

African psychology and the Africentric paradigm to clinical diagnosis and treatment

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Abstract

The notion of clinical or psychological diagnosis in African psychology is used, at times, to refer to the redressive action that is taken to determine the source of a difficult/abnormal illness. The need for such an interventive action arises in the face of a sudden or 'strange' illness that befalls a family member and refuses to abate after all medicines (including Western psychiatric hospitalization) have been administered. Under such a situation, the tendency within the Africentric paradigm to mental health and illness is to see such a challenging illness as an extraordinary or abnormal illness that carries a hidden message that must first be decoded before a decisive solution to achieving a cure can be found. Consequently, recognizing certain illnesses as 'symbolic illnesses' or ones with a hidden meaning, indigenous African peoples routinely persuade themselves that they must go beyond the 'information given' (Bruner, 1986) to determine 'who' is speaking through such an illness and what they are expected to do to effect a cure. In this way, they try to set their eyes not only on what is happening to the sick one (the observable manifestations of the illness) but also on the question of identifying the agent behind its onset and escalation in their approach for questioning the misfortune. This article draws attention to the missing link in the Western paradigm to psychopathology and treatment that makes it unable to deal decisively with certain illness presentations of the Black African client.

Keywords

African divination systems, African healing traditions, African psychology, Africentric paradigm, psychological diagnosis, psychopathology

This article aims to achieve two main goals. The first is to demonstrate that there is a *qualitative* difference between the notion of psychopathology as understood in the Western, Eurocentric perspective of Psychology, and the way psychopathology is approached within the Africentric

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paradigm. The term 'Africentric paradigm' refers to the ideology that guides the epistemology (or the manner of approach) to research and practice in contemporary African-centred scholarship (Bangura, 2012; Mazama, 2001). The principal tenet of the Africentric paradigm is that research and practice in the African context should be undertaken according to the worldview and philosophical assumptions of the Black people of Africa (Asante, 1998; Crossman, 2004). The second aim is to specify, through the process of deconstruction, the hidden inadequacies of the existing models of psychopathology propagated by Eurocentrism. The overall objective is to point out the gap that exists in the current Eurocentric approach to psychopathology that needs be closed through the introduction of the Africentric paradigm to illness and healing.

The notion of deconstruction

Cuddon (1991) indicates that the term 'deconstruction' comes from the verb 'to deconstruct', which is often used as a synonym for the process of criticizing and highlighting the inadequacies and lack of finality in the meaning range of a given idea or concept (e.g., the Eurocentric notion and models of explaining psychopathology imported to Africa). Hence, in deconstructing psychological illness or sickness in this article, the term 'psychopathology' as used in the Western, Eurocentric perspective is not considered to be completely wrong; however, its explanatory power is limited, since its Bio-Psycho-Social (BPS) Model is unable to accommodate some aspects of the African experience of psychopathology or psychological illness (Bodibe & Sodi, 1997; F. S. Edwards, 1983, 1984; S. D. Edwards, 1985, 1986; Farrand, 1984; Horton, 1962, 1967, 1995; Jacobson-Widding & Westerlund, 1989; Le Roux, 1973; Lund & Swartz, 1998; Naidoo, 1996; Pillay, Naidoo, & Lockhart, 1999; Straker, 1994; Swartz, 1998).

This observation is influenced by the understanding that the deconstructive practice as implied in the earlier clarification offered by Cuddon (1991) is, among other things, a process of drawing attention to the fact that when an established technical concept (like psychopathology, sickness, or illness) is imported into a new cultural context (such as Africa), it may not be able to carry all the connotations associated with that same or similar concept in the new context. In this way, the process of deconstructing psychopathology or psychological illness assists in recognizing the restrictive range of meaning of the Western notion of psychopathology or psychological illness grounded in the Eurocentric paradigm, particularly when it is transferred from its original knowledge system (Western) to a foreign one (African).

Consequently, one of the major aims of this article is to problematize (drawing inspiration from the Africentric paradigm) the prevailing BPS theory of psychopathology championed in the Western psychological literature. It is necessary to engage in such a task, since within the Eurocentric paradigm of mental health and illness, the sources of psychopathology are believed to originate from either the individual concerned or the society in which he or she is born and raised, or from the individual's own biology or physiology. However, the Eurocentric tendency to focus its aetiological explanation of mental illness on only three possible sources of human disturbances, namely, the biological, the psychological, and the social domains, is insufficient when certain types of psychopathology encountered in Africa (like healing sicknesses, such as *amafufunyane*; F. S. Edwards, 1984; D. L. Mkhize, 1998) are considered. A review of the prevailing Western models of psychopathology is therefore necessary in order to elucidate the limitations inherent in these models.

Western paradigms of psychopathology

Influenced by the Eurocentric paradigm, Western psychology sees psychopathology as arising in three main ways:

1. As a 'disease' of the mind that originates from abnormality in the patient's anatomy and nervous system. This is the so-called biomedical model or the somatic or biogenetic perspective. Following this perspective, Western psychology sees the body as the site of psychopathology, and the problem of psychopathology as something that could be resolved by means of western medicine through adequate diagnosis and medical prescription.
2. The second understanding of mental illness following the Eurocentric paradigm is the idea of psychopathology as a psychological abnormality. This is the so-called psychological model which sees psychopathology as originating from an individual's faulty cognitions, which is said to give rise to an individual's behaviour being dominated by irrational thinking and beliefs, biases, assumptions, and fears. This model is also referred to as the *intra-psychic theory* of psychopathology, originally propagated by the Freudian psychoanalytic framework, but now also emphasized by the cognitive theorists (such as Aaron T. Beck, Albert Ellis, and others).

Following this model, the mind is understood as the site of psychopathology. That is to say, under the intra-psychic theory of psychological dysfunction, psychopathology or any kind of psychological illness including *amafufunyane* (F. S. Edwards, 1984; Lund & Swartz, 1998; D. L. Mkhize, 1998) is seen as something that comes from within, rather than from outside, the mind of the individual. To manage the challenge of psychopathology under this model requires the use of psychotherapy or professional counselling to help the client to develop an alternative way of seeing life and responding to the problems of living.

3. The third model of psychopathology available in Western psychology under the Eurocentric paradigm is one that sees psychopathology as a product of stressful life-worlds or social contexts in which people live and work. This is the so-called *social-cultural model* of psychopathology. According to this model, the site of psychopathology is in society: in people's toxic interpersonal relationships, difficult and unsuccessful friendships, stressful work-settings, pathogenic marital and family systems, and so on. According to this perspective, such negative human systems are pathogenic. Hence, the problems of anxiety, chronic envies and jealousies, depression, and schizophrenia take their origin from negative interpersonal systems.

In an attempt to emphasize that none of the above three conceptualizations operating alone is sufficient to serve as a complete model of explanation in psychological practice, G. L. Engel, in 1977, published an article in *Science* which was considered to be a more inclusive model of psychopathology and was referred to as the BPS framework. The BPS model has come to be adopted in Western psychology, particularly in South Africa, as the most comprehensive way of understanding psychopathology.

A few Western scholars (Clare, 1999; Pilgrim, 2002) have, in several contexts, demonstrated that not everybody in Western psychological practice is in agreement with the extraordinary importance vested in the notion of the BPS model of psychopathology. However, such protestations have not been able to shift the pervasive dominance and control of that framework, within the South African context of psychological practice. Clare, as summarized by Pilgrim (2002, p. 590), observes that those favouring a holistic model have recently expressed a concern that psychiatry is simply becoming neuropsychiatry, with the BPS model losing its earlier gains. Against this understanding, Clare (1999) posed the following question:

As mental hospital gives way to acute district general hospital and community facilities, are the psychological aspects of disease being reabsorbed within the very core of medicine or is psychiatry slowly

being filtered and the social domains it has for two centuries so painstakingly valued and endorsed being remorselessly discarded? (p. 111)

Clare's lament, Pilgrim (2002) observes

points to a [. . .] reason to conclude that the BPS model is not a stable orthodoxy within psychiatry. History suggests that the biomedical model is a hardy perennial. Instead of the 'shell-shock problem' permanently suppressing a crude biodeterministic position, in the wake of Victorian eugenics, it merely created the conditions of accommodation. (p. 590)

In Pilgrim's view (2002),

This 'return to medicine' was evident on a larger scale in the USA, with the revisions of the American Psychiatric Association's Diagnostic and Statistical Manual. The latter shifted from an aetiological emphasis (favoured by the BPS model) to one of noncommittal neutrality about causality and a focus on current behavioural features. This shift might appear to be inoffensive to all comers, as it seems to avoid any partisan stance. However, its advocates make an explicit link between DSM and the legitimacy of a 'medical model', which can now rescue the term from the pejorative connotations created by 'anti-psychiatry'. (p. 591)

Indeed, according to Pilgrim (2002), one

final indication of a losing battle for the BPS model is its relative lack of visibility within those psychiatric texts after 1980, which set out explicitly to discuss models of causality in psychiatry. Take two examples, the first an introductory primer about psychiatry and the second a more scholarly philosophical analysis. Tyrer and Sternberg (1987) in their 'Models for Mental Disorder' outline four models, which they call 'disease', 'psychodynamic', 'behavioural' and 'social'. Of these, the last is the nearest to a BPS model (citing work from the Institute of Psychiatry). (p. 592)

These detailed citations have been entered into largely to demonstrate that even the very BPS model that is being propagated in South African psychiatric and psychological practice as the master model of aetiological explanation in working with clients who present with psychopathological conditions is losing its hold and respect in Europe and North American contexts.

However, what is argued in this article is that although the Africentric paradigm does not reject the Eurocentric paradigm in seeing the BPS framework as containing possible explanations for psychopathology, it expands on this view and provides a missing dimension unaccounted for in the Western, Eurocentric paradigm of mental illness.

The Africentric paradigm of mental illness: closing the gap

The missing dimension in the Eurocentric paradigm of mental illness is the *Spiritualist perspective* encompassed in the Africentric paradigm and accounting for the origin of certain instances of mental illness (Berg, 2003; Bodibe & Sodi, 1997; Bührmann, 1981; Cheetham, 1975; F. S. Edwards, 1984; S. D. Edwards, 1985, 1986; Erdtsieck, 2001; Freeman & Motsei, 1992; Gobodo, 1990; Helander, 1989; Hirst, 1993; Holdstock, 1981, 2000; Horton, 1962, 1967, 1995; Kalu, 1978, 1992; Magesa, 1998; Mbiti, 1969; D. L. Mkhize, 1998; Naidoo, 1996; Ngubane 1977; A. Nwoye, 2006b, 2014; Robertson & Kottler, 1993; Turner, 1968; Uys, 1986; Whyte, 1981, 1997; Yoder, 1981).

Instances of abnormal behaviour encountered in Africa

In Africa, the following examples (drawn from Whyte, 1997) are taken as other instances of psychopathology often ignored in Western psychology:

1. Women who changed partners and could not stick in marriage (Whyte, 1997);
2. Young men with strange behaviour like disappearing into the bush and refusing to talk or eat for several days, or climbing up a high rock and refusing to come down;
3. A woman with the sickness of 'running' or hysteria (as used by Whyte, 1997);
4. Men who were unable to maintain marital relationships, despite the fact that they were wealthy;
5. People reporting fits or seizures, fainting, signs of spiritual possession, and unexplainable psychosis (cited in Whyte, 1997);
6. School girls found to remove their clothes in public (an incidence that occurs frequently in Mombasa, Kenya, and also supported by research among the Bunyole of Uganda by Whyte (1997). A similar incidence has been found among people in South Africa by Wittstock, Rozenthal, and Henn (1991).

The above list which is not at all exhaustive demonstrates that in Africa, psychopathology does not refer only to the key problems of mental illness, such as psychosis or schizophrenia, but also to irregular or strange behavioural presentations that often arise from mysterious origins. For this reason, the tendency adopted in the African paradigm of mental illness is to view each of these abnormal presentations or illnesses not as ordinary illnesses or discomforts but as problems that carry a hidden text and message that must first be decoded and its meaning interpreted before a proper resolution or cure can be found. In this way, in seeing any particular illness, physical or psychological, as a 'symbolic illness' or one with a hidden meaning, indigenous African elders routinely assume that when faced with such strange behavioural manifestations, they must go beyond the 'information given' (Bruner, 1986), that is, beyond the external manifestations of the illness, to determine 'who' is speaking through such illnesses and what the relatives or family members are expected to do on behalf of the sick individual to effect healing. In that way, the family members of the sick try to identify not only what is happening to the sick individual (the observable manifestations of the illness) but also the question of identifying the invisible agent behind the onset and escalation through consultation with agents (hermeneuts or interpreters) of the hidden forces that are assumed to be responsible for the possible onset of these illnesses (Animalu, 1990; Berg, 2003; Bodibe & Sodi, 1997; Bührmann, 1977, 1981; Chukwu, 2008; Daynes & Msengi, 1979; F. S. Edwards, 1984; Erdtsieck, 2001; Freeman & Motsei, 1992; Hirst, 1993; Holdstock, 2000; Horton, 1962, 1967, 1995; O.U.Kalu, 1978; K. Ogbaa, 1992; Magesa, 1998; Mbiti, 1969; D. L. Mkhize, 2003; H. B. Mkhize, 1981; M.A.C. Nwoye, 2011; Peek, 1991; Ngubane, 1977; Oruka, 1990; Robertson & Kottler, 1993; Sokhela, Edwards, & Makunga, 1984; Sundkler, 1961; Swartz, 2002; Touche, 2009; West, 1975).

These observations, taken together, mean that the Africentric paradigm, unlike the Eurocentric perspective, recognizes the possibility of the origin of psychopathology arising not only from the illness of the body, or that of the mind, or social contexts, as emphasized in the West (Engel, 1977) but also, at times, originating from the spiritual or the ancestral background of the individual manifesting the illness.

The Africentric paradigm of mental illness equally teaches that there are intermediaries (or hermeneuts) to spiritual forces that could be approached for a solution when such illnesses are

encountered. This is because in the Africentric paradigm of mental illness, misfortune can be traced beyond the visible world or world of the senses, to the invisible world of the spirits and the ancestors from where the problem may arise. This follows from the assumption in African culture and worldview that the visible and the invisible worlds are highly interconnected and influence one another, and further that some people have the capacity to communicate, as intermediaries, with these invisible spirit forces to find out the intentions of such spirits or invisible agents when they bring illness to human beings (Animalu, 1990; Cheetham, 1975; F. S. Edwards, 1984; Erdtsieck, 2001; Holdstock, 2000; Horton, 1962, 1967, 1995; Kalu, 1978; K. Ogbaa, 1992; Mbiti, 1969; D. L. Mkhize, 1998; M.A.C. Nwoye, 2011; Peek, 1991; Touche 2009; Turner, 1968).

Approaches to clinical diagnoses within the Africentric paradigm

The notion of clinical or psychological diagnosis within the Africentric paradigm is used to refer to the interventive action that is taken to determine the source of a difficult illness. The need for such an intervention arises in the face of a sudden or difficult illness that refuses to remit after all medicines (including Western hospitalization) have been administered (Bodibe & Sodi, 1997; F. S. Edwards, 1983, 1984; S. D. Edwards, 1985, 1986; Erdtsieck, 2001; D. L. Mkhize, 1998; Ngubane, 1977; Peek, 1991; Turner, 1968; Whyte, 1997). Under such a situation, the tendency within the Africentric paradigm of mental illness is to perceive certain types of illness as abnormal illness, which, like an *analogic communication* (A. Nwoye, 2002, 2006a, 2006b), has a meta-message to transmit to the relatives or family members of the sick individual. The understanding is that it is only by first identifying the import and content of such a meta-text that a proper solution to achieving a cure to the presenting illness can be found. Hence, some types of psychopathology, such as sudden psychological illness, and other categorical states of incoherent thoughts and actions, are understood in Africa as instances of dramatic, *analogic*, or symbolic rather than ordinary experiences. The tendency in the diagnostic process within the Africentric paradigm is to 'read' such illnesses as 'texts' pregnant with meaning. This implies that sudden, severe, psychological illnesses are approached as meta-communications to be 'read' and interpreted, rather than to be categorized or classified as emphasized in the Western *Diagnostic and Statistical Manual of Mental Disorders 5* (DSM-5; American Psychiatric Association, 2013). Recognizing such illnesses as 'symbolic illnesses' or metaphors with hidden meanings, indigenous African elders realize that they must go beyond the surface manifestations of the illness to determine 'who' is speaking through such illnesses and what such agents intend to convey.

Consequently, psychopathology in the African perspective is viewed as an aspect of *social dramas* as propounded by Turner (1980). According to Turner (1980), there are two kinds of dramatic experiences that can be noted in human communities: *social dramas* and *stage dramas*. Social dramas, according to him, are those set in motion by the occurrence of a *breach*, which gives rise to the development of *crisis*, requiring redress or remedial intervention to ameliorate the situation.

Stage dramas, on the other hand, are those orchestrated on the theatrical stage, basically social in nature, aimed at mimicking the ways in which triumph is achieved when real social dramas of existence are confronted, addressed or dealt with, and effectively transcended (Turner, 1980). Seen in the above light, psychopathology is perceived as the occurrence of a breach in the normal routine of an individual's existence, changing the victim's inner and outer equilibrium from peace and harmony to illness and distress.

In the face of such an unexpected disruption in a person's life, the relatives of the concerned client, influenced by the spirit of rotational sensitivity or the philosophy of *constructive alternativism* (Kelly, 1955) or the notion of *behaviour as an experiment* (Kelly, 1985), while trying to track

down the meaning behind a given difficult or 'mysterious' illness, tend to interrogate not only the observable manifestations of the illness through the use of symptomatic idioms. They also engage in identifying *the agent* behind its onset and entrenched stubbornness.

The pragmatics of uncertainty that accompany the illness motivate relatives of the sick individual to take a subjunctive mood to organize a *wider plan of action* (to eliminate all of the possible routes from where the illness could arise) to arrest the situation. In this way, they resort to personalistic (or agent-related) idioms of explanation in the face of difficult psychological illnesses. What is diagnosed is not necessarily the symptom manifested but *the facts and the details* behind its eruption. Following this approach, Black African peoples in the situation invest in a 'thick reading' of the text presented in the form of the illness, going beyond the characters composing the text and placing particular emphasis on personalistic (or agent-related) idioms of explanation in their approach to questioning the presenting misfortune. For this reason, the major search or diagnostic questions in the face of a difficult illness, in the African perspective, becomes 'Who is speaking?' 'And for what intended message?' (Whyte, 1997).

Rituals of questioning misfortune

As a way of gaining concrete answers to the above questions, relatives of the sick individual engage in what Whyte (1997) refers to as the rituals of questioning misfortune.

Mechanisms of clinical diagnosis within the Afri-centric paradigm

As a way of ascertaining the hidden meaning in a particular illness, or whether a particular ancestor or *spirit being* is at the root cause of that illness, relatives of the sick individual engage, where necessary, in more than one approach to *questioning misfortune* (Berg, 2003; Bodibe & Sodi, 1997; Devisch, 1985; S. D. Edwards, 1985; Erdtsieck, 2001; Gobodo, 1990; Hirst, 1993; Holdstock, 1981, 2000; K. Ogbaa, 1992; D. L. Mkhize, 2003; Olsson, 1989; Ngubane, 1977; Peek, 1991; Robertson, & Kottler, 1993; Sokhela et al., 1984; Turner, 1968; Whyte, 1981, 1997; Yoder, 1982), operating, in that case, as the sick person's spokesperson in search of meaning to be attached to his or her illness.

In searching for such a meaning, the person understood in most communities in Black Africa to be the relevant intermediary in dealing with such matters is the diviner, known in various African communities by different names, such as the *iSangoma*, among the Zulu of South Africa; the *N'ganga wa pepo*, among the people of Tanzania (Erdtsieck, 2001); the *Babalawo*, among the Yoruba people of Nigeria; and the *Dibia afa*, among the Igbo of Nigeria. In this process, two major diagnostic mechanisms are followed: *instrumental divination* and *mediumistic divination*. In both methods, the central technique is divination, and an attempt must be made to define the notion of divination as understood in Africa. Commenting in that regard, it can be said that *African divination is the skilled process of ascertaining the concealed infurcation and demands of ancestors or other spiritual agencies, underlying a given illness*. It is therefore a kind of African cultural way of knowing – helping members of the mundane and the spirit world to carry messages across to one another (F. S. Edwards, 1984; Evans-Pritchard, 1937; Magesa, 1998; Mbiti, 1969; Mendonsa, 1982/2000; Peek, 1991; Olsson 1989; Prince, 1968; Turner, 1968; Zuesse, 1975).

Instrumental divination: the Zande poison divination method

The poison divination method, very popular among the Azande people of Southern Sudan, (Evans-Pritchard, 1937), is one of the most researched methods of instrumental divination in Africa. In

practice, it involves a straightforward process. It entails the introduction of a poison into an animal, usually a fowl. The poison comes from a specific creeping plant called *benge* (Magesa, 1998).

Three people take part in this process: *the owner of the fowl* who brings the fowl and whose problems are the subject of the divination procedure, *the operator* or the administrator of the poison (who holds the fowl and introduces the poison), and *the questioner*, who addresses the pertinent inquiries to the oracle. According to authorities (Evans-Pritchard, 1937; Magesa, 1998), the standard questions in this process take the following form: 'If such is the case, poison oracle kill the fowl', or 'If such is the case, poison oracle spare the fowl'. The verdict of the oracle depends on whether the fowl lives or dies. However, the process is not as simple as that.

This is because one must know how many doses of poison to administer, whether the oracle is working properly, in what order to take the questions, whether to put them in a positive or negative form, how long a fowl is to be held between the toes or in the hand while a question is being put to the oracle, when it ought to be jerked to stir up the poison, and when it is time to throw it on the ground for final inspection.

In addition, according to authorities (Evans-Pritchard, 1937; Magesa, 1998), one must know how to observe not only whether the fowl lives or dies but also the exact manner in which the poison affects it, for while it is under the influence of the oracle, its every movement is significant to the experienced eye. Also, one must know the phraseology of address in order to put questions clearly to the oracle without error or ambiguity. This is a complex task when a single question may be asked in some cases.

Also, it needs to be pointed out that in Zande poison divination, a judgement of the accuracy or validity of the oracle depends on the testimony of two test administrations. In that case, if a fowl dies in the first test, then another fowl must survive in the second test, and if a fowl survives in the first test another fowl must die in the second test for the judgement to be accepted as valid.

The poison oracle procedure is thus not an easy process for the inexperienced practitioner. In its execution, it resembles the effort made in the test and measurement tradition to arrive at a valid judgement through the administration of a confirmation test, before the result of the first test administration can be taken as valid.

The mediumistic divination

Notably, with regard to mediumistic divination, the diviner is the object through whom the oracle speaks. In other words, the speech of the oracular agent is delivered through the words of the diviner, who serves as the medium. Some iSangomas use a variety of culture-specific objects or instruments to get at the information that is needed. Turner (1968), supporting the above, observes that the mediumistic diviner's task is that of helping to bring into words what is hidden or unknown so that people can deal with the 'stakes' in an appropriate way. Because this information is not always obvious, but exists in the 'spaces between things', it requires skill and clever technology to access it. In this way, according to Mary Douglass, as quoted in Peek (1991), 'any culture which admits the use of oracles and divination is committed to a distinction between appearances and reality. The oracle offers a way of reaching behind appearances to another source of knowledge' (p. 194).

Should it be *discovered* that an ancestral spirit or another kind of spirit agent, or even a human being, is causing the disorder, then the diviner will identify the procedure to be followed in dealing with the situation. In most cases, this may involve a sacrifice or simply recognition and an affirmation, through verbalization of the name of the ancestor concerned. The understanding is that the spirit in question will relent since it has been aggrieved for being forgotten. Hence, the affliction is often interpreted by the diviner as confronting the sick individual in his or her own personal

capacity or in his or her capacity as representative of a kin group, all of whom may have been at fault in the issue provoking the spirit or the ancestor in question.

It should be further noted that a peculiar kind of spirit possession involved in mediumistic divination is the type in which the possessed is conceived of as serving as an intermediary between spirits and members of the human group concerned. In that case, the accent is on possession as a medium of communication – a point of view, which distinguishes spirit possession that takes place in mediumistic divination, from the condition of madness. However, it should be observed that in mediumistic divination, the diviner always goes into a state of possession and becomes an instrument of speech for the possessing spirit. But, in mediumistic divination, the diviner can also become in a sense the possessor of the spirit, to achieve illumination (Crapazano & Garrison, 1977; F. S. Edwards, 1984; Foster, 1976; Mbiti, 1969; Mendonsa, 1982/2000; D. L. Mkhize, 1998; Olsson, 1989; Ngubane, 1977; Peek, 1991; Turner, 1968; Zuesse, 1975).

In line with the above, van Binsbergen (1981) suggests that the kind of possession that takes place in mediumistic divination is one that involves an extremely momentary and very intensive state (usually accompanied by drumming, singing, and sometimes smoking). In this regard, authorities (Myerhoff, 1986; Turner, 1968) caution that the type of dancing that erupts in mediumistic divination rituals is not just ordinary dancing. Myerhoff (1986) notes that the drumming and dancing that accompany the rituals of affliction act as ‘positive agents’ that help the trance state to occur.

Implications and conclusion

A number of implications follow from the above discussions, including the following: First, that Western psychology’s tendency to define humans only in material, tangible, or observable terms (e.g., in terms of body and behaviour) should be questioned, as it ignores attention to human spirituality, which in African psychology is an important influence in human well-being (A. Nwoye, 2015). Second, Western psychology’s assumption that human behaviour is what it is with no significant meaning beyond what is actually observed is again an assumption that must be considered unacceptable in African psychology, since human beings in Africa live most of their lives according to what people’s words and actions mean to them (A. Nwoye, 2014). Thus, the African universe, unlike the Aristotelian universe, is an interpreted universe (A. Nwoye, 2006b). In this way, certain psychological illnesses in Africa can only be effectively explained and decisively dealt with through the application of the African perspective. It therefore cannot be emphasized enough that the Africentric paradigm to clinical diagnosis and intervention encompasses not only the BPS model of illness explanation endorsed by the Eurocentric paradigm but also the spiritualist explanatory framework excluded by the Eurocentric perspective to illness causality explanation, giving rise to a more inclusive explanatory framework to mental illness, namely, the Bio-Psycho-Social-Spiritualist (BPS-S) model.

Hence, the Africentric paradigm as a more holistic (Sanford, 1966) paradigm of mental illness deserves more respect and serious attention than it currently receives, as it thrives where the western medical model has failed, mainly because it is grounded in other ways of knowing that supersede explanations of mental illness espoused by the Western Eurocentric model.

In addition, the Africentric paradigm of mental health and illness endorses the solution-focused approach to diagnosis and intervention. This means that in contrast to the Eurocentric perspective which encourages the belief, grounded on the psychoanalytic framework, that the longer the length of treatment, the better the outcome, the Africentric model is influenced by the pragmatic theory of truth. This is a framework which believes that in matters of illness and healing, truth is defined in action. Hence, in the Africentric perspective, the governing assumption is that what works is the

truth (A. Nwoye, 2006b); and that the quicker or the less time it takes to achieve the successful resolution of the problem, the better. Similarly, it should be mentioned that although in many places in Africa the indication appears to be that the role of the diviner is a woman's birth right (like in southern Africa where most diviners are women); in some places, such as among the Igbo of Nigeria, for example (Achebe, 1958), that office is open to members of both sexes. In this case, the office is not a birth right as such; consequently, people have to be 'called' or chosen by the ancestors or a given spiritual agency for such a function.

Furthermore, divination sessions in Africa are always conducted in public, not in secret, in the presence of an observer-witness. In addition, in the African perspective, a divination session proceeds on the assumption that the ancestors of both the client and the diviner are present or, at least, 'on call' (Evans-Pritchard, 1937) in support of the search for a diagnosis of the client's illness.

In closing, it must be emphasized that it is not the argument of this article, that all African psychologists who support the Africentric paradigm of clinical diagnosis and treatment are expected to play the role of iSangomas to those clients who present with a difficult illness. The point to be taken away from this discussion rather is that the DSM-5, espousing the Eurocentric paradigm, is not the only possible diagnostic system for understanding clients with difficult mental illness. The present discussion suggests that in the Africentric paradigm, the BPS model should lead to referral to an appropriate traditional healing expert (typically a well-acclaimed iSangoma, not a charlatan) who is versed in the use of divinatory epistemology as an avenue for effecting an intervention.

In sum, therefore, one can say that one of the aims of African Psychology in general, and the present discussion in particular, is to enable clinicians in the South and other regions of Africa to recognize the strength and limits of Western Psychology, particularly when confronted with the needs and problems of Black African clients with difficult illness presentations.

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