

Sankofa: Understandings of Culture and its Relevance for Mental Health Provision in Ghana

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Abstract

The culture of a people has great implications for the people of that society. The attitude, perceptions, beliefs and values are greatly influenced by their culture, which invariably affect their behaviour. This paper discussed the unique cultural identity and values of Ghana and how relevant they are for the mental health care provision in Ghana. The culturally sensitive psychological assessments and competency interventions were also discussed. Furthermore, the relevance of cultural values, the Ghanaian family systems as well as the interrelatedness in the social network regarding mental health interventions to facilitate healthcare have been emphasized.

Keywords: Culture, mental healthcare, interventions, cultural competency

1.0 Introduction

“Wo san w’akyi ko fa a, yenkyi”

The above is an Akan maxim meaning, “to return for something, is not abhorred”. Sankofa means, “return for it” (Gyekye, 1996).

Western Psychology is traceable to Greek Philosophy. After all, the word itself is composed of the Greek work *psych*, which means “soul or mind,” and *ology*, which means “study of.” (Holdstock, 2000). Psychology thus started as a part of philosophy and became an independent discipline much later. As a discipline, it took sides with the natural sciences opting for the laboratory as the basis of its investigations, in its pursuit of scientific goals. The ontological position it holds is that there is only one truth; an objective reality that exists independent of human perception. According to (Denzin & Lincoln, 2000) the objective of science is to analyze and measure causal relationships in a manner that is value free. To achieve this end there is the use of randomization, structured protocols and blinding among others. Thus, Psychology became rooted in a method that was the empirical study of fundamental human behavioural processes. This generalization, however, gave rise to several issues. According to Moscovisi (1972) researchers in the United States usually based their research on issues relevant to their societies using middleclass Caucasians. Amir and Sharon (1978) in studies conducted in Israel, reveal that they were unable to replicate almost half of major socio –psychological research findings from the USA. These studies which were found to be generalizable in the United States however, have been found to have little or no relevance to other cultural and ethnic groups. This led the researchers to conclude that theories arrived at in one culture were unsuitable if totally generalized to other cultures. Besides, according to (Kagitcibasi, 2007) 90 % of psychological research comes from the West although 80% of the world’s population is not from the West. This domination in terms of western influence led Guthrie (1975) to write the noted book, “Even the rat was white”. Similarly, Jahoda (1970) made this observation on psychology:

“When I mention a psychological subject, I mean a subject from a western industrialized culture, and not only one from a western industrialized culture, but an American; and not only an American but a college student” (p.2).

This culture blindness emanates because western psychology does not take cognizance of differences in values systems and cultures in diagnosing diseases found in other societies and ethnic groupings (Sam & Moreira, 2012).

2.0 Cultural Competence

Scientific psychology was introduced to non-western countries by western scholars and indigenous students who had returned back home after studying psychology in western universities. In their attempt to establish the discipline and practice of psychology as scientific, psychologists in non-western countries have rather swallowed hook, line and sinker western theories, concepts, methods and tools in research using them on local respondents (Kim, 2001). Berry (1989) describes this as a distorted non-western copy of western psychology. This is because given the differences in culture, value systems and worldview, it is not possible for western psychology to effectively appreciate and explain the full gamut of psychological phenomena as it occurs in culturally diverse non-western societies.

In recent times, several appeals have mounted and culminated in a call for culturally competent healthcare and professionals (Herman et al. 2004). In the United States, the growing diversity of the population led to calls from

minority groups such as African Americans, American Indians and Alaska Natives, Asian Americans, and Hispanics for the mental health system to meet their varied multicultural needs.

Another reason that led to the calls was the abundant evidence from research which showed major disparities in the health status between various ethnic groups, as well as clear cultural bias in health care provision (Schulman et al. 1999). According to (Sue, 1998) other ethnic groups were less likely to use services or to prematurely terminate treatment as compared to white Americans. Also in terms of quality of healthcare, racial and ethnic minorities received lower quality and did not receive cutting edge treatments as compared to white Americans (U.S. Surgeon General 2001). These disparities were proven not to have been caused by factors related to access; such as insurance status, but by problems with the rendering of the service itself (Smedley et al. 2003).

Justice or ethical grounds have also propelled calls for cultural competency (Whaley & Davis, 2007). The goals of many professional organizations include equity and fairness in the delivery of services. The APA Ethics Code (APA, 1992) and the APA Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (APA,1993) “accord appropriate respect to the fundamental rights, dignity, and worth for all people” (Principle D:Respect for People’s Rights and Dignity, p. 1599). Among the first to raise the issue of cultural competency were counseling psychologists through organisations such the Association for Non-White Concerns in Personnel and Guidance in the 1970s and the Association for Multicultural Counseling and Development in the 1980s. Through APA Division 17 (Counseling Psychology) and the National Institute for Multicultural Competence many counsellors have advocated for multicultural guidelines. In the field of clinical psychologists, APA Division 12 (Society of Clinical Psychology) established the section on the Clinical Psychology of Ethnic Minorities. The American Psychiatric Association’s Steering Committee to Reduce Disparities in Access to Psychiatric Care in 2004 also came up with a framework to increase awareness of culture and its impact on mental health. The National Association of Social Workers in 2007 also defined and then set standards for cultural competence in social work practice (Whaley & Davis, 2007).

The terms “cultural sensitivity,” “cultural responsiveness,” and “multicultural competence” are all terms that have been used interchangeably to characterize the need for greater sensitivity to culture in mental health. According to (Davis, 1997, p. 4) cultural competence is:

“The integration and transformation of knowledge, information, and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques, and marketing programs that match the individual’s culture and increase the quality and appropriateness of mental health care and outcomes”

Many models of culturally sensitive therapy have been developed (Hall et al. 2003). While some have looked at it from the viewpoint of ingredients essential for cultural competence such as having respect for cultural differences and similarities that exist for diverse groups. Other models focus on the outcomes gained from being culturally competent such as positive clinical outcomes, thus, having cultural knowledge or skills is important to the extent that positive outcomes are achieved, such as: The model of cultural competence (Sue et al. , 1992) proposes that the culturally competent counselor:

1. Is culturally aware - where the therapist is sensitive to his or her own cultural beliefs and how this may affect the counselling relationship,
2. Has cultural knowledge that suggests that the therapist is knowledgeable of his or her clients culture, worldview and self concept
3. Has cultural skills - which presupposes that the therapist is able to apply culturally competent interventions in dealing with the client.

In this view, cultural competency involves a constellation of the right personal characteristics (awareness, knowledge, and skills) that a counselor or therapist should have. This model for cultural competency is the most widely recognized framework, and it formed the basis for much of the multicultural guidelines adopted by the American Psychological Association (APA. 2003)

Another framework is the Sue (2001) threefold model of cultural competence that integrates five race- and culture specific constituencies who merit such competence (African Americans, Asian Americans, Latino Americans, Native Americans, and European Americans); 31 specific competencies divided into three domains (beliefs/attitudes, knowledge, and skills); and four “foci” or levels of analysis to which cultural competence should apply (individual, professional, organizational, and societal).

There is also the skill or tactics model which presents cultural competency as a skill that has to be learnt or that the therapist has and can choose to apply according to the situation or client he or she is faced with. Thus it is similar to skills such as expertise in sexual dysfunctions (Whaley & Davis 2007).

Process-oriented models are concerned with the complexities that come to bear on the complex client-therapist-treatment interactions and processes involved. For example, López (1997) considers the essence of cultural competence to be “the ability of the therapist to move between two cultural perspectives in understanding the culturally based meaning of clients from diverse cultural backgrounds” (p. 573).

The American Psychological Association's (2003) official practice guidelines on multiculturalism, although drawing inspiration from Sue's research, refrain from a listing of competencies. The APA notes that, "it is not necessary to develop an entirely new repertoire of psychological skills to practice in a culture centered manner" (2003, p. 390). Instead the guidelines focus on using three processes that apply basically to providing quality services to all clients; "focusing on the client within his or her cultural context, using culturally appropriate assessment tools, and having a broad repertoire of interventions" (APA, 2003, p. 390)

Generally speaking, putting in place appropriate research strategies, proposing theories that conceptualize cultural competency and training practitioners has been difficult. This is because of issues with the different meanings and descriptions ascribed to cultural competency and the inadequacy of research designs to evaluate its treatment outcomes.

3.0 What kinds of cultural competency interventions have been attempted?

Researches that have been done on cultural competency have used therapists who were bilingual, or spoke the ethnic language of clients who had limited proficiency in the English language. The languages used have included Spanish (Martinez & Eddy, 2005) Korean (Shin, 2004) and Chinese (Dai et al. 1999). Apart from the language used, communication patterns studied, showed other cultural competency adaptations. According to Armengol (1999) in reviewing patterns of interaction among less-acculturated Hispanics/Latinos, in therapeutic settings, a formal mode of address was used if that was the stated preference of participants. In instances where first names were preferred, the more formal personal pronoun form of "you" (i.e., "usted") was employed. Group facilitators were also addressed by their professional title (*Doctora*), even when using their first name. The use of such practices showed cultural values involving deference toward authority figures. (Rossello et al., 2008). In other intervention approaches, adaptations consistent with culture have included cultural rituals such as unity circles, drum calls and pouring of libation to ancestors, which are African-based rituals (Harvey & Hill, 2004).

In terms of content, interventions involving African American girls (Belgrave, 2002), youths (Harvey & Hill, 2004), and adults (Longshore & Grills, 2000) have incorporated principles of spirituality, harmony, collective responsibility, oral tradition, holistic approach, and interpersonal/communal orientation that are often found in African American worldviews. Similarly according to Zane and colleagues (1998), in a preventive intervention program among Asian Americans developed to prevent substance misuse of high-risk Asian youths and their families, cultural competencies focusing on Asian familial values, acculturation issues, and intergenerational communication were incorporated. Parents participated in small-group workshops that also included topics involving cultural values, intergenerational communication, and family. The studies indicate that cultural competency adaptations can range from simply providing ethnic language provisions to introducing multifaceted changes in intervention philosophy, delivery, and format.

Comas-Díaz (2006) asserts that many Latinos answer questions by telling stories that enable the answer to proceed out of their stories. In order to improve the self-concept, emotional well-being, and adaptive behaviors of Puerto Rican children, researchers (Malgady et al., 1990) used *cuentos* (Puerto Rican folktales) or biographies of heroic persons. Themes such as social judgment control of aggression, and delay of gratification within Puerto Rican American culture and experiences were presented. Because the children were dealing with characters that were familiar to them, it was proposed that this would motivate them, and help them to identify with the values and behaviours.

A number of studies have examined whether cognitive behavioral therapy (CBT) could be culturally adapted. Kohn (2002) looked at the degree to which CBT intervention could be adapted in a culturally sensitive manner in treating depressed low-income African American women experiencing multiple stressors. Examples of ways in which the adaptation was effected included changes in the language used to describe cognitive-behavioral techniques and inclusion of culturally specific content such as African American family issues, in order to better situate the intervention in an African American context. Compared with a non-adapted CBT intervention group, women in the adapted CBT group exhibited a larger drop in depression.

4.0 Psychology in Africa

"All human life processes including the spiritual, mental, biological, genetic, and behavioral constitutes African psychology" (Azibo, 1996: pp. 6-7). According to Azibo (1996) African psychology has its roots in ancient Kemet, a civilization beginning around 3200 BC. Azibo further states that African psychology is traceable to a time period when Africans an "organized system of knowledge (philosophy, definitions, concepts, models, procedures, and practice) concerning the nature of the social universe" (p. 4).

From this point of view, African psychology existed before Western psychology. According to (Holdstock, 2000: p. 64), "western psychology pays little or no attention to the tacit wisdom embedded in Africa's oral sources of knowledge like proverbs, folklore, and practices". Moreover, current methods and tools of the discipline are unable to translate them effectively into concepts that are familiar to western psychology. African psychologists, however, are largely unaware of this. Reasons why this is so, include, an extensive western

acculturation of African scholars and researchers. They, therefore, continue to promote and propagate western values and epistemologies to the neglect of their own. According to Sinha (1989) the psychology developing in Africa, and in India, is a product of western content and value orientations.

The DSM -IV diagnostic criteria of Antisocial Personality Disorder (APD) (APA, 1994) provides an example of why western conceptualizations of mental disorder do not fully capture the basic understanding of maladaptive behaviors in Africans and people of African descent. For people of African descent, the criteria that signify mental disorders in the DSM IV have deep socio psychological history. One of the criteria for diagnosis of APD, include failure to conform to social norms such as those of honesty, as indicated by repeated lying, conning others for personal profit or pleasure, impulsivity or failure to plan ahead, irritability and aggressiveness. Others include consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honour financial obligations. However, taking work behavior among African Americans, Akbar (1985) advances that during slavery, work depicted not only labour but punishment from childhood till death. The benefits derived from the work however went directly into the pockets of slave owners. Thus, among African Americans, work has come to be symbolize and be associated with servitude while liberty is associated with avoiding work. It must be noted however, that this historical factor does not explain all scenarios. Racism, inequalities in education and unavailability of jobs have all been identified as other contributory factors. These factors both historical and current thus serve to provide a context to conceptualize mental health disorders.

The euphemisms referred to, typically fit African American male youth, typically less privileged and urban. This has added to negative stereotypes about black youth, racial profiling and discrimination. Most often crime has been attributed primarily to people of African descent. Interestingly, however, crimes that are more white-collar in nature are not described as antisocial. It is against this backdrop that mental health practitioners in Africa started the process of self-rebuilding. This consisted of a re-education of and a regeneration of African people. This re-education effort ignited the spirit of nationalists such as Franz Fanon, Cesaire and Achebe to lead the crusade. As one of the major theorists in African-centered psychology, Daudi Azibo is one of the foremost theorists when it comes to Africentric psychology. According to Azibo, psychology that is African-centered and liberated must be able to stand against the cultural and political domination of eurocentric psychology. In reaction to dimensions of the DSM -III's universal criteria for mental disorders, Azibo developed the Azibo Nosology. The Azibo Nosology is underpinned by the following: (1) the nature of the relationship between personality order and disorder, (2) the utter criticality of the self in personality or mental order and disorder, and (3) the reality that values are fundamentally inherent in the diagnostic process (p. 178). With the Nosology, Azibo (1989, p. 178) constructs a "diagnostic system to classify the intricate cultural manifestations of mental illness". The basic conceptual schema consists of the following theories and concepts that manifest within Africana experiences:

- (1) mentacide
 - (2) psychological misorientation
 - (3) negromachy
 - (4) alien and anti-self-disorders, self-destructive disorders, and organic disorders and
 - (5) psychological brainwashing, psychological burnout and oppression violence reaction
- From the point of view of Azibo, mental health is conceptualized as a close relationship between man and nature in a relationship that cannot be mutually exclusive. According to him, mental health is:
- "the achievement in the psychological and behavioral spheres of life of a functioning that (a) is in harmony with and (b) embraces the natural order,...[where] the natural order (the third advance) is the ultimate regulator of all life and, therefore, that the criterion of mental health/illness is grounded therein"* (Azibo, 1981: p.176).

Thus, the basis of his nosology is that the human being is in harmony with nature. This is at odds with the basic assumptions of science which sought to portray humans as opposed to nature in their quest for civilization. Taking inspiration from the expositions of African cosmology in Baldwin (1976) Azibo rejected the eurocentric theory of humanity vrs nature conceptualisation and asserted that the basic principle in the cosmology of African people is the Human-Nature unity (Azibo, 1989).

Akbar (1985) another well-known African scholar, also articulated his conception of African mental disorders. Akbar classified the four mental disorders exhibited among people of African descent as:

- (1) the alien-self disorder evidenced by a person' lack of awareness to issues concerning race and/or culture,
- (2) the anti-self-disorder that shows when a person is antagonistic toward their cultural selves and others that are representative of and/or reflect their cultural selves,
- (3) the self-destructive disorder that refers to characteristics like drug abuse, alcoholism and forms of self-directed violence, and

(4) the organic disorders which are grouped/classified as mental disorders that are believed to have a biological roots but actually are from psychosocial conditions (Akbar, 1985).

It was Akbar's attempt at categorization of mental disorders among Africans that gave Azibo the impetus to begin the process of broadening the frameworks for developing diagnoses which was Africentric in origin and scope.

5.0 Mental Health in Ghana

In the early 19th century, under the colonial era, patients suffering from mental illness in the Gold Coast (now Ghana) were usually kept in prisons. Prior to this period, patients were left on their own to fend for themselves, or sent off to traditional healers. In 1888 the colonial government passed a legislative instrument (The Lunatic Asylum Ordinance), signed by Governor Sir Edward Griffiths, to establish a 'lunatic asylum' in a vacated High Court building in Accra. It was not until 1904 that a purposeful psychiatric hospital was built, called The Accra Psychiatric Hospital. The hospital was officially commissioned in 1906, initially to accommodate 200 patients. By the late 1940s, with psychiatric treatment primarily in the form of custodial care, there was soon overcrowding. The Accra Psychiatric Hospital has undergone major expansion in the past 50 years and currently houses about 700 inmates; about one-third of them are long-term because they have no place to go (Sefa-Dedeh, 2014).

Despite recent advances in psychiatric services, many citizens still believe in the traditional forms of psychiatric treatment. Up to 70% of patients or their relatives would choose herbal or traditional treatment (Ewusi-Mensah, 1996). It is quite normal for a patient to be taken from hospital by a relative in order to seek traditional or spiritual help. This is due to belief that mental illness is caused by supernatural evil forces. Twumasi (1975) observed that in Akan cosmology, illness is not only the result of a physiological change; the supernatural is usually cited as a causal factor. Within this conception the etiology of good health and disease are far more behavioural than biological. According to Twumasi (1975) there are two theories that help one to understand the causes of illness. The first is (Sunsum mu yadee) literally meaning "illness in the spirit". This is spiritually caused illness. Its origins are traced to sorcerers or magical powers, gods and witches/wizards. Some illnesses in this category include impotence, madness and epilepsy. On the other hand (Honam mu yadee), "illness in the body" are those not attributed to supernatural causes like malaria, headache, waist pains and piles. According to (Twumasi, 1975) man as made of a mortal part called onipadua (Body) inherited from the mother, a spiritual part (sunsum) referred to as personality and a life force called okra (soul). Good health therefore depends on a harmonious relationship between these components. Some diseases involve only The "onipadua" or affect the body. By contrast, illnesses affecting "sunsum" or "okra" are not so easily located and have a supernatural cause.

Psychopathology is seen as a witchcraft attack. The evil spirits may attack upon being invoked through a curse on the individual or his or her family. Their operations can be in two forms; simply attacking the individual or physical possession. In other cases the attack may be from gods upon whose rules the individual or their family has violated. In this case the attack is viewed as a form of punishment (Assimeng, 1989). Also if a person invoking spiritual powers becomes afraid or fails to abide by the rules regarding the invocation, he or she can be inflicted with mental illness. Lastly according to (Sefa-Dedeh, 2001) a person who refuses to accept witchcraft could also suffer mental disorders.

In the traditional belief system a person is born with their personality or "okra". Due to the fact witches can attack a person with weak "okra", certain rituals may be performed to strengthen a person's okra, eg. "w'aben ne ho" (Danquah, 1968). Thus according to (Sefa-Dedeh, 2001) without disputing the belief that one can be attacked by witches it is possible to prevent what makes one susceptible to attacks or makes ones okra vulnerable. This may help to make the individual stronger and more able to cope, just like medicine is given to a sick body to help it recover. On the other hand Lothstein (2002) argue of the importance of being sensitive to individual and uniquely held beliefs and practices within a religion. The majority of people however hold both of traditional and physiological notions of the causes of mental illness (Ofori- Attaa & Linden, 1995). Although some attribute mental illness to the use of illicit drugs and worry, others also believe in spiritual attacks and invasion. Often the symptoms evidenced by complaints such as, "I am being attacked spiritually" "I do not understand what is happening" "I think someone is behind it", (Sefa-Dedeh, 2001).

Religion is important in mental health care because, the belief in a higher power gives clients the strength to cope with the challenges of psychological disorders. It also minimizes clients abandoning therapy, since they believe that God is working through the therapist to bring healing to them. It also fosters positive attitudes about their healing and recovery that contribute to better treatment outcomes (Danquah, 1979).

6.0 The Family System

In Ghanaian culture, the family is recognized as a fundamental and highly prized institution. Family in the African society means the extended family which includes the nuclear family within its ambit. Values which symbolize the concept of family include love, caring, cohesion, solidarity mutual respect and mutual responsibility. According to (Twumasi, 2005) if the traditional healer decides to take on a patient for treatment, the relatives of that patient appoint an okyigyinafo (patient's supporter) who will be with the patient throughout his or her stay for treatment. He may also discuss pertinent issues regarding the patient with the medicine man and also pay fees and provide support. No family will ever fail to support a sick relative, for to do so would be a standing reproach to the whole extended family unit. The privileged status of the family in Ghanaian society could be used to the advantage of the client by enabling the family to provide appropriate support during the process of therapy. Allowing a family member to stay with a sick relative, may even be incorporated into therapeutic models that enable the client to benefit from the support of relatives while receiving psychological or psychiatric treatment. This may even help with their reintegration back into the community and avoid situations where the family is unwilling to take back relatives who have been receiving psychological or psychiatric help.

7.0 Culturally Sensitive Psychological Assessment

Psychological assessment with children in Ghana could also incorporate elements that are familiar to them and that are readily located within their communities. Sternberg et al. (2001) for instance, developed a Test for Tacit Knowledge for Natural Herbs with Luo children of a rural Kenyan community. The test sampled from common illnesses in the Luo community and standard herbal treatments for those illnesses in that community. Also many children in rural sub-Saharan Africa are familiar with clay or other local materials as a medium of expression than they are with paper, paper and other mass produced toys. Intelligent behavior in Arica is conceptualized as having an emphasis on it's social as well as practical elements. This has led to the development of the Panga Munthu Test (Make-A-Person Test) by Kathuria and Serpell (1999) for use by children in rural Africa. Wet clay is presented to children and they are asked to 'make' a person with the clay. Figures created by the children are then quantitatively scored for accurate representation of human physical characteristics. In the Panga Muntu Test with rural Zambian children, an interrater reliability of .89 was observed (Mpofu, 2002). Clay, bamboo, raffia and other locally found resources may also be used in assessment instruments. Culturally specific interventions such as cited above may be incorporated in Ghanaian settings to reduce cultural and testing biases that usually become evident with Eurocentric based testing materials.

According to (Twumasi, 1975), the traditional healer sees no differences in conceptualization between biomedical and social factors. Physical, social as well as psychological factors join together to form the social causation theory in the explanations of illness. In like manner, no illness is thought to be completely cured until its basic underpinnings, found in the social and economic environment of the individual has been dealt with. *"The traditional medical practitioner is familiar with the cultural traditions, the fears and the wishes of his clientele, so he utilizes such knowledge in his curative practices, in a form of psychotherapy..."* (Twumasi, 1975, p.36).

Traditional medicine is therefore made up of three dominant themes; the social frameworks that underlie issues such as mutual dependence and respect, prevention and treatment modalities, as well as basis of belief which is in this case, is the belief in the supernatural world. An example of this unity of thought in diagnosis and treatment modalities in traditional medicine is the death of a young person at the shrine (the young person may have been known to be disrespectful while alive). Reasons that are advanced to explain this death would include punishment by ancestors because of his or her misconduct. The gods or spirits therefore viewed as custodians of society's morality because they keep watch over their affairs. "He told lies, about the property, and the spirits killed him or his uncle's ghost killed him because he failed to look after his relatives, or his ancestors felt disgraced by his conduct so they killed him" (Rattray, 1972, p. 148). Thus, value systems are very important in Ghanaian society and have serious implication for mental health service delivery.

8.0 Value of Humanity

The African concept of humanity derives from the view that humanity is a creation of God. The Akans express it this way:

"All human beings are children of God; no one is a child of the earth". Due to the fact that God is worthy of honour and respect, the human being also, who is an offspring of God, is equally worthy of honour and respect. The human being's value is stressed and human fellowship is considered vital for the effective functioning of society. "It is the human being that counts; I call upon gold, it answers not; I call upon cloth, it answers not; it is the human being that counts".

These values of humanity and human fellowship have important ramifications for the mental health of Ghanaians. According to Osei (2004) some of the factors contributing to increased psychological problems in Ghana are as a result of the breakdown in communal/collective living which has resulted in decreased social

support for individuals. Also the economic conditions have made individuals develop a focus on chasing after wealth and money as against spending time with family and friends. If the value of humanity is incorporated into a culturally sensitive mental health care, it would serve to re-educate clients about social morals and help them to realign to cultural values in an effort to maintain a sense of equilibrium, as dictated by his or her worldview.

9.0 Moral Values

Moral values are another important aspect of Ghanaian culture worthy of discussing. According to (Gyekye, 1996) morality comprises rules and norms dictated by the society, the purpose of which is to guide conduct. Moral values are thus not only principles that guide behavior but goals aspired to by the society. Good character is highly treasured in Ghanaian culture. However, there is the notion that character is learned and therefore can be unlearned. This is expressed in the Akan maxim,

“One is not born with a bad “head”, but one takes it on the earth”

This goes to suggest that if a client has acquired certain habits that do not augur well for his daily life and living, these character traits can be unlearned in a bid to make his or her life more fulfilling. According to (Gyekye, 1996) it is the collective successes and failings of individuals that make up the nation. Thus, individual degeneration, leads to a decline and subsequently to a fall of the nation. The Akan maxim, says, ‘*We help our ears not our brothers*’, which is a truth on the virtue of honesty. This means that in giving evidence and in general speech, we speak the truth that we know; that we heard with our own ears and not here say or in an effort to try and please people who are close to us. After all, “an unpleasant truth is better than a pleasant falsehood”. Values like honesty if well cultivated by both client and therapist will ensure better mental care delivery. The client will be dealt with in truth by the therapist and likewise the client will not withhold essential information from the therapist.

Conclusion

To conclude, it must be stated that the effect of culture on individual’s behaviour and general outlook cannot be overemphasized. Although recently, many efforts have been made to make mental health care more culturally competent and specific, there still remains a lot to be done. Even within the same culture there are individual differences and nuances and therefore there must not be a one size fits all approach. Going forward, yes, the symbol of “Sankofa” must be a guide; to return to our roots for the jewels that have been abandoned and labelled as cursed. However, in our quest we must also be guided by the adinkra symbol of “Ofamfa”, which suggest a critical examination of our actions. Guided by these two lit torches of “Sankofa” and “Ofamfa”, it is my firm belief that Africa and psychology in Africa will provide the inspiration needed to lift the African continent to its place of glory.

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