

Decolonizing the notion of mental illness and healing in Nigeria, West Africa

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INTRODUCTION

In a well-received lecture at TEDGlobal, Nigerian novelist Adichie (2009) expounded upon what she termed ‘the danger of a single story’. Drawing from her experiences as a growing child in Nigeria, she explored the subtle ways power structures tend to make a single perspective the most definitive way of understanding a concept – thus marginalizing other perspectives and knowledge frameworks. In specific relation to how she evolved her personal understanding and identities as an African, Adichie berated this perspectival hegemony and its colonial/imperialistic undertones, and urged her audience to resist the comfort of a single perspective or story about any place or people. Drawing from the postmodern undertones and the pluralist ethos set forth by Adichie (2009), this paper explores, in generic terms, the marginalization of indigenous knowledge systems by Western paradigms specifically in the much contested field of mental health and treatment. By advocating for a pluralistic arena that does not position non-Western indigenous health frameworks in disadvantaged or subordinate categories, I argue for the irreducible legitimacy of traditional healing methods and, ultimately, for the adoption of these methods as complementary partners with mainstream psychotherapeutic praxis in a decentralized space.

Critical psychology is closely allied with social constructivist perspectives in its focus on how power differentials between contesting ideas about (in this case) healing and wellbeing are often ignored – creating hegemonies that are oppressive and insensitive to local, *other* needs. By questioning the conventional notion that how things are is how they should naturally be, critical psychology provides the narrative fodder to empower the marginalized to decisively reappraise their participation in systems that enforce silence and conformity to a single apparatus for understanding the world. The strengths of critical psychology, however, are not merely theoretical, but practical, and evinced in the lived experiences of indigenous peoples. By articulating the frustrations of non-mainstream practitioners and consumers of indigenous healing, critical psychology finds its crucial *raison d’être*. In developing this narrative, it is instructive to consider those frustrations, experiences and trends that reinforce the need for a decolonizing of therapeutic praxis and the recognition/celebration of indigenous healing systems. These rather disturbing, yet enlightening, trends should give occasion for reflection about practices that have gained a certain sort of ‘invisibility’ (Waldron, 2010) or cultural normativity, which allows for the operationalization of Western thought ‘within a hidden and unmarked space, resulting in its re-production and re-affirmation within discourse, social structures and institutional practices’. Hence, I also

address the need to speak new conceptions of social justice and equity to power, and redefine the 'normal'.

Constantine, Myers, Kindaichi, and Moore (2004) report a startling underutilization of psychotherapeutic facilities among indigenous people in the United States of America. Apparently, there exists a general hesitancy and reluctance exhibited by people of colour in the States to use formal mental health services. Among the reasons espoused for this growing trend are the high cost of traditional health services, the felt urge to locate less stigmatizing forms of therapy and the compelling need to utilize less formal, more indigenous forms of therapy that are life-affirming and nurturing to constructed identities. Concomitantly, Constantine, Myers, Kindaichi, and Moore (2004) state that non-White Americans are reportedly less likely to utilize mainstream therapeutic facilities because they do not see these services meeting their deeply engrained needs. As the case would have it, this reluctance exercised by ethnic minorities is not limited to the United States. Thus, other reports on mental health underuse (Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004; Constantine, Wilton, Gainor, & Lewis, 2002; Nwoko, 2009; Washington, 2010; Centre for Addiction and Mental Health, 2009) have shown that culturally diverse groups across the globe are increasingly participating in indigenous therapeutic spaces. Supported by cultural perspectives (such as the largely African view which implicates the spiritual realm in the understanding of behavioural problems) that are incongruent with mainstream psychotherapeutic praxis, a significant section of indigenous people (understood here as non-Western people), reports show, leans heavily on the expertise, influence and meaning of traditional healers, communal worldviews and historically transmitted rituals respectively. This indigenous suspicion of the efficacy of Western psychotherapy is reinforced by indigenous styles of conceptualizing the human person in relation to her world and the meaning of mental illness.

The critical issue I am concerned with is, however, not merely the 'fact' that more non-Westerns are irritated by Western conceptualizations of mental health and the assumptions that empower psychotherapeutic praxis, or the 'fact' that there are *other* systems of healing and meaning radically different from that espoused in classical psychotherapy. The deep-seated diversity of perspectives about mental wellbeing and distress are well taken for granted, and need not be established here – except in passing to more decisive concerns. The investigation of indigenous forms of healing is an ongoing project, and the culture-specific resources, owned and sustained by these diverse groups, provide a vibrant source of

fascination for investigators. These indigenous forms of healing are culture-sensitive, holistic, spiritual, collectivistic, and rich in variety. For instance, some pastors, clergymen and priests play the role of healers for some in the African American and Latino populations (Constantine, Lewis, Conner, & Sanchez, 2000); Asians sustain close-knit family networks that serve as healing sources in times of distress (Solberg, Ritsma, Davis, Tata, & Jolly, 1994); and, some American Indians engage in elaborate sun-dances and pipe festivals in their quest for a sustained sense of rejuvenation and wellbeing (Garrett & Wilbur, 1999). What is of crucial concern, nonetheless (as exemplified in critical psychology's thrust), is how these *other* systems fare in the arena of competing ideologies, and how practitioners might apply these concerns in progressive ways. Waldron (2010) states that health systems and perspectives different from Euro-Western paradigms are marginalized and rendered illegitimate by the imperialistic character of the latter. Founded on modernist assumptions and positivistic notions of universality, mainstream clinical praxis depicts all other conceptions of health as naïve, antiquated or substandard. By internalizing Western perspectives, etiologies, nosologies and diagnostic systems as standard, clinical practitioners help reinforce a hierarchy of mental health beliefs and treatments. Assessments, diagnoses and treatments are shaped by Western hegemonic perspectives that are radically at odds with the beliefs and practices of culturally diverse groups, thereby creating a crisis situation for groups not represented by Western claims. I investigate the claims to universality and legitimacy, which are normative qualities of orthodox clinical practice. By reviewing such claims in the light of postmodern assumptions about the nature of 'truth' and the discredited notion of metanarratives, I argue for the promotion of indigenous knowledge platforms in healing and wellbeing. Informed by the view that treating indigenous individuals from a non-indigenous perspective is a subtle form of colonial oppression (Stewart, 2008) as it does not legitimize their worldviews or treat their cosmologies as valid in their own right, I espouse a pluralistic configuration for mental healthcare – one which does not privilege one paradigm above the other. Consequently, I argue for a situation of complementary alliances between so-called 'orthodox' cosmologies and indigenous paradigms, a submission which differs in significant ways from the calls for an integration of the latter in the former. I submit that given Nigeria's poor, minimalist and centralized approach to mental health, promoting indigenous therapy could solve the challenges of mental health delivery. By assuming a social constructivist viewpoint, I articulate the fragility and constructedness that attend any social system or institution – including Western healing practice. In short, the refreshing breath of air that critical psychology brings to the Nigerian mental health situation cannot be

over-celebrated. Additionally, by alluding to the political nature of psychotherapy (such as the frailties of diagnosis and assessment), and critiquing what may be called Western therapy's myth of neutrality, I show how every paradigm (Western and non-Western) is laden with values, locally constructed and spoken to power by interested (as opposed to disinterested and unbiased) groups, historically embedded, and storied – such that to assume one culture's suppositions about human *be-ing*, mental health and treatment have anything to do with a universally objective referent is to ignore the 'danger of a single story'.

THE MARGINALIZATION OF INDIGENOUS KNOWLEDGE

Ethnopsychotherapeutic practices have long been recognized as existing side by side with 'orthodox' therapies (Ovuga, Boardman, & Oluka, 1999). Based on the belief systems of culturally diverse groups, non-Western mental healing traditions have, from the margins, served as a source of alternative healthcare delivery to indigenous people, who are generally suspicious of Western psychotherapy – or are alienated from the service. Unrecognized, many indigenous healing methods, studied by a growing number in the academia unsatisfied with mainstream psychotherapy, continue to serve locals across the globe (Raguram, Venkateswaran, Ramakrishna, & Weiss, 2002; Abbo, 2009; Kabir, Iliyasu, Abubakar, & Aliyu, 2004). For instance, in Zacharias (2006), the effectiveness of *Curanderismo*, an indigenous therapeutic paradigm that has evolved from the Oaxacanean people of Mexico, is reported to rival that of Western psychotherapy – given the acceptance of orthodox treatment outcomes. The complex nosologies and treatment modalities employed by the *Curanderos* are reportedly enriched and informed by a holistic inclusion of a spiritual dimension in their mental health and illness scheme – a concept largely missing in most Western psychotherapeutic practices.

The Igbo of Eastern Nigeria also have an elaborate cosmology that implicates healing and illness, deviance and wellbeing. Nwoko (2009, p.37) states that 'in Igbo perception, every ailment comprised the invisible, spiritual or supernatural origin and visible or natural origins. Hence they commonly perceived ailments especially the protracted ones like insanity as dual rooted.' Consequently, the Igbo therapeutic system accommodates various classifications of healers called *Dibia*, who possess skill bases that define the healer's role as a mediator between the spiritual and the physical realms. Similarly, Yoruba healers (*babaláwo*) play the role of diviners, and often employ water-themed rituals to confront spirits and gods, who are often viewed as the primal causes of deviance or madness (Rinne, 2001).

Various other indigenous therapeutic systems subsist across the globe – existing alongside Western psychotherapy. These frameworks are often irreducibly different from Western conceptions of normality and abnormality. Waldron (2010) states:

‘The notion that physical and mental illness are conceptualised and experienced similarly throughout the world is one of the many erroneous assumptions made about culturally diverse peoples around the world by some health practitioners working within Western medicine and psychiatry. Every society embraces particular ‘cultural theories’ or ideologies that set the parameters within which normal, abnormal and deviant behaviour is defined. These cultural theories on illness, treatment/healing and health often stem from diverse observations, understandings and interpretations of specific symptoms, the behaviour of persons affected by illness and how symptoms are uniquely experienced and explained in specific cultures’ (p.50).

The unique descriptions and narratives diverse communities construct around their varying conceptions of healing and deviance define their approach to indigenous therapy. These systems of traditional healing are sacred and vital to the communities that uphold them – because it represents their beliefs, values, and their constructed identities. For instance, the care provided by the local Oaxacanean healers, the *curanderos*, ‘often represents the sole health resource that is reliably accessible to the general public’ (Zacharias, 2006; p. 382). Thus, these healing traditions, their actuating cosmologies, and their active agents, are a vital aspect of the lives of the communities they are constructed to serve. However, the existence and perpetuation of traditional therapeutic contexts is threatened by the hegemonic status of classical psychotherapy. Zacharias (2006; p.382) states that ‘the clearly significant care provided by *curanderos* is rarely acknowledged by the hegemonic system of Western medicine. For example, Mexican law recognises the practice of *curanderos* as culturally important, but not medically valid.’ Additionally, Zacharias (2006; p.383) adds: ‘The dominant attitude in public discourse concerning the symbolic aspects of *Curanderismo* has been one of rejection. This continues to be the case due to the growing influence of biomedicine in Mexico. In regard to Mexican medical policy, this lack of recognition has led to a situation where this important medical resource remains underestimated and underresearched.’ The ‘underground’ status of *Curanderismo* is similarly suffered by other traditional healing practices in culturally diverse groups due to the Westernization of ideas on mental health and illness. The hegemonic framework of Western psychotherapy casts diverse

understandings of mental health in subordinate positions, hence creating a hierarchy of knowledge by which indigenous frameworks are evaluated and delegitimized.

Today, classical clinical practice is recognized as standard, universal in its applications, and commonsensical enough to be viewed and understood by anyone who exercises correct thinking. The not-so-obvious implications of the universalist claims of Western psychotherapy is that other systems, other cosmological matrixes, other narratives about human *be-ing*, other conceptualizations of history, and other perspectives on the essentially contested ideas of normalcy and abnormality, are illegitimate deviations from real knowledge. A pyramidal structure of knowledge about human wellness is thus sustained, situating Western-oriented explanations of the human person and society at the tip, and other frameworks at the graded bottom – depending on their proximity to the ‘truth’ of Western therapy. Waldron (2010, p.51) addresses this power inequity by affirming that ‘it is Western scientific traditions, epistemologies and practices that often dominate within the social structures of Western and non-Western societies, resulting not only in the normalization and privileging of these traditions, epistemologies and practices, but also the pathologizing of non-Western ideologies and practices.’ This dichotomy of knowledge systems translates to less than equitable circumstances for indigenous persons around the globe and their age-old cultures and perspectives about therapy – a situation characterized by denial of access to other forms of therapy, an erosion of cultural identities and value systems, an establishment of passive reception of ‘meaningless’ narratives, and the destruction of social ties of kinship and other functional bonds critical to livelihood. Other insidious features of marginalization are the oppressive imposition of a social space and the forced internalization of new values. It might be helpful to understand the dangers of psychotherapeutic colonization with some examples employing two of Western psychotherapy’s inter-related sacred tenets, confidentiality and autonomous independence. Confidentiality describes a tacit and explicit pact between a client and a clinician, in which the clinician is ethically constrained not to disclose information about a client to anyone external to the therapeutic context. A therapeutic alliance, consequent upon clinician-client negotiation of these constraints and values, is necessary in a stylized Western psychotherapeutic context. Though there are perceived limitations to this ethical submission of confidentiality, the notion is rooted in the idea of the human self as an autonomous, independent entity (Wright, Webb, Montu, & Wainikesa, 2002). Consequently, the idea of confidentiality is being questioned in non-Western contexts because it reifies the self as independent and does not accommodate

varying conceptions on the self. Gergen and Gergen (1988) remind us that there are competing views on the self, which is perceived in many non-Western cultures as relationship. Similarly, the therapeutic outcomes of Western psychotherapy idealize the healthy individual as autonomous, independent and rational, whereas, in many other non-Western cultures, the idea of an individual as autonomous and ‘rational’ is the very description of abnormality. Thus, regarding psychotherapeutic colonization, Stewart (2008, p.12) states that ‘counselling Indigenous individuals from a non-Indigenous perspective (i.e., Western perspective) is a form of continued oppression and colonization, as it does not legitimize the Indigenous cultural view of mental health and healing’.

Ultimately, the Western hegemony, itself constructed in a social moment and just as inherently vulnerable as other conceptions, serves to perpetuate crippling stereotypes (Ocholla, 2007) that do a disservice to indigenous worlds. Diverse ways of healing and being that hold promise for new alternatives in psychotherapeutic thought are considered illegitimate and therefore, not very useful. The diagnostic, therapeutic, and nosological systems of Western psychotherapy are thus viewed as the evolving default of mental healing – to the perpetual subordination and oppression of indigenous knowledge systems.

One of the innumerable ways indigenous spaces within the Nigerian context are territorially abused by the claims to power emanating from the so-called western hegemony are by the institutional use of the DSM (Diagnostic and Statistical Manual) in understanding mental discomfort. The Manual prepared by the American Psychological Association is quite popular among the sprinkling few of Nigerian clinical practitioners, and is frequently referred to and enforced as the standard perspective on mental illness. In a nation with largely disenfranchised people, who experience a strong disconnect between their hopes for a better life and prevalent socio-conditions, there are strong feelings of dependence on authority figures and professed experts – especially on persons who have some form of formal education and western professional training. This situation is easily exploited by clinicians who, in the few functioning centralized mental health centres in the country, dispense diagnoses of mental illnesses and their attendant treatment procedures – all the while failing to acknowledge the narratives that shape indigenous lives. At the inception of my clinical practice, during intake interviews that were largely carried on by my supervisor, I often experienced silent discomforts about the less-than-appropriate power dynamics between the client and clinician – a sentiment I failed to express for fear of being labelled a ‘heretic’. Situated within the suburban mix of neighbourhoods of Enugu in eastern Nigeria, the

Neuropsychiatric Hospital in which I received my training regularly received community members who enquired about the most effective ways to get a ‘wash-wash’ (local parlance for a quick cure of problems thought to be inflicting the brain). When most inquirers, during intake interviews, expressed their opinions about what could be ailing them, I observed that the active clinician readily reduced the narratives of the client to terms agreeable to the DSM catalogue – only listening for ‘highlights’ that readily recommended an easy diagnosis. The DSM, in its Nigerian employment, makes it entirely feasible to do away with the initial irritation of listening to ‘tales’. By devaluing the cultural stories and meaning frameworks constructed by clients, the DSM manual propagates a single story – and its uncritical employment by clinicians in non-western contexts only serves to create more problems than can be handled in traditional ways. The DSM silently insists that there is a singular therapeutic referent, and consequently provides a context which synchronizes client behaviour with symptomatic expectations informed by ‘western’ ideas of mental illness. Far from being a promoter of mental health in Nigeria, western clinical praxis effectively silences competing paradigms and colonizes indigenous behaviour – successfully constructing only one way to experience life difficulties and, thus, only one way to ‘treat’ them. The current subjection of Nigeria’s rich baritone of cultural plurality to the homogenizing effects of western ideas is even more troublesome when one considers the thrillingly multifarious approaches to wellbeing available in the country. Owing to the neo-colonialist influences of these orthodox ideas on mental health, the Yoruba mythology – which implicates the divine in mental illness and the use of water in alleviation of problems – and the Igbo mythology – which invests upon the *Dibia* the power to consult other-than-physical forces to come to one’s aid as well as the community support that spontaneously assists community members with loss and grief – are cast off as primitive deviations of western philosophies.

The notion that there are meta-narratives (from which indigenous knowledge systems are warped digressions) and the problem of power inequities and imbalance between Western and non-Western systems are really an epistemological issue. That is, at the root of the universalist claims and the globalizing ideals of Western psychotherapy is the problem of knowledge. Duran and Duran (1995; in Stewart, 2008; p.12) state that ‘a postcolonial paradigm would accept knowledge from differing cosmologies as valid in their own right, without their having to adhere to a separate cultural body for legitimacy’. Paradigmatic controversies about what can be known, the philosophical nature of knowledge, and the relation of the knower to the known, form the essential matrix of discourse about

decolonizing healing. Unfortunately, academic discourse on the philosophical undertones of clinical practice in Nigeria, and how this might liberate new spaces for indigenous practice as well as enrich the ‘mainstream’ psychotherapeutic institutions, is all but lacking – frowned upon by the orthodoxy of scientific rigour and the fear of relapsing into philosophical ‘talk’. The next section briefly confronts the issues and delineates the argument as a clash of modernist and postmodernist ideas about the nature of legitimate knowledge. It is shown that if there are no objective referents by which any observer might claim to have perceived ‘truth as it is’, that is, if knowledge is co-constructed and culturally embedded, biased, political, gendered and vulnerable, then the globalizing force of Western clinical orthodoxy and the hierarchical classifications of knowledge systems can give way to more equitable circumstances for the survival of indigenous knowledge systems.

THE POSTMODERN MOMENT: DECONSTRUCTING EVIDENCE AND LEGITIMACY

Is knowledge essentially the product of the West, and the by-product of Western systems? Mainstream psychology is founded on the logico-positivist ideas intimately connected with modernism (Waldron, 2010). But the advent of postmodernism is gradually undermining the foundations of modernism and the characteristic quest for objective knowledge that has defined psychological discourse and, more specifically, the institutional search for the laws of abnormality in psychotherapeutic discourse. It is therefore critical to note that ‘with the emergence of postmodernism, the positivistic worldview of objective reality is being challenged. The postmodern worldview, as exemplified by the metatheory of social constructionism, has great influence on our understanding of how knowledge is constructed and how intervention is carried out in different helping professions’ (Shek & Lit, 2002, p.105).

The epistemological conflicts underlying the current debates on the legitimacy of indigenous healing frameworks and the undesired hegemonic influence of Western psychotherapy are constituted by two alternative, ‘hardly compatible’ discourses: objectivism and constructivism (Botella, 1998). The former is associated with positivism, which is largely discredited in academic discourse today, while the latter is more associated with postmodernism. Both discourses are centered around the question: ‘what is truth? How is knowledge produced? What is evidence and how can we tell if knowledge is legitimate or not?’ Objectivism is characterized by the notions of truth as an objective referent, separate

from the observer, existing regardless of the participation of potential knowers, and only accessible by the rigorous application of a system of rules or procedural accuracy. Using alternative appellations such as 'positivism', 'modernism' and 'received view', Botella (1998) concurs with the idea of objectivism as procedural quest for an objective referent by stating that 'the core assumption that identifies the discourse of objectivism is that Reality exists independently of the observer, and can be known with objective certainty if the right means are used. This objectivist view has its roots in Newtonian physics and in the worldview of Modernism, which influenced psychology in its historical origins. When applied to clinical psychology and psychotherapy, this discourse carries not only epistemological implications, but also methodological, technical, and ethical ones.' Objectivism searches for foundations of knowledge, and, in its quest, attempts to delineate true knowledge from false knowledge. Exploring the historical underpinnings of the evolution of objectivism and its centrality to scientific discourse is not an objective of this section or paper. It might suffice the reader, however, to understand how the epistemological project or quest for 'truth' was severely undermined by the critiques of important thinkers like Foucault, Wittgenstein (who dismissed the dogma that language and meaning must conform to a single logical structure – hence the advent of 'language games' (Weinberg, 2008)) Lyotard (and his stylized suspicion for metanarratives) and Derrida, who questioned the possibility of apprehending knowledge that is unshaped, untainted, and removed from human experience and advocated for the deconstruction of oppressive knowledge systems. In other words, the old regime of truth as correspondence with a pre-given suffered severely from new critiques that implicated the perceiver in the perceived and eradicated the possibility of science as a neutral procedural correspondence with reality. Botella (1998) comments on constructivism:

As for the nature of knowledge, constructivism assumes that knowledge is a hypothetical (i.e., anticipatory) "construction". Thus, it departs from the traditional objectivist conception of knowledge as an internalised representation of reality. This constructivist assumption can be traced back to Kant's philosophy and to Popper's notion that no knowledge originates in pure observation, since every act of observation is theory laden... Constructivism cannot rely on the original/copy correspondence metaphor, since it departs from a representational conception of knowledge. Justification by means of the

authority of truth is then regarded as an illusion, a "never achieved ideal or horizon concept"...

Akomolafe & Usifoh (2010, p.13) addressed the failing notion of truth as representation: 'Far from being an apolitical, self-evident pregiven, truth, as conceived today, was contextually spurned from a moment that was constrained to respond to its own endemic vagaries and crises. Today the notion faces a critical challenge in the chaotic vortices of postmodern thought.' Consequently, the idea of knowledge quickly spurned into constructivistic metaphors, which cast knowledge as constructed, myth, metaphorical, political, historical, engendered, situational, storied, participatory and local. Hence the triumph of the indigenous and the particular over the colonial and the universal. 'In effect, the triumph of the postmodern is possibly the realization of the socially constructed nature of reality and the interested observer, and truth is a deeply political process of change that is relative to the local hegemonies of interpretation. The postmodern radicalizes and decentralizes knowledge as 'interpretation and nothing but this. Things appear to us in the world only because we are in their midst and always already oriented toward seeking a specific meaning for them. In other words, we possess a preunderstanding that makes us interested subjects rather than neutral screens for an objective overview' (Akomolafe & Usifoh, 2010).

The implications of the postmodern moment for psychotherapeutic evidence and legitimacy are monumental. In the Nigerian situation, for instance, the current invisibility of traditional paradigms to governmental practice and the persistent refusal to recognize the inherent values brought to the fore by indigenous approaches to life and wellbeing become unjustified. If 'truth' is not the exclusive preserve of any one culture, logical structure, or procedure, then 'truth' is myth, co-constructed by culturally diverse groups – 'equally' owned and performed by the Yoruba, Igbo, Urhobo, Hausa and the idealized West. The universalist claims of mainstream psychotherapy to legitimacy thus fails to hold further credence. In social constructivist conceptualizations, assessment, diagnosis and treatment are recast as political processes informed by localized myths about human *be-ing*, healing and deviance. Western psychotherapy is not superior in its ability to access pregivens about the nature of abnormality or therapeutic interventions; hence, orthodox clinical praxis is not the standard, and indigenous healing frameworks, deviations from that standard. Legitimacy cannot be granted any one healing tradition based on its supposed proximity to noumenal realities or extra-discursive therapeutic 'laws' – except as defined within the social space from which the practice emanates. The supposed hierarchy of healing frameworks thus disintegrates into

decentralized arenas of healing praxis – conditioned by diverse cultures that may be perceived as being radically irreducibly unique and yet also allowing for confluences and similarities with other healing traditions.

Even more consequential to healing discourse in the postmodernist moment is the deconstruction of evidence or efficacy. Foreign to the postmodern re-conceptualizations of truth as myth and healing as intersubjective is the notion of efficacy, which retains undertones of modernist thought. Applied to psychotherapeutic discourse, efficacy studies are conducted to judge the success of an intervention strategy at producing certain behavioural outcomes. In sum, efficacy discourse is concerned with if psychotherapy *really* works. This discourse has been transferred to indigenous healing methods and the growing discomfort of their advocates with hegemonic mainstream psychotherapy. Zacharias (2006, p.381) states:

In the past four decades, scientific evaluations of therapy outcomes have become a central preoccupation of western psychotherapy research. This intense research interest was provoked by the famous assertion by prominent psychologist Hans Eysenck, who in 1952 put into doubt the belief that rates of psychotherapeutic change outweigh the effects of spontaneous remission. Clearly, there have been fewer studies evaluating the effectiveness of indigenous treatment approaches. However, in a globalised world, dominated by hegemonic ideologies, concepts, and discourses, there is also an increasing need for traditional healing systems to participate in the transcultural discourse legitimising their essential positions and interests. Transcultural and ethnotherapeutic research in the field of medicine and psychotherapy can play a central role in achieving this goal.

Though, Zacharias (2006) goes on to state that Curanderismo results rival Western psychotherapy's, he notes that indigenous traditions need not subject their therapeutic outcomes to any hegemonic influence. The discourse of efficacy and therapeutic outcomes is thus transformed from 'what works' or 'what is true recovery' to 'what is meaningful'. Efficacy studies are often Trojan horses, subtly transmitting the values of one culture and the ideas of recovery and healing. The beliefs and perspectives articulated about what is expected of psychotherapy are not universally or objectively true. Indigenous healing paradigms can resist advances at colonization of therapeutic outcomes by insisting on the intersubjective nature of healing and the centrality of meaning to the therapeutic encounter.

PROBLEMS OF MENTAL HEALTHCARE IN NIGERIA: PATHWAYS TO THE OTHER

Decolonizing healing and, thus, liberalizing the healing context for the flourishing of indigenous health systems, holds promise for revitalizing the Nigerian mental healthcare system. The problem of healthcare delivery in Africa's most populous nation has been a perennial problem that is not helped by the rather scarce data available on the subject. However, public consciousness on the issue of mental health is not totally absent. On September 13, 2010, at a workshop advocating grassroots change in mental health delivery services, Chief Medical Officer of the Lagos State University Teaching Hospital (LASUTH), Dr. Femi Olugbile, commented:

‘We are starting from the premise that 90 percent of persons with mental illness do not get any care at all and this is unacceptable because it is a major debilitating factor on our society as a whole in every aspect including commerce. We need a practical way of delivering mental healthcare at the grassroots level...’

He also articulated some of the challenges facing the system in Nigeria:

‘There is a disconnet [sic] in distance terms. The reason why there are so many psychotic people wandering the streets in the urban centres is that they cannot get care where they live so they are dislocated. If care was available it is unlikely that people would become chronically psychotic and wander around’ (Ogundipe, 2010).

Dr. Olugbile concluded his remarks by advocating for more health centres and the training of personnel. Though the establishment of more psychiatric centres in the country might do well to aid Nigerians living in urban areas, I argue that the more critical solution to healthcare underdevelopment in Nigeria is the promotion of indigenous health care and the creation of policies that would support their partnership with mainstream psychotherapeutic centres.

Nigeria's scant mental health system leaves much to be desired. The World Health Organization (2006) report on the status of mental health service in Nigeria states that:

‘There is considerable neglect of mental health issues in the country. The existing Mental Health Policy document in Nigeria was formulated in 1991. It

was the first policy addressing mental health issues and its components include advocacy, promotion, prevention, treatment and rehabilitation. Since its formulation, no revision has taken place and no formal assessment of how much it has been implemented has been conducted. Though a list of essential medicines exists, they are not always available at the health centers. No desk exists in the ministries at any level for mental health issues and only four percent of government expenditures on health is earmarked for mental health' (p.5-6).

Additionally, the report, bemoaning the lack of data on its researched subject, reveals the lack of beds, the irregularity of admission policies into the seven poorly funded government-owned facilities that exist, and the dismal numbers of psychiatrists and psychologists serving large, mostly urban, communities. The report concludes with the call for a review of policies on mental health and the establishment of community outreach centres. Other suggestions about how to salvage the poor situation of mental healthcare are outlined by Nwoko (2009), who calls for the integration and assimilation of traditional healing practices into mainstream psychotherapy and the provision of platforms for complementarity where irreducible differences lie.

While I do not disagree with the sentiments of the previous authors, it is my opinion that, given the present hegemonic position of Western psychotherapy, traditional therapies stand an unfortunate chance of losing their uniqueness and identities once integrated into orthodox clinical praxis. Moreover, professional sentiments towards unorthodox healing traditions are unlikely to change overnight or with a policy decree. Relations between orthodox and unorthodox 'experts' are likely to be hostile in the initial stages and, if not addressed, for a long while after that.

What is however needed is a decentralized, pluralistic, healthcare delivery system that does not over-burden a common centre, which is community-driven and sustained, and is supported by administrative and local governance frameworks. This researcher recommends that

- 1) Policy changes should be effected to provide legislative and budgetary support for traditional healing systems. These systems must be recognized as credible alternatives to the mainstream psychotherapies.
- 2) A community-driven development approach should serve as the vehicle to galvanize dormant communities to participate in co-created therapeutic arenas. Agents of this

sort of social change might be drawn from the university communities around the country.

- 3) Multiple arenas for ongoing discourse about the contested nature of mental health and illness should be supported by government and made attractive for private participation. These arenas or platforms should accommodate submissions from all sides of the healing debates, and provide critical learning resources for participants.
- 4) Qualitative researching and the investigation of narratives must be accommodated within Nigerian academic discourse. The hegemonic nature of quantitative researching, statistics and the proliferation of papers that do not have social action potentials need to be addressed. There are numerous alternative research pathways that translate to social change, increased participation and the breakdown of parallelism between the real needs of society and the academia.

CONCLUSION: PROMOTING POLYVOCAL CONTEXTS

The purpose of this paper has been to explore the imbalance of power in global therapeutic discourse or the hegemonic marginalization of indigenous therapies, and thus examine the epistemological conditions that have created this oppressive situation. By enunciating critical psychology's thrust, we can promote more socially equitable conditions – in which non-western healing frameworks can flourish and serve communities of indigenous people. While orthodox therapies have their benefits, we continue to demote indigenous practices to the peril of hundreds of thousands of communities seeking therapeutic meaning. There are numerous opportunities for partnership and complementarity between non-Western and Western praxis, but the appropriation of these opportunities must be preceded by the deconstruction of Western psychotherapeutic hegemony. It is hoped that this submission will aid the reimagination of our tortured healing spaces, the inclusion of voices hitherto silenced by the false dichotomies of Western/non-Western healing, the recognition of local praxis, and the celebration of the irreducible difference of these traditions.

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