Psychotherapy in Africa

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Psychotherapy in Africa is divided into traditional or faith healing and western psychotherapy. The settings of traditional healing methods are distinguished according to (1) the episodic out-patient setting, (2) the continuous out-patient setting, and (3) the in-patient setting. Furthermore culture-specific treatment methods are characterized by (1) relationship to the body, (2) action, codified rituals, emotion and associated processes of regression, catharsis and flooding, (3) spiritual dimension and inclusion of altered states of consciousness, and (4) wholistic methods. Western psychotherapy in Africa is summarized, and an integrative psychotherapy approach for African clients is outlined on the basis of a cross-cultural model considering 10 cultural categories: (1) time frame/focus, (2) clear-cut (directive/caring role model, (3) gender focus/identity, (4) person-centered and multilateral identification, (5) locus of control, (6) defence/coping, (7) core relationship, (8) age-group/peer group relationship, (9) body/emotion-mind focus, (10) cognitive/emotional style.

Traditional and Faith Healing

Introduction

Characteristic of traditional healing methods in Africa is that much of it has not been recorded and written down. This orally transmitted healing knowledge is usually only known to initiated traditional healers and it will be transferred by the healers themselves or spiritually, for example, by ancestral spirits (e.g., Peltzer, 1992). Therefore it may not be surprising that researching and recording traditional healing methods may encounter certain difficulties (e.g., Krauss, 1990; Peltzer, 1987, 1992). Most research has so far been conducted by Europeans and North Americans (e.g., Bascom, 1969; Bibeau, 1979; Evans-Pritchard, 1937; Edgerton, 1971, 1980; Gelfand, 1964; Harding, 1975; Hielscher, 1992; Janzen, 1978; Prince, 1966; Peltzer, 1987; Warren, 1974; Yoder, 1982; Zempleni, 1969), more recently increasingly by African scientists (e.g., Anumonye, 1973; Chavunduka, 1978; Makanjuola, 1987; Ngubane, 1977; Osei, 1978; Twumasi, 1975, 1985), and the least by African healers themselves (e.g., Abate, in print; Mume, 1977; Lambo, 1980). Most literature on traditional healing in Africa is on mental disorders (Corin & Bibeau, 1980). Although in a traditional context mental and physical disorders cannot as such be separated, most traditional healing methods are geared towards ameliorating psychosocial problems and disorders (Peltzer, 1987). It seems that this has also been confirmed by statistics on the diseases of patients consulting traditional healers (e.g., Good & Kimani, 1980 in Kenya; Peltzer, 1983 in Malawi; Peltzer, 1981b in Zimbabwe); in Ethiopia most disorders treated by traditional healers (herbalists) seem to be of a physical nature (Werner, 1986). The types of most psychosocial problems and disorders treated by traditional healers for example in Malawi are according to their rank: (1) social disorders (economic and occupational problems, family problems, sorcery, witchcraft, theft, security and legal problems), (2) psychoneurotic disorders (hysteria, depressive neurosis, anxiety neurosis), (3) functional psychotic disorders, (4) psychosomatic disorders (menstrual problems, impotence, asthma) (5) alcohol and cannabis related disorder, (6) psychosocial problems in patients with infertility, epilepsy, sterility, organic psychosis mental handicap and developmental disabilities, (7)

psychosocial rehabilitation/care of chronic and/or terminal diseases (Peltzer, 1987, 1988b).

In order to understand traditional healing in Africa, the major research focus has been in the areas of a typology of different traditional healers and theories or concepts of illness (e.g., Gelfand, 1964; Chavunduka, 1978; Janzen, 1978; Makanjuola, 1987; Warren, 1974). Hereby it was, however, discovered that nosology and etiology can not be separated from specific traditional healing methods (e.g., Ngubane, 1977). But on the whole there are only a few studies trying to analyse traditional healing in more detail (e.g., Bibeau, 1979; Peltzer, 1987, 1992; Prince, 1966; Zempleni, 1969) and even fewer studies which have done follow-ups of traditional treatment (Assen, 1991; Peltzer, 1987).

Looking more closely at the different healing methods, a difference is made in some studies between physical and psychosocial or symbolic treatment methods. The psychic treatment effects of herbal remedies has not been studied much, although a number of healers use plants with active psychotropic components (Makanjuola & Jaiyola, 1987; Sofowora, 1979). The treatment of psychosocial disorders does not only take place at the place of the healer but often within the family where therapeutic family sessions can be conducted or the family members reach a first consensus on the nature of the illness which then will be confirmed by the traditional healer (e.g., Zempleni, 1969; Janzen, 1978). However, in the following chapter only traditional treatments outside the family setting practised by professional traditional healers are here further dealt with (see e.g., Twumasi, 1984). In the following I wish to differentiate traditional healing methods according to their different settings and culture-specific factors. The culture-specific factors which are found in both western and traditional treatment methods are excluded here.

The Settings of Traditional Healing Methods

The settings of traditional healing methods can mainly be distinguished according to time coordinates of healer-patient interaction:

(1) episodic out-patient, (2) continuous out-patient and (3) in-patient setting (Kleinman, 1980).

The episodic out-patient setting. The episodic out-patient setting is often particularly at first contact dyadic whereby spiritual powers may be looked upon as an additional dimension of the interaction. Before and after the first healer-patient contact, relatives are certainly included in the treatment process. Bibeau et al. (1980) have observed that in present Zaire the patient plays a more central role in the treatment whereby the family is no longer included as a partner but only as an assistant. The typical form of the episodic out-patient setting is that the healer uses part of his/her house as practice.

A less common form of an episodic out-patient setting is when the healer conducts home visits, since normally the patient should be taken to the healer. Home visits certainly also take place if the patient is unable to come. Thus, for example Mrs. Majako in Harare conducts her "kufemba" ceremony during home visits only accompanied by musicians who influence the spiritual sphere of the consultation. Mr. Rametse from Lesotho (Peltzer, 1996a) sometimes conducts home visits of two to three days in order to perform a healing ritual for specific ancestors of the patient. Hereby, the treatment is often preventive but also curative for particular members of the family or the whole family. For example, the family-owned hotel of a patient had been almost burnt down the previous year and the performed ritual was to protect the family from future misfortune. The particular methods used were:

First evening: The walls of the family house and the domestic animals are sprinkled with holy water so that specific ancestors are made to come to the place and that the house is protected from evil influences.

Second day: Speech by the healer, the member of the family who is bringing the sacrifice can now address the ancestors requesting them to fulfill specific wishes, sacrificing of different animals (goat, ox), ritual preparation and eating of sacrificed animals by the members of the ceremony symbolizing the ancestors, etc.

(Peltzer, 1996a, in more detail on the role of sacrifice animals for treatment: Machleidt & Peltzer, 1991; Peltzer, 1987; Prince, 1966,).

A rare form of out-patient treatment is the identification of witchcraft among a whole community, a village or a school class. Thus, for example, a delegation of some people came as representatives of a village to the healer Bwanali in Malawi (see Peltzer, 1987) in order to have detected who is behind the witchcraft in their village causing frequent child death in their village. An example of treating "epidemic hysteria" in a school class of girls by the healer Nana Afua Saah has been described by Peltzer (1981/82). In other cases the healer is often called by letter in order to perform divination and conduct treatment in institutions like a school, a company or a village (see Wendroff, 1985).

Another form of episodic out-patient treatment are so-called witchcraft finding ceremonies. Here, whole villages and communities are being cleansed from witches and wizards by a witchfinder. In the process all inhabitants concerned are summoned magically to surrender their witchcraft instruments. Besides that all inhabitants are provided with preventive medicine so as to protect them from witchcraft. These witch-finding sessions have even become a social movement from village to village and specific regions, particularly during the time of political and social changes, for example, from the 1950's to the 1970's in Malawi (Peltzer, 1987) or at the beginning of the 1980's in Zimbabwe (Peltzer, 1982). Those from traditional healers conducted cleansing ceremonies seem to have decreased, and it seems that now political and economic insecurity is tried to overcome by joining Christian movements (Mullings, 1984; Peltzer, 1985a; Piault et al., 1975). Such Christian movements including the so-called "born again" Christians do not aim at only temporary effects like in the anti-witchcraft cults where only external cleansing and protection takes place but more long term effects changing the ill-making way of living and personality (Peltzer, 1995b).

The continuous out-patient setting. The treatment in possession cults usually takes place in an out-patient setting. If symptoms in a patient are caused by a potentially good spirit, it can be expressed

in possession or possession trance of the patient whereby often an initiation in a possession cult is required (see e.g., Corin, 1976 in Zaire; Heintze, 1970 in Zimbabwe). The members and the leaders of such cults meet regularly, and particularly if new patients are initiated. In Ethiopia and Sudan one calls such cult groups "Zar" (Taha, Ahmed, & Mohamed, 1989), in Senegal "Rab" (Zempleni, 1969), and in northern Malawi "Vimbuza" (Peltzer, 1987). A similar function have the Orisa cults in Nigeria (Prince, 1974). Often members of these cults perform dances accompanied by drumming, clapping hands and songs leading to kinetic trance. At the same time a socialization process into ritual possession takes place, which can be reinforced particularly in times of recurring symptoms or in a crisis situation (e.g., Peltzer, 1987). An original form of a regular out-patient primarily preventive but also curative ritual takes place among the "!Kung" in Botswana. Hereby most members of the community participate in all night weekly healing sessions whereby the healing power or "n/um", is the most valued resource at the dance, and often the most valued resource in all community life (Katz & Wexler, 1989). Besides that, there is a wide range of continuous out-patient services in the context of Christian churches in the form of independent or healing churches (e.g., Peltzer, 1985a) or "born again" Christian communities (e.g., Peltzer, 1995b). In this transitional or Christian context each member will also be initiated like in the traditional possession cults and has to follow a number of behavioural rules. These healing churches seem particularly important for combating alcoholism and adapting to chronic and terminal diseases. Thus, some healing churches have developed a specific treatment programme for alcoholics whereby a drug-free community including dry alcoholics play a major role (Peltzer, 1985a).

The in-patient setting. In-patient treatment can take place in the family house of the healer or in a specifically erected house in the village or community of the healer. The in-patient treatment in the house of the healer is usually only possible for one to three patients often including relatives. According to observations of the author in Ghana, Nigeria and Zimbabwe (Peltzer, 1981b, 1995a) such type of treatment setting can be used specifically for mentally ill patients. Unusual was a traditional healer in Highfield in the city of Harare who treated five to

ten in-patients in her family house. Hereby the family members of the healer participated in the treatment process of the mentally ill patients, aggressive patients were chained and yet they were able to communicate freely with their environment, e.g. with pedestrians passing by (Peltzer, 1982). In-patient treatment in healing centers or villages are, as far as I have seen, and have learnt from literature in Malawi, Ghana, Nigeria mainly not only for mentally ill but also for physically ill patients. Thus, for example the healer Patriensa owns a large cocoa plantation including a Primary School, and other infrastructure, for her patients in the Ashanti region in Ghana (see also for Ghana: Appiah-Kubi, 1981). I have described such healing centers in Malawi in detail (Peltzer, 1987) whereby the treatment methods can be classified as follows: (1) herbal and symbolic therapy, (2) "milieu therapy", (3) dream interpretation, (4) counseling during daily "ward rounds" or group sessions, (5) praying and songs, (6) a certain diet, (7) kinetic trance, dancing and sacrifice. Milieu therapy can be further characterized by (1) organization, (2) environment, (3) culture, and (4) family. The organization of such a healing community involves the chief healer in his/her instrumental and emotional expressive healing function, assistants, patients and relatives. The environment is a village milieu which offers on the one hand real life situations with activities like fetching water, washing or cooking and on the other hand a modified milieu due to the healing activities taking place. The treatment goal is a progressive resocialization into culturally adapted forms of community life whereby the spiritual dimension of the ancestors and group solidarity are systematically enhanced. This can for example happen in the form of prayers, ancestral veneration, rituals or sacrifices. Since normally a relative cares for the patient in the healing center, the familial context of the psychosocial disorder can be further assessed, treated and especially the relative helps in the rehabilitation of the patient (Peltzer, 1987).

Culture-specific Treatment Methods

Here traditional treatment methods primarily for psychosocial disorders should be described which basically differ from western methods. Some traditional healers seem to emphasize spiritual aspects in the treatment of mental disorders. Thus, the Nigerian Chief J. O.

Lambo (brother of the pioneering psychiatrist T. A. Lambo) describes his treatment method as follows (Lambo, 1980):

> It may be unbelievable that I have to tell you that the occult method of healing is more certain and efficacious than the physical method. The occult method of healing involves many things as incantation, atonement, spiritualism. Through divination which involves clairvoyance and extra-sensory perception the patients can be vividly x-rayed and the affected part of the body could be clearly seen.

Mpho Rametse from Lesotho also indicates the relevance of divinatory methods including the interpretation of dreams. Besides that he considers his Basotho tradition (like ancestors, ancestral spirits, pacifying the ancestors through various rituals, spiritual cleansing) a prerequisite for traditional treatment (1995a). In this context some authors (Ilechukwu, 1989; Peltzer, 1987; Pfeiffer, 1991; Quekelberghe, 1991) have classified culture-specific treatment methods applicable to healers in an African setting.

Relationship to the body. Here exist a number of methods having an effect on the body, including the active bodily movement in the context of therapeutic rituals. In particular they are: rhythmic movements during dances, stimuli of pain and temperature, providing of food, bodily incisions, effects of herbs, but also vomiting and purging. Often smell, bodily contact and vision play a major role during healing processes. Mostly the applied herbal extracts convey symbolic messages, which according to Makanyouola (n.d.) can be classified into nine symbolic associations: (1) meaning of the name of the remedy, (2) sound of the name, (3) form/appearance of the remedy, (4) physical qualities, (5) behaviour of the remedy (e.g., leaves which "go to sleep"), (6) used part of the remedy (e.g., head of an animal for the head problem of a patient), (7) "supernatural" symbolic, (8) for symbolic wholism (e.g., pepper or salt), and (9) colour symbolism (e.g., black hen against witchcraft). Due to colonial and post-colonial influences the symbolic aspects of instrumental treatment, e.g. herbs, has been more and more decreased, which can also be shown in terms of urban-rural differences. Besides

that, a number of symbolic physical aspects have been integrated into Christian healing practices, for example, the holy water (Peltzer, 1987).

Action, codified rituals, emotion and associated processes of regression, catharsis and flooding. Not only from the healer but also from the patient action in various ways is expected during the encounter in order to gain control over the illness and its underlying spiritual powers. Thus dreams are more directly expressed and acted out as in a western context (Peltzer, 1985b). Especially non-verbal healing rites can be used to directly experience certain emotions or states of consciousness. During dance ceremonies, accompanied by possession trance, normal conduct of behaviour is often lifted so that the patient can express his/her repressed affects and behaviour pattern. Thus, flexible regression to earlier developmental stages or the sudden discharge or catharsis of strong affects are systematically promoted, similarly to the behavioural method of flooding. The confrontation with strong affects in situations, particularly during possession rites, is continuously increased until total psychic and physical exhaustion of the patient is attained (Quekelberghe, 1991). Sacrificial rituals are described by various authors (e.g., Machleidt & Peltzer, 1991, Peltzer, 1987, Prince, 1966, Zempleni, 1977). An example of a sacrificial ceremony in Malawi includes the following stages: (1) symbolic or token sacrifice, (2) calling the spirits and spirit possession, (3) preparations and songs, (4) the killing of the sacrifice, (5) preparation, fumigation and eating of the sacrifice, and (6) protection rites (Peltzer, 1987).

Spiritual dimension and inclusion of altered states of consciousness. The patient is directed by the charisma and spiritual powers of the healer, triggering hope and willingness to actively participate in the healing process. The patient considers the healer as a responsible and authoritative father figure taking over from him/her therapeutic functions (Pfeiffer, 1991). "Spiritual" processes are very often the basis of diagnosing the cause of illnesses and subsequent treatment procedures. Hereby the healer uses usually spiritual power of ancestral spirits or gods in order to name the patient's problem; this naming process is at the same time treatment process without the patient being possessed spiritually. The divinatory process has been described

by various authors (Bascom, 1969; Mendosa, 1982; Peltzer, 1981/82, 1987; Prince, 1966; Young, 1977) deriving certain mechanisms from it, for example, divination in different time contexts, expressing the patient's problem, precision of divination, corrective divination, generalizing divination, generalizing specific divinations (Peltzer, 1987). Moreover, there is the possibility that the healer speaks as a non-possessed person to spiritually possessed patient or even that the healer is in a process possessed by different spirits of the patient. This may be posssible in the following sequence: (1) healer-unknown spirit, (2) healer-our mother-in-law/spirit, (3) healer- mother-in-law spirit of the patient, and (4) healer- mother-in-law/witch spirit of the patient.

Wholistic methods (physiological, psychological, medical, religious). Although the patient possibly consults the traditional healer as an individual, his/her family, colleagues, friends, among others, and the environment are in an intensive way integrated into the treatment process. The disorder of the patient is broadened through the healing process from the individual and one-sided conception to the social (family, group, community), natural/supernatural, and legal/political context of the disorder. The interactive healing process can be described in terms of a number of categories which emphasize a wholistic and non-western concept, for example, a cyclic/episodic/processual time frame, present time focus, clear-cut/external/person-centered role model, multilateral identification, external/public/formal control focus, emphasis on specific defence mechanisms, libido/respect towards authority/age group, narrative/consensus centered cognitive style.

Conclusion

Up to know, detailed descriptions and explanations of traditional healing practices, in particular follow-up assessments of treatments, are still missing in Africa. Therefore the question of efficacy of traditional healing methods is only difficult to answer. Only a few African scientists seem to be interested in this area of research, and there is a tendency that traditional healing is becoming less relevant giving way to Christian healing movements and biomedical medicine. For example, a comprehensive book on traditional treatments by Gelahun Abate (pers.

comm., 1980) from Ethiopia does, due to historical-political reasons, not contain any religious-spiritual-magical healing concepts, which certainly would have been very important for the treatment of mental disorders (Werner, 1986). This spiritual-magical vacuum, which has been developing through colonial-religious influences, has been more and more filled by Christian healing churches. Thus one can conclude that, in the meantime, there are for example also in-patient treatment settings in churches under the direction of priests (e.g., Uyanga, 1979). Certainly, there are still a number of relevant areas of traditional healing, which have been underresearched, like the role of traditional treatment methods for mentally handicapped patients (c.f., Peltzer & Kasonde-Ng'andu, 1989). It seems very important not only to analyse the repertoire of herbal remedies (e.g., Harjula, 1980; Iwu, 1986), but also to investigate in-depth culture-specific treatment methods (e.g., for schizophrenia, see Peltzer & Machleidt, 1992; or for AIDS, Madu et al., 1996). Hereby traditional healer associations and their further professionalization can give important inputs for further research (MacCormack, 1983; Twumasi, 1984).

Western Psychotherapy

Introduction

Psychoanalysis as a therapeutic method has up to now been mainly applied to patients in "western" cultures, while e.g. in African societies mainly traditional healing and psychological treatment methods are used. The psychological treatment methods are primarily eclectic in regard to behaviour therapy, family therapy, humanistic methods, relaxation techniques, hypnosis and analytic oriented sessions (Ebigbo, 1996; Madu et al., 1996; Peltzer, 1995, Peltzer, 1996a; Peltzer & Ebigbo, 1989b). Psychoanalysis is only used as a method of research like the ethno-psychoanalytic studies by Parin, Morgenthaler, & Parin-Mathey (1971, 1983) in West Africa. Even Levine (1973) emphasizes that psycho-analysis is important as a research method and that it can be applied to all cultures. In case psychoanalysis is used as treatment method in the Third World certain modifications and adaptations of the psychoanalytic

technique are made (Devereux, 1985; Ducey, 1981; Ducey & Teschke, 1979; Ortigues & Ortigues, 1966; Parin et al., 1971, 1983; Roheim, 1932). In the Third World psychoanalytic treatment has been much used in Latin America and Asia but not in Africa.

Psychotherapy may appear to be a luxury in African countries. However, diseases of poverty, like protein-energy malnutrition, or consequences of war (Peltzer, 1996a) require psychosocial counseling for their effective treatment and diseases of affluence, like specific psychosocial disorders, require psychotherapy. Medical, including psychiatric, services provide drug therapy for an increasing number of psychologically ill patients in African countries.

Psychological disorders are increasing and are similarly frequent in African countries (where they amount to one fifth of all contacts in general health services) as in industrial nations (e.g., Harding et al., 1980; WHO, 1981, p. 26). Thus, Dhadphale, Ellison, & Griffin (1982) found 25% psychiatric morbidity among patients attending primary health clinics in four district hospitals in Kenya, whereby primary health workers only identified less than 4% of these cases as suffering from psychiatric problems (see also Ndetei & Muhangi, 1979).

Most of the psychotherapeutic care is provided by traditional and faith healers, however, with increasing problems of urbanization, the traditional healer often seems to fail to solve the patient's problem adequately when addressing newly structured psychopathologies like psychosomatic disorders, substance abuse and other chronic diseases associated with increasing problems of urbanization (Peltzer, 1987). Faith healers might have created positive support for urban clients, but they usually lack knowledge and insight into the nature of psychosocial disorders (Peltzer, 1987). As a result, more and more patients especially in urban Africa, feel the need for psychotherapy (Coleman-Nelson, 1991) considering socio-cultural inclusions into psychotherapy (e.g., Morakinyo, 1983b; Olatawura, 1975), especially in cases of marital and family problems (Ebigbo, 1989e; Lopez & Hernandez, 1987).

Research in industrial countries has shown that appropriate psychological treatment not only benefits the patient, but also alleviates the unnecessary strain placed on costly medical resources by untreated psychological problems (American Psychological Association, 1983, p. 10, McGrath & Lawson, 1986, p. 65). From a wider perspective, other financial ramifications of untreated psychological problems may ultimately cost far more than the appropriate treatment. In the area of employment, for example, decreased productivity, greater absenteeism, accidents, grievances, employee turnover and increased training costs are typical reflections of psychological problems (American Psychological Association, 1983: 12). Consequently, WHO (1988) is propagating psychosocial treatment in their Global Medium-Term Programme and applications of such programmes seem to be promising (Freund & Kalumba, 1982; Holtzman, Evans, Kennedy, & Iscoe, 1987; Sartorius, 1989b).

Psychotherapy in a western sense and psychotherapy research seem to be new endeavours in Subsaharan Africa at this point in time (see also Coleman-Nelson, 1991). Several authors (e.g., Binitie, 1982a; Kapapa, 1980; Jegede & Olatawura, 1977; Lambo, 1978; Olatawura, 1975; Prince, 1987) have pointed out the need and problems encountered with psychotherapy with African patients, e.g. a lack of acceptance of (expressive) psychotherapy was explained as a lack of psychological mindedness, lack of interest in introspection, reluctance to speak of family problems beyond the confines of the family or psychological causes not dating back to childhood. Another problem, so Ebigbo (1982) encountered has been that Africans complain of physical disturbances even in psychological cases and expect physical treatment in the form of drugs and injections. Jegede and Baiyewa (1989) state that the dependence on psychotropic drugs (especially anxiolytic and antidepressant drugs) for neurotic illness in the African setting does not give satisfactory results in many cases; also intensive psychotherapy seems not to be possible since the patient's aim is symptom relief and not self-understanding or personality change. There is a clear need to discover more effective psychotherapy methods of helping neurotic patients, especially for the more educated (Jegede & Olatawura, 1977).

A cross-Cultural Model

In order to consider culture-specific psychopathology and treatment methods a cross-cultural model considering African cultural, social, economic and historical conditions was developed (Peltzer, 1995). The basis for this model is the assumption that, according to a number of more recent studies, cultures may differ along specific dimensions, e.g. in terms of "individualism-collectivism" (e.g., Hofstede, 1980; Triandis et al., 1986). In this line individualistic societies (e.g., USA) emphasize personal characteristics like personal autonomy, competition, achievement and independence, whereas collectivistic societies (e.g., in Asian or African societies) emphasize solidarity, cooperation and harmony. Therefore on the basis of his own research, ethno-psychoanalytic and ethno-sociological research results, the author has expanded the characteristics of "individualism-collectivism" to the application of psychology to health care.

The basic thesis of this tridimensional cross-cultural model is that cultures differ in regard to the extent of human-human, socio-object and object-oriented interaction. Thus, for example, Agiobu-Kemmer (1984) has shown in a comparative study on Nigerian and Scottish mother-infant interaction that Scottish children spend more time with physical objects (in absence of human beings) and also more time in socio-object interaction (child-other human being-object interaction) than Nigerian children, whereas Nigerian children clearly spend more time with other human beings than with objects.

The difference with regard to human or person and object-oriented interaction can be further described in form of a number of conceptual categories, which again can be subdivided into three specific dimensions: (1) age group and peer group as separate dimensions, (2) age and peer group in the same dimension, and (3) the body/emotion-mind dimension (see Table 1). The advantage of this tridimensional over a bidimensional model is that the socioeconomic influence of human beings is divided into the influence on the age group and on the peer group. "Age group" here means socialization on the basis of respect or aggression towards elder people, ancestors, God, and "peer group" means socialization on the basis of peers, play mates, work mates or friends.

The different variables shown in Table 1 indicate, according to the differential person and object-oriented interaction a number of psychological behaviour patterns applicable to our field of psychotherapy in African cultures. In the following, ten cultural categories in the context of psychotherapy in Africa are described according to the cross-cultural model: (1) time frame/focus, (2) clear-cut (directive/caring role model, (3) gender focus/identity, (4) person-centered and multilateral identification, (5) locus of control, (6) defence/coping, (7) core relationship, (8) age-group/peer group relationship, (9) body/emotion-mind focus, (10) cognitive/emotional style.

Cultural Categories According to the Cross-cultural Model as Applied to Psychotherapy in Africa

Time frame (cyclic, episodic, processual), *time focus* (present). Individual sessions could last 60 to 90 minutes each on a (normally) weekly basis for a period of at least five to ten sessions. The processual character included that at the beginning sessions were longer, especially the initial interview could last up to two hours and sessions were spaced to two to three weeks towards the end of the therapy. It is to be conceived to make rather informal appointments (in passing) and dwell on an episodic as well as lasting rather than continuous or regular relationship.It is an operation under temporal perspective roughly equivalent to a disregard for punctuality (c.f., Lager & Zwerling, 1980). Termination is open-ended, short and fast reflecting the episodic and processual character.

According to Malan (1963, p. 209), a given aspect of psychopathology should be the limited aim in terms of working through briefly. This has the advantage that the therapeutic result may be greater than could possibly be expected. For instance, the aim of Mr. F.'s therapy for social phobia was to work briefly through his passive dependency needs and the therapeutic result did not only include the relief of the social phobia, but also an improvement of his impotent tendencies. Moreover, the focal technique (Malan, 1963, p. 219) was formulated in terms of one essential interpretation, which was applied by guiding the patient through partial interpretation, selective attention, and selective neglect.

Table 1. Cross-cultural model Cultural categories according to the cross-cultural model as applied to psychotherapy in Africa

Dimension	Conceptual Category	Person-Oriented Interaction	Object Oriented Interaction
Age group (vertical/ (diachronic)	Time frame	-cyclic	-linear
		-episodic	-continuous
		-processual	-structural
	Time focus	-present	-past/future
	Role Model	authority/control/ punishment as	authority/control/ punishment as
		-care	-sanction
		-clear-cut	-ambiguous
Peer group (horizontal/ synchronic)	Gender focus	-separated	-mixed
		-distinct	-diffused
	Gender identity	-strong	-weak
Age and peer group	Identification	-person-centered	-object-centered
		-multilateral	-unilateral
	Control focus	-external	-internal
		-public	-private
		-shame	-guilt
		-formal	-informal
	Defence/coping	-projection	-introjection
		-identification	-reaction formation
		-avoidance	-isolation
		-denial	-undoing
		-somatization	-displacement
	Core relationship	-hierarchical (parents-children)	-egalitarian (husband-wife)
		-united	-separated
	Adult-child relationship		
	Libido/respect		
	Aggression	-age group	-peer group
		-peer group	-age group
Body/emotion-mind	Focus	-unity	-dualism
		-body/emotion	-mind
	Cognitive/ emotional style	-consensus centered	-conflict-centered
		-coexistence of opinions	-disagreement of opinions
		-narrative	-monocausal

Interpretation of childhood problems in relation to the patient's complaint was usually not indicated, since psychoneurosis in the transitional Zambian or Nigerian is not fundamentally based in childhood. However, in a few patients with a more modern personality, childhood experiences played a bigger role in the interpretive process. For example, Ms. C., a Zambian patient, grew up in a boarding school in Europe and her social phobia could directly be related to negative sexual experiences during her childhood.

Clear-cut (directive)***/caring role model.*** The psychotherapist is expected to directly name the symptoms, causes and prognosis (fate) of the patient's problem rather than asking many questions and may do most of the talking. His interpretations should be general, to a certain extent, so that they can make up firm statements. For example, Mr. F., a Zambian patient, who had social phobia, takes sleep producers and appears to have passive dependency needs. At this stage it is for the therapist to name the patient's problems:

> You seem to have problems in your mind which you can not solve. This comes especially in the evening, when you are alone and then you cannot sleep. You are a person who does not speak out your anger and problems, you would rather keep quiet than object to what your superiors say to you at work. Also at home, your wife appears to be a more dominant type; she does most of the talking, even when you are expected to talk. You may have had some problem with your penis, since you are sometimes afraid of failing with your wife *(it should be mentioned that social phobia usually includes psychosexual problems*). Generally, you have inferiority feelings and you are afraid to fail at work and with your family. This problem has been there for some time, even when you were young and you feel it may never go away, but we will do something about it.

To all this the patient agreed, he got very attentive, he may have felt that a traditional healer was divining to him or may have heard it in

similar words from someone else before and he became very ready to follow the advice of the therapist.

Another example is by stating some major suspected symptoms in case of an alcoholic as follows: "fighting and shouting at innocent people", "spending lots of money on alcohol instead of buying food for his family", "feeling headaches, thirsty and tired in the mornings". As a result, the patient may be impressed and accept that "you know what you are talking about" and he may at the same time increase his/her positive expectation of the treatment.

At this point, patients may transfer omnipotent powers and dependency needs to the therapist, but the latter should only remain on that level to a certain extent. The therapist may say: I will tell you where the problem lies, how it came about and I will also show you the way and strategy to overcome the problem, but you have to go that way yourself. Hereafter concrete directives should be prescribed, like relaxation techniques, story or essay writing and paradoxical intention or symptom descriptions (c.f., Ebigbo, 1986b; Masamba, 1985).

The therapist should avoid writing notes during the session and should maintain face-to-face contact to establish a more active and direct interaction with the patient.

The approach of the therapist is practitioner (not client) centered meaning he/she should do more of the talking than the patient. The therapist is to apply a more activist, directive and judgemental model, at least at the initial phase of the therapy. Credibility and "gift giving" are important. Techniques based on this approach are "naming" the problem/ illness (rather than questioning), explicit guidance, advice, suggestion, reassurance, confrontation, use of modeling and rehearsing activities (e.g., culturally appropiate assertiveness, parenting skills) in regard to social skills training (c.f., De La Cancela, 1985; La Fromboise, et al., 1990; p. 640f.; Sue, 1981).

Furthermore, the cultural context should be blended in with religious beliefs, myths, proverbs, or stories so as to consider the ancestral/spiritual authority dimension.

Gender focus (separated, distinct), *gender identity* (strong). Gender focus and identity were to be considered in the problem manifestations, in regard to the relevance of the same sex socialization and the compliance of a more cultural expectation to have a therapist by the same sex. Therefore the clients selected for individual psychotherapy should match the gender of the client and psychotherapist. Thus, the author often found that patients willingly talked about their problems, especially on masculine and sexual issues.

However, when the author saw patients from the opposite sex for a longer period it was made sure that an official atmosphere was created. For example, when a single female Nigerian patient came for her fourth psychotherapy session, she was accompanied by her uncle. When the uncle got the impression that the therapy session had an official character he left the session before it had ended.

Person-centered and multilateral identification. In the time the patient is referred for psychotherapy, he/she has already undergone unsuccessful treatment from various different health resources: medical and psychiatric services or traditional and faith healers. For example, a 36-year-old Nigerian patient with insomnia and bodily complaints went three times for different biomedical treatment (injection, valium, tests for venereal diseases), then for psychiatric treatment where he "received only relaxation and no medicine". Thereafter he went to nine different traditional healers (Babalawos) where he received medicine for protection and was to conduct a sacrifice. He found quick but not lasting relief so that he went to three healing churches where he prayed and was treated with Holy Water. After this spiritual treatment he went again more for physical treatment: first self-treatment with tonic, second drug treatment at a mental hospital and third x-rays and drugs at a private hospital. Finally, he received in-patient psychiatric and psychotherapeutic treatment. His own narrative to his account was:

> "The problem started in March; I had chest pain. As I was treating the chest pain, I had punching in my stomach. This at times is followed with noise. This often disturbs my sleep. This continues

until July. During the month of July I did a series of tests to find out what actually was behind my sleeplessness. I went to three hospitals. Nothing abnormal was discovered. I started with native medicine. I went to eleven healers and two church elders. I also tried to seek a solution from a healing church. When I discovered that these did not help, I went to Aro Mental Hospital; I was treated under emergency. I went to a private doctor. There was no help until I came here."

Having undergone a number of unsuccessful treatments, most patients came into psychotherapy with positive feelings (c.f., Sifneos, 1972:105). Some, however, gave up before the psychotherapy had started, thinking that this different and strange form of therapy could not bring about any solution. With illness chronification, as was the case with many patients seen, a greater possibility exists that the patient tends to believe that his/her illness may be caused by some witchcraft or magic. Therefore the different illness etiologies and treatment possibilities (traditional, transitional, biomedical and psychosocial), were explicitly explained to the patient, who had a great need to understand each step of the therapy, especially from the traditional angle. For instance, the Zambian patient Mr. X. had been drinking six to eight bottles of beer almost daily to put himself to sleep, until he came to the point where the beer was no longer sufficient and his way out was to take sleep producers. By the time he was referred for psychotherapy, both alcohol and sleeping tablets were no longer able to produce his expected sleep. After explaining the function of the drug as a repressor of negative emotions it became evident to the patient, as with many patients at this stage, that a "talking therapy", which aims at recognizing and working through negative emotions was indicated (c.f., Bot, 1989). Although there is often the expectation of the ability of the therapist to produce a quick cure, most patients gradually understand that they can no longer remain passive, like in drug treatment, but have to become more active.

Multilateral identification can be seen at two different levels, namely that several persons/therapists/authorities (including traditional/faith healers, church elders) are identified with (more or less at the same time or episodically) or that the therapist is seen as covering many facets of

life by being competent in medical, religious, and psychosocial or even economic matters representing "omnipotent powers". Thus, different alternative treatment approaches should be elaborated upon and linked with the concept of illness, which is multirelational/referential/dimensional, as well as with the present problem solving strategies and health-seeking. Thus, co-therapists should be identified and utilized, e.g. an elder brother, uncle, faith healer. "Floating" transferences of the client with different relatives and authorities other than the therapist is to be considered for a trusting therapeutic relationship. One should not be surprised when confronted with financial or legal matters of the client but one should try to be competent in various matters of life, or else be in touch with persons representing such expertise.

Locus of control (external, public, shame, formal). In regard to external locus of control the therapist is to convey expertise, an air of confidence, should not be hesitant to make reference to his/her educational background and work experience, and may be addressed as "Doctor" (of psychology).

Most clients believe that the problem/illness originates from outside themselves in the environment including other people or witchcraft. Thus, an extrapsychic (social) conflict focus should involve external techniques. Thus, for diagnostic purposes abbreviated projective techniques or a dream drawing can be applied. This may satisfy the patient's needs for expertise and confidence in the diagnostic value of some instrumental object. At the same time, it brings about some projective information for the therapist and some suggestive value associated with an obscure object for the patient.

Public locus of control and shame may cause discomfort and fear of loosing privacy in the patient when asked about personal information including family matters. Self-disclosure can thus not be much expected and personal data have to be inferred from assumptive statements. Moreover, the extrapsychic conflict focus may be addressed by home work assignments as well as behavioural therapy (guided by contractual agreement between client and practitioner) about planning social actions/behaviour, identifying circumstances of problem situations,

environmental stimulation like changing of sleeping arrangements or ordeal therapy.

Religious experience should be integrated into the therapeutic process. For example, Mr. J., a Zambian patient, dreamt that he was with his grandfather, who had passed away some years ago and that he had instructed him to take some leaves and throw them on his grave. In addition, he should take some bark of a specific tree, put it into his pocket and move with it wherever he goes to "keep bad spirits at bay". In this context the ever present protective value of the therapist should be emphasized in terms of his availability and "protective prescriptions". For instance, a number of the patients feared that they might "go mad" at some stage, although they might not express it. Here, a reinforcement of the rules and instructions laid down by the therapist is indicated and the reassurance may be given that nothing like "madness" or death will happen to them, provided that the therapist's rules are followed, like expressing and addressing one's personal problems instead of continuously suppressing them with drugs, etc. Moreover, it can be added that in this way the evil or negative emotions are kept away or controlled in favour of a cheerful spirit or life-style. In order to support this process, direct suggestions can be used, like mobilization of positive imaginations, consolation, encouragement, taking by surprise, ignoring abstinence, change of milieu, bodily exercises, simple language and repetition of key phrases (Langen, 1969, p. 99). This should preferably be done in the patient's mother tongue, however, it was also found that a foreign language, here English, was associated with extra powers and suggestive value.

A formal locus of control can be established by a firm setting of boundaries in the structure and hierarchy of the verbal (greeting) and non-verbal (office) arrangement or formal dressing at the initial and subsequent contacts.

For example, a Nigerian patient, Mr. M., complained of a number of bodily complaints, especially when he stays in the house of some of his relatives. He believes these relatives are against him and are trying to bewitch him. Therefore he had stopped going to visit and stay at their

house. The therapist assured him in various ways and made him go to the very house in order to greet one of the women who was believed to cause the trouble or witchcraft. Although he was not to stay there, the patient at first refused to go but eventually he went. On return, he was very happy since he not only managed to greet that woman but also to stay there over night without developing his usual bodily symptoms.

Another example is that especially if patients come from an environment which is relatively known to the therapist, it may be possible that the therapist gets relevant personal information on the history of the patient from other sources than the patient himself. Thus, a Nigerian patient, Mr. A., who presented with an anxiety disorder only reported on his stress at his place of work. On exploration, also together with his wife, no marital problem became evident. When his wife (he was not able to do it himself) conducted a relaxation exercise with him he imagined that he was touched by three or four young women at the beach. From other sources it became known to the therapist that he also had a serious marital problem due to extra-marital affairs.

Another Nigerian patient, Mrs. B., was admitted for severe burns and the psychotherapist was called to assist her overcoming traumatic experiences. Although she only revealed to the therapist during the whole treatment programme that she got the burns due to an accident with her cooker, it became known from other sources that her husband threw the cooker at her on purpose and she caught fire.

Defence/coping (projection, avoidance, denial, somatization). In addition to projecting his/her problems onto the body (somatization), the African mind projects his/her conflicts onto the environment (other people, witchcraft). Hence there is a lesser interest in introjective but rather in projective and somatization issues. Avoidance and denial can be understood as a particularly consensus as opposed to conflict-centered human interaction, which in return has its effects on psychopathology and normal everyday as well as therapeutic interaction, e.g. when not having done specific assignments, unpunctuality or not turning up. Defence mechanisms particularly relevant to the clinical context are: identification, projection, denial, somatization, conversion, dissociation.

When used as a defence, identification refers to the automatic and unconscious assumption of qualities and characteristics of some emotionally important person, to avoid or lessen conflict which stems from either the real or the symbolic loss of that person or from fear of real or fantasized aggression by that person (Laplanche and Pontalis, 1972). For example, an Angolan refugee in Zambia was complaining about pains in his legs. He said that the pain started after his beloved mother who used to complain about the same type of pain in her legs, had passed away. Identification plays a major role in the African context, since the oral organization of the Group Ego relies on changing and multilaterial identifications and it not only plays a role during the time of personality formation, as in western cultures, but during the whole life span (Parin et al., 1983, p. 415). Whenever a certain relationship is perceived as dangerous, four different types of identification take place, especially in the traditional and partially transitional African: (1) the "good" father or mother, (2) the paternal or maternal lineage, (3) the patron relationship and (4) the identification with the peer group (Parin et al., 1983, p. 416). Similar forms of identifications are exceptional in the western context. For example, the case of the "patron": a stranger of either sex can become a patron, if he/she generates aggression or fear. The person is fairly dependent on the patron, he expects his care both in general and in the form of material gifts, for which he, in return, admires the patron, subdues himself towards him and follows his demands. This form of defence seems to be particularly common in the transitional African, since the traditional hierarchy from which he broke away can no longer give him security (Parin et al., 1983, p. 556).

A special type of identification which is very common in clinical practice is "projective identification" (Parin et al., 1971, p. 512): a disharmony in the (peer) group dimension quickly generates the coping mechanism of persecution; that is, hostile intentions (witchcraft or sorcery) are read into the acts of others, against one's own hostility towards them. For example: A girl is suffering from guilt feelings since she disappointed her lover and married a different man, with whom she now has problems. Instead of accepting these guilt feelings as part of herself, she projects the anxiety produced by her disappointment of another, earlier, lover whenever guilt feelings arise in the form of paranoia in her environment (Ebigbo, 1987, p. 80).

Projection refers to the automatic and unconscious attribution of one's disowned attitudes and urges to some external agent, usually a person or persons (Laplanche & Pontalis, 1972). Projection can also be directed towards the authority or age group dimension. Here the client tries to participate in the omnipotent powers of authorities like elders, ancestors or God. This form of defence mechanism, in contrast to projective identification, can be called participatory projection. A typical and common form of participatory projection is "spirit aggression". For instance, where a patient suffers from conversion symptoms it is traditionally attributed to "ancestral spirits".

Participative projection has two goals: (1) defence of powerlessness and frustration and (2) increase in self-esteem (Parin et al., 1971, p. 510). In the female patient with conversion hysteria, this may mean that she feels powerless and dependent on her elders and ancestors, since they have punished her with this illness, but at the same time she may participate in the powers of the ancestors or gods to help herself and recover. The latter is also marked with increased recognition by her environment after she has become possessed by ancestral spirits or gods. Another example may be observed in clinical practice, when the client considers the doctor as omnipotent and when participating in his or her power, the client can increase his self-esteem. Another important form of participatory projection comes into play in the illness concept of "violation of a taboo". For instance, the taboos against sex and cooking during menstruation can be seen as a defence mechanism which men construct for themselves against castration anxiety (Manson, 1984, p. 242; Stephens, 1984, p. 242).

Denial refers to the automatic and involuntary exclusion from awareness of some disturbing aspect of reality or the inability to acknowledge its true significance (Laplanche & Pontalis, 1972). Clinical syndromes or life circumstances in which denial may be observed are: patients with a fatal illness (cancer, AIDS) who deny their impending death, amputated patients or ordinary grief after the death of a relative.

Somatization is defined as the presentation of physical symptoms in the absence of organic pathology or the amplification of physical

complaints accompanying organic disease beyond what can be accounted for by physiology. These somatic terms (see Kirmeyer, 1984, p. 160f) can be viewed as a type of defence mechanism, based on either individual psychopathology or supported by the social group as a culturally constituted defence mechanism. Somatization is very commonly used in the African context (Ebigbo, 1986a, p. 84; Le Gurerinel, 1971) and almost all psychosocial disorders also demonstrate themselves with certain core symptoms of somatization. For instance, in hysteria, depressive neurosis, infertility, functional psychosis, brain-fag syndrome, anxiety disorder and essential hypertension, the following core symptoms of somatization were found in Malawi (Peltzer, 1987, p. 255) and Nigeria (Ebigbo & Ihezue, 1982); pain, heat sensation, crawling sensations and the feeling of heaviness in the head. Important to note here is that depression is also often expressed in somatic terms, not typically with guilt feelings as is the case in the western context (see Binitie & Uku, 1982; Morakinyo, 1983a).

Core relationship (hierarchical, age-group). The therapist being in a "parental" and responsible position, is to utilize the patient's dependency needs and show responsibilty for decision making, especially at the beginning of the therapeutic relationship. Being required to be also in a paternal/maternal role, the therapist should by age be older than the patient.

Especially in case of marital and family therapy it has to be considered that the conflict focus is often directed towards parents-children or between the two respective families rather than solely the couple itself (c.f., Table 1). The united adult-child-relationship (c.f., Table 1) involves including significant members of the extended family whereby the client is to progressively become integrated into the family. This can be done through the creation of obligations and rituals strengthening family ties. Finally, one should not be surprised when clients avoid bringing up problems to please (not to offend) and show respect towards the therapist. In return, the therapist has to pay respect to the existing core relationship in the family of the client, for example, he/she should ask first the husband, second the wife, and third the children on the illness or family problem (c.f., Tseng & Hsu, 1991).

An example for the differential core relationship in a family (husband-wife versus parents-children):

> A Zambian, Mr. F., complained to the therapist that his wife refused to cause abortion. On exploration, together with the wife, it was found that the wife wanted to strengthen her own family and relatives by having another (the fifth) child. She accused her husband of only supporting the members of his family, that is, his younger siblings. The husband argued that he is the first born in his family and consequently he was obligated to support his own family. In addition, he fought for the concept that he would rather have less children in order to educate them well.

Age-group and peer group relationship. Transference easily occurs, especially at the beginning of the therapy, since the patient comes to the doctor with a "built-in transference", based upon the traditional respect accorded to a wise person and elder who has esoteric knowledge (c.f., Varma, 1983). For this reason of positive identification with the therapist, negative transference hardly occurs, apart from acting out negative feelings indirectly through blaming someone else and not the therapist or through avoidance of coming for therapy. In order to maintain a therapeutic relationship for several or more sessions, the psychotherapist will change his role in the process, namely from a "judge" or equivalent to the eldest man (in the family) at the beginning of the therapy to the therapist and helping person in subsequent sessions (c.f., Ebigbo, 1989b). For this to happen the therapist has to come down from his authority level and meet the patient on a more egalitarian level, in which both therapist and patient jointly work together towards the solution of the problem. In addition, the therapist should join in the external orientation of the patient's authority by mobilizing floating transference authorities like kinship, church, political or other group leaders, for as soon as the patient's pressing pain or problem decreases, he or she will no longer feel any need to come for therapy (c.f., Tseng & McDermott, 1981).

Typical transferences encountered were in terms of a repetition of an old relationship and passive dependency needs and thus reexperiencing conflicts with superiors; for example Ms. C., A Zambian with social

phobia, dreamt: "I was with Dr. Karl Peltzer and I told him that I knew what I was suffering from, it was lack of love; I asked the Dr. to tell me how I'll get cured, now that I know what my disease is."

Typical counter transferences were, that the author perceived the African patient unnecessarily different to the western patient, or that I wanted to prove that I was different (better) to other whites the patient may have experienced.

Body/emotion-mind (unity, body/emotion focus). Unity of body-mind involves the recognition of the socio-economic realities of the patient and how these lead to contradictions, interactive, adaptive, and maladaptive behaviour. Considering the importance of the mind expression, it was found that patients with an advanced formal educational level (at least '0' or 'A' level) had developed enough introspection for psychotherapy. It can be said that under conditions and methods of brief psychotherapy as outlined it is possible to obtain improvement, not merely in "symptoms", but also in neurotic behaviour patterns. The criteria of selection for brief psychotherapy should consider a high formal educational level of at least 10-12 years, and a prognosis is favourable when there is a willingness on the part of both patient and therapist, including traditional and/or faith healer, to become involved (c.f., Malan, 1963, p. 274).

"Psychologically" ill, including depressive, patients are expected to very often complain of various types of somatic symptoms (Cawthron & Acuda, 1981; Ebigbo, 1982, p. 29; Prince, 1990, p. 33). Kleinman (1988, p. 115) also talks about a predominance of somatic over psychosocial idioms of communication. Consequently, also the treatment expectations among clients are object-related in the form of drugs, herbs, and injections.

However, physical symptoms often represent bodily metaphors of complaints for negotiating personal or social troubles that for one reason or another cannot be dealt with openly. Therefore bodily symptoms should be linked and interpreted to the client with his/her social environment. For assessing the body focus a culturally adapted "Enugu Somatization Scale" (ESS) has been developed by Ebigbo (1982).

Furthermore, intensive use of body (emotion) relaxation techniques like Autogenic Training (Ebigbo, 1986b), especially at the beginning of the therapy, and paradoxical suggestions to address the need for physical and ritual therapy as well as the production of observable change. In this context the following aspects are important: relaxation therapy, dance and music therapy, sensitivity training, tension reducing rituals like taking a bath, induction of strong emotions, both positive and negative, non-possessive warmth and empathy. Hereby the focus is on the idiom of the body as a unique metaphoric production of the patient and as a culturally prescribed code rather than the dynamic interpretation.

For example, a 22 year old male Zambian student wrote down the following complaints:

- Feeling of movements on the head and along the backbone;
- Quick movements along the arm when lifting something heavy;
- Frequent numbness of fingers, arms, legs and head;
- Twitching and convulsion of the body.

The interpretation by the therapist referred to the movements on the head and along the backbone as problems and worries which are a burden to him; he is unable to control them and even sees them as movements at the back. His elder brother is much better at lifting some-thing; he, himself, is rather a "soft" man. In the guided affective imagery about a house, he imagines his mother with younger children including himself, because physically and psychologically, though not intellectually, he is still a child and is symbolically failing to lift something heavy which an adult could easily do. The numbness or paralysis is referring to jealousy and witchcraft, which are believed to affect a person's body that way. The jealousy stems from his mother's relations, who are against him since his mother has spent money on his education. The twitching and convulsion reflects his fear to develop epilepsy, again due to witchcraft, which is not inherited but comes from the same relatives on his mother's side. (c.f., Ebigbo, 1989a; Peltzer, 1987).

Cognitive/emotional style (consensus-centered, coexistence of opinions, narrative). The psychotherapist should not see the consultation of the traditional healer as a vanishing of transference towards him, but a floating transference, which stems from the ability of the patient to have multilateral rather than monolateral identification with authorities (Neki et al., 1985). It is therefore important that the psychotherapist has a regular working relationship with the more prominent traditional and faith healers in his area.

For example, Ms. B., who lived as a refugee from Uganda in Zambia, complained to the therapist about conversion symptoms and she wanted advise on how she could win the love and marriage of an already married man. She tried to put the therapist under pressure, firstly by saying that she intended to get a love potion from a certain traditional healer and secondly by threatening to commit suicide because of the rejection of her married boyfriend. On consultation with the same traditional healer (R. Vongo, pers. comm., 1987) it was found that she had told the healer the lie that she was married to that same man and that the so-called husband was mistreating her. Therefore she demanded a love potion from the healer since the husband had other girlfriends. When the boyfriend discovered that she had used a love potion on him, she went back to the healer crying and demanding for medicine to kill the boyfriend. However, the healer refused and insisted that he could only give her medicine for luck and love, not for killing. Thereafter, the psychotherapist continued working with the patient on the therapy focus of "always trying for impossible married men".

Monocausal interpretations and the search for positive or negative and better or worse family members (father, mother) of the client should be avoided by the therapist. The latter should rather give situative and consensus oriented positive explanations. Hereby, reframing can reactivate positive and constructive problem solving strategies. Themes can change during the process of therapy although they may be maintained during a single session. Psychoanalytic therapy should be used to make a conscious link between the bodily discomfort and the underlying social

or psychological problems like at home, place of work, school, street. The interpretation of symptoms, causes or dreams, or interactional and historical-genetic insight seems to be more relevant than transference analysis.

Associative anamnesis helps to set the focus on the psychosocial rather than biophysical nature of the complaint. For example, the Zambian patient Mr. K. complains about headaches -his elder brother is, like himself, in the same year at University but he has no headache problem. By asking the difference between the patient and his elder brother, the focus of the therapy could be established, namely that his elder brother has a different mother than himself and the relatives of the patient's mother are against him, which is not the case for the elder brother having supportive relatives on his mother's side.

By making a formulation of the patient's personal problem, the history of the patient is in associative anamnesis centered around his symptoms and precipitating (like loss of a relative) as well as predisposing personality factors (c.f., Sifneos, 1972, p. 100).

Information and bibliotherapy should be provided. Insight or truth can be demonstrated by referring to expert books, reported cases in the press or better to cases seen and cured. Making reference to life histories by comparing the story of the patient with other (more severe) cases, hope and expectant faith is created as well as group ties are strengthened in the patient. This also addresses the preferred narrative cognitive style or truth of the patient (c.f., Table 1).

It also helps to make reference to the therapist's training in both traditional (African) and modern psychotherapy, since most patients under therapy were transitional, meaning that they were more or less in both cultures. Thus, a consensus-centered approach (c.f., Table 1) or shared world view, according to Torrey (1972), facilitates the synthesis or integration of the analysis and coping strategies offered by both traditional and modern culture.

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