

CHAPTER 2

Psychotherapy in Africa

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INTRODUCTION

Africa is the second most populated continent in the world and with its one billion people it accounts for 14.8% of the world's population. With more than a thousand languages spoken and a variety of religious beliefs and cultures, it represents a continent rich with diversity. At the same time a range of stressors are present in Africa. Although stressors are a universal experience, patterns of stressors may differ from place and time to time, with citizens from African countries currently experiencing emotional problems due to ethnic conflicts and wars (1;2), immigration and refugee problems (3;4), problems of drug abuse and misuse (5), and emotional problems associated with HIV/AIDS (6).

There has long been interest in the epidemiology of psychiatric disorders in Africa. Two recent studies from Nigeria (7) and South Africa (8) have assessed the prevalence of mental disorders in Africa using representative samples. As part of the World Mental Health Surveys (WMHS) of the World Health Organization the prevalence, severity, and treatment of *DSM-IV* mental disorders in a range of countries were evaluated. A 12 month prevalence of mental disorders in Nigeria, a low income country, was reported as 4.7% (9). This is in accordance with results reported from other lower-income countries (10). In South Africa, a middle-income country, the lifetime prevalence of any mental disorders was 30.3% which is substantially higher than the lifetime prevalence of 12.1 % seen in Nigeria (7), but lower than that reported in many high-income countries (10).

Despite the presence of mental disorders reported in African countries, the need for treatment is not always met. The survey from Nigeria indicates that, of the people reporting severely disabling disorders, only about 8% had received treatment in the preceding 12 months (7). In South Africa 25.5 % of people suffering from any mental disorder had received treatment in the past 12 months (11). Generally speaking, between 76.3% to 85.4% of people in developing countries suffering from serious disorders do not receive treatment, compared to a range of 35.5% to 50.3% in developed countries (9). WMHS data also indicate that many people who are seeking help in low- and middle-income countries are not treated with evidence based interventions (9).

This treatment gap is partly caused by the scarcity of resources in African countries. There is a dearth of human resources (psychiatrists, psychologists and other mental health

professionals), a scarcity of mental health resources (psychiatric beds, diagnostic equipment, essential medicines) and inadequate financial resources (12). It has been estimated that Africa has 0.04 psychiatrists, 0.05 psychologists, 0.20 psychiatric nurses and 0.05 social workers per 100 000 inhabitants, compared to 11 psychiatrists, 9 psychologists, 104 psychiatric nurses and 58 social workers per 100 000 inhabitants in the UK (12). Most African countries have not given priority to mental health policies, resulting in half of the continent's countries not having a mental health policy at all (12).

Psychotherapeutic treatment for mental disorders has been found to be effective (13), but most of the evidence-based publications derive from high income countries (14;15). Although such data is promising, it remains unclear whether psychotherapeutic interventions designed for western countries are effective in the low- and middle-income countries of Africa. They may need to be adapted to the African context to make them efficacious, and a range of issues around their effectiveness if rolled out also needs to be considered – such as the lack of resources noted above, and the possible unwillingness of people to use psychotherapeutic treatments due to particular belief structures or to mental health illiteracy.

In this chapter, the evidence derived from studies on the efficacy of psychotherapy in Africa will be reviewed. Such a review will hopefully provide some insight into the current status of psychotherapy in Africa and provide a starting point for future research and development. We begin, however, by discussing recent developments in the globalization of psychotherapy, and by presenting a theoretical framework for understanding contemporary debate about the need for the “Africanization” of psychotherapy.

GLOBALIZING PSYCHOTHERAPY

Globalisation has brought international debate to many academic disciplines, including psychology. Since at least the early eighties, psychology has experienced considerable growth with substantial information exchange through international journals and other media (16). The internationalization of psychotherapy, on the other hand, has arguably received less attention. Even though psychology and psychotherapy have extended their

reach globally, relatively little is known about the specific forms psychotherapy takes in different countries and its efficacy, acceptability and feasibility in non western societies.

Training, recognition and practices of psychotherapy differ substantially in countries worldwide. Most educational systems for psychotherapy are based on either the United States or the European model. Countries may have various intellectual and academic histories; consequently the theoretical orientation of psychotherapy training may differ. At the national level, governmental or professional entities are generally responsible for ensuring the process of recognising psychotherapy within communities. However, very little consistency can be found in the recognition of psychotherapy with regards to the licensing or certification across countries. The providers of mental health services also differ across countries; in different parts of the world, traditional healers and religious leaders may provide more counselling services than other mental health professionals.

PSYCHOTHERAPY IN AFRICAN COUNTRIES

It remains unclear to what extent traditional healers are consulted by Africans with mental health problems. The nationally representative study from South Africa indicates that respondents consult mental health professionals more often than traditional healers for their mental health needs (17). Some authors, on the other hand, report that most of the psychosocial care in African countries is provided by traditional and faith healers (18;19). Studies investigating the utilization of traditional healers before people present themselves to mental health services are also not consistent. In Nigeria it has been reported that 26% of people presenting themselves to mental health services have consulted a traditional healer prior to that (20). Only 6% of the people in a study in Ghana consulted a traditional healer before seeking help from mental health professionals (21). The need for psychotherapy for African people and problems encountered with psychotherapy in Africa has been described by various authors (19;22-27). The lack of empirical research in this field and the ongoing debate on the 'Africanization' of psychotherapy will be elaborated on in the theoretical section of this chapter (see below).

In 1996 the World Council for Psychotherapy - African Chapter (WCP-AC) was inaugurated. The main objective is to promote psychotherapy in Africa by organising conferences on psychotherapy, publishing and developing training programmes (28). The WCP-AC has organised various African Conferences on Psychotherapy to enable psychotherapists in Africa to come together and share their experiences. In addition, several volumes have been published on psychotherapy in Africa (18;29-33). The Journal of Clinical Psychology recently launched a series of sessions on international psychotherapy (34). The authors compared practices in psychotherapy across eight different cultures (35). The South African case study illustrates how difficulties in treatment can occur when a clear gap is evident between the cultural background of the clinician and that of the patient. This finding emphasises the importance of considering socio-economic and cultural factors in psychotherapy practices (36).

Considering the variety of psychosocial care available, it is imperative to define psychotherapy. Broadly speaking, psychotherapy can be defined as the treatment of a behavioural disorder, mental illness or emotional condition by psychological means. This definition will therefore include all treatment based on verbal communication between a mental health professional and client aimed at treating a mental or emotional disorder. Traditional healing ceremonies are symbolically meaningful events applying therapeutic techniques aimed at reducing anxiety and emotional distress in individuals (37). The ceremonies evolve around contact between a traditional healers and a patient for treating emotional or mental problems and therefore can be considered psychotherapeutic treatments. For the purpose of this chapter, the main focus will be directed at evidence from Africa for the efficacy of cognitive behavioural and psychodynamic psychotherapeutic interventions for psychiatric disorders.

THEORETICAL FRAMEWORK

Most literature on psychotherapy originates from western cultures. Psychotherapy derived from western theoretical perspectives is based on western thinking and orientation, and so is arguably less meaningful in non Western countries. This hypothesis gives rise to a perennial international debate on whether western psychotherapy techniques should be

adopted or adapted for use in developing countries. Stemming from these concerns, one may take the issue a step further and question the generalisability of efficacy data on (western) psychotherapy in relation to the African context (38). Neither health nor ill health occurs randomly within populations; they are both rooted in social processes. Overlooking the culturally bound nature of Western theories of psychology when duplicating a Western treatment in non-Western countries, may result in neglect of cultural factors that may influence the efficacy of the intervention in that specific country. Cultural factors can influence the conceptualization of mental health and psychotherapy by both patient and care provider.

The explanatory models of both therapist and patients are important factors for treatment adherence. Explanatory models in many low- and middle-income countries may be less likely to acknowledge the role of biomedical causes (39;40). This affects the attitudes of people with regard to what kind of help is needed and the acceptability of psychiatric interventions. The literature reports that the attitudes of people in developed and developing countries often differ regarding the kind of help that is needed to resolve a disorder (41). Studies have suggested that compatibility of patients' and therapists' explanatory models are essential for a successful psychotherapeutic process (42), indicating the importance of considering culture in psychotherapy.

Two main theoretical approaches can be seen to circulate amongst professionals in the field of mental health. The first may be termed a modernist, clinical, etc or universalistic approach; it argues that the central aim of psychology as a science should be to establish a universally applicable and ideologically neutral set of scientific propositions for human behaviour (43). This position states that while mental contents and some processes might vary between cultures, the regulating systems of the mind are identical for all humans (44). Most psychotherapeutic techniques used at the moment are mainly developed in a universalistic framework in which the client is considered to be the bearer of specific dysfunctions without taking into account socio-cultural, ethnic or other social determinants. So the universalistic approach to psychotherapy reflects the assumption that all interventions suit all cultural groups and are universally effective and acceptable.

On the other hand the postmodernist, anthropological, emic or relativistic approach does not view human behaviour as universal and argues that the 'relevance' of psychology is context-based. This view considers knowledge to be not as neutral and universal as claimed by modernists, but historically specific and implicated in questions of social power, serving an ideological purpose by justifying power (45). Medical and psychiatric nosologies are perceived as cultural artefacts in this approach. This position emphasises the importance of cultural factors in determining the experience and perception of mental disorders. In line with this assumption, some authors believe that it is impossible to apply psychotherapy in Africa without significant modification (28).

Several authors have indeed reported problems with practising psychotherapy in Africa, suggesting a lack of acceptance of psychotherapy in African countries. Causes for this reported in the literature include; lack of psychological mindedness, lack of interest in introspection, reluctance to speak of family problems outside the family structure (22), complaining of physical disturbances even in psychological cases, expectation of symptom relief in the form of physical treatment such as drugs and injections (23), and not regarding self-understanding or personality change as a solution (19). Nevertheless, similar problems are experienced with psychotherapy in Western countries and there are few empirical data on how African and western problems differ from each other in these respects.

The universalistic and relativistic approaches both have limitations in explaining psychology and illnesses across cultures. Overemphasis of the universalistic point of view may lead to misinterpretation of particular psychological processes. On the other hand, relativism does not sufficiently appraise the relative advantage of one intervention over another. The relativistic view also arguably runs the risk of stereotyping Africans – by assuming that universal mental processes are not operational, but rather that “African” processes are involved. A resolution for this ongoing debate is unlikely to be quick and easy. It may be useful to approach the matter from different angles, assuming that indigenous psychologies, which are relevant in each particular cultural context, may be just as parochial and ethnocentric as Western psychology is considered right now. Human beings in different parts of the world do not only differ from each other in interesting ways, they are also similar in equally important ways (46-48). Therefore, the study of universal aspects of behaviour is important.

Considering the limitations of both the modernist and postmodernist approach, a more integrative approach, taking into consideration both etic and emic aspects of psychology and psychotherapy, seems to be appropriate. Some authors believe that relativism can be used to acknowledge and analyze universalism in a different way (49). By conducting emic research in different cultures and exploring the commonalities between cultures a *derived etic* can be established. This is done by establishing universal trends amongst cultures. With a *derived etic*, the universals arise from local observations instead of from the imposition of one's cultural and philosophical norms on a different culture as in the *imposed etic*. A theoretical orientation of integrating psychotherapeutic universals with contextual phenomenon should be aspired in terms of psychotherapy in Africa. In this way one can develop etic from emic data, so recontextualising data to construct new universals. The integrative approach gives space to scientific knowledge and meaning construction.

Various examples can be found of the integrative approach in published African psychotherapy studies. Some authors report an urgent need for the 'Africanisation' of psychology, by incorporating and integrating African visions and interpretations in psychological theories (50). For example, Ebigbo et al (1997) developed harmony restoration therapy in Nigeria, based on the underlying African theory that he who is at peace with his world, does not fall sick (51). His psychotherapeutic treatment is therefore based on African perceptions while using a Western psychoanalytical approach (52). The *ubuntu* model of psychotherapy proposed by van Dyk and Nefale (2005) was developed for people struggling with conflicts and tension that emerge between traditional African culture and a modern Western culture (52). *Ubuntu* therapy acknowledges the simultaneous presence of multiple cultures within an individual and therefore integrates Western theories and techniques with African world views. Clients' conflicts are addressed at psychotheological, intrapsychic, and interpersonal dimensions of their life while considering conflicting cultural dilemmas. It is necessary for Ubuntu therapists to neutralize their personal explanatory models and seek ways to understand patients' explanations and experiences of mental disorders (52). Another important kind of integration that is taking place in Africa is the integration of cognitive-behavioural and psychodynamic approaches, particularly in the area of posttraumatic stress disorder. Several groups have argued that such integration may well prove of practical benefit to patients (53-55). Exploration of integrative therapies has

the potential of abolishing the unwillingness of people to use psychotherapeutic treatments due to superstitious beliefs and ignorance in some parts of Africa.

REVIEW OF AFRICAN LITERATURE

A comprehensive literature search was conducted in different databases combining terms indicative of psychotherapy, clinical trials and African countries. This search revealed only a limited number of controlled studies published on psychotherapy for the treatment of mental disorders in Africa.

The many wars and conflicts in African countries make post traumatic stress disorder (PTSD) one of the main focuses of intervention studies. A clinical trial on the effectiveness of testimony psychotherapy for PTSD symptoms was conducted in a rural community in Mozambique (56). The two hundred and six participants from two different villages in the former war zones in the country were screened on the self-inventory for PTSD and thereafter randomly assigned to an intervention group or control group. The intervention group received a 60 minutes long testimony session and the control group did not receive any intervention. Both the intervention and control group reported a reduction in PTSD symptoms after the intervention. After 11-months there were indications of a superior positive result for the control group, but only in women.

Neuner and colleagues (57) evaluated the efficacy of narrative exposure therapy (NET) for PTSD in a randomized controlled trial with Sudanese refugees in Uganda. Refugees with PTSD were subjected to NET, supportive counselling or psycho-education. The treatments were carried out by an experienced therapist trained in NET and counselling. NET seemed to significantly reduce PTSD symptoms and after a one year follow-up the NET group still showed significant better outcomes on PTSD measures compared to the other groups.

The same research group evaluated the efficacy of psychotherapy by lay counsellors for PTSD in another refugee settlement in Uganda (58). Narrative exposure therapy was compared with flexible trauma counselling and a control group. Nine refugees from the communities received a 6 week counselling course to become lay counsellors. Participants

were given treatment by these lay counsellors for 1-2 hours a week for 6 weeks. Both active treatment groups significantly improved in measures on the Posttraumatic Stress Diagnostic Scale (PDS), with no significant difference in effect between them. This study indicated that short-term psychotherapy conducted by lay counsellors can be an effective way to treat PTSD symptoms in an African refugee context.

In Uganda an international research group adapted (59) and evaluated the efficacy (60-62) of interpersonal psychotherapy for depression in rural communities. For the randomized controlled trial 30 villages were randomly selected in the Masaka and Rakai districts. Women and men who believed they had depression symptoms were screened using the Hopkins Symptom Checklist and a questionnaire to assess functional impairment. Half of the villages were assigned to the intervention condition and the other half to a control condition. The participants in the intervention condition received group interpersonal psychotherapy for 16 weeks, while participants in the control condition did not receive any treatment. During each session of the group interpersonal therapy, the group leader reviewed each participant's depressive symptoms. The group leader facilitated support and suggestions for change from other participants in the group. There was a significant reduction in both depression and dysfunction scales in the intervention group compared to control (60). This clinical trial indicated that group interpersonal psychotherapy is efficacious in reducing depression and dysfunction in rural Ugandan communities even 6 months after completing the intervention (61).

The same research group conducted an intervention for depression symptoms amongst adolescents in 2 camps for internally displaced persons in northern Uganda. The adolescents were screened on eligibility by using a locally developed scale for depression (APAI depression symptom scale) and randomly assigned to the psychotherapy, activity-based intervention or waiting control group. The intervention group met weekly for 16 weeks, after which symptoms of depression, anxiety and conduct problems were assessed with the APAI. Girls receiving psychotherapy significantly improved on depression symptoms compared to controls. The boys, on the other hand, did not show a significant decrease in depression symptoms. The creative play condition did not appear to have any effect on

depression and none of the interventions showed an effect on anxiety or conduct symptoms (62).

Other clinical trials from South Africa have indicated that rational-emotive therapy significantly improved scores on measures of cognition, self-concept, self-esteem, anxiety in self-concept problems (63), and significantly reduced the intensity of Type A behaviour (64). A psychotherapeutic intervention, delivered by local lay women, had a significant positive impact on the quality of the mother-infant relationship and on security of infant attachment in a South African township (65).

A study from Nigeria indicated that patient's pre- and postoperative anxiety and depression can be reduced by the introduction of self-instructional training and rational emotive therapy (66). In a South African study a short-term psychotherapy programme combined with anticonvulsant drugs has also indicated the possible prevention of long-term disability that occurs from drug refractory seizures in epilepsy patients (67). Even psycho-education, conducted among Nigerian adult patients with epilepsy, showed a decrease in depression and measures of psychotic disorders together with an increase in epilepsy knowledge (68).

Psycho-educational studies can be considered psychotherapeutic based on the definition of psychotherapy given earlier. In Africa, psycho-educational interventions have been used to bring about behavioural change. There are a number of published randomized controlled trials for various disorders or conditions, with most of them revolving around HIV/AIDS. Some of these publications report positive results (69-71), while others have reported no efficacy of behavioural interventions (72). Another study has suggested that a community-based intervention programme can effectively reduce smoking (73). In a study from Nigeria, group psycho-education was found to be effective in improving patients' compliance with scheduled clinic appointments after being discharged from a neuropsychiatric hospital (74).

CRITICAL ANALYSES OF AFRICAN EVIDENCE BASED LITERATURE

Based on a number of basic criteria, as suggested in the Cochrane Handbook (75) (including the allocation to conditions conducted by an independent (third) party, blinding of assessors of outcomes, completeness of follow-up data, etc), the quality of the 5 controlled clinical trials on psychotherapy for mental disorders in Africa appears to be reasonable. Bolton and colleagues conducted an intention-to-treat analysis, still showing efficacy for group interpersonal psychotherapy (61). However, the outcomes of all the other studies were limited to completers-only analyses, which may give an overestimation of the treatment effect.

All of the reported studies are published by international research teams (76); first the research group in Uganda who empirically studied the effects of interpersonal psychotherapy for depression in adults and later in adolescents, second the group studying the effects of NET for PTSD in refugee camps in Uganda first with professional and later with lay counsellors and finally, a study investigating the efficacy of testimony psychotherapy in Mozambique. This number of publications is of course very low, especially for an entire continent consisting of 50 countries.

Two of the three psychotherapeutic interventions used in the reported clinical trials are developed for specific populations often found in developing countries. The interpersonal psychotherapy used by the research group in Uganda is originally developed in western countries, but was adapted to the local African context for the clinical trials described in the publications (59-62). The testimony therapy used by Igreja et al (56) in Mozambique was first described in 1983 by Lira and Weinstein working with survivors of political violence during the Pinochet dictatorship in Chile (published under pseudonyms Cienfuegos and Monelli) (77). Testimony psychotherapy is developed and used in the treatment of traumatized victims of war or other organized violence in non western countries. The narrative exposure therapy used by Neuner et al (57;58) has also been especially developed to meet the needs of traumatized survivors of war and torture. It is based on the principles of the above mentioned testimony therapy and cognitive behavioural exposure therapy. In a pilot study the authors also found indications for the

efficacy of NET for PTSD symptoms in children in refugee camps in Africa (78) and Sri Lanka (79).

The testimony therapy trial in Mozambique was negative (56). Although the reasons for these findings are not known, several possible explanations exist. First, this was a small community, and there might have been contamination between the active and control groups. Second, the intervention comprised of a limited number of sessions. Similarly, it is possible that the effect of the intervention itself was ultimately much smaller than the effect of the attention and focus on a single village by an international research team. It is very likely nonspecific treatment effects are present in the encounter with European therapists. Although the work by Bolton et al (2007) is significant, it is important to note that the control was rather non-specific. Therefore it is hard to say whether the effect found was due to IPT or due to non-specific components of IPT (60). Nevertheless, the perceptions of participants (from testimonials) suggest how vital the problem solving element of IPT is. Neuner et al (57) included a supportive counselling group to control for non-specific treatment effects and thus can potentially say more about the efficacy of the content of their intervention than the other two research groups. Although nonspecific treatment effects could have influenced the effect, they cannot fully account for the efficacy of narrative exposure therapy, as the supportive counselling group did not benefit to the same extent.

AREAS FOR FUTURE RESEARCH/DEVELOPMENT IN AFRICA

The studies described in this chapter show that evidence based psychotherapy can be implemented in African countries. They also indicate that adaptation of a western psychotherapeutic treatment, when done in cooperation with the local population, can potentially produce a culturally meaningful, feasible and acceptable treatment.

Although this review indicates that there is no need for pessimism regarding the possibility of collecting evidence on the efficacy of psychotherapeutic interventions in African countries, it is clear that evidence-based psychotherapy research is scarce, consisting of only 5 studies in 3 countries on a continent of more than 50 countries. This is consistent

with recent findings of a review of psychological treatments for anxiety and depression in low- and middle-income countries. Few empirical studies are published but results of the meta-analysis indicate that psychological treatments of depression and anxiety disorders are also effective in low- and middle-income (LAMIC) countries, and may encourage global dissemination of these interventions (76). The quality of the clinical trials in Africa is reasonable in some cases, but the fact that most studies only conducted completers-only analyses and waiting list was the major control may have led to a considerable overestimation of the true effect. The limited number of results indicated that psychotherapeutic activities in Africa have not been sufficiently empirically studied and published. Besides that, there are no empirical studies on the efficacy of traditional healers despite an anecdotal literature on the subject (80).

As mentioned earlier a part of the treatment gap is caused by a lack of human resources. There is a huge disparity in the distribution of mental health professionals in Africa. For example, Angola does not have any psychiatrists, psychologist, social workers and psychiatric nurses according to the last WHO surveys in 2005. The only mental health professionals in Malawi and Djibouti are psychiatric nurses, Equatorial Guinea has nothing but social workers and Guinea-Bissau solely psychologists. Of the fifty African countries, seven do not have a psychiatrist, twelve no psychologists, twelve no social workers and eleven no psychiatric nurses. Seychelles and South Africa appears to be best off with its mental health resources. The inequity in access to mental health care and inefficient use of available resources are other factors contributing to the gap found in the treatment of mental disorders. The high prevalence of stigma and discrimination contributes to a failure to seek help even when there is access (81).

Keeping this in mind the use of lay counsellors and primary health settings can be helpful in filling the gap in human resources and dealing with access and stigma issues. Skilling up psychiatric nurses at primary health settings could be a way to increase the amount of mental health services offered to communities (82;83). Besides that, research studies have used lay counsellors to conduct interventions (58;60;62), indicating that psychological interventions carried out by lay counsellors with limited training could be an effective treatment in Africa. This is an aspect that should be explored while trying to develop cost-effective and efficacious treatments for psychiatric disorders in Africa. The

mobilization of community resources is also proposed in a report by the World Health Organization together with ideas of integrating mental health services into existing primary care services to cope with the under-resourced situation (84).

The mobilization of another community resource, namely traditional healers, may also be relevant. Since the emotional problems of many Africans are still taken care of by traditional healers, research should perhaps explore ways on how to relate their interventions to western psychotherapy or on how to train traditional healers to provide mental health services. It is important to investigate the effectiveness of traditional healer's current techniques in Africa. Simultaneously, training opportunities for traditional healers in western techniques should be explored. If such an investigation reveals a demand for training them in mental health skills, they could be provided training in limited psychotherapeutic techniques to deal with specific mental health problems. The possible services provided by traditional healers should be thoroughly evaluated and monitored, because everyone with mental health problems has the right to treatments that are both efficacious and safe. Regardless of the Western or traditional origin of the interventions they should fulfil the same uniform standards and tests before being implemented in the communities. There is a need for local conceptual models of how psychotherapy works. The objective would be to integrate all local psychologies, including indigenous and western ones, into a universal understanding of change in the psychotherapeutic process.

This chapter has attempted to review psychotherapy studies in African countries. Several future challenges exist for research in this field. For one, the small amount of data available does not allow for definitive conclusions to be drawn. In addition, it is still unclear if the efficacy results presented here can be extrapolated for different populations and treatments. And lastly, based on the outcomes of intervention studies, one may consider further exploration of the efficacy of local adaptations of Western treatments in African countries. Integrative psychotherapies, combining western techniques with African life philosophies and perceptions (like Ubuntu and Harmony Restoration Therapy), arguably need to be explored. Results of such an investigation could potentially be valuable in the development of manuals on how to adapt psychotherapy for common mental disorders in the African context.

General recommendations for psychotherapy in Africa derived from this chapter are therefore; 1) promotion and implementation of government policies emphasizing the importance of mental health in Africa, 2) finding ways to introduce psychotherapeutic techniques in African countries despite socio-economic and resource problems, e.g. task-shifting to lay counsellors and integration of mental health services in primary health settings; 3) exploring the feasibility of providing mental health training to traditional healers; 4) investigating integrative psychotherapies; and 5) encouraging international as well as African research institutions to commit themselves to research in this field. Clearly, there is a need for additional research on psychotherapeutic treatments in African countries, including not only efficacy studies, but also effectiveness studies.

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