Psychology in Africa or African Psychology?
Discourse on paradigm shift in psychotherapy and psychological practice in Africa

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Abstract. Psychology in Africa or African Psychology is a million dollar question that remains to be debated by psychologists in Africa and those in diaspora as to the true status of psychotherapy and psychology practice in Africa. What is Psychology in Africa, or should it be African psychology? The focus of this paper is to present a discourse on the need for a paradigm shift in psychotherapy and the practice of psychology in Africa. The following questions will further assist us in the direction of debate: What is the current practice of psychology in Africa? Do we need to have African African-centred psychology? Do we need a shift of approach from Psychology in Africa to African psychology? The answers to these questions would be the platform and departure on which the status of psychology is discussed in Africa anchored on the debate on the relevance of culture in psychology teaching and practice in Africa.

Keywords: Psychology in Africa/African Psychology/Discourse/Paradigm shift/Psychotherapy/.

Introduction:

In an earlier lecture titled ‘Universalising Psychology: The Voyage of an African Psychologist’ (Idemudia, 2013), I did propose like in similar settings (Idemudia, 2003) that the teaching and psychotherapeutic practice in Africa is too Eurocentric and therefore psychology in Africa should be universalized. Many of the ideas discussed in these lectures are also represented in this paper arguing for correctness and for African psychology rather than psychology in Africa.

Weiten (1998), in his book claimed that psychology was born in Germany and notwithstanding, psychology as a discipline blossomed into adolescence in America. Like many adolescents, however, the young science did enter a period of turbulence and turmoil (and even in its adulthood, psychology is still very controversial across cultures).

Throughout psychology’s history, most researchers have worked under the assumption that they were seeking to identify general principles of behaviour that would be applicable to all of humanity. In reality, psychology has largely been a Western (North American and European) enterprise with a remarkably provincial slant (Gergen, Gulerce, Lock & Misra, 1996). The vast preponderance of psychology’s research has been conducted in the United States by middle and upper-class white psychologists who have used mostly middle and upper-class white males as subjects (Segall, Dasen, Berry, & Poortinga, 1990).

Traditionally, Western psychologists have paid scant attention to how well their theories and research might apply to non-western cultures, to ethnic minorities in western societies, or even to women as opposed to men.

Why has the focus of Western psychology been so narrow? According to Albert (1988), a host of factors can explain:

(1) Cross-cultural research is expensive, difficult and time-consuming.

(2) Psychology has traditionally been interested in the individual as its basic unit of analysis.

(3) Some psychologists’ worry that cultural comparisons may inadvertently foster stereotypes of various cultural groups, many of which already have a long history of being victimized by prejudice.

(4) Ethnocentrism- the tendency to view one’s own group as superior to others and as the standard for judging the worth of foreign ways-may have contributed to Western psychologist’s lack of interest in other cultures.
Cultural Determinants:

Every society embraces particular cultural theories or ideologies that set the parameters within which normal, abnormal and deviant behaviour is defined. However, the psychologies of North America and Europe dominated African academies which led to a common argument about understanding African epistemologies as a necessity for the development of psychological knowledge that is appropriate to the continent (Nsamenang & Dawes, 1998). African psychology is a discipline that challenges the philosophical assumptions on which all theory relating to persons of African ancestry is based and the challenge is self-conscious and focuses on theoretical principles, premises, and postulates (Rowe, 2013). African psychology aims to establish the requisite knowledge and skills for implementing African-centred psychology to structure and deliver an instructional curriculum and to certify psychologists to address the particular psychological needs of African ancestry (Rowe, 2013). African psychology is also a body of knowledge that is concerned with understanding African life and culture (Kazdin, 2000).

According to Idemudia, (2005), cognition includes our thoughts, ideas, beliefs, understanding and knowledge. Western psychologists believe in cognitive paradigm based on complex unit of analysis called cognitive schemas. But this approach unfortunately, has always down played or neglected the role of culture in psychological studies and the application of this to illness behaviour. According to Nsamenang and Dawes (1998), psychology came to Africa as a complete intellectual package instead of originating from a natural growth initiated on an African soil and according to Owusu-Bempah and Howitt, (1995) contemporary psychology in Africa remains largely ethnocentric in its methods, theory and practice.

Psychology understands that neither health nor ill health occurs randomly within populations. Both are rooted in social processes such as the pattern of social interactions between individuals or groups defined as cultural bond based on values and norms, which help perpetuate patterns of health (Idemudia, 2008). Culture is a way of life of a given people. Studies have shown that health and or illnesses are culturally defined and treated, since cultural meaning systems inform aspects of illness and some diseases are culturally specific (Harkness & Keefer, 2000). Unfortunately, the percentage of variance explained by culture on health issues in an African community is neglected and as such deserves special attention. Cultural cognition of illness and well being is about how Africans know, perceive, and think about illness, well being and the consequences it has for behavioural outcomes in prevention and management with theoretical implications. Not only do cultural definitions influence the interpretation of an event as stressful, but also our understanding of the role of life events depends on the cognitions of such people.

The Proposition

My contention and proposition is that that psychology must not be seen from the eyes of the West but a universalized eye. In the eyes of African psychology, health and/or illness is culturally defined and treated, since cultural meaning systems inform aspects of illness and some diseases are culturally specific and that cultural bonds help perpetuate patterns of health. I have tried to define culture (Idemudia, 2003b) as a way of life of a people. In other words, culture is the sum total of all things that refer to customary roots of a given people and this include symbols, language, parables, idioms, songs, stories, celebrations and all expressions of way of life. It also encompasses kinship, ways of relating to each other, and even ways of expressing illness and yielding to treatment.

According to Harkness and Keefer (2000) health and or illness are culturally defined and treated since cultural meaning systems inform aspects of illness and that some diseases are culturally specific. If we accept Harkness and Keefer’s assertions, then it will be implied that a society has its ways of defining illness behaviour, some certain behaviours that fits into what is regarded as abnormal and also possibly how these behaviours are treated. This is my approach to this paper. It is not just a dry theory but a practical approach: An approach that will help us to understand African Psychology.

According to Ebigbo (1989), both physical and mental diseases originate from various external causes such as a “breach of a taboo or customs, disturbances in social relations, hostile ancestral spirits, spirit possession, demoniacal possession, evil machination and intrusion of objects, evil eye, sorcery, natural causes and affliction by God or gods. An evaluation of some African psychologists has shown how Africans perceive illness. Tsala Tsala (1997) have also claimed that disease is systematically acknowledged as having a supernatural origin such as being caused by ancestors or divinities, the practice of sorcery and various evil spells. To an African, biology alone does not explain disease causation, because it is seen as a social phenomenon, and as such has significance for the whole ethnic group and immediate community members. Also Africans believe that diseases can be transmitted from one generation to another as long as the stains of a fault have not been cleared. Many collective rites exist, whose aim is to stop transmission of some diseases that runs in the family.

If we should do a random survey of general experiences of clinical psychologists in African countries, I am positive that one theme among them will stand out: That clients attribute their problems to non-biologic causes especially to unnatural causes (Idemudia, 2004).

In my previous studies (Idemudia, 2003a, 2005), I have tried to explain that many Africans tries to attribute mental illness or even diseases to breach of taboos/customs, disturbances in social relations, hostile ancestral spirits, spirit possession, demoniacal possession, evil machinations,
intrusion of objects, evil eye, and affliction by gods and sorcery. Wicked people out of jealousy/envy or just being plain wicked can make bad things (like blindness, illness (physical and mental or even death) happen to other people. In therapy, witches and wizards are blamed to be causing the problem(s) which is what is also leading to the proliferation of churches and mosques where some claim to be seeking powers for protection. In some cases, it is plain extreme stress. It is in this light that Africans in therapy prefer to use treatments that recognizes their ways of thinking and value system. A detailed description of different researchers on the nature of help-seeking behaviour and health-utilisation behaviour among Africans has been described in detail, (Idemudia 2003a, Madu and Idemudia 1997, Idemudia 1995) and elsewhere (Gordon, 1990).

African Psychology recognizes the importance of culture in their day to day interaction. This knowledge is enshrined in our languages. For example, in many African languages there are no words like ‘cousin(s)’ (not to talk of 1st, 2nd or 3rd). We have names for ‘Father’ (‘Aba’ in Esan people of Edo State, Nigeria), ‘Mother’ (Nene), etc. One’s first or second cousin is regarded as a brother or sister and as such sexual behaviour among such relatives is regarded as incest and a taboo. Who I am (the self) is also embedded in cultural experiences (Fig 1). How cultural experiences influences the self is discussed elsewhere.

Principles of African Psychology:

African psychology is embedded in some principles which incorporate religion and spirituality. In addition, African society is other/family-centred and living is about cooperation not competition. Self in relation to other is the focus of individual experience (Grills, 2006). Detailed explanations of the self of an African person/family and wellbeing have been given elsewhere as illustrated on Figure 1, (Idemudia, 2012):

Given these perspectives, isn’t about the teaching and practice of psychology in Africa starts to focus on integrating the values of African psychology with western psychology? According to Kleinman (1980), patients and healers have their own “explanatory models” that is their particular understanding of what a human being is and how psychosocial disorders that may appear are to be accounted for and treated. Cook’s (1994) research findings revealed cultural variability in the extent to which different cultures subscribe to biomedical, psychosocial and phenomenological beliefs about chronic illness.

African psychologists should start to develop theories, produce books. Books with African pictures, examples of way of life etc. These books should be recommended for schools. These can have attitudinal and motivational change for our students. Relying on books from the western world limits our understanding of African psychology, understanding disorders in general and consequently restrict the way we approach treatment. Furnham (1997) also notes further that cultural attitudes towards illness particularly affect availability of professional help.

The issue of acceptability of professional help is particularly important because if cure is recommended to a patient who does not believe in the theories of cause, and or cure, of an illness, the patient suffering from such illness may not follow the guidelines for the cure or may ensure that the cure is ineffective. The theories of cause and cure of diseases, of necessity have to be meaningful to the patient in terms of the realities he/she understands.

Increasing awareness of the limited cultural scope of our research also creates a corresponding increase in cross-cultural research on psychopathology and psychotherapy.

On psychotherapy, what happens when people seek psychotherapeutic help? According to Sue & Zane (1987) this has been shown to be related to one’s ethnic background.

Researchers in the United States of America have found that mental health services for minority groups are inadequate. As evidence of this problem, Sue (1992) cites statistics indicating that blacks, Native American, Asian Americans, and Hispanics tend to terminate psychotherapeutic treatment earlier and also average fewer sessions than whites.

Between 42 and 55% of minority clients failed to return after a single session, compared to a 30% dropout rate for white clients. Among the reasons for these findings are lacks of bilingual therapists and therapists’ stereotypes about ethnic clients. The single most important reason may be that therapists do not provide culturally responsive forms of therapy. They may also be unaware of values and customs within a culture that would help in understanding and treating certain behaviours.

How does culture sensitivity affects psychotherapy? Sue, Fujino, Hu, Takeuchi, & Zane, (1991) analysed the services, length of treatment, and outcomes of therapy for several ethnic groups in the Los Angeles mental health system. Ethnic match (in which the client and therapist were members of the same ethnic group) was related to length of treatment and was also associated with success of treatment among Mexican Americans.

Also, the study showed a long lasting period and successful treatment when clients for whom English was not their primary language have the same ethnic background and spoke the same language as the therapist. The researchers concluded “match is important because it is related to length of treatment”.

It is possible that views and observations concerning the African client in this paper will be increasingly incorporated into understanding disease classification and the implication it also has for psychotherapy practice during the coming years. Such a process would represent the current globalization in the mental health sector. It is from a perspective of social
Figure 1. Detailed explanations of the self of an African person/family and wellbeing.
and cultural change then, that we must consider the current utilization of mental health resources among Africans particularly those in Diasporas. This process would mean an integration of some sorts. However, many questions remain concerning how such integration might occur. One area of concern is how these beliefs systems can be measured and whether such methods would be subject to adequate empirical testing and outcome research before they become widely used. On the other hand, depending on how these and related concerns are resolved, it is possible that empirically validated, spiritually oriented integrative psychotherapeutic forms will emerge within a contemporary, Western framework.

In the words of Nzewi (1989) ‘the major issue in the understanding of diagnostic categories and aetiological factors in other cultures is not merely discovering equivalence of concepts cross-culturally or matching patterns of symptoms’. More important than these are the understanding of the vocabulary, belief system and the perceptions of the patients. According to Sollod (1993) it is unfortunate that western psychology has tended to de-spiritualize psychotherapeutic endeavour thereby overlooking the spiritual dimensions of life and of experience.

According to him a wide range of spiritual healing traditions emphasizes the central importance of the connection of all life to spiritual or cosmic realities. In these views, healing is usually seen as restoring a condition of wholeness or harmony (Carlson & Shield, 1989). Also, there are needs for therapists to develop greater cultural understanding and knowledge. In addition, therapists from diverse ethnic backgrounds and ethnic-specific therapeutic services are needed. There is also a need for more bilingual and bicultural personnel who could work more effectively with clients from different cultures and those for whom English is a second language.

Conclusion:

In conclusion, the current practice of western psychotherapy in Africa must be revised. The concept of African or African-Centred Psychology/Psychotherapy should be pursued vigorously. ‘Psychology in Africa’ implies an imported discipline while ‘African Psychology’ implies home-brewed psychology (which can be exported to others when fully processed).

Any form of psychology teaching (including assessments) or psychotherapeutic practice without cultural justification is like building a house on a sandy ground. It is without substance and a mere surface scratching. Grossly, psychotherapy is measured in terms of total quality of human life. According to Triandis (1996), when the indigenous psychologies are incorporated into a universal framework, then we will have a universal psychology”. In the words of Awaritefe, (1997) “a science which is oblivious of its cultural environment condemns itself to irrelevance.

References:


