

Psychotherapy In Nigeria

Alfred Awaritefe

Department of Mental Health, School of Medicine,
College of Medical Sciences,
University of Benin, Benin City, Edo State, Nigeria.
Email: alfawa2000@gmail.com

Abstract

There is no exact word for psychotherapy in many Nigerian languages, numbering over 250. But equivalent words exist for expression such as counselling and cognitive behaviour therapy. The practice of these arts predated the advent of the Europeans. When modern psychology arrived in our shores, we naturally adopted the Euro-American models of psychotherapy. All that makes psychotherapy necessary can be found in our country: trauma due to child abuse, and neglect, abuse of human dignity, tribal wars, political conflict, poverty, migration and stress-provoking lifestyles, among others. The Aro village system developed by Lambo is an attestation to the usefulness of some of our native approaches and to the efficacy of social support that is inherent in the African traditional system. The introduction of a bilingual group psychotherapy at Aro in the early 1990 was a natural follow-up to this development. Group therapy is the most popular form of psychotherapy as it is practised in most teaching hospitals and psychiatric establishments. Meseron therapy and harmony restoration therapy are the two foremost indigenous approaches to psychotherapy in Nigeria. Meseron therapy is cognitive-behavioural in orientation while harmony restoration therapy is existential-phenomenological. Other therapies commonly taught and practised include: Rational Emotive Behaviour Therapy; Cognitive Behaviour Therapy; Behaviour Therapy; The Psychodynamic Therapies, etc. Modern psychotherapy services are available in private clinics/consultations, schools, hospitals and medical centres. The services are offered by a wide variety of professionals ranging from clinical psychologists and psychiatrist, to social workers, nurses and pastors. At present, focused training in psychotherapy is inadequate, in spite of the efforts by the universities and the Nigerian Association of Clinical Psychologists. This is an important lacuna that the School of Psychotherapy and Health Sciences, Okija, has come to fill.

Key words: *Psychotherapy, Nigeria, Meseron, Harmony Restoration, Training.*

Introduction

“Psychotherapy” is an umbrella term for all psychological treatment methods which may vary to a lesser or greater degree in their origin, postulation about the nature of man and the cause of psychological disturbance,

specific techniques of treatment, and the goals and outcome of treatment. It is customary to simplistically refer to psychotherapy as treatment by psychological means, just as chemotherapy is regarded as treatment by use of chemical

substance. Just as chemical substances vary, so do psychological means vary. The study of psychotherapy consists in acquiring knowledge of various means of psychological treatment and the practice of psychotherapy is the practical application of such knowledge. Psychotherapy seeks to impact positively on the psyche and thus bring about a desired change in behaviour. In her paper "Psychological support during the process of life change", Anna Paukova [2014] puts it succinctly; "Life changes are the key point in psychotherapeutic work. Actually, a person comes to therapy in order to change something: him – or herself, situation, environment, life in all. Every psychotherapeutic modality suggests its own conceptualization of conditions which facilitate changes."

I have searched in vain for an equivalent Nigerian word for psychotherapy. In my own language, the Urhobo language, an exact word for it does not exist. The nearest I arrived at were two expressions: (1) *uchebro*, meaning "giving advice"; (2) *iroro ema*, meaning "moulding one's thought or thinking", that is, helping an individual to think straight or correctly.

I verily believe that equivalent expressions to these Urhobo words do exist and can be found in other Nigerian languages.

The two words, *uchebro* (**giving advice**) and *iroro ema* (**helping an individual to mould his/her thinking**) will clearly resonate well with many psychologists, the one is reminiscent of counselling and the other of what is today called "cognitive therapy".

It was usually the case that a concerned individual woke up one morning and remembered a bad dream he had the previous night. Worried, he sought to know the meaning of it all and resorted to someone he trusted could help him. The help giver was more often than not an old

man of wisdom. Consultations with these indigenous practitioners were not limited to issues of the interpretation of dreams but covered a wide range of concerns that burdened the human mind. In our villages and towns, the practices of these arts are indigenous to us and have been with us from time immemorial.

In the early 1980's at the University of Benin Teaching Hospital, I engaged myself in the treatment of and research into erectile dysfunction. It was then I came across a method of psychological treatment employed by an indigenous practitioner. Let me endeavour to describe it as it was narrated to me.

Upon being approached by a man suffering from erectile dysfunction, this particular indigenous practitioner would listen attentively and empathically. He would have the patient seated on a stool in a quiet room. Then he would invite into the room an attractive young maiden who served as a co-therapist. The patient was asked to remove his clothes. Upon a signal from the practitioner, the trained maiden would rush at the man and start tugging at his penis.

The practices of our indigenous practitioners were often laced with proverbs to which the patients could relate, because they made sense to them. One or two of the examples will suffice:

1. "A man, who thinks alone, ends up committing incest", meaning that "an individual who does not seek advice or consult with others ends up making serious mistakes and getting into trouble."
2. "A beetle does not grow whiskers in the fire." meaning "it is an impossibility."

From the foregoing, the following conclusions can be drawn:

1. That psychotherapy is indigenous to us and has been with us long before the advent of the Europeans.
2. The modern Western Psychotherapies contain some ingredients which are readily seen in the indigenous African examples that I have referred to.

Thus, counselling psychology relates to *uchebro*, cognitive therapy relates to *iroro-ema*, and various aspects of behaviour therapy can be seen in the example of the treatment of erectile dysfunction and similar psychopathologies.

It is, therefore, intriguing that when psychology arrived on our shores, many of us travelled to Europe and America to study psychotherapy. There we learnt about what **Sigmund Freud** had found out about how his fellow Jews brought up children within the family and the theories he wove around his observations. There, we learnt that **Ivan Pavlov** in Russia observed that his dogs in the laboratory were salivating to the presence of food and eventually to the sound of a bell. Therapeutic methods were built upon **Pavlov's** observations, we studied much more and returned home, parading ourselves as men and women with special knowledge!

Expectedly, the psychotherapy that our learned men and women brought home from Europe and America was the Euro-American model and took no cognizance of any such practices among our native medicine men. Consequently, with the exception of very few recent attempts, native Nigerian psychotherapies have remained uninvestigated, unexplored, unknown and unaccepted by the emerging elite. The thinking is: "Anything European or American is the best; anything African is the worst." This way of perceiving and thinking has been cultivated and sustained by Euro-American education, culture, and associated media machinery. This cultivated

cognitive change among the native Nigerians is not without its psychosocial and political impact. Thus today, countless numbers of Nigerians, both lettered and unlettered, yearn to migrate to Europe and America, which they see as lands where people get rich without working for it. The untold human catastrophe arising from such large-scale migration, is already being recorded in Europe, where thousands of lives are lost each year in their attempt to cross over illegally from Africa to Europe. It is a human catastrophe of monumental proportion. All this the impact of negative cognitive formation and change. The majority of Nigerian emigres in this category are not victims of internal wars, they are not from the war-torn zones of the country, they are victims of external brain-washing.

The cognitive process is similar to that described by Aniebona [2014] on how the black American began to hate himself. Quoting extensively from Hussein Bulhan's book "Franz Fanon and 'The Psychology of Oppression'", she writes:

"in Fanon's view the family can transmit the most complimentary ideals to the child and attempt to give his psyche durable defenses that will keep it whole. But when that child goes out into the world outside of his community he is inevitably assaulted by racism [Bulhan pp 191 – 193]. Then there is temptation to disown one's ethnic or racial identity because it causes discomfort or outright hatred. The stereotypes are many; the black person is dangerous, is violent, is lazy, is relatively unintelligent, is overtaken by sexual acting out, etc. The attack on the self are endless

and relentless. One might feel the need to do an amputation of the real self and become what is acceptable” [p.13].

Running away from one’s denigrated and despised fatherland is a practical form of the metaphor of doing “an amputation of the real self.”

Madu and Pritz [2014] have clearly delineated the psychological, economic, social cultural and political life experiences which condition individuals to seek relief in psychotherapy. These include trauma due to child abuse and neglect exemplified by child labour and street hawking by underage children, different forms of abuse of human dignity [for example, human trafficking and the kidnap of over 200 school girls in Chibok, North-eastern Nigeria], tribal wars as seen in Modakeke-Ife in Osun State, poverty, migration, the menace of marauding herdsmen, political conflicts and stress-provoking lifestyles, among others, all of which are prevalent in contemporary Nigeria. Nigeria thus looks like a vast natural clinic-cum-laboratory for the study and practice of psychotherapy.

The Aro Village System

In 1954, Thomas Adeoye Lambo started what is called the “Aro Village System”, at the then Psychiatric Hospital, Aro, Abeokuta, as an experiment in community psychiatry. The village system generated interest far and wide, and it moved psychiatric patients from the wards into the neighbouring villages around the hospital with their relatives. Doctors and nurses visited them to administer treatment. This was a major innovation considering the stigma attaching to the psychiatric patient at that time, and which has persisted in one way or another till this day.

The *Aro* Village System was dubbed a kind of psychotherapy. The reason is not fat-

etched. The ubiquitous presence of the patient’s own relatives offered a unique form of social and psychological support.

Lambo was the first Nigerian psychiatrist to practice the village therapeutic system. Like Dr. Tigani El Mahi of Sudan the first psychiatry in Africa, Dr. Lambo also collaborated with traditional healers. He recruited them as paid employees, with two of them forming a team with one psychiatrist. The traditional healer cared for the patients in the village setting under the remote guidance of the psychiatrist. His words: “they [the traditional healers] supervised and directed the social and group activities in the villages under our guidance” [Lambo, 1964, p 7]

The essential features of the Aro village system were as follows:

- (i) Four villages, each about a kilometre radius from Aro Hospital were chosen.
- (ii) Psychiatric patients were then admitted into these villages instead of the Aro Hospital.
- (iii) Doctors, nurses and other health personnel visited the patients in the villages to offer medical treatment as needed.
- (iv) In between consultations, the patients and their relatives took part in the routine social activities in the village without intrusion by hospital staff.

According to Sijuwola, [1979] there are criteria that a patient must meet to be eligible to participate in the Aro village system. The two most critical ones are:

- (i) “There must be at least one relative to stay with the patient in the village”.
- (ii) “The patient must come from a rural environment” [Sijuwola, 1979]

The relapse rates of schizophrenic patients treated by using the Aro village system and the base Aro Hospital have been studied by

Sijuwola [1979]. He found that the outcome of the Aro village system was superior to that of the standard Aro Hospital in that the former produced fewer relapses than the latter.

Sijuwola's [1979] findings are very important in establishing the psychological value of the Aro village system. He explains his data as follows:

As a result of their experience of the Aro village system, patients and relatives become more informed about psychotic symptomatology and this fact

- (i) Reduces their criticism of the patient, presumably because they [relatives] have developed increased tolerance.
- (ii) Makes relatives invite the doctor promptly because they [relatives] become conscious of early warning signals.

In connection with the above data, it may also be helpful to explore the following observations:

Moving from a rural environment to a standard hospital ward in first-rate hospital like Aro, is like moving from a village to a city. A schizophrenic patient in this situation will experience additional inner turmoil compared to one who moved from one village to another similar village. The effect of such psychologically unsettling experience would impact on treatment outcome and relapse rates. Moreover, the continuous presence and company of a relative in the "treatment" village could produce a sense of security and emotionally stabilizing effect. Furthermore, the participation in routine village social activities could create a feeling of belonging and freedom as compared to the enforced relative "ostracism" of being kept in a hospital psychiatric ward. All these are ingredients of the psychological variable of social support which is known to impact positively on mental health. Thus the better

treatment outcome of the Aro village system as compared to the Aro hospital can be explained in terms of social support. Research aimed at unravelling the psychological variables operating in the Aro village system and their mechanism of action will be worth the effort. Be that as it may, the Aro village system is a therapeutic community and not a system of psychotherapy per se.

Professor Lambo's protégé, Ayo Binitie, introduced what he called the "therapeutic neighbourhood" to the Psychiatric Hospital, Uselu, Benin City, following the same principle. Much later when he became a professor of psychiatry at the University of Benin, Binitie then developed what he called "psychotherapy by environmental manipulation". This therapy consists of removing the patient from the disabling environment or treating the aspect of the environment that disables the patients. The system was well received among the psychiatric community in Nigeria. Asked at a subsequent seminar at the Neuropsychiatric Hospital, *Aro*, what syndrome this system of psychotherapy could be used to treat, the author was not forthcoming.

These early efforts at developing psychotherapy in Nigeria were commendable, especially if one considered the challenges of the time. Psychiatric patients were seriously stigmatized, psychiatry in Nigeria was not yet fully accepted by its parent, medicine, and so were its methods. But it was because we started too late, and we started by importing foreign ideas to which our people could not easily relate.

Commendable as they were, these early efforts did not really meet the criteria for an acceptable system of psychotherapy. As every student of psychotherapy knows, an acceptable system of psychotherapy must have:

1. A theory of personality
2. A theory of psychopathology which is deducible from the former
3. A clearly spelt out method of treatment, that is, the steps or techniques to use and that are teachable to prospective students and practitioners.

Group Psychotherapy

Group therapy is probably the most common therapy practiced in Nigeria, judging from the fact that it is practiced in all Teaching Hospitals with a psychiatric department and in all psychiatric hospitals in the country. The reason for its popularity is that many patients can be reached despite the dearth of qualified manpower.

I spent my sabbatical year 1989/1990 at the Neuropsychiatric Hospital, Aro, Abeokuta, which then served also as the WHO Collaborating Centre for Research and Training in Mental Health. As a member of the Scientific Research Group of the centre, I proposed that the centre set up a one-year internship training programme for clinical psychologists in Nigeria at the Aro Hospital. The training programme, among other things, was intended to sharpen our skills in psychotherapy. The Scientific Research Group of the centre headed by Professor B.O Osuntokun, a foremost neurosurgeon, totally accepted the proposal. In the end, however, the opportunity eluded us.

One of my assignments at Aro was to facilitate group therapy for in-patients of the Hospital. I discovered that the patients came from various ethnic nationalities [there are about 250 such groups in Nigeria]. Most of the in-patients were Yoruba-speaking [apparently because the hospital is located in a Yoruba-speaking part of the country]. But there were many other ethnic groups as well: Ibos, Effiks, Urhobos, Binis, etc., most of these latter could not speak Yoruba but

could communicate in English. The only way to conduct a group session in this situation was to use at least two languages. So I introduced the bilingual group psychotherapy using Yoruba and English languages.

This bilingual group approach to psychotherapy necessitated the use of at least two interpreters, one of whom could be a patient, translating the proceedings from Yoruba to English and from English to Yoruba.

Our psychotherapy groups were open, which means that new members could join the group any time and also old members could leave, as they were discharged from the hospital. The groups could be as large as fifteen members and were heterogeneous, consisting of adult male and female patients with various diagnoses.

With some attention paid to the manifest content and latent content of patients' experiences and verbalizations, this approach could be described as psychodynamic.

The group therapy sessions held once a week for a duration of about one hour and fifteen minutes in a beautiful, circular hut built adjacent to the ward. The selected patients were brought to the hut from the wards by young psychologists and/or nurses. Miss Shade Jinadu who later retired as a director in the services of the Psychiatric Hospitals Management Board, used to commute from her base at the Yaba Psychiatric Hospital in Lagos to participate in these proceedings as a young psychologist, memorable courtesy of the then provost of the Neuropsychiatric Hospital, Aro, Abeokuta, Professor Moses Olabode Akindele.

Essential Questions

It is customary to expect that a paper of this kind will attend to a few questions. Some of these are stated below and an attempt is

made to give some information in relation to each. At the end of this presentation, it is hoped that the reader will find some answers to his or her questions. The questions are as follows:

1. What is psychotherapy?
2. What variants are available in Nigeria?
3. Where can one access psychotherapy services in Nigeria?
4. Who are those who offer psychotherapy services in Nigeria?
5. Where can one train to become a psychotherapist in Nigeria?
6. Are there existing types of psychotherapy in Nigeria that are home-grown or indigenous?
7. What is the relationship between traditional medicine psychotherapy and Western-oriented psychotherapy in Nigeria?

What Variants of psychotherapy are available in Nigeria?

Many forms of psychotherapy are available in contemporary Nigeria, ranging from those practiced by the traditional medicine psychotherapists to the more familiar Western-oriented psychotherapies. This paper will be concerned only with the latter. The Nigerian Association of Clinical Psychologists [NACP] features a number of exact psychotherapies on its annual continuing education programme. These include, but not limited to, the following:

1. Rational Emotive Behaviour Therapy [REBT]
2. Cognitive Behaviour Therapy [CBT]
3. Behaviour Therapy
4. Carl Roger's non-directive therapy
5. The psychodynamic therapies: Sigmund Freud, Alfred Adler, Karl Jung, etc.
6. Meseron Therapy
7. Harmony Restoration Therapy

8. Group therapy of different types, including family therapy

It may also be noted that the psychotherapy approaches listed above are also the most popular. However, by far the most popular is group therapy because it is used as a routine in all the Teaching Hospitals and Psychiatric Establishments across the country.

Where can one access psychotherapy services in Nigeria?

Psychotherapy services are easy to access in Nigeria. As a guide to a prospective user, we provide some specific information as follows:

1. Every department of psychology in any Nigerian University has some trained experts who can offer psychotherapy.
2. Every department of counselling in a Nigerian University has staff that can offer psychotherapeutic services.
3. Every department of mental health or psychiatry in the University has trained staff who can carry out psychotherapy.
4. Most teaching hospitals in Nigeria have psychologists and psychiatrists who conduct psychotherapy of one type or the other.
5. Some church institutions, for example, the Roman Catholic Consulting Centres across the country.
6. Specialized institutions for psychotherapy for example, International Federation for Psychotherapy [IFP] Centre for Psychotherapy at Enugu.
7. The School of Psychotherapy and Health Sciences at Okija.
8. Private clinics and/or consultations run by established clinical psychologists.

Note: *"In drawing up the above list, our focus is on places where needy individuals can go to receive help.*

We are aware that fees and levels of expertise may differ from place to place. We also know that the list is not exhaustive; for instance, some large industrial concerns do have their own private arrangement, often within their own organization, to handle issues requiring psychotherapy”.

Those who offer psychotherapy services in Nigeria

Psychotherapy is a serious business, which requires several years of training to be certified. Offering a semester course of psychotherapy in a university can only give such an individual some orientation; it cannot make him or her a psychotherapist.

In contemporary Nigeria, those who conduct psychotherapy are:

1. Clinical psychologists
2. Nurses with additional specialized training in psychotherapy
3. Social workers
4. Psychiatrists
5. Counsellors
6. Reverend Fathers, Reverend Sisters, Pastors etc.

It is envisaged that, in the near future, there will be some auditing to regularize the training and certification requirements.

Psychotherapy training in Nigeria

Institutions for training of psychotherapists in Nigeria are still in their infancy. In fact, the older practitioners of psychotherapy in the country all trained abroad. Psychotherapy is currently offered as a two-semester course at the B.Sc degree level and a one-semester course at the M.Sc degree level in departments of psychology of Nigerian Universities. Less than this amount of time is devoted to psychotherapy by those individuals studying nursing, psychiatry or

social work. Nor is there enough time given for practicum. Dissatisfied with the present state of affairs, some individuals resort to online training and certification.

The NACP continuing education programme in psychotherapy has a role to play here. Although it was not designed to accommodate novices in psychotherapy, perhaps the time has come to overhaul the teaching programme in order to partly meet this much desired need.

It is obvious that the School of Psychotherapy and Health Sciences, Okija, has come at the most auspicious time. It fulfils a dual need, each with its own multiplier effects: to challenge our intellect to rise to the occasion by improving on existing psychotherapy methods and techniques and also by developing or devising new technologies; by producing manpower that will serve as guardians of our health in both prophylactic and curative ways.

Home Grown or Indigenous Psychotherapies

“Make sure Meseron therapy does not fizzle out like many others I have seen.” This was the encouraging advice I received from Olufemi Morakinyo, a Professor of psychiatry at the Obafemi Awolowo University, Ile-Ife, Nigeria. I deduce from the above statement that there were many previous psychotherapies that were home grown but which had “died a natural death”. I do not intend to exhume them, because I do not even have space now for contemporary ones that are worthy of mention. I would rather say a word or two about the two home grown therapies that have become the “matters of the moment.”

Harmony Restoration Therapy

The Harmony Restoration Therapy [Ebigbo, 1995] postulates the existence of three worlds [cosmos]: endocosmos is the world

within the individual; mesocosmos, the world comprising significant others and other human beings generally; and thirdly exocosmos, which is the world of spirits, ancestral deities, gods and the Almighty Creator. According to harmony restoration therapy, psychological disturbances arise when there is disharmony in the relationship between the individual and his worlds. This idea is in accord with an Igbo adage which states that “a man who is at peace with his environment does not fall ill.” Treatment, therefore, consists of making peace with the environment, including the propitiation of ancestral spirits and gods, etc.

Harmony Restoration Therapy has much in common with another African approach to psychotherapy referred to as “Constellation work.” “Constellation work started with the pioneering work of Bert Hellinger in the 1970s in Kwa-Zulu-Natal, South Africa. It is a therapeutic process that integrates parts of family systems therapy, existential-phenomenology and ancestral belief.” [Mayer & Viviers, 2014].

Meseron Therapy

Meseron (Awaritefe, 1995) posits that man is a striving creature, equipped with psychological instruments for striving; namely, perceptive capacity [awareness function], appraisal mechanism [interpretive function], and operational facilities [thoughts, words and actions or deeds].

We rarely sit down to think about how important and potent words are, although we use them every day. Words can calm or excite the emotions, demotivate or motivate, and influence our thinking and actions. Therefore words can be used as special tools in our daily lives.

The average traditional Nigerian man or woman believes in the potency of the word. Therefore he does not use negative words to refer to himself or his loved ones. Words, together with thoughts and deeds

comprise man’s “operational facilities”, with which he can impact on himself and his environment. Man as a striving creature is under obligations to make the effort to employ the operational facilities to change himself and his environment.

Psychological disturbances arise as a result of (i) distortion in appraisal mechanism, e.g making negative statements, (ii) acquiescing to negativity, e.g resigning in the face of difficulties and (iii) incongruence of striving and goals, e.g making inappropriate choices or decisions.

Since the individual caused the problem with his inappropriate statements [words], he needs to learn to make appropriate statements in place of the former. In striving to do this and related activities, he thereby actively rejects the status quo. Hence the Urhobo expression, *Meseron*, meaning “I reject it.”

Meseron therapy has been described as having affinity with the cognitive therapies. Caroline Ofovwe [2011], a Professor of Clinical Psychology at the University of Benin College of Medical Sciences, Benin City, and Vice President, World Council for Psychotherapy African Chapter (WCPAC), has developed a conceptual model for Meseron therapy. She continues to write and publish on it and applies it in clinical work with her patients.

Conceptualization of Patients

There are two different ways in which therapists conceptualize their patients, two ways that are diametrically opposed. I call them paradigm 1 and paradigm 2.

Paradigm 1: Patient’s attributes as perceived by the therapist

1. Powerful external forces control him [the patient]
2. He is helpless
3. He needs other more powerful external forces to deal with the threat.

4. So he resorts to making sacrifices to appease the deities or bribe them to fight on his behalf. Hence the sacrifices of animals, etc thereby encouraging excessive use of the defense mechanism of projection.

Paradigm 1 represents the ways the traditional medicine man perceives his patient. According to Laosebikan [1982], this is also the way the patient sees himself, because it is in consonance with the way of thinking in our culture. This agreement in the way they perceive causation enables them to agree also on what is considered the appropriate approach, i.e offering of sacrifices to the gods & spirits. It has been argued that this mutual agreement between the patient and the traditional healer on the causes and necessary treatment of disorder is the reason for the success and popularity of the traditional healers.

Paradigm 2: patient's attributes as perceived by the therapist

1. He controls himself and determines his own fate [what happens to him]
2. He is not helpless
3. He is equipped with instrument he can use to deal with threat and other troubles.
4. All he needs to do is to make the necessary effort – strive.

Paradigm 1 seems to aptly describe the posture of Harmony Restoration therapy, with its admittance of the need to propitiate ancestral gods and spirits and thus the focus on external locus of control. On the other hand, paradigm 2, more appropriately describes the posture of Meseron therapy with its emphasis on the internal locus of control.

Traditional Medicine Psychotherapy and Western-oriented Psychotherapy in Nigeria

A certain practice in some psychiatric clinics in Nigeria is worthy of note. During the initial interviews with first attenders, they are usually asked if they have been receiving treatment elsewhere. If it is revealed that the patient is receiving treatment from traditional healers, he is encouraged to complete the traditional treatment before embarking on the modern treatment. This is a form of tacit cooperation, which the modern psychotherapist offers to his traditional counterpart. This is done in the interest of the patient because it allays his hidden fears of continuing harassment by evil forces.

A major approach to psychotherapy in Nigeria, harmony restoration therapy [Ebigbo, 1995] is proposing to capitalize on this experience by formally involving the traditional medicine men in their practice, presumably in the area of propitiation of ancestral deities and other spirits and gods [exocosmos]. These facts, notwithstanding, there are so many factors separating the traditional medicine psychotherapist and his western trained counterpart. Their training apart, the most critical factors include

- (i) Their thinking, and perception of the patient, which I have presented in paradigm 1;
- (ii) Their notion of the causation of diseases or disorders; and
- (iii) Their notion of the appropriate methods of treatment.

Notion of the causation of disorders

1. The traditional psychotherapist believes that diseases/disorders are caused through the agency of evil spirits, gods, offended ancestors, bewitchment, curse, etc. Researchers from early 1970s to the present time have produced similar findings

[Binitie, 1976, Awaritefe 1985, Madu and Ohaeri 1989, Madu 2013]. This is totally at variance with the numerous and diverse formulations of modern psychotherapy.

What collaboration can the two approaches have here? Research or practice? It is difficult to imagine, but it is not impossible. It is only a matter of time.

Notion of appropriate methods of treatment

In his research into Umunna therapy, Ejiofo [2016] found that the Igbo people had a special native doctor for the treatment of psychotic disorders as distinct from the doctor that treats physical illness. This presupposes that the Igbos that he investigated are conversant with and accept the notion of a mind-body dichotomy, with each part requiring a different kind of treatment. However, the general outline of treatment remains the same. Thus for both physical and mental disorders we have;

- (1) Consultation: Meeting between the therapist and the patient's significant others to find out the family history of the disorder.
- (2) Divination
- (3) Incantation
- (4) Traditional sacrifices
- (5) Ikpualu [removing the sin, involves sacrifices]
- (6) Dream interpretation, free association, transference and analysis of defenses.
- (7) Flogging
- (8) Fasting
- (9) Concoction [not included in Ejiofo's list]

Of the nine items on the list of the treatment outline, seven are not agreeable to the modern psychotherapist. The two exceptions are: consultation with the

patient's family and concoction. Dream interpretation in the context of traditional medicine is far removed from what is known in psychoanalysis. Thus again in terms of the appropriate methods of treatment, the traditional medicine man and the modern psychotherapist have very little, if anything, in common.

Even so, there is a ray of hope. Ejiofo [2016] reports that sometimes it is possible to get a priest involved in the treatment proceedings. When this happens, offensive items on the treatment list such as divination, traditional sacrifices, etc are replaced by: "fasting, worship, almsgiving, prayers, anointing, laying on of hands, psycho-education, and even exorcism..."

It is encouraging that there are now traditional medicine practitioners who are willing to cooperate with priests in this way. It is, however, doubtful if such traditional medicine practitioners will cooperate with lay modern psychotherapists in the same way, because this kind of cooperation will make them lose influence and income. The practice of divination and the offering of traditional sacrifices bring in income in cash or kind. This situation makes the continued cooperation between the traditionalists and the modernists uncertain.

One more vital point needs to be made on this issue. By asking the traditional medicine man to remove "offensive" treatment procedures such as divination, traditional sacrifices, *Ikpualu* etc and replace them with prayers, anointing, laying on of hands, almsgiving, worship, psycho-education, etc, what is left is no longer traditional medicine or therapy. It is now a brand new type of therapy which may be called church therapy or faith healing.

Faith Healing

There is something that the traditional medicine practitioners and the faith healers have in common; the way they perceive the

patient and the notion of the causation of ill health. For them both, the patient is a helpless victim of the forces of darkness. The patient also sees himself as such and agrees with them. Secondly, the faith healers and the traditional medicine man believe that the patient needs a powerful intermediary to mediate between him and the troublesome forces. They place themselves in the position of that intermediary. The patient also agrees with them, because the culture of the people says so. Thus, the faith healers and the traditional medicine man practice within the framework of the cultural expectation of the people. This is the secret of their success.

The modern chapter in the practice and development of psychotherapy in Nigeria opened with the opening of a psychotherapy centre at Enugu and more or less simultaneous organisation of the first Nigerian conference on psychotherapy in Lagos. Both events were organised by **Professor Peter Ebigo** of the **University of Nigeria Teaching Hospital, Enugu**. The World Federation of Psychotherapy Centre at Enugu practised psychotherapy and trained young psychologists in psychotherapy. This was clearly a milestone in the development of psychotherapy in Nigeria. It gave psychotherapy a clear visibility and placed it outside the precincts of a hospital. It gave psychologists the freedom to practice their profession as it should be.

The present conference holding today at Okija is noteworthy in its own right, for it is the first ever conference of the World Council for Psychotherapy to take place in Nigeria. It is brought by one of the leaders of the newer generation of Nigerian Psychologists, **Professor Sylvester Ntomchukwu Madu**, Deputy Vice-Chancellor, Chukwuemeka Odumegwu Ojukwu University, Uli Campus, (Former Anambra State University), Anambra State,

Nigeria, President – World Council for Psychotherapy African Chapter (WCPAC), and Vice President – World Council for Psychotherapy (WCP). The conference affords us the much needed opportunity to review the progress that has been made since 1995, when two major Nigerian psychotherapies, Meseron Therapy and Harmony Restoration Therapy made their debut in the Nigerian psychological space. I am aware that since then, several new methods of psychotherapy have been proposed by Nigerian psychologists and many more will hopefully follow.

It is important, even critical for the development and progress of this discipline, that these new forms of treatment be studied carefully by both students and practitioners and applied in their professional practice. It is only in this way that their strengths and weaknesses can be appreciated and further progress made.

The activity of psychotherapy reflects the complexity of man, thus psychotherapy is like a city with many unexplored territories. It is in vain to predict that any future generation of psychologists will complete this exploration.

In the final analysis, the end of psychology is to help man understand himself and so find peace. Psychotherapy can assist to achieve this goal in a very practical way. Ladies and gentlemen, we are gathered here in the pursuit of that enterprise.

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