CENTRAL HOSPITAL
MEDICAL SOCIAL SERVICES
ATTENDANCE LIST**

DATE: 15.08.17
 TOPIC: Spirituality in Social Work
 PRESENTER: Zolota Ruvakamba
 TIME: 14 hrs
 VENUE: OPD, CONFERENCE ROOM

NAME AND SURNAME	PROFESSION	HPCNA NUMBER	CONTACT NUMBER	SIGNATURE
Miriam W Hardeste	social worker	SW000565	0814588925	
Abbott Kuthumbula	Social worker	SW000685	0813215000	
Helena Matengh	Senior Social worker	SW000502	0812772827	

2

Appendix K: Discussions from the 1st Workshop: 17 August 2017



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To develop guidelines for social workers in the mental health settings to incorporate spirituality in their practice.

Group 1 Date 14/08/2017

Names of Group participants

Cynthia Kambona
Abbott Kalimbala
.....
.....

Discuss and deliberate on the relevant theory/ies, approaches, perspectives guiding and supporting spiritually sensitive-social work; Social work values and ethical principles that guides the spiritual sensitive-social work; Essential skills that one should consider employ when considering a spiritual sensitive- social work, as well as roles and skills to apply when the client's spirituality is detrimental to his/her treatment and recovery process.

Relevant theory/ies, approaches, perspectives

Holistic approach, look at the person in totality.
Eg. social, spiritual, physical & emotional.
Strength perspective, ecological perspective.

Social work values and ethical principles

Non - Judgemental, Confidentiality, Individuality
empathetic, & respect and dignity.

Essential skills and roles that one should consider employ when dealing with a spiritual sensitive case

Skills Communication Skills, where you respond in a empathetic
manner. Assessment Skills → Cratering history in Collateral.
Roles Facilitator, broker,

Specific skills and roles to apply when the client's spirituality is detrimental to his/her treatment and recovery process.

Skills Need to understand persons background.
Establish rapport

Roles Advocate

To develop guidelines for social workers in the mental health settings to incorporate spirituality in their practice.

Group .. 2

Date... 17 August 2017

Names of Group participants

Mrs. Erika-M. Kamnata

Ms. Izan Diergaardt

Discuss and deliberate on the relevant theory/ies, approaches, perspectives guiding and supporting spiritually sensitive-social work; Social work values and ethical principles that guides the spiritual sensitive-social work; Essential skills that one should consider employ when considering a spiritual sensitive- social work, as well as roles and skills to apply when the client's spirituality is detrimental to his/her treatment and recovery process.

Relevant theory/ies, approaches, perspectives

Amplified reflection (Reflective Listening)

Biopsychosocial model, Sociological theories, Problem-Solving Model

Social work values and ethical principles

Respect people's ^{self-}determination

Confidentiality ; Objectivity

Transparency ; Accountability

Essential skills and roles that one should consider employ when dealing with a spiritual sensitive case

Skills Active listening Skills = reflection, paraphrasing, summarising, questioning, non-verbal communication

Roles Advocate, Facilitator, Mediator, Educator, Counselor, Networker, Enabler

Specific skills and roles to apply when the client's spirituality is detrimental to his/her treatment and recovery process.

Skills ~~Networker~~ Assertiveness, Objectivity, Professionalism, Non-judgemental

Roles Networking, Facilitator, Advocate, ~~Research~~, Counselor

To develop guidelines for social workers in the mental health settings to incorporate spirituality in their practice.

Group 3. Date 17-08-2017

Names of Group participants

Changu Nando
Michelle v.d. Merwe
.....

Discuss and deliberate on the relevant theory/ies, approaches, perspectives guiding and supporting spiritually sensitive-social work; Social work values and ethical principles that guides the spiritual sensitive-social work; Essential skills that one should consider employ when considering a spiritual sensitive- social work, as well as roles and skills to apply when the client's spirituality is detrimental to his/her treatment and recovery process.

Relevant theory/ies, approaches, perspectives

Social learning theory - believe what others believe, to fit in
Strength based theory - spirituality can be strength factor in patients recovery
Social cultural theory - believes changing because of social & cultural aspects of life.

Social work values and ethical principles

Respecting the clients spirituality but also have a non-judgemental attitude.

Spirituality is a part of wellbeing & s/wk must challenge unjust laws, norms and stereotypes.

Essential skills and roles that one should consider employ when dealing with a spiritual sensitive case

Skills Open minded, empathic, patient, confident & humble.
Roles educating, linking, broker, Networker

Specific skills and roles to apply when the client's spirituality is detrimental to his/her treatment and recovery process.

Skills knowledge of patients spirituality, in depth assessment
confidence
Roles facilitator, counselor, educator

To develop guidelines for social workers in the mental health settings to incorporate spirituality in their practice.

Group A. Date 17/08/17

Names of Group participants

Ruvane S. Zimunya
Selma Uusiku

Discuss and deliberate on the relevant theory/ies, approaches, perspectives guiding and supporting spiritually sensitive-social work; Social work values and ethical principles that guides the spiritual sensitive-social work; Essential skills that one should consider employ when considering a spiritual sensitive- social work, as well as roles and skills to apply when the client's spirituality is detrimental to his/her treatment and recovery process.

Relevant theory/ies, approaches, perspectives

1. Strength based approach since spirituality itself can act as a strength.
2. Psychosocial theory -> because spirituality may be a component of the social life
3. _____

Social work values and ethical principles

- self determination
- honesty
- right to social justice.
- dignity & worth of person
- integrity
- competence
- respect for client
- informed consent

Essential skills and roles that one should consider employ when dealing with a spiritual sensitive case

Skills communication • empathy • cultural competence

Roles _____
counsellor, broker

Specific skills and roles to apply when the client's spirituality is detrimental to his/her treatment and recovery process.

Skills assertive skills: (skills of assertiveness)

Roles referral role • facilitator • educational role

To develop guidelines for social workers in the mental health settings to incorporate spirituality in their practice.

Group S. Date 17/08/2017

Names of Group participants

JENNIPHER ZIFASI
Ms HELENA MATENGI
.....

Discuss and deliberate on the relevant theory/ies, approaches, perspectives guiding and supporting spiritually sensitive-social work; Social work values and ethical principles that guides the spiritual sensitive-social work; Essential skills that one should consider employ when considering a spiritual sensitive- social work, as well as roles and skills to apply when the client's spirituality is detrimental to his/her treatment and recovery process.

Relevant theory/ies, approaches, perspectives

- psychosocial and solution focused therapy
- Empowerment theory, social and cultural theory

Social work values and ethical principles

- Non-judgemental
- Competency
- Social justice
- Respect of the Client
- Integrity and dignity

Essential skills and roles that one should consider employ when dealing with a spiritual sensitive case

- Skills Listening skills
- Roles Facilitating and educating the client

Specific skills and roles to apply when the client's spirituality is detrimental to his/her treatment and recovery process.

- Skills Communication and listening skill
- Nonjudgmental
- Roles Educator and Counsellor
- facilitating.
- Networking

To develop guidelines for social workers in the mental health settings to incorporate spirituality in their practice.

Group 6 Date 18.08.17

Names of Group participants

Miriam Sindala
Esperanza Amukanga

Discuss and deliberate on the relevant theory/ies, approaches, perspectives guiding and supporting spiritually sensitive-social work; Social work values and ethical principles that guides the spiritual sensitive-social work; Essential skills that one should consider employ when considering a spiritual sensitive- social work, as well as roles and skills to apply when the client's spirituality is detrimental to his/her treatment and recovery process.

Relevant theory/ies, approaches, perspectives

System theory, psychodynamic theory, spiritual theory, strength theory, ecological theory

Social work values and ethical principles

- ↳ Confidentiality
- ↳ Judgementality (Non-Judgemental)
- ↳ Respect
- ↳ Dignity

Essential skills and roles that one should consider employ when dealing with a spiritual sensitive case

Skills listening, attentively, empathy, non-judgemental
Roles Body language, non-verbal communication,

Specific skills and roles to apply when the client's spirituality is detrimental to his/her treatment and recovery process.

Skills listening, empathy, non-judgemental, case sensitivity, emotional & mental wellbeing
Roles Educating, advocating, linking to appropriate linking system.

Appendix L: Follow up deliberations from the 2nd workshop: 4 Oct 2017

4 October 2017

2nd Workshop (Follow up): Development of guidelines for practice

Venue: Central Hospital, Maternity Boardroom

Facilitator: Mrs. Zelda Rukambe

Objective of the day

Continuation of the development of guidelines for social workers in the Medical social work settings to incorporate spirituality in their practice.

Main focus

More detail deliberations of the most relevant theories, values, roles, skills for application.

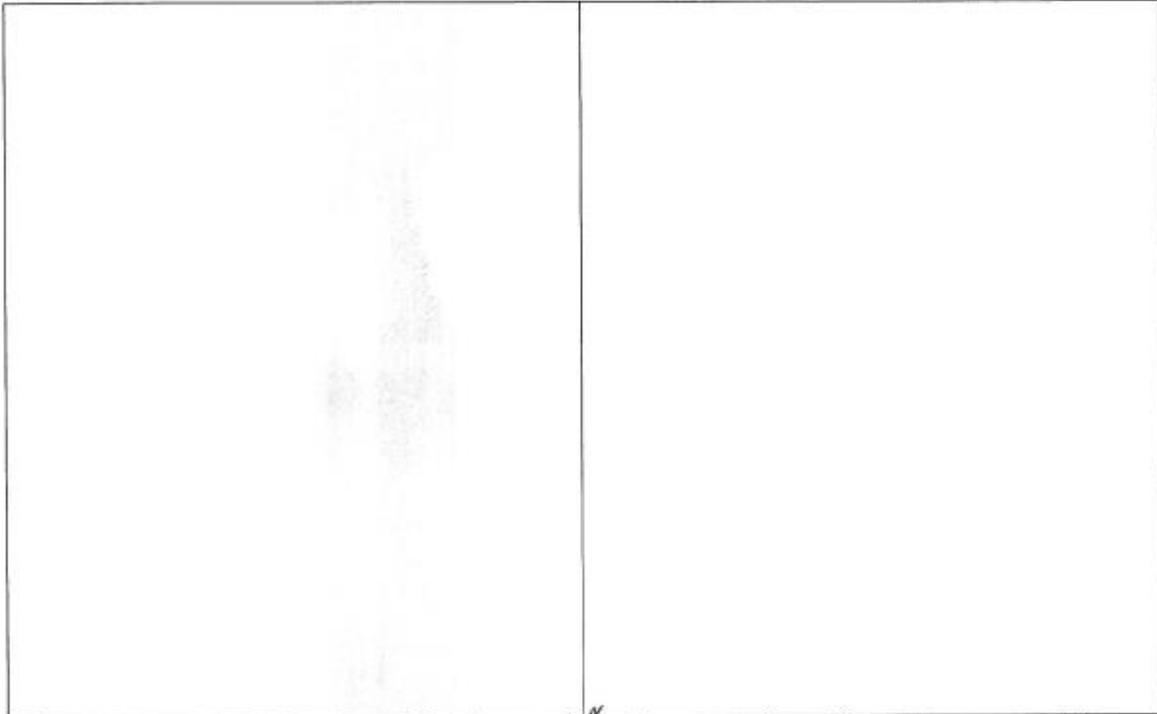
Values	Explanation (how and why is it relevant/fitting)
Confidentiality	It is suitable because of the nature of the cases just dealt with. Eq. when a client believes in smoking dappa to rebuy/study but doesn't want the social worker to tell his parents. As such the SW will then have to determine what the most appropriate action is.
Non-Judgemental & Acceptance	By being non-judgemental the SW becomes more willing and accepting to assist the client, to understand their beliefs and come up with appropriate solutions. As a result the client might also be more open to talk about their issues/spirituality.
Respect	Applicable because people are unique; some people have spirituality while others don't. As such one does not only respect the persons spirituality but their human dignity, self-worth and the person as a whole.

Self-determination	A good value in spirituality for instance "when a client ask for their pastor to be present during a session. However when self-determination becomes detrimental other values and roles need to be taken into account. (eg. assertiveness or other skills). Also competency will enable the SW to help the client reach reasonable goals/expectations
Competency	Very important skill to assist the social worker in outlining reasons to the client on why their reasoning might be wrong/harmful. Must be competent enough to pin-point errors to the client. Eg. "telling a client that believing in snakes are unreasonable"
Objectivity	Helps the SW stay objective in reaching a clients goal and stay focused rather than judging or being bias. Other skills like listening, assertiveness, paraphrasing etc. will also be easily applicable during sessions. Eg. "When your community see you on the television at a certain church. (eg. N.G. Kerk) and people change their attitude towards you"

Its difficult to rank the values because they are all equally valued and important.

Theories	Explanation (how and why is it relevant/fitting)
Person-Centered approach	<p>Help clients at their level and don't focus on what the SW think the client believe. Client should be the driver and most important person during the sessions.</p> <ul style="list-style-type: none"> * Client should guide SW on their believes and not the other way around. * Pt explained that he didn't have any coping mechanisms but found some in his spirituality. As such he started using morals & values from spirituality to help him drink his medication.
Bio-psychosocial approach	<ul style="list-style-type: none"> * Looking at a person holistically at their physical, spiritual and emotional pain. * Spirituality also affects other people around the client as such social factors also need to be assessed
Systems approach	<ul style="list-style-type: none"> * People are influenced by different systems; family, media, peers and school. * People are influenced by where they are coming from eg. like in different cultures where people believe in witchcraft, everything in their life will be about witchcraft like falling a subject. As such spirituality is influenced by their background. * SW can also better help clients get a realistic solution through assessing their emotions, behaviors and rational eg. CBT and REBT

<p>Strength - perspective</p>	<ul style="list-style-type: none"> * SW make use of clients abilities, skills, talents and spirituality/culture to solve a specific problem: * SW need to listen to the client in order to facilitate in establishing an appropriate and realistic solution.
<p>Multidisciplinary approach.</p>	<p>Ex. "At rehab centers some SW involve pastors from different churches to assist during sessions/assessments."</p> <ul style="list-style-type: none"> * SW facilitation skills come in to cater for the persons specific needs as a client as some clients might not agree to just 1 pastor as their spirituality is different.



You don't just use 1 approach but different approaches/theories according to the problem and need at the time. As such its difficult to sort them because of different phases.
 Discussion on Western Theories and Indigenous theories in the application of spirituality in Social work in the Namibian context

- * Some think that there are no need for indigenous Theories (African specific Theories) because he still deal with the person in the same context / way with the same goal even though the definitions might differ.
- * As such the ~~can~~ only issue is the name of the Theory as the context, content and approach is still the same. The explanations of different Theories eg. CBT are difficult and will need extensive explanations as some languages / cultures dont have specific words to explain. (limited vocabulary).
- * Eg. Person Centered approach being same as Umbuntu.
- * Definitions might differ because of background like on ancestral beliefs & morals

Skills	Explanation (how and why is it relevant/fitting)
Listening Skills / Communication skills	

Cultural Competency	
Building Rapport with Empathy	
Holistic understanding of human beings.	

Roles	Explanation (how and why is it relevant/fitting)
Referral (Referrer)	As social workers you are trained to be a pastor social worker, not a pastor or spiritual leader. Thus, the SW will have to refer the client to a pastor who can assist them, as it is their expertise. SW can also act as a facilitator when pts are in the hospital and need spiritual help in order to reach a goal or find a solution to a problem.
Educator	Eg. "Educating clients that using oil (spiritual) on a wound or with medication might deter their recovery." or "Educate mothers that who are positive - that breastfeeding their children does not necessarily mean that their new born babies will become HIV+, then but that feeding them for more than 6 months might."
Broker / Linker	SW can bring in traditional leaders or other spiritual leaders to explain a certain topic to a client (linkage). Even though a SW might know the answer/solution it is always better to link with other people & resources to better explain a situation.

Advocator	Eg. "Pt couldn't understand the language that the dr. spoke (English), s/he had to advocate on behalf of pt for dr to translate and explain in the language that they understood."

Appendix N: Inputs from the experts in drafting the guidelines

Guideline Task
Som Dept 15-1

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02 October 2017

For the attention of: Zelda Rukambe
University of Western Cape

REVIEW REPORT: Guidelines for social workers in the mental health settings to incorporate spirituality in their practice.

CANDIDATE: Zelda Rukambe

DEGREE: PhD in Social Work

REVIEWER: Dr Z Soji

Kindly receive my report of the review of the guidelines for social workers in the mental health settings to incorporate spirituality in their practice.

General comments

The guidelines are located within the field of social work. The guidelines are designed for use in the area of social work and mental health. The guidelines are based on the empirical data and/or findings and the review of relevant literature.

Specific aspects considered

1. Scope of the guidelines

The statement of the problem or the question that must be addressed by the guidelines is clearly articulated. There is a good alignment between the research aim, the research objectives and the proposed guidelines. The overall objective(s) and the rationale for the guidelines is specifically described and therefore, no change is required. The target population to whom the guidelines are meant to apply are specifically described.

2. Stakeholder Involvement

The views of the target population (social workers) are sought through the interviewing process and the data from the interviews informed the content of the guidelines. It is however not clear whether the views of the recipients of the services (client group/ reps of client groups) as well as other stakeholders such as community/traditional/spiritual leaders have been sought.

Guidelines input

3. Rigour of Development

The methodology used for the development of the guidelines is clearly described in the proposal. From this methodology, it would appear that a systematic process (use of empirical data and the review of literature) were used to search for evidence. The strengths and limitations of literature have however not been included.

4. Applicability

The guidelines are framed by the professional values and principles and therefore are relevant for social work practice. The guidelines are comprehensive and the language used is more relevant and suitable for professional use. The guidelines would however need to indicate/reflect the interconnection between culture, spirituality, religion and professional values and the interactions as well as intersections of these areas to ensure inclusivity in their application. This is more relevant considering some of the theories indicated such as the systems thinking, the ecological systems perspective and social learning theories that frame interventions. The skills needed and social work roles that would act as facilitators for the application of the guidelines are clearly described. I would suggest the inclusion of the skill of bracketing as this will enable social workers to be able to bracket their own belief systems and this facilitate their ability to "be with" the client. The potential barriers in applying the guidelines and recommendations have not been highlighted.

Recommendations

I would also like to suggest the need for social workers to be aware of the intra-personal functioning of the person.

1 MB

2

Knowledge on human dimension eg: intra personal functioning

Dr Z Soji

- brief overview
- clarify details of theories, Role, skills, is western framework? ability?

MB Indigenas
- Person centered
- we start where the person is and what is important for him/her and family

1-10

Guidelines Input Expt 1-2

Guidelines for social workers in the mental health settings to incorporate spirituality in their practice. *It would be beneficial to define the term guideline and contextualize*

Introduction and Rational

In Namibia, there is currently a lack of empirically based social work practice literature involving spirituality or spiritually sensitive-social work. This guidelines is developed as part of the resent completed research exploring spirituality in mental health in the Namibian context for social work practice and researchers. Thus, the content of this guidelines is based on the research participants' responses and from the relevant literature review conducted. The guidelines is developed for social workers in the mental health settings with the aim to guide them on how to incorporate spirituality in their practice. However, this guidelines is also applicable in any other social work settings.

Introduction to the planned protocol

These are some of the key steps I thought would be relevant

Protocol developmental process

Purpose and service principles

Define relevant concepts

Role players

Training section/ workshop

Sustainability

Continuous support and orientation

Literature reveals that spirituality in social work practice is a very important aspect that should be paid attention to, as indicated below:

- Guidelines and knowledge on spirituality and social work is needed because social workers are expected to consider spiritual aspects of their clients in their social work practice as an ethical principle to the benefit of their clients. The potential success in

Appendix O: Editorial certificate

26 November 2018

To whom it may concern

Dear Sir/Madam

RE: Editorial Certificate

This letter serves to prove that the thesis listed below was language edited for proper English, grammar, punctuation, spelling, as well as overall layout and style by myself, publisher/proprietor of Aquarian Publications, a native English speaking editor.

Thesis title

SPIRITUALITY AND SOCIAL WORK IN THE NAMIBIAN
MENTAL HEALTH PRACTICE: GUIDELINES FOR
SOCIAL WORKERS

Author

Zeldah U. Rukambe

The research content, or the author's intentions, were not altered in any way during the editing process, and the author has the authority to accept or reject my suggestions and changes.

Should you have any questions or concerns about this edited document, I can be contacted at the listed telephone and fax numbers or e-mail addresses.

Yours truly



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6 August 2019

To whom it may concern

LANGUAGE EDITING – ZELDAH U. RUKAMBE

This letter serves to confirm that a Doctor Philosophy in the Department of Social Work thesis entitled **SPIRITUALITY AND SOCIAL WORK IN THE NAMIBIAN MENTAL HEALTH PRACTICE: GUIDELINES FOR SOCIAL WORKERS** by Zeldah U. Rukambe was submitted to me for language editing.

The thesis was professionally edited and track changes and suggestions were made in the document, which if followed by Zeldah U. Rukambe will result in a thesis with a high standard of English.

Yours faithfully

N. Mlambo

Dr N. Mlambo

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