Culture, Spirituality and Health illness Behaviour: An African Perspective.

Abstract:
Africa is a continent that is rich with diverse cultures. In Africa, health and social behaviours are anchored on culture with spiritual underpinnings. These underpinnings have frameworks within religious beliefs and practices. The various branches of the Social Sciences, including Psychology, understand that neither health nor ill health occur 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. Studies have shown that health and or illness are culturally defined and treated, since cultural meaning systems inform aspects of illness and some diseases are culturally specific and spiritually explained. Unfortunately the percentage of variance explained by culture and spirituality on health issues in an African community is neglected and as such deserves special attention.

The aim of this paper therefore is to understand in detail the cultural and spiritual underpinnings of health/illness behaviour, wellbeing and theory implications from an African perspective. Cultural understanding of Illness development and wellbeing is about understanding the process of thought and how illness is perceived with spiritual explanations and the theoretical implications of these cognitions and the consequences it has for behavioral outcomes in prevention and management.
The links between indigenous theories of a mind-body perspective, conflicts/stress, solidarity and breakdown will be reviewed to explain the culture-spiritual connections in Africa. Not only do cultural definitions influence the spiritual interpretation of an event as stressful, but also our understanding of the role of life events depends on the cognitions of such people. This paper intends to demonstrate how these cultural cognitions affect behaviour outcomes in terms of culture and spiritual dimensions.

Introduction:
People exhibit different behaviour in every society. Some behaviours are labelled 'mad', "crazy', 'strange' or even sometimes are given some psychological names such as 'psychoses, 'neurosis' and many more. According to Davey (2008), Lemma (2005), strange behaviour in one culture may be normal in another culture which is why Berry et al, (1980) and Gergen & Gergen (2010) asserted that mental problems are an integral part of cultures and therefore should vary across cultures. However, I have always argued that some of these behaviours should be culturally defined and as such labelled.

Again, I have tried to define culture (Idemudia, 2003) 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. Unfortunately the role of culture, spirituality and health has been neglected in disease and health research particularly with regard to the perception of health, culture and in some sense spirituality. Health studies in the social sciences understand that neither health nor ill health occur randomly within populations. Both are rooted in social processes such as the pattern of social interactions between individuals, groups or nations and people's reactions to and perceptions of their social, physical environments. There are also the overarching systems of values and norms, which help perpetuate patterns of diseases.

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.

There is a serious debate of what Spirituality is all about but of course from the western perspective. Google online Dictionary (2018) defines it as **"**the quality of being concerned with the human spirit or soul as opposed to material or physical things". In black Africa, our ways of life are intertwined in such a way that makes the separation of spirituality from cultural practices difficult which again informs health issues and decisions. 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 issues of spirituality, culture and health research.

The African Attitude and Perception of illness behaviour:

An evaluation of some African psychologists has shown how Africans perceive illness. For example, in the words of 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.

How do the African attribute and perceives etiological factors of illness? According to Tsala Tsala (1997) every disease is systematically acknowledged as having a supernatural origin-the grief of 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 a 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.

According to Taussing (1980), the most important thing about society is the relationship between people and as a result, we need to recognize the human relationships embodied in symptoms, signs and therapy. Pearce (1989) also argued “it is too simplistic to see disease as something physical, which attacks the body”. According to him, disease causation can be due to “things we see and things we don’t see”. Many of the things we don’t see are included in African belief systems, cultural, spiritual and social values, philosophies, expressions etc.

Ebigbo and Ihezue (1982) then summarized that the common element in African belief system is simply that physical and mental illness is the result of distortions or disturbance in the harmony between an individual and the cosmos, which may mean his family, society, peers, ancestors, or a deity. According to Lambo (1978), for example, the African way of thinking does not draw a line between the living and non-living, natural and supernatural, material and immaterial, conscious and unconscious. These sets of phenomena, which in the west, are conceived of as opposites, are understood in Africa as unities. The seen and unseen exists in a dynamic interrelationship. Past, present and future harmoniously weave one into another. The dream world and the daylight world have equal reality.

Also, in Africa, people interact with one another not on the basis of how things are, but how they perceive them. Africans perceive ill health to have material, moral, supernatural and pre-natural causes which can only be determined both by physical observation and divination, (Ezeabasili, 1977).

According to Tsala Tsala, (1997) this way of viewing health and disease, as a matter of harmony or disharmony between an individual and a larger context is similar to the holistic perspective being advanced currently by western researchers. (See Carlson & Shield, 1989).

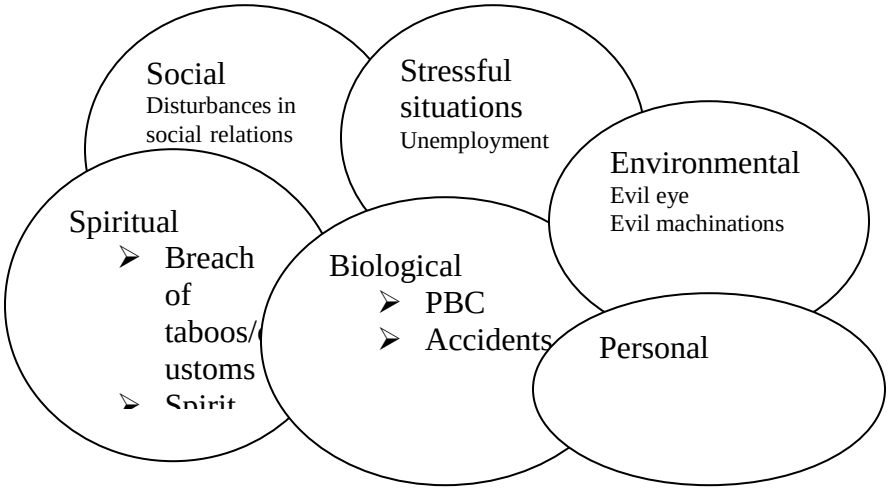
Africans understand and are aware of the seriousness of mental illness. The way Africans conceptualizes mental illness also negate the generally accepted western theories which indicate that the dominant belief among Africans in terms of causation of diseases, both mental and physical, is that they are exclusives spiritual or supernatural in origin.

The element in the African belief system is simply that physical and mental illness is the result of distortion or disturbances in the harmony between an individual and the cosmos, which may mean his family, society, peers, ancestors, or a deity. According to Lambo, (1978) for example, the African way of thinking does not draw a line between the living and the non-living, natural and supernatural, material and immaterial, conscious and unconscious. These sets of phenomenon which in the west, are conceived of as opposites, are understood in Africa as unities. The seen and unseen exists in a

dynamic interrelationship. Past, present and future harmoniously weave into one another. The dream world and the daylight world have equal reality.

To an African, biology alone does not explain disease causation. Disease causation can be personal, biological, stressful situational factors, social, environmental and spiritual, (Idemudia, 2003, 2004a, and 2004b). Pearce (1989) has argued that 'it is too simplistic to see disease as something physical, which attacks the body, rather, disease causation can be due to things we see and things we don't see'. Many of the things we don't see are included in African belief systems, cultural, spiritual and social values, philosophies expressions and can be communicated as reported as paralanguages during assessment and therapy.

Idemudia, (2004a) has described in detail the body-psychopathology link. However, it is important to note and understand that this belief system is holistic and therefore, the African therefore sees causation of physical and mental illness as balls of problems (fig 1 below) that overlap each other with both internal and external, and natural and unnatural causes, (see Idemudia 2004a for details).
Fig 1:



These balls of problems can be intermingled/overlap in some patients that one needs a good understanding to be able to make a good diagnosis. The case history 2 further illustrates a case in point here.

Psychopathology, spirituality and culture: (Theoretical Perspectives).
That the concepts of culture, spirituality and mental health are intertwined is a theoretical as well as a practical reality.

Matsumoto (1996) defines culture as the "set of attitudes, values, beliefs, and behaviours shared by a group of people, but different for each individual, communicated from one generation to the next". From this definition he argued that

culture is not rooted in biology, race and nationality. He also described the dualism in culture with the dimensions of individualism and collectivism (IC) which refers to the degree to which a culture encourages, fosters and facilitates the needs, wishes, desires, and values of an autonomous and unique self over those of a group. Detailed descriptions of both dimensions have also been done by Van der Walt (1997). According to Nefale and Van Dyk (2003) both dimensions are encountered amongst different groups in different parts of the world but in different degrees. The grading of communalistic and individualistic cultures may range from very weak and passive to very strong and active. In Africa for example, the communalistic culture has already started to change because of the dynamic nature of culture. These changes (stratification, integration, change, poverty, wars, famine, and migrations) have brought about significant inner conflicts experienced by Africans.

According to Pearce (1989) these aspects of group life are seen as problematic, when as a result of them, the individual finds a situation stressful. The concept of a stressor (noxious stimuli leading to sustained emotional arousal) has been well documented and viewed as the link between societal or institutional processes and the health of the individual (Innes, 1981).

Also, the links between conflict/stress and breakdown have also been recognized in indigenous theories of causation. Nzewi (1989) have documented the emphasis placed on good/moral behaviour and social harmony in the etiology of health in among the Ibos of Nigeria. African societies (Yorubas, Ibos of Nigeria; Hehe of Tanzania, Luo in Kenya, the Amhara in Ethiopia) believe that disruptive behaviour and the breaking of taboos are punishable through misfortunes and ill-health.

The African also believes that illness and health may also depend on keeping the terms with one's pre-life accord, (Prince 1975). This is what many would refer to as "Destiny". Acceptance of faith. Explained differently, when a person is born, he or she (due to an earlier agreement with God) lives the life that has been predetermined for him or her. As a result, deviations of any sort can then result in mental ill health. This concept also explains partly the belief in reincarnation (a continuous cycle between life and death). For example, the concept of "Ogban-Nje" (pathologic reincarnation) explains most forms of mental illness/possession particularly among females in southern part of Nigeria.

In addition, some societies in Africa also believe that illness can even befall a relative for another ones wrong doing. According to Pearce (1989) this idea appears to be similar to the western view that defective interactions within a family could result in psychosocial disturbances in one member (the scapegoat). While the western (social) perspective link outcomes to causes via naturalistic and mechanistic models (Freudian model based on physics), African social models use spiritual/religious idioms of explanation. Both models however, view illness as a sign of distress in social relationships in contrast to the traditional biomedical model.

Case histories 1 and 2:

- ***(Nigeria): Mr X 32 years old was mentally disturbed and contemplated suicide and was convinced that his ancestors were out to kill him. Review of his case study revealed that he had engaged in illicit sex with one of his fathers' wives. . (Mume, 1974). A taboo in many African societie****s*

- ***(London) In 1997, at psychiatric treatment centre in London, the author met a Kenyan who was diagnosed as "schizophrenic" because he contemplated suicide, depressed and violent. After a detailed interview with him I found that this young man of 30 years, illegally migrated from Kenya after he had sold his father's plot of land before coming to UK. Now he was arrested and sent to an asylum where he has spent almost a year. His thoughts as at the time I met him were hinged on the fact that he is experiencing theses problems because he sold his fathers land which led to his depression*****.**

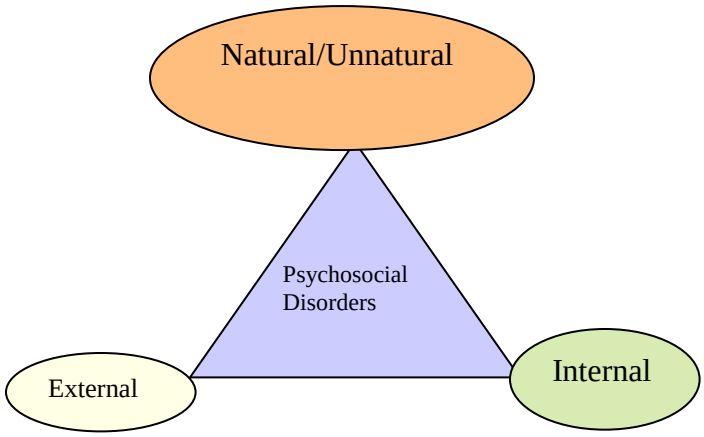
The Body-Mind Psychopathology Link

According to Ebigbo (1989) a combination of cultural conflicts (conflicts, stratification, change, famine, externalized attitude toward illness) can bring about anxiety-related-types of psychopathology among Africans. These psychic burdens emanating from such cultural conflicts need to be understood in the African perspective and idiom. According to Ebigbo, the body is the mind and the mind the body; therefore, physical images are then often used to describe feelings of the mind and dispositions of the external mind (as in witchcraft), which are often attributed to the body. As a result complaints of ill health, are always expressed physically, and the treatment is expected to be physical as well, (Ebigbo and Ihezue 1982) although it can be spiritually caused.

Psycho-physiological complaints are often formulated as subjective bodily sensations including heat in the head and body, a sensation of worms crawling all over the body, a sensation of heaviness in the brain, the sense that the heart is melting and wants to fly away and lump in the throat, (Okhomina & Ebie, 1973; Ebigbo & Ihezue, 1982).

Several mental health researchers in Africa (Lambo 1963, Ayorinde 1977, and Ebigbo and Ihezue 1982) have described these complaints as the somatization of emotional distress. These somatic complaints are usually presented by patients to obscure some psychic distress or according to Morakinyo (1985) presented as "cloaked phobic states".

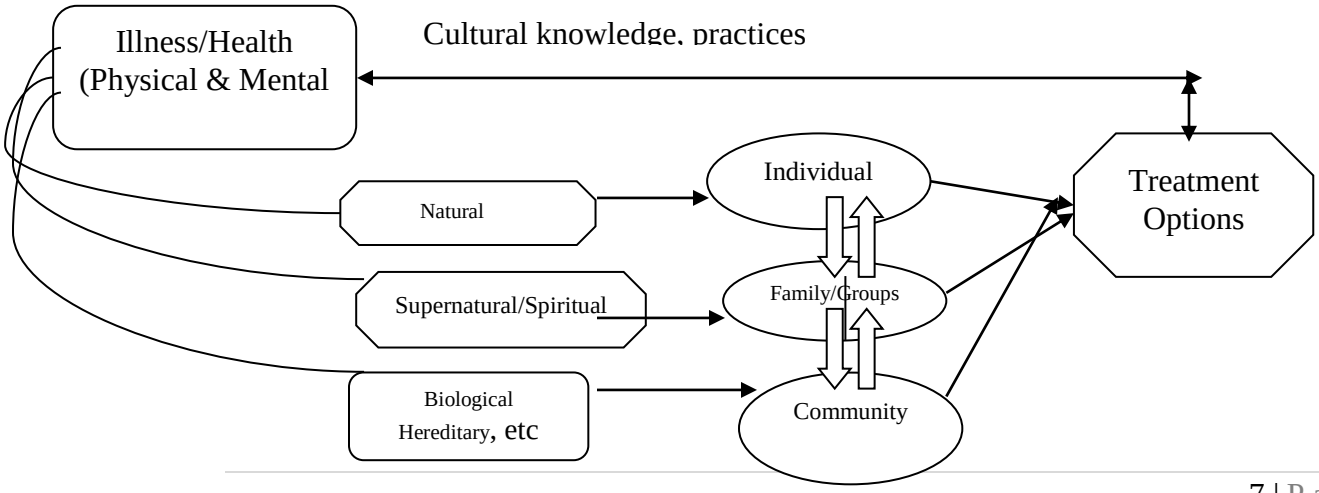
However, from my personal experiences with African clients, it is clear that physical and mental illnesses are seen and presented as a continuum with one affecting the other with spiritual underpinnings. When Africans attribute causes to psychosocial disorders it is viewed from both natural and unnatural causes having sources of external and internal factors. This is illustrated in figures 2 and 3 below:



Illness attributions:

- Physical or Mental disorders can be attributed to
- Breach of taboos/customs
- Disturbances in social relations
- Hostile ancestral spirits
- Spirit possession
- Demoniacal possession, e.g. (Ogbanje)
- Evil machinations
- Intrusion of objects
- Evil eye
- Intrusion of objects
- Affliction by gods and sorcery

A Cultural and Spiritual Approach to Mental Health and Psychotherapy



There is no doubt that the African prefers 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-utilization behaviour among Africans has been described, (Idemudia 2003, Madu and Idemudia 1997, Idemudia 1995) and elsewhere (Gordon, 1990).

Given this perspective, how would I describe a transitional African (transitional-because they are more likely to seek the help of a psychotherapist) suffering from a mental problem be helped? A transitional African is one who has received western education and as such has acquired both the African and Western values. The traditional African is firmly rooted in African values and has nothing to do with western values. As Kleinman (1980) pointed out, 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.

Let me illustrate further by quoting the work of Bourguignon, (1989). This illustration is based on the thinking of which treatment can be based. According to him, *"there was a case in which a man suffered from impotence, with the result that his wife had not conceived, so their marriage was threatened". A diviner was consulted and "explained that the man's impotence was caused by the shade of his dead grandmother. In this case, impotence is then not seen as either a physical or an emotional problem, but one involving relationships with ancestors. According to him, the concern here is not so much with the man's dysfunction but rather with its reproductive or familial consequences. Here, the human being is viewed as an intimately integrated into a familial and social system and it is the social relationship with ancestors, spouses, and descendants, which are investigated in cases of illnesses, rather than physical or emotional disturbances.*

It should be noted however, that not only do cultural definitions influence the interpretation of an event as stressful, spiritual but also our understanding of the role of life events depends on the models and links used by the researcher. Usually omitted in the causal chain of events are the broad politico-economic processes, which help structure the micro-situations within which individuals interact. The importance of these micro forces and social relationships are hidden by the focus on 'objective' events and the mitigating characteristics of individuals, (Nzewi 1989).

For example, just as we can become narrowly focused when we study people only at a certain age, we can also miss important aspects by studying people from only one culture. Studying the differences in behaviour of people from different cultures can tell us a great deal about the origins and possible treatments of abnormal behaviours and the role of spiritual dimensions in their lives. Unfortunately, most research literature originates in Western cultures producing an ethnocentric view of psychopathology that

can limit our understanding of disorder in general and can also restrict the way we approach treatment. 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.

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 that he/she understands.

Increasing awareness of the limited cultural scope of our research is creating a corresponding increase in cross-cultural research on psychopathology and psychotherapy. Also, the characteristics of different cultures can also reflect on symptom report. Symptoms or descriptions of them can be very dissimilar in different societies. For example, Nigerians who are depressed complain of heaviness or heat in the head, crawling sensations in the head or legs, burning sensations in the body, and a feeling that their belly is bloated with water (Ebigbo, and Ihezue 1982). In contrast, people in the United States report feeling worthless, being unable to start or finish anything, losing interest in usual activities, and thinking of suicide. Natives of China, on the other hand, do not report loss of pleasure, the helplessness or hopelessness, guilt, or suicidal thoughts seen in depressed North Americans (Kleinman, 1980). Again, many symptom report of depression among Africans do not result in suicides. These few examples illustrate that applying a standard definition of depression across different cultures will result in vastly different outcomes.

On psychotherapy, what happens when people seek psychotherapeutic help? According to Sue & Zane (1987) this has been shown to be related to ones 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, Stanley 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 a lack 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) analyzed 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".

CONCLUDING COMMENTS:

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 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, is it 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. The aetiology and symptom presentation of patients are often functions of culture. For example, though the clinical picture presented in delusional and hallucinatory states may be the same trans-culturally, it is obvious that the cultural beliefs, environmental factors and nature of interpersonal relationships, all determine the contents of the delusions and hallucinations.

According to Sollod (1993) it is unfortunate that western psychology has tended to de-spiritualize psychotherapeutic endeavor 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). Contemporary psychology and many contemporary psychotherapeutic approaches express the perception of human beings as cut off and isolated, not only from nature and from other individuals, but also more significantly from activities of cosmic purpose. Copernican, Newtonian and Freudian conceptual revolutions have led to the notion of human beings as purposeless, determined organisms acted upon by physical and biological laws. Even in humanistic approaches, meaning is usually seen as a subjective and arbitrary creation (Tart, 1987). According to

him, contemporary psychotherapy has much to gain from a worldview that reconnects human beings with one another and with universal and spiritual purposes (Bergin, 1980).

Is the call for a merger of the rational approach with cultural dimension to be seen as a way forward in the effort to assist victims to overcome their emotional and mental disorders? Considering the roles of cultural experiences in dealing with human problems especially in understanding the fears and aspirations, which often has become the foundations of health problem (see Buhrmann 1984; Collin & Sollod 1991) should be the major concern of psychologists working with African clients. It is the task of psychologists to explore, for proper understanding and diagnosis, the effects of spiritual and cultural influences on mental illness.

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.

In conclusion, the current practice of western psychotherapy in Africa must be revised. Psychotherapy without cultural justice can be better termed placebo-psychotherapy. It is without substance and is void of healing, (Idemudia 2002). Grossly, psychotherapy is measured in terms of total quality of human life. In the words of Awaritefe, (1997) “a science which is oblivious of its cultural environment condemns itself to irrelevance.

REFERENCES:

Awaritefe, A. (1997). The mind-body in an African context. *Ife Psychologia: An International journal, 5* (1), 140-149

Ayorinde, A. (1977). Heat in the head or body: A semantic confusion. *Afric J Psychiat, 1*, 59- 63.

Bergin, A. E. (1980). Psychotherapy and religious values. *]ournal of Consulting and Clinical Psychology, 48*, 95-105.

Bourquignon, E. (1989). Competition and complementarity in the utilization of Health References in Africa. In Peltzer, K and Ebigbo, P. (ed). *Clinical Psychology in Africa, Working group for African Psychology*: University of Nigeria Enugu-Nigeria.

Buhrmann, M. V. (1984). *Living in two worlds: Communication between a white healer and her black counterparts*. Cape Town: Human & Rousseau.

Carlson, R. & Shield, B. (1989). *Healers on healing*. Los Angeles: Tarchef.

Collin, S. & Sollod, R. (1991). *The relevance of traditional healing for psychotherapy: Content arid/or context*. Paper presented to the 6th Annual Convention of the Society for the Exploration of Psychotherapy Integration, Philadelphia, PA.

Cook, P. (1994). Chronic illness beliefs and role of social networks among Chinese, Italian and Anglo-celtic Canadian. *Journal of Cross-Cultural Psychology 25, 452-465.*

Davey, G. C. (2008). *Psychopathology: Research, Assessment and Treatment in Clinical Psychology*. West Sussex. Wiley-Blackwell.

Ebigbo, P.O. (1989). The Mind, the body and Society: An African Perspective. In K. Peltzer and P.O. Ebigbo (ed*). Clinical Psychology in Africa*. Enugu, WGAP, 482-484.

Ebigbo, P.O. and Ihezue U.H. (1982) Uncertainty in the use of western diagnostic illness categories for labelling mental illnesses in Nigeria. *Psychosomatic Africaine 3 XVIII (1),* 59 – 74.

Ezeabasili, (1977). *African Science, Myth or Reality*? New York: Vantage Press.

Furnham S. (1997). Overcoming Neurosis. Lay attributions of cure for five specific disorders. *Journal of Clinical Psychology, 53,* 595-604.

Gergen, K.J. & Gergen, M. (2004). *Social construction: Entering the dialogue.* Ohio. The Taos Institute Publications.

Gordon, J. S. (1990). Holistic medicine and mental health practice: Toward a new synthesis*. American Journal of Orthopsychiatry, 60* (3), 357-370.

Harkness, S. & Keefer, C.H. (2000). Contributions of cross-cultural psychology to research and interpretations in education and health. *Journal of Cross-Cultural Psychology, 31,*92-109.

Idemudia E.S. (1995). A Therapeutic Confrontation approach to treating refugees with progressive Psychopathology: Specific Problems and techniques*. African Journal for the Psychological Study of Social Issues 2*, (1&2), 176-185

Idemudia E.S. (2003). Tradotherapy and Psychotherapy in Africa: A Synthesis. In

Sylvester Madu (Ed) *Contributions to Psychotherapy in Africa.* UNIN Press. The University of the North for the World Council for Psychotherapy, African Chapter, South Africa. Pp 32-44.

Idemudia, E.S. (2002). Psychotherapy practices in Nigeria. In Alfred pritz (Ed) *Globalised Psychotherapy*. Facultas Universitatsverlag-und Buchhandels AG, Vienna. Pp 575-592 Bergasse (For World Council for Psychotherapy (WCP)-Austria.

Innes, J. (1981). Social Psychological Approaches to the study of the induction and Alleviation of Stress: Influences upon Health and illness. In G. Stephenson and J. Davies (Ed*). Progress in Applied Social Psychology*. Chichester: John Wiley and Sons, pp. 155-190.

Kleinman, A. (1980). *Patents and Healers in the context of culture*. Berkeley, University of California Press.

Lambo, T.A. (1963). *Psychosomatic disorder in West Africa.* WHO Technical Report Series 275.

Lambo, T.A. (1978). Psychotherapy in Africa. *Human Nature, 1*(3), 32-39.

Lemma, A. (2005). Introduction to psychopathology. London. Sage Publications Ltd.

Madu S.N. & Idemudia E.S. (1997). Traditional healer's approach to the treatment of apoplexy (Hemiplegia) –Paralytic stroke (A case study in Nigeria. In S.N., Madu, P.K., Baguma, and Alfred Pritz, (Ed); *African Traditional Healing (Psychotherapeutic Investigation).* Vienna: Austria Facultas Universitaetsverlag Berggasse 5, A-1090. Pp. 175-181

Matsumoto, D.C. (1996). *Culture and Psychology* – Boston , Brooks Kole.

Morakinyo O. (1985). Phobic States presenting as somatic complaints syndromes in Nigeria: Socio-cultural factors associated with diagnoses and psychotherapy. *Acta Psychiatar Scand; 71,* 356-365

Mume, J. (1974*). Traditional Medicine in Nigeria Agbaro:* John Nature Cure Centre.

Nefale, M.C. & Van Dyke, G.A.J. (2003). Ubuntu Therapy – A Psychotherapeutic model for the African Client. In Madu S. (Ed). *Contributions to Psychotherapy in Africa. South Africa:* The University of the North Press for the World Council for Psychotherapy.

Nzewi, N. Esther (1989) Cultural factors in the classification of Psychopathology in Nigeria. In K. Peltzer and P.O. Ebigbo (ed). *Clinical Psychology in Africa*. Enugu, WGAP, Pp. 208-216

Okhomina, F.O.A and Ebie, J.C. (1973). Heat in the head as a Psychiatric symptom. In Adonakoh C.C. (Ed) *Proceedings of the 4th Pan Africa Psychiatric Congress workshop on Neurosis in Africa:* Accra: New Times corporation.

Pearce, T.O. (1989). Social organization and Psychosocial Health. In Peter, K and Ebigbo, P (Ed) *Clinical Psychology in Africa* .pp 47 – 55).

Prince, R. (1975). Some Yoruba views of the causes and modes of treatment of anti-social behaviour. *Afric J Psychiat, 2,* 133- 7

Sollod R.N. (1993). *The Comprehensive Handbook of Psychotherapy integration.* In George Stricker and Jerold R. Gold (Eds). Plenum Press, New York.

Sue S. (1992). Cited in Sue, D., Sue, D., & Sue, S. (1997). *Understanding Abnormal Behaviour.* New York: Houghton Mifflin Company.

Sue, Fujino, Hu, Takeuchi, & Zane, (1991). Response of African American and Caucasian Women to Cognitive Behavioural Therapy for PTSD. *Behaviour Therapy, 30,* 581-595.

Sue, S. & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42,* 37-45.

Tart, C. (1987). *Waking up: Overcoming the obstacles to human potential*. Boston: Shambala.

Taussing, M. (1980). Reification and the consciousness of the Patent. *Social Science and Med.* 14(B), 3-13)

Tsa-Tsala (1997). Beliefs and Disease in Cameroon. In S.N. Madu, P.K. Baguma and Pritz, A. (ed.) *Psychotherapy in Africa: First investigation. Vienna.* World Council for Psychotherapy. Pp 44.

Van Der Walt, B.J. (1997). *Afrocentric or Eurocentric? Our task in a multicultural South Africa.* Potchefstroom: pu for CHE

Brief Bio

Formerly the Head and Subject Chair, Department of Psychology, Prof (Dr). Erhabor Idemudia is a full professor of research at the Faculty of the Human and Social Sciences, North-West University, (Mafikeng Campus), South Africa. He has a BSc (Psychology), MSc and PhD in clinical Psychology from the University of Ibadan, Nigeria. He is an NRF Rated Established Researcher/Scientist in South Africa and a 2015/2016 recipient of the Georg-Forster Life-Time Achievement Award in Research for senior professors by the Alexander von Humboldt Foundation, Germany. He is also an Alexander Humboldt Fellow, Germany (since 2003), Leventis Fellow, UK, Salzburg Fellow, Austria, etc. He is currently the General Secretary and Registrar of Membership-World Council for Psychotherapy (African Chapter) and member of the Board of the World council for Psychotherapy. He is an Associate Editor of the Journal of Child and Adolescent Mental Health, South Africa amongst others and serves as external examiners to several universities in Africa, Europe and North America. He has taught and done research at the University of Ibadan, Nigeria, University of London, UK, Jacobs University, Bremen, Germany, the University of Namibia, Windhoek, University of Limpopo, South Africa and North-West university, South Africa. Prof Idemudia, has over 200 publications in peer reviewed journals and books. He is the author (with Prof Boehnke, Germany) of "I'm an alien in Deutschland: A quantitative mental health case study of African Immigrants in Germany (with an epilogue by John W. Berry)". *Email: erhabor.idemudia@nwu.ac.za*