Africa

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Introduction

Contemporary Africa is a continent comprised of 54 countries, and home to more than 1.18 billion people, of which more than half (608 million) are children under the age of 19 years (World Bank, 2015). It is a continent of vast social, cultural, and economic diversity: consider that the official languages recognised by governments of the 23 countries that make up all of the North American continent are English, French, Spanish and Danish ("Official and Spoken Languages of the Countries of the Americas and the Caribbean," 2015); while South Africa alone has 11 official languages. Nigeria, the most populous African country, is comprised of more than 250 distinct ethnic groups, and 50 different indigenous languages (Bojuwoye & Mogaji, 2013).

Many historical processes and factors have contributed to the current socio-political status of the continent, not the least being colonialism (Pakenham, 1991) and the subsequent fight for independence (Ziltener & Künzler, 2013). The continent has on the one hand significant social capital, but on the other, grapples with a range of challenges and often devastating difficulties including political conflict, warfare, racial oppression, genocide, human rights abuses and atrocities, and gender violence; all of which threaten the mental health and psychological well-being of African people. Health epidemics such as HIV/AIDS and tuberculosis have taken an overwhelming toll, especially in sub-Saharan Africa, where life expectancy is the lowest at under 55 years in nine African countries, even after significant increases since 1990 (WHO, 2014). By 2005, an estimated 17 million children under the age of 17 had lost one or both parents to AIDS (UNICEF, 2006), leaving countless people vulnerable to a plethora of psychosocial problems.

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Poverty and social inequality are also strongly associated with mental illness (Lund et al., 2011). There has been significant economic growth and technological innovation in recent years, but 46 countries remain classified by the World Bank as 'low income' (LI) or 'low-middle income' (LMI) (WHO, 2008), and more than 415 million people in sub-Saharan Africa live on less than $1.25 per day (The World Bank, 2011). However, in upper-middle income countries such as South Africa, Botswana and Namibia, poverty may not necessarily be the greatest threat to mental health. Wilkinson and Pickett (2010) have argued that—more than poverty—income and social inequality are responsible for high prevalence rates of mental illness and substance abuse in rich countries. Southern Africa has the highest levels of income inequality in Africa, with a Gini co-efficient of 60.46 in Botswana, 60.97 in Namibia, and the highest Gini index in the world belongs to South Africa, at 63.38 (World Bank, 2015).

In 2010, mental and substance use disorders accounted for 19% of all years lived with a disability (YLD) in sub-Saharan Africa, making them the leading cause of disability (Charlson, Diminic, Lund, Degenhardt, & Whiteford, 2014; Whiteford et al., 2013). While epidemiological data for the continent are scarce, available studies show that between one in six (Gureje, Lasebikan, Kola, & Makanjuola, 2006) and one third (Stein, Williams, & Kessler, 2009) of people in Africa will suffer from a mental disorder at some point in their lives. However, up to 90% will not have access to treatment (WHO, 2008).

A Brief History of Psychology in Africa

Traditional indigenous African healing practices have long addressed psychological and spiritual matters (Kadri & Bennani, 2013; Kpanake & Ndoye, 2013; Mkhize, 2013; Okocha, 2013; Senyonyi & Achieng Ochieng, 2013; Stockton, Nitza, Ntinda, & Ncube, 2013). The formal scientific constructs and practices of clinical psychology have their origins in western biopsychosocial approaches to mental health and illness (Nsamenang, 2007). This approach has its origins in the early to mid-twentieth century, where almost entirely throughout Africa, academic psychology began as a subject in education and teacher training (Bojuwoye & Mogaji, 2013; Kpanake & Ndoye, 2013). Career guidance and school-based counselling have been the primary objectives of such training. With the exception of South Africa, clinical psychology programs are recent additions to relatively young psychology departments (Cooper & Nicholas, 2012; Moodley, Gielen, & Wu, 2013; Stevens & Wedding, 2004).

As a discipline, clinical psychology is somewhat unique in that it straddles both the health sciences and the arts or humanities and is informed by (and informs) medicine, philosophy, sociology, and anthropology. As a result, it is arguably—perhaps more than any other discipline in the sciences—profoundly political. Its history and presence in Africa are controversial, with critical theorists asserting that psychology is yet another means by which colonial powers have sought to displace and subvert indigenous knowledge, asserting superiority of practice and thought (Holdstock, 2002; Mkhize, 2013); and that its continued existence is a perpetuation of social oppression (Howitt & Owusu-Bempah, 1994). For example, psychology has been

used as an oppressive tool to justify slavery in Africa; to show that African children have sub-normal intelligence; and to argue for racial segregation by using psychometric tests to scientifically 'prove' the inferiority of black people (Long, 2013, 2014; Nsamenang, 2007; Oyebode, 2006). Notably, the infamous architect of the apartheid system in South Africa, Hendrik Verwoerd, was a professor of Applied Psychology at the University of Stellenbosch, in Cape Town (Cooper & Nicholas, 2012). However, more positive applications may be seen in the contributions of Joseph Wolpe and Arnold Lazarus, considered to be pioneers of behaviour therapy and integrative methods, which provided a base for subsequent evidence-based psychotherapies (Cooper & Nicholas, 2012; Stein, 2012). (For more comprehensive accounts of psychology's history in Africa, see Cooper, 2014; Nsamenang, 1995; Moodley et al., 2013; Stevens & Wedding, 2004). More recently, Africa is emerging as a leader in the global mental health movement and in efforts to develop equitable mental health care, with studies such as AFFIRM (Lund et al., 2014), PRIME (Lund et al., 2012), and Project EMERALD (Marais & Petersen, 2015), which are multi-country research projects that are breaking new ground in intervention development and delivery.

In the chapter ahead, various aspects of the discipline of clinical psychology within the African context will be presented, beginning with an overview of the current state of mental health in Africa. The training and regulation of clinical psychologists around Africa will then be presented, followed by a consideration of matters pertaining to diagnostics. Finally, the psychotherapies and interventions most widely used will be discussed, along with a brief exposition of the implications of the global mental health movement for clinical psychology on this continent. Since a comprehensive consideration of this topic would require several volumes, this chapter can only represent a limited view of the subject. The aim of this chapter is to provide a very broad overview of clinical psychology in Africa, acknowledging that our experience and perspective is overwhelmingly South African.

Africa's Current Mental Health Status

Matters of Epidemiology

Not surprisingly, the majority of available studies investigating the epidemiology of mental disorders have been conducted in countries with high income (HI) economies. A recent systematic review and meta-analysis of all studies that utilized a national or regional general population sample between 1980 and 2015 identified 174 studies overall, 106 surveys from HI settings and 68 surveys within LMI settings. Results indicated that approximately one in five respondents (18%) met criteria for a common mental disorder during the 12-months preceding assessment and 29% were identified as having experienced a common mental disorder during their lifetime (Steel et al., 2014). However, it appears that the availability of nationally representative data is increasing in a number of low-income countries, with very limited data available from Africa (Baxter, Patton, Scott, Degenhardt, & Whiteford,

2013). Given this lack of data many assumptions about the prevalence of mental disorders in Africa are made from other populations, despite varying cultural, environmental and genetic factors (Baxter et al., 2013).

In order to address this research gap, the World Mental Health Survey (WMHS) collaboration has provided an infrastructure for researchers in LMI countries to conduct population surveys (Kessler & Ustun, 2008). A total of 28 LMI countries have conducted these surveys, two from Africa. First, in the Yoruba-speaking part of Nigeria, the lifetime prevalence for any disorder was 12.1% and 5.8% had a 12-month disorder (Gureje et al., 2006). Interestingly, anxiety disorders were the most commonly identified disorder, yet none of the Nigerians interviewed reported symptoms of generalized anxiety or post-traumatic stress disorder. These prevalence rates are of the lowest reported amongst the countries participating in the World Mental Health Surveys (Gureje et al., 2006). Although the reasons underlying the low estimated prevalence remains unclear, it is possible that this is due to under-reporting, or the social and cultural factors specific to Nigeria and other African societies. A different pattern emerged in South Africa, where results from the South African Stress and Health Study (SASH) (Stein, Williams, & Kessler, 2009), the first nationally representative study of psychiatric morbidity in South Africa, showed that the lifetime prevalence for any disorder was 30.3%, including anxiety disorders (15.8%), substance use disorders (13.3%) and mood disorders (9.8%). The 12 month prevalence of mental disorders was 16% (8.1% anxiety, 5.8 substance use and 4.5 mood disorders) (Herman et al., 2009; Stein et al., 2009).

Although these nationally representative studies provide valuable insight into the prevalence of CMDs in South Africa and Nigeria specifically, much additional work is needed to gain an understanding of the epidemiology of mental disorders in other African settings. One possible way to address this gap is to include mental health data in more general health surveys, should obtaining funding for mental health surveys specifically, be a barrier.

Mental Health Policies

According to the WHO's *Mental Health Atlas* (WHO, 2011), only 19 of the 46 African countries that are WHO member states have dedicated mental health policies that are state endorsed, with 80% of those countries also making reference to mental health in their general health policies. Two thirds of African countries have mental health plans in place, and almost 45% have legislation in place that deals specifically with mental health issues (compared with Europe's 80%). Calls to prioritise mental health have come from a wide range of organisations and sources, and the WHO's efforts to guide governments via initiatives such as the *mental health Global Action Programme* (mhGAP) and the *Mental Health Policy and Service Guidance Package* (WHO, 2003) have been useful: 56% of those African countries with mental health policies either revised or implemented their policies for the first time since 2005 (WHO, 2011). However, this figure represents the lowest level of policy development

of all the WHO regions and may represent a challenge to the objectives of the WHO's *Mental Health Action Plan 2013–2020* (2013), which include strengthening effective governance and leadership for mental health; and providing comprehensive, integrated and responsive mental health services in community-based settings (WHO, 2013). Saxena, Thornicroft, Knapp, and Whiteford (2007) suggest that the stigmas associated with mental illness and the scarcity of research about cost-effective interventions in local settings might pose as hindrances to mental health policy development in the region.

Mental Health Resources

As evidenced above, while some ground has been made in underscoring its centrality to health, mental health largely remains non-prioritised and under-funded across African states (Monteiro, 2015). Where expenditure is concerned, Gross National Income (GNI) per capita is closely correlated with mental health expenditure per capita, such that wealthier countries allocate a greater proportion of their health budget to mental health than LMI countries do (Saxena et al., 2007). In Africa, the median percentage of health budget that is allocated to mental health is 0.62, while Europe's is almost tenfold that amount (WHO, 2011). It is noteworthy that Africa has the highest median expenditure on mental hospitals (as a percentage of all mental health expenditure), possibly reflecting a slower rate of decentralisation and less developed community-based services (Saxena et al., 2007).

In terms of human resources, the WHO's *Mental Health Atlas* (2011) counts 1.7 human resources working in the mental health care sector per 100,000 people in Africa, with 0.05 psychiatrists and 0.04 psychologists for every 100,000 people (compared to Europe's 8.59 psychiatrists and 2.58 psychologists per 100,000 people). Only 23% of African countries provide training on mental health to primary health care (PHC) doctors. However, Africa has the highest percentage of countries with an official policy or legislation that enables PHC nurses to diagnose and treat mental illness; a trend that is more evident in low-income countries than in countries with high-income economies and is perhaps indicative of the shortages of mental health specialists. With more nurses working in mental health than any other professionals (0.61 per 100,000), it is also the reason that innovations in mental health services are looking increasingly towards interventions delivered by this resource (WHO, 2011).

Training Programs and Regulatory Organisations

In the broadest terms, the practice of clinical psychology is comprised of assessment, diagnosis, and treatment or rehabilitation. The latter might range from providing psychotherapeutic intervention, to simply making recommendations as to the best possible treatment approaches, to referring to another appropriate professional or service. It would

be reasonable to assume that clinical psychology training across contexts would seek to provide trainees with a sound knowledge of how to provide appropriate and relevant services in all three areas. However, given the complexity of Africa's particular (and diverse) mental health challenges, determining the appropriate content and model of training is not always as straightforward. Graduate training programmes in clinical psychology can be expensive; limited resources—including access to funding—are among the challenges faced by academic departments that provide such training, especially in countries where the discipline is considered low-status. Where state funding is concerned, psychiatric illnesses are often regarded as a low priority in the face of other life-threatening epidemics such as HIV and AIDS, TB, malaria and recently, Ebola.

Only ten African countries have professional associations of psychologists, namely, Botswana, Egypt, Ethiopia, Kenya, Morocco, Namibia, Nigeria, South Africa, Sudan, and Uganda (Reynolds Welfel & Kacar Khamush, 2012). Zimbabwe, Namibia and South Africa are the only three countries that have state regulation for the practice of professional psychology (Namibia Ministry of Health and Social Services, 2009; Reynolds Welfel & Kacar Khamush, 2012). Typically, higher education institutions provide training in psychology under the auspices of their education departments or teacher training (Bojuwoye, 2006). While a wide variety of counselling courses are offered in academic and private spheres (Hohenshil, Amundson, & Niles, 2013; Moodley, Gielen, & Wu, 2013), academic institutions that offer applied psychology degrees at postgraduate level (usually educational or counselling psychology degrees) are few and far between Programmes in clinical psychology are even less common. Amongst those African countries that do offer graduate programmes in clinical psychology, there is often limited information available about course content and a lack of clarity concerning the minimum requirements to qualify for this specialist role. It is of interest to note that only 28% of applied psychology programmes in African countries include clinical supervision as a component of their training (WHO, 2010). This is probably primarily due to the severe limitation in human resources in mental health; as well as the lack of specialists to provide on-site training (Hall, Kasujja, & Oakes, 2015).

North Africa

Psychotherapy has a long history in North Africa. However, as is seen elsewhere across the region, in Egypt, the term 'psychology' is often used interchangeably to denote psychiatric, psychotherapeutic and counselling practices, which has led to some confusion as to the differentiation between roles of each professional (Amer, 2013). Academics frequently lament the fragmented identity of psychology as a discipline in Egypt (Amer, 2013; Mikhemar, 2013; Mohamed, 2012). There are several universities that offer postgraduate diplomas in applied psychology and undergraduate degrees in psychology, but there are no specific academic requirements for the practice of clinical psychology (Mikhemar, 2013). Licensure as 'psychotherapist' is extended to those who have completed training in psychiatry or neurology; have specialized

training in psychotherapy, or a psychology postgraduate degree; and, have at least 2 years of clinical experience at an accredited institution (Amer, 2013). In contrast, neighbouring Libya's training of psychologists is limited to a bachelor's level education, typically focused on education, but there is currently no formal training in applied or clinical psychology and no professional regulatory body (Weissbecker, 2011). Similarly, while Sudan has a professional association for psychologists (Reynolds Welfel & Kacar Khamush, 2012), psychology is considered a low-status discipline and as such, education in the field is limited and no licensing or regulatory functions exist (Adil, Abdallah, & Badri, 2010). Moroccan universities offer 2-year postgraduate diplomas (master's-level equivalent) in psychology, but no standardized licensure and certification process yet exists (Kadri & Bennani, 2013). Algerian psychologists fought a long battle to find professional protection and recognition under state law, and recently established a professional association, under which several universities are accredited to offer postgraduate training in clinical psychology (Kacha, 2012).

West Africa

Nigeria, the most populous African country, has 28 universities with accredited psychology departments that offer graduate and postgraduate degrees in psychology, many with training in clinical psychology up to master's and PhD level (Bojuwoye & Mogaji, 2013; Mefoh, 2014). According to Oppong Asante and Oppong (2012) the University of Ghana is the only one of four universities in Ghana to offer postgraduate training in clinical psychology, including a Master of Philosophy and PhD. With no licensing body, the only legal requirement to assume the specialist title of 'Psychologist' is a postgraduate degree in psychology (Oppong Asante & Oppong, 2012). Kpanake and Ndoye (2013) report that all francophone West African countries (including Benin, Burkina Faso, Senegal, Niger, and Togo) have academic programmes in psychology, but only Togo's Université de Lomé has a 2-year postgraduate master's degree training programme in clinical psychology, which includes coursework and an internship. Burkina Faso's Université de Ouagadougou offers a 4-year degree programme (within the Philosophy Department) that focuses on clinical psychology in the second 2 years and also includes an internship (Kpanake & Ndoye, 2013). Of these, none are state regulated and only Nigeria has a professional association for psychologists (Reynolds Welfel & Kacar Khamush, 2012).

East Africa

Like much of Africa, formal psychology training in East African universities, such as those in Zambia, Zimbabwe, Kenya and Malawi, typically falls under education and teacher training (Bojuwoye, 2006; Chamvu, Jere-Folotiya, & Kalima, 2006; Koinange, 2004). Recently, the University of Gondar launched the first Master of

Arts in clinical psychology in Ethiopia, a 2-year programme that aims to produce graduates skilled in science, theory and practice (Wondie, 2014). Similarly, Makarere University in Uganda also offers a Master's in clinical psychology of 2 years' duration (Hall et al., 2014, 2015) and a professional association exists but membership is open to anyone with a bachelor's level education in psychology (Hall et al., 2014). Zimbabwe's universities offer degrees in psychology, up to master's degree level but there is no clear differentiation between various sub-disciplines (no specific category for clinical psychologists exists), which is echoed in the broad nature of the national regulatory body's licensing category for psychologists (AHPZ, 2015). In Kenya, there are no clinical psychology training programmes (Koinange, 2004; Okech & Kimemia, 2012) and with only three clinical psychologists (none of whom work in public service), no regulatory body (Ndetei & Gatonga, 2011). Universities in countries such as Tanzania (Hassan et al., 2009) and Zambia (Mayeya et al., 2004) do not currently house dedicated psychology departments; nor do they have regulatory or licensing bodies.

Central Africa

In Central African countries, academic and applied psychology training programmes are also scarce. The Democratic Republic of the Congo (DRC) has 600 universities and higher education institutions of which only three have Psychology departments and all fall under Social and Educational Psychology; none offer clinical psychology programmes (Bazibuhe, 2013). Similarly, as a discipline of low academic status in Cameroon, the few institutions that do offer applied psychology programmes are in the field of Educational Psychology, guidance and counselling (Nsamenang, 2013; Tchombe & Kassea, 2006). Programmes in the Congo, the Central African Republic (CAR), and Chad are almost entirely absent.

Southern Africa

This is in stark contrast with the neighbouring region of Southern Africa, where South Africa currently has 14 universities that are accredited by the national regulating body to provide training in clinical psychology (HPCSA, 2015). In this country, a minimum of a masters-level degree in clinical psychology is required, which is comprised of a year of course work, the successful completion of a research dissertation, and a minimum of 1 year's internship training at an accredited institution (usually a tertiary-level psychiatric hospital) (HPCSA, 2009). In order to register as an 'Independent Practitioner', newly qualified graduates are also required to complete 1 year of public or community service at sites identified by the National Department of Health as those most under-resourced. Likewise, the University of Namibia offers a similar masters-level training in clinical psychology (University of

Nambia, 2015). Botswana offers an undergraduate degree in applied psychology, but does not offer postgraduate training in clinical psychology, nor is the practice of psychology legally regulated (Stockton et al., 2013).

Psychopathology, Culture, and Nosology

Notions of what constitutes healthy or unhealthy human behaviour are at least in part determined by the belief and value systems espoused by the societies in which they occur (Amuyunzu-Nyamongo, 2013; Nsamenang, 2006). For example, many lay people assume that auditory verbal hallucinations are a sign of serious mental illness; a symptom of psychosis; and, evidence of a psychiatric illness such as schizophrenia or bipolar mood disorder and of course, this is one plausible explanation. However, perceptual experiences that are not shared by others are not always signs of psychopathology (for example, the phenomena of hypnagogic/hypnopompic hallucinations) (McCarthy-Jones, 2012). Furthermore, in some cultures psychotic phenomena may be understood as having altogether different meanings, such as the result of being cursed or possessed by evil spirits (Bhikha, Farooq, Chaudhry, & Husain, 2012; Swartz, 1998). For example, *amafufunyana* has been described by South African mental health scholars as a complex condition with important social functions, that might include (but is not limited to) signs and symptoms that resemble those of schizophrenia (Niehaus et al., 2004; Swartz, 1998), and is believed to be the manifestation of spirit possession involving sorcery (Lund & Swartz, 1998). As corollary to this, a non-pathological perspective of hearing voices might include the supernatural ability to receive spiritual knowledge from a higher power or from one's ancestors (Bhikha et al., 2012), as seen in *ukuthwasa*, another example from South Africa, which refers to a range of experiences that are believed to be the result of a calling from the ancestors to become a healer (Swartz, 1998). Neither *amafufunyana* nor *ukuthwasa* have fixed definitions or sets of criteria, but are thought to provide explanations for a range of psychological experiences and problems, including epilepsy (Keikelame & Swartz, 2015; Swartz, 1998).

While there are many approaches to psychiatric nosology (Avasthi, Sarkar, & Grover, 2014), the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5), along with Chapter V of the WHO's International Classification of Diseases (currently, the ICD-10) are the two most widely used psychiatric taxonomic systems in the world (Reed, Mendonça Correia, Esparza, Saxena, & Maj, 2011). Reed et al.'s (2015) global survey of 4887 psychiatrists' attitudes toward the classification of mental disorders found that 83% always/often use a formal classification system, with 64% most often using the ICD-10. Of the five African countries that were included in the survey, more South African and Nigerian psychiatrists reported often/always using formal classification systems (95% and 94% respectively), however, only 20% of South African psychiatrists reported most often using the ICD-10, compared to 83% of Nigerian psychiatrists. None of the 77% of Kenyan psychiatrists who reported using classification systems made use of the

ICD-10. In North Africa, 55% of Egyptian psychiatrists reported a preference for the ICD-10 over Morocco's 22% (Reed et al., 2015).

In a similar study of psychologists' attitudes towards the diagnostic classification of mental disorders, Evans et al. (2013) found that more than 65% of 1817 psychologists from 23 countries around the world often/always use a classification system. Of the 106 psychologists from four African countries, almost 70% reported often/always using a diagnostic classification system, with 55% (75.5% weighted) using the DSM-IV most often and 37%, the ICD-10 (38.3% weighted). Where South African's preference was only marginally for the DSM-IV (49.4% against 45.6% for the ICD-10), Uganda's psychologists appear to favor the DSM-IV substantially more (69.2%) than the ICD-10 (7.7%). However, while most South African universities and psychiatric hospitals train students diagnose with the DSM, medical insurance companies require the use of ICD-10 diagnostic codes, possibly explaining the low differentiation in preference for South African psychologists. Importantly, more than one third of all participants felt that the diagnostic criteria of the ICD-10 and the DSM-IV were difficult to apply across cultures; while those from Africa, the Eastern Mediterranean, and Latin America more often agreed that the Euro-American bias of both systems was problematic (Evans et al., 2013).

A long-standing tension exists between proponents of the biomedical model of psychopathology and those who support anthropological notions of mental illness (Stein, 1993; Town & Wiley, 2006); a debate that has been highly relevant to African psychology. A biomedical approach has emphasized growing evidence of genetic and biopsychological mechanisms underlying many psychiatric disorders, although few validated biomarkers have been identified (Insel & Wang, 2010; Nesse & Stein, 2012). An anthropological perspective has emphasized that the ways in which a disorder manifests is determined by sociocultural and environmental factors (Bentall, 2014; Canino & Alegría, 2008; Patel, 2014; Swartz, 1998). When it comes to help-seeking, the personal and cultural meaning that is made of the phenomenon and the experience thereof (including etiology) will directly inform the kind of help that is sought, if any at all. Referring to common mental disorders such as depression or substance abuse disorders, Patel (2014) notes a 'credibility gap', explaining:

> … the vast majority of people who have a diagnosis of depression or harmful drinking, based on a psychiatric interview or clinical diagnosis, do not understand their problem as a distinct health condition with a biomedical causation; instead, they utilise culturally meaningful labels and causal explanations for their distress as being inextricably linked to their personal lives. (Patel, 2014, p. 17)

The subjective meanings that are attributed to the experience of mental illness must be central to psychologists' conceptualisation of the most appropriate and helpful ways to intervene at both the community and individual levels. However, the lack of resources and the very real and growing treatment gap necessitates innovative thinking about equitable and cost-effective approaches to psychological treatments.

Psychotherapy and Interventions in the Context of Global Mental Health

Patel's (2014) argument becomes all the more pertinent when considering that many African people turn to traditional healers to treat their health and psychological problems (Sorsdahl et al., 2009; WHO, 2002). This shows that the ways in which people make sense of their symptoms, otherwise known as explanatory models of mental illness, may determine the kind of help that is sought and have a direct bearing on the uptake of mental health services. Furthermore, according to Amuyunzu-Nyamongo (2013) and Fournier (2011), the preference for traditional healers (including religious healers) is due to the widespread stigma and taboo associated with mental illness and because "mentally ill people are usually shown [more] empathy from the community if they visit a traditional healer than if they choose to seek help from a mental hospital" (Amuyunzu-Nyamongo, 2013, p. 62). This underscores the necessity of psychological treatments and therapies that are compatible with the worldviews of the communities that they seek to serve (for more on this issue, see for example, Campbell-Hall et al., 2010; Holdstock, 2000; Nwoye, 2015; Sher & Long, 2012; Sorsdahl et al., 2009).

Psychotherapeutic Approaches

All psychological treatments or therapies are grounded in theories that hypothesize about the mechanisms and dynamics that cause the psychological problems that those treatments seek to remedy. A psychological theory seeks to explain the etiology of a problem, while the corresponding treatment uses that theory's explanation to forge a way back to health. The implication is that theories are based on assumptions about what it means to be a mentally healthy person; a way of being and relating, and of experiencing oneself in the world that is in keeping with particular notions of well-being and health. While this may seem logical, it is important to bear in mind that definitions of mental health and well-being often vary across cultures. For example, some psychoanalytically-derived theories regard the processes of separation and individuation as central to psychological maturity and functional adulthood. As such, relational problems (like those often experienced by people with Borderline Personality Disorder) might broadly be explained as deeply rooted and unconscious ambivalence towards those developmental events; as separation comes to represent the threat of rejection; and individuation—abandonment and loneliness (Edward, Ruskin, & Turrini, 1991). The objective of psychotherapy might be to uncover the repressed injuries that impeded the ego's ability to develop appropriate defences to tolerate the losses inherent to individuation, and then to develop healthier defence mechanisms. The ultimate goal is clear: separation and individuation. However, many traditional African cultures espouse a collectivist worldview, where the idea of independence from the family of origin, children, and

community is anathema. For example, in South Africa "Ubuntu" is a well-known Nguni term that refers to the idea of a communal humanity; the principle of community above self; and which translates as "People are people through other people" (Nyamburu Machiri, 2009). The concept of individuation might well be seen as being at odds with Ubuntu, and a therapy that has separation and individuation as its primary therapeutic goals might be inappropriate, at best. Furthermore, we now know that psychological development (both healthy and unhealthy) is profoundly influenced by our broader socio-cultural environments. An awareness of this is central to considering the application of these theories to contexts in which they did not originate; where particular ideas of healthy behaviour and being in the world are at odds (or even simply a poor fit) with the worldview or circumstances of the people they seek to understand and help.

Due to the discipline's western roots, and partly as a result of globalisation, the psychological theories most frequently taught in clinical psychology programs are generally in keeping with those taught at American and European institutions (see Hohenshil, Amundson, & Niles, 2013; Moodley, Gielen, & Wu, 2013; Stevens & Wedding, 2004). These include psychoanalysis and its psychodynamic derivatives (for example, therapies informed by the theories of Klein, Kohut, Fairbairn, Bowlby, and more recently, theories of intersubjectivity); Rogerian person-centred therapy; behavioural and cognitive therapies and their derivatives (such as cognitive behavioural therapy, rational emotive behaviour therapy, solution-focused therapy, and problem-solving therapy); systemic theories such as family systems theory, are also widely taught in programs and applied in practice (Amer, 2013; Bojuwoye & Mogaji, 2013; Kadri & Bennani, 2013; Kpanake & Ndoye, 2013; Lazarus et al., 2006; Weissbecker, 2011). Therapies based on systems theory are frequently cited by those western therapies that are amongst the most compatible with many Africa cultures' strong orientation towards family, and values that prioritize collectivism and community (Kpanake & Ndoye, 2013).

Community psychology also has a strong presence in African training programs (Lazarus et al., 2006). Its context-driven conceptualisation of psychological problems as evidence of social and environmental disequilibrium resonated powerfully with African scholars who were dissatisfied with Eurocentric individualistic models that largely disregard social and political factors (Ratele et al., 2004). Furthermore, community psychology prioritizes prevention over cure and seeks to develop interventions that are grounded in the needs of the community, as determined by the community members themselves (Duncan, Bowman, Naidoo, Pillay, & Roos, 2007). Also, given the centrality of indigenous healing as well as spiritual and religious beliefs to conceptions of mental illness, academics have repeatedly called for the development of African-centred therapies (Edwards, 2011; Nsamenang, 2006). Community psychology, as a context-driven philosophy of care, actively seeks to engage and include indigenous knowledge and practice.

The indigenisation of western psychotherapy models has been another major point of discussion in African psychology (Mkhize, 2013; Sher & Long, 2012). Where indigenous therapies are those that originate in a particular cultural setting (for example, psychoanalysis is indigenous to European culture); the indigenisation

of therapies refers to the adaptation of therapies developed elsewhere, for application to other settings (Mkhize, 2013). In Africa, this has primarily meant adapting western therapies, such as CBT, to local settings. These adaptations are particularly relevant and applicable to the global mental health (GMH) movement, discussed next.

Global Mental Health and the Call for New Professional Roles

The GMH movement is driven by the imperative to equitable mental health across all income contexts, from low to high (Patel, 2012). It aims to develop and implement effective and accessible interventions so as to reduce the treatment gap in mental health and reduce the widespread disability related to the prevalence of mental illness. The movement's advocacy for viable, quality approaches to mental health treatment has generated substantial support for task shifting; an approach that may translate into more cost-effective ways of delivering health services to more people, so ultimately providing feasible strategies for reducing the large mental health treatment gap (Rebello, Marques, Gureje, & Pike, 2014). Endorsed by the WHO, task shifting (also known as task sharing) is defined as "… involv[ing] the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health" (WHO, 2008, p. 2). Where mental health is concerned, this means that less complex diagnostic cases can be carried by non-specialist health workers (NSHW) so as to free up specialist human resources (such as clinical psychologists and psychiatrists) to deal with those cases that require greater expertise and management (Kakuma et al., 2011). However, the WHO's advocacy for the integration of mental health in to primary health care means that NHSWs (such as nurses, community health workers, and lay counsellors) are placed at the forefront of mental healthcare delivery (WHO, 2007), necessitating a reconsideration of the roles that specialists might play. In addition to being clinicians; clinical psychologists' duties might be expanded to included intervention design, human resource management, training and clinical supervision of NHSWs (Patel, 2009); roles that will almost certainly change the face of the discipline's practice in public health settings, not just at primary care level. Furthermore, while task-shifting treatments to NHSWs offer a cost-effective solution to under-resourced mental health services, it cannot be thought of as a substitute for the skills of specialists like clinical psychologists.

In response to the growing treatment gap and the GMH movement's endorsement of equitable mental health services, several Southern African countries, including Botswana, Namibia and South Africa, introduced a mid-level category of mental health professional in the form of the 'registered' or 'psychological counsellor'. This qualification includes a 4-year Honours-equivalent degree with a curriculum that is psychology-focused and includes a 6 month practicum (Abel & Louw, 2009; University of Botswana, 2015; University of Namibia, 2015). This is an added tier

of mental health expertise that might prevent specialists from becoming encumbered by administrative and human resource management work. The potential of this category within an integrated primary health care service has not yet been well explored.

GMH is not simply concerned with the accessibility of mental health services, but also with the promotion of equitable services in terms of standards and quality of care. To this end, the utilisation of treatments and interventions that have been empirically tested and shown to be effective is central to GMH's agenda (Vikram Patel, 2012). According to Kazdin (2014), 320 evidence-based practices (EBP) for mental health and substance abuse disorders have been identified, including interventions for people across the lifespan. However, he also notes that EBPs are not invariably more effective than treatment as usual (although the standardization and parameters for treatment as usual in psychological care are rarely clear, making it potentially harmful), and concerns have been raised regarding some of the methodologies employed to generate evidence for such treatments (Kazdin, 2014). Furthermore, much of the evidence for the efficacy of therapies such CBT has been generated in western or high-income settings, and the empirical support for their adaptability and application to African or low-income contexts is still relatively thin, sometimes with mixed results (Monteiro, 2015; Spedding, Stein, & Sorsdahl, 2015). This has served as a significant source of criticism for the GMH movement (Kirmayer & Pedersen, 2014; Swartz, Kilian, Twesigye, Attah, & Chiliza, 2014) and is an area that requires a great deal more attention if treatments are to be successfully and effectively task-shifted to NHSWs.

Conclusion

Africa is a vastly diverse continent, where the history of psychology is complex and contentious. Contemporary clinical psychology has found traction to varying degrees in countries across the continent and has largely developed in response to the many challenges faced by African countries. However, for a variety of reasons, mental health is still largely non-prioritized (Tomlinson & Lund, 2012) in most African countries and the substantial treatment gap is growing. The global mental health movement's has advocated for the development of innovative strategies to make equitable mental health services more accessible to those who need them; strategies that are evidence-based and robust enough to be task-shifted to less qualified human resources.

Where these developments are concerned, the future of clinical psychology in Africa faces several challenges. First, evidence for the adaptation of interventions to local contexts needs further development. The call for evidence-based practice is an important one to heed, especially in view of task shifting mental health care to NHSWs: ensuring that psychotherapies and interventions are supported by sound research is essential. However, this does not negate the need for practice-based evidence: the understanding of what makes an intervention work within a given context (Wand, White, & Patching, 2010). Furthermore, common elements treatment

approaches (Murray et al., 2014) that are grounded in values-based practice (Fulford, Peile, & Carroll, 2012), might facilitate more meaningful adaptations of therapies to local contexts and require further investigation. Second, where training is concerned, more attention needs to be given to the lack of supervision in clinical internships; and training programs for clinical psychologists need to address the potential role changes for the profession: emphasising program and intervention development, and supervision and training of NHSWs (which arguably requires a different set of skills to those used to supervise other clinical psychologists, who have the same or similar training in mental health) (Pillay, Ahmed, & Bawa, 2013). Third, if the global mental health movement is to be successful in achieving its agenda, the potential of mid-level specialists such as registered counsellors, requires thorough investigation. The expertise gap between community health workers and specialists is simply too wide. The role that a cadre of professional counsellors might play, and the contributions they might make to an integrated mental health service requires thorough exploration. Finally, the temptation to see task-shifted approaches as the panacea to the pressure of a growing treatment gap must be resisted. The specialist skills of clinical psychologists are essential, especially in contexts where innovative approaches are being developed and tested. Task shifting is one cost-effective solution. Government prioritization of mental health as an issue with profound implications for health, social and economic development has to be another. To the advocacy of increasing mental health resources in Africa and around the world, the discipline of clinical psychology must lend its voice.

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