

Meseron Therapy

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Abstract

Meseron therapy was developed by Alfred Awaritefe in 1995, the word Meseron is an Urhobo word which means "I reject it". The core component in Meseron therapy is the power of the spoken word which cuts across cultural and religious boundaries. A general opinion is that words are powerful; they can make or mar, indeed, life and death are said to lie in the tongue. [Prv. 18:21] The Urhobos characteristically reject the unwholesome by saying "Meseron" i.e. "I reject it" at the mention of anything unwholesome. Incidentally this practice has found its way into conventional expression among Nigerians as reflected in an increased sensitivity to reject the unwholesome, unwelcome and unpleasant with phrases like "I reject poverty", "I reject ill health" "it is not my portion" "God forbid" and so on. This widespread "I reject it" mind-set makes Meseron therapy a viable tool in clinical practice if well harnessed. Meseron therapy possess therapeutic strength and value with its undertone of optimism and resilience. However, Meseron therapy does not subscribe to empty optimism, the flipside of rejecting the unwholesome is accepting the wholesome. Research evidence abound on its use in therapeutic interventions like the management of fear, emotional disorder, as an antidote to stress etc. Meseron therapy also compares favourably well with western therapies of cognitive and motivational perspectives. This paper attempts to expose the rich theoretical viewpoints of Meseron therapy with the hope that its use in research/clinical practice will be further enhanced.

Keywords: *Meseron, Therapy, Urhobo, Nigeria.*

Introduction

Psychotherapy is defined as a healing relationship using socially authorized methods in a series of contacts primarily involving words, acts and rituals—regarded as forms of persuasion and rhetoric Frank (1991). In departure from a narrow perspective of psychotherapy as "the use of psychological theories and methods in the treatment of psychiatric disorders" Eysenck (1952). Madu (2003) called for broad-mindedness in the definition of

psychotherapy, he posits that psychotherapy should include some effective emotional healing activities of African traditional healers, religious faith healers, and African originated forms of psychotherapy. Generally, psychotherapy involves the use of psychological methods in the alleviation of maladaptive behaviours, with the aim of improving wellbeing and mental health. The focus extends beyond the alleviation of symptoms to the development of positive human qualities in line with WHO current

definition of mental health as “not just the absence of mental disorder, but a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”

There are diverse psychotherapies based on different theoretical orientations ranging from the Psychoanalytical, Behavioural, Humanistic to the Cognitive, in the same vein the goal and target can be equally varied, encompassing individual, group, insight/ action oriented, supportive or family psychotherapies. Further still, psychotherapies can be categorized into being western or non-western or indigenous and non-indigenous. Although the foundation of psychology is deeply rooted in Euro American ideology, over the years scholars have stressed the need for the emergence and incorporation of non-western ideologies. The promotion of non-western therapies is borne out of the opinion that non-western cultures have their inherent worldviews deserving of recognition and appreciation, moreover both types of psychotherapies are concerned with the same objectives as is evident from the definition and goals of psychotherapy. Additionally, the incorporation of indigenous psychotherapy into main stream psychotherapy acknowledges the concept of

cultural diversity and the need to meet individuals at a level they can relate with thus enhancing the gains as well as achieving the goals of psychotherapy. To this end, a number of psychotherapies have emanated these include Ubuntu therapy from South Africa, Harmony restoration therapy (Ebigbo, 1989) and Meseron therapy (Awaritefe, 1995) from Nigeria.

Meseron therapy was developed by Alfred Awaritefe in 1995 from a broad conception of man as a striving being. The word “Meseron” is an Urhobo word which means “I reject it.” The power of the spoken word remains a core component in Meseron therapy. The widespread acclamation of the power of the spoken word creates a veritable platform for Meseron as a therapeutic tool if well harnessed. Meseron therapy subscribes to the assumption that the spoken word has the ability to sensitize an individual for constructive engagement with his/her experiences. By way of an example, mere words like “*this is how I am, I cannot change myself*” significantly differentiates the reactive individual from the proactive individual who says “*I do not like this position, I reject it and I choose to change it*” The former by his/her verbal declaration seizes to strive and is relegated to a position of passivity and/or inaction, conversely the latter is energized to act and take charge.

The conceptual framework of Meseron therapy (Ofovwe, 2005) provides four salient steps that serve as a guide for the therapeutic process; viz:

- a.) Acknowledgement of the disabling symptom/problem.
- b.) A desire to be disassociated from the symptom/problem.
- c.) A conscious effort to overcome.

d.) A will to take on a desired behaviour

By way of application, the therapist;

- a) Awakens the patient to an objective appraisal/realization of the presenting problem.
- b) Creates a realization that silence/inaction/not rejecting is synonymous to consent and acceptance of the status quo
- c) Encourages the patient to reject the undesirable behaviour and
- d) Encourages the patient to mobilize the relevant attitude/resources to overcome the undesirable state by embracing a definite positive stand.

The implications of some basic tenets associated with Meseron therapy will be briefly highlighted to express the depth of Meseron therapy. This include;

- (1) A focus on the individual's present experience: This view point is consistent with the behaviourist stand point in contrast to the psychodynamic stance which is archaeological in nature. A focus on the present liberates the individual from events in his/her past which cannot be controlled. This in itself relieves the individual from a deterministic hold with the prospect of creating a "victim." or the individual playing to the gallery. The therapeutic benefit of being in control cannot be overemphasized
- (2) The rejection of the negative and unwholesome: A hold on the negative over the positive promotes depression and associated mental health symptoms as is consistent with the negative triad of cognitive attributes in depression. (Beck, 1976) whereby the depressed individual holds a negative view of self, the environment and the

future. On the contrary, Meseron therapy insistence on rejecting the unwholesome and embracing the positive provides the necessary mind set for changing maladaptive behaviour and confronting negative thoughts. Aroyewun & Ariyo (2014).

- (3) Indeed, the current social mobilization slogan in Nigeria "change begins with me" can be said to be consistent with the underlying empowerment and resilience embedded in Meseron therapy. The ability to say No! underscores the power resident in the individual which may go undetected without an active mobilization of inherent resources consistent with the striving nature in man.

The benefits of Meseron therapy which include culture friendliness, adaptable tenets, broad spectrum of application and cost effectiveness are highlighted in a case report on the use of multiple psychological techniques in the management of stuttering. Ofovwe and Awaritefe (2014).

The growth and adoption of Meseron therapy in clinical practice in Nigeria

Meseron therapy is not a new therapy considering its development over twenty years ago. Although there are reports of its successful use in practice ("Meseron therapy in the treatment of depression" Awaritefe,1997b; " Meseron therapy in the management of anorexia nervosa" Awaritefe, 2004; "Meseron techniques in the management of children's fears" Ofovwe, 2004; "Transactions in Meseron therapy: case of a stroke patient with secondary depression" Awaritefe & Ofovwe, 2004; " African originated therapy: Meseron as an antidote to stress" Ofovwe, 2005; Meseron therapy: An African Approach to psychological treatment, Awaritefe & Ofovwe 2007; "Confronting

negative thoughts using Meseron therapy: A clinician's approach " (Aroyewun & Ariyo 2014) the discrepancy between its age in Nigerian psychology literature and its adoption in routine clinical practice poses a challenge and calls for exploration. To this end, a cross sectional study titled "Awareness and use of Meseron therapy among clinical psychologists in southern Nigeria" (Ofovwe & Ezemokwe (2015) provides relevant information which can serve as a panacea to the growth and adoption of Meseron therapy in clinical practice in Nigeria as well as in other parts of the world. The study revealed that:

- (1.) Clinical psychologists in academia had significantly lower level of awareness of Meseron therapy than those in practice.
- (2.) Adoption of Meseron therapy was low due to reasons which range from preference for western therapies, lack of guidelines for use and lack of opportunity for use.

It is expedient to discuss the implications of these findings:

Low level of awareness of Meseron therapy among the academia: The low level of awareness of Meseron therapy among the academia is very critical. A sure way of increasing awareness and further expanding the theoretical base of the therapy can be achieved through academic discourse. It is thus pertinent that those in academics should rise up to the occasion; teach students, provide theoretical expositions and conduct researches as means of expanding the scope of the therapy. As posited by Ofovwe & Ezemokwe (2015), if the new generation of clinicians have no theoretical understanding of the concepts and underlying principles of the indigenous therapies, they are likely to underrate their relevance and usefulness. Undoubtedly, clinical practice will be enriched by research work on Meseron

therapy, indeed the benefits of collaboration between clinical psychologists in academia and those in clinical practice cannot be overemphasized.

Preference for western therapies:

Primarily, all psychotherapies have a common goal of providing relief from distress and enhancing wellbeing. This provides a unifying ground which aptly addresses the fact that despite a plethora of psychotherapies there is unity in diversity Ofovwe (2013). Furthermore empirical evidence indicates that different approaches to psychotherapy tend to be similar in terms of outcome (Wampold, 1997). No therapeutic style has been found superior to the other hence Rosenzweig (1936) argued that all forms of psychotherapy have cures to their credit, and proposed the famous "Dodo Bird verdict" based on Lewis Carroll's Alice in Wonderland, stating that all have done well and deserve to win. Research also upholds the common factor theory which asserts that factors such as client characteristics, therapist characteristics, the process of change and the counselling context rather than the therapeutic orientation account for effectiveness of the therapeutic encounter. Lambert & Ogles (2004)

The use of western therapies is not wrong in itself, what may not be profitable in the overall interest and growth of indigenous therapies is an attitude of total adoption of western therapies to the neglect of indigenous therapies. The rationale behind the development of culture free/fair tests was borne out of a need to meet different individuals at a level they can appreciably relate to and hence produce maximum benefit, in the same vein the use of indigenous therapies meets some individuals at a level of understanding they can appreciate and work with.

Western psychotherapies can be traced to the foundation of psychology as a discipline, and thus have enjoyed long years of adoption and trials, unfortunately this is not the case of indigenous therapies that are still in their early stages of development. The preference for western psychotherapies over indigenous therapies is stifling. Indigenous therapies should be given a chance to grow, that way they can be used alongside western therapies and their similarities and differences highlighted as addressed by Ofovwe and Awaritefe (2008) in their work on Rational emotive therapy and Meseron therapy: a comparative analysis. Interestingly, indigenous healing methods are not viewed as a legitimate and empirically valid form of healing by many Western mental health bodies (LaFromboise, 1988). The onus thus rests on non-western practitioners and researchers to propagate non-western ideologies and therapies.

Notably, preference cannot be equitably discussed when one party has not been given a fair hearing. In other words the premise has not provided the impetus for choice; it must be stressed that except a conscious effort is made to independently develop as well as integrate non-western therapies with western therapies the issue of preference becomes a fallacy. Not surprisingly, a number of scholars (Durojaiye (1993), Peltzer and Bless, (1989), Owusu-Bempah and Hoffitt (1995), Nsamenang (2007) have resisted the cling to Euro American psychological ideologies to the neglect of home bred orientations.

Lack of guidelines for use: Meseron therapy does not lack guidelines for its use, previous clinical interventions provide basic guidelines that can serve as a platform to build on. The importance of a manual cannot be overemphasized, yet the ingredients necessary for such a template

can only be gotten from works borne out of interest in indigenous therapies.

Lack of opportunity for use: A claim of lack of opportunity for use seems a weak excuse. As a therapeutic tool, Meseron therapy can be profitably applied to a number of psychological problems ranging from depression, phobia, and anxiety, to wellbeing issues like motivation and resilience.

Conclusion

In the context of positive psychology, in which emphasis is placed on positive human qualities and experiences over elimination of distressing symptoms (Seligman & Csikszentmihalyi, 2000; Snyder & López, 2002). We propose that the philosophical ideologies of Meseron therapy be applied as a strategy for the development and promotion of resilience. The benefits of resilience has been severally reported; resilient people persist in the face of obstacles and, when necessary, accept circumstances that cannot be changed. Resilience provides a buffer to protect us from psychological and physical health consequences during difficult times.

Current global experiences call for the development of resilience. The need to open new vistas in positive psychology particularly in the area of resilience as it pertains Meseron therapy cannot be overemphasized. The association between an "I can" mind-set and a vigour to conquer ones circumstance by a conscious refusal (Meseron= I Reject it) positively correlates with the attributes of resilience. Furthermore, our present political, social and economic climate calls for a therapy that focuses on the elimination of symptoms of distress without neglecting the need for empowering the individual in required skills such as highlighting strengths that are hitherto unused,.

Meseron therapy has great potentials. The level of its current application can be traced to lethargy in exploring the wealth and depth of indigenous ideologies despite repeated calls in this regard. This is thus a clarion call to all to explore the yet untapped resources embedded in our indigenous therapies particularly Meseron therapy. A multifaceted approach is recommended to enhance the development and advancement of indigenous therapies; the government via social mobilization, practitioners through therapeutic applications and the academia through the provision of theoretical material and research work.

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