



Counseling and Psychotherapy

—An African Perspective

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Abstract

There is an urgent need for more intentional counseling and psychotherapy in Africa, with better documentation of the continent's psychosocial needs followed by deliberately planned interventions. Despite this critical need, Africa is a resilient region that has survived famine, wars, and pandemics. Resilience does not negate the reality of historical and current traumas and the need to strengthen formal and informal modalities of counseling and psychotherapy. Resilience is coupled with unexploited natural resources, rich human capital, traditions, values, and wisdom that bind people together. The purpose of this paper is to state that although the influence of Western psychology and theory-based psychotherapy is slowly growing, effective practices need to be rooted in African value systems. Efforts are made in this paper to explore Africa's mental health and psychosocial needs. We discuss the presence of preventive and healing cultural resources despite the prevalent disconnection of development initiatives with peoples' mental health needs. Due to overemphasis on Western psychology, many current formal mental health training programs lack accuracy in assessment and intervention. Definitions, diagnoses, and therapeutic approaches encounter stigma that was mainly absent in traditional Africa. Here, "illness" was labeled and embraced as "difference," followed by acceptance and support versus the current labeling of various conditions as "abnormal." As much as DSM-5-TR claims universality, many Africans believe that global research to support the general application of current coding criteria is scanty. Similarly, psychometrics has been normed on Western, mainly white populations, with insufficient African standardization. The global assumption is that diagnosis based on these clinical assessments can be trusted as a basis for treatment. This paper will try to recommend that evidence-based integration-focused assessment, counseling, and psychotherapy can take root in Africa by mainstreaming interventions into every level of society and embracing the World Health Organization's Task-Shifting model.

Subject Areas

Psychology

Keywords

Counseling and Psychotherapy, African Values and Wisdom, Traumatic Stress, Mental Health Inequality, Task-Shifting

1. Introduction

One-third of the world's disability is related to mental illness, resulting in enormous personal suffering and morbidity (Anderson *et al.*, 2011) [1]. Africa is not spared. The continent has faced pandemics, wars, and famine over time, leaving behind a populace needing counseling and psychotherapy. However, just like in many low- and middle-income countries, where 75 to 95 percent of people with mental disorders are unable to access mental health services, Africa faces poor budgetary and human resource investment in mental health compared to the massive need in the Continent (Ivbijaro, 2021) [2]. This author adds that there are factors that prolong mental health inequality locally and globally, calling for the support of civil societies to intervene and encouraging research that produces knowledge on identifying these factors and tackling the treatment gaps.

For example, Cabo Delgado Province's case in Mozambique, where internal wars have raged for many years. The extremely violent attacks on the population have left an estimated 1.3 million people needing urgent humanitarian assistance and protection (OCHA, 2021) [3]. The distress is alarming with the killings and destruction of villages, and concerns about this population's mental health and psychosocial well-being are rising. This status has been complicated by the disruption of COVID-19 that affected the people and the economy. Does Mental Health Psychosocial Support Services (MHPSS) exist in such communities?

Reading through the 2021 European Union Humanitarian Implementation Plan (HIP) covering Southern Africa and the Indian Ocean region (SAIO)—Angola, Botswana, Comoros Islands, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Zambia and Zimbabwe (ECHO, 2021) [4], the comprehensive 20-page document *does not* mention mental health and traumatic stress needs in these populations or any means of mitigating the same. The context discusses the traumatic incidents destabilizing people: political conflict, displacement, natural calamities, HIV and AIDS, refugees, El Nino floods, etc. Research indicates traumatic stress and many other mental health outcomes as the aftermath of disruptions of such immense proportions (Lee *et al.*, 2020) [5]. However, with a budget of EUR 44,500,000, there does not seem to be a mental health plan nor any funds set aside to engage in mental health research or consultation of mental health practitioners, especially

psychologists, in these regions. This omission is prevalent in humanitarian interventions in Africa, and local partners funded by the same groups also leave out mental health as an immediate, pervasive need. If the European Union cannot include mental health and trauma needs in a 2021 Humanitarian Implementation Plan, will African governments prioritize the need?

Despite the failure to prioritize mental health and trauma services in Africa, a continuum of care exists—from traditional prevention, training, and counseling practices to current western-education-informed mental health practices. Generally, counseling is an interactive growth-learning process where an individual acquires, either individually or within a group, skills on how to deal with life's problems and challenges. Through counseling, the helper expresses care and concern toward the individual in need, helps them to identify and clarify their challenges, and grows skills towards making informed choices and solving personal or interpersonal problems (Shayo, 2011) [6]. Psychotherapy is a treatment process by psychologists or psychotherapists to help people deal with psychological issues, such as depression, anxiety, and posttraumatic stress disorder (Cook *et al.*, 2017) [7]. In today's society, most mental health services, counseling, and psychotherapy are driven by Western humanitarian models that are more problem-oriented than prevention-focused. As aforementioned, formal counseling and psychology in Africa are not funded or legislated, and few countries have Mental Health Policies.

2. Method

This paper is set to explore factors that contribute to resilience in Africa. After many years of tribal wars, slavery, colonialism, famine, armed conflict, AIDS, the Covid-19 pandemic, and so on, the Continent remains healthy and thriving, with a capacity to spring back from adversity, creatively recover and resist destruction (Maguire & Hagan, 2007) [8]. Researchers define social resilience as a social entity—or community's capacity to bounce back or respond positively to adversity through resistance, recovery, and creativity. Beyond the individual, society and culture impact resilience (Armitage *et al.*, 2012) [9].

3. Africa's Prevention and Life Coaching

Various studies indicate that, in traditional Africa, counseling focuses more on prevention and coaching than intervention and problem-solving. In many communities, laid-down behavior patterns are taught, and adherence is communicated through parenting, socialization, and the various stages of maturation. This meant that the focus on counseling was not problem-oriented but aimed at growth and teaching for life. Through rites of passage, roles and behavioral expectations were clarified and validated, with dissent punished, sometimes with ostracization. Counseling then was not so much about solving mental and behavioral problems but teaching ways of life from the individual to the family and the community. Such teaching was through the people's wisdom, communicated

through proverbs, folk tales, traditional songs, poetry, and dance. For example, training parents in responsible child-rearing to avoid child abuse and neglect was tied up in tradition, primarily through child naming (Mwiti & Dueck, 2006) [10].

Life was viewed as cyclic—from the unborn to the dead and back to the unborn. Among my tribe, the Meru of Mt. Kenya region of Kenya, every child is named after a family member, alive or dead. The firstborn son is consistently named after the *father's father*; if female, she is the *father's mother*. To this day, the *baby naming ceremony* is a grand occasion where the *born* adult invites peers to come and give a fitting name to the baby based on the older adult's personal qualities and virtues. This ceremony reminds the parents, especially the baby's mother—the child's direct caregiver, that in nurturing the baby, she is, by extension, rearing the adult after whom the baby is named. To this extent, the *adult* child's peers and the baby's namesake would be watching the family to confirm that the child was growing up as expected. If there was consistent neglect, punishment would be meted out to the mother by a group of women, all *agemates*, to the aggrieved party.

Once, women received news that a baby boy crawled into an open fire and got burnt. The baby's mother was known to be notoriously negligent in child care. The wife of the baby's namesake arrived at the specific home before dawn along with her peers, bearing branches of stinging nettle. They called out to the baby's mother: "Come out and explain where you were when *our* husband got burnt. Come, we need to teach you a life lesson." No one could interfere, not even her husband or neighbors when screams of anguish filled the air as the women beat the baby's mother with branches of stinging nettle. This would be a lasting counseling session, an example to many against child abuse and neglect.

Among the Meru, traditional parenting modalities face erosion from modernization and Western education. Counseling and training young people for life have mainly been abdicated to schools or formal religious training, with little realization that schools are significant in academics. Some churches are leading integrated adolescent rites of passage programs incorporating parents into church-initiated programs (Mwiti, 2005) [11]. This, at least, is closing some divide. However, along with such programs, the direct role of parenting training and counseling cannot be delegated. Mwiti (2016) [12] argues that, whereas traditional Meru societies socialized young people through the *Gaar*—the training abode of men, counseling and training their sons from childhood to manhood; then the *Kiuru*—the mentoring and guidance of girls by mothers and their peers to womanhood, the *Gaar* is currently empty while the *Kiuru* stands. Men seem to have abdicated the boy training and counseling responsibility.

Young men, knit together in age sets and peer accountability, are now targets for substance abuse, relationship problems, and lack of direction due to poor socialization and a poor sense of identity. The result for many of these young men is role confusion (Chen *et al.*, 2007) [13]. Role confusion has been linked with emotional dysregulation, hopelessness, low motivation, and marital conflict. Vulliez-Coady *et al.* (2016) [14]. Underline that if role expectations are not clari-

fied through maturation, boundaries are often crossed, creating misunderstanding and conflict. African psychology emphasizes that an individual systematically matures through rites of passage, where boundaries are clarified and role expectations elucidated and reinforced.

For example, a man has three developmental stages among the Maasai of Kenya: childhood, middle warriorhood, and senior warriorhood. The Meru of Kenya had six developmental stages (Mwiti, 2014) [15]. During each stage, continuous training would be provided and required values reinforced through folk tales and proverbs or wise sayings. Sitting around the crackling fire in the evening, children would be treated to folk tales of the tribe's heroes or narratives of what happened to anyone who disregarded the wisdom of the fathers. The end of each developmental phase was marked with ceremonies depending on the age of the graduating set. Graduating in locations ensured that one's *nthuki* or age group would serve as accountability partners throughout one's lifetime. No one was supposed to bring shame to the age set. Graduating from adolescence to adulthood is a colorful ceremony that marks the culmination of training and coaching young men and women for life. After this rite, childish behaviors are supposed to remain behind as the whole graduating age group adopts a name for themselves and appoints each other as accountability partners as they mature into the next age group. Training from boys to men and girls to women is part of counseling and mentoring in Africa.

African wisdom guided individuals through life stages with clearly defined roles and responsibilities. Premarital counseling was provided for those who reached marriage age. Marriage counseling was made available for struggling couples, backed by social support and spiritual practices. Counseling through parenting was present to ensure that parents fulfilled the tribal group expectations with success for their children. Elders counseled and mentored younger leaders with reminders that integrity was non-negotiable. Holistic counseling included care for the environment so that wet beds were protected and trees would not be felled carelessly. For anyone with emotional disturbance, there would be encouragement, spiritual help, and herbal treatment if symptoms persisted. Chronic mental illness was dismissed as a curse or a difference to be tolerated and managed. The same care was given to the differently abled without labeling them "the *disabled*".

Ceremonies, taboos, and rituals strengthened adherence to holistic counsel and wisdom. For example, pestilence or drought was a spiritual message from God. Spiritual leaders would call the community to examine their lives and see if they had erred by mistreating the helpless or forgetting to observe some practices. Such observances would be followed by sacrifice and repentance with the belief that the calamity would be reversed. During periods of drought, at the end of such rituals, rain fell. Such stories of holism with God's presence with his people persist. Today, some of this curriculum remains, and even where absent, expectations of values related to one's age still group abide by. The attrition of knowledge due to oral literature mandates African psychologists to recall, research,

write, and integrate these modalities into today's academia and practice.

3.1. African Preventive Counseling

In traditional Africa, community cohesion and value systems provided resilience and cushioned the mentally different from neglect. Acceptance of personality and behavioral diversity made it easy for families and communities to care for one another. Besides approval, the common practice when dealing with mental health struggles was to blame external forces such as witchcraft or the gods for the condition. However, today, with the unraveling of community bonds through urbanization and the universality of value systems, more vulnerable individuals need more protection of communal cohesion, a reality that challenges Africans to build alternative communities.

A Transiting Continent

As the continent transits into more westernization and a tendency towards individuality, many people are convinced that African indigenous psychology models should be documented and integrated into university psychology modules. These can provide integration to identify and preserve the values and practices for resilience and inform counseling and psychotherapy with evidence-based models.

While examining the traditional roots of wellness in Africa, it is clear that psychology and psychotherapy in Africa need to be contextualized because Africa has always had its way of understanding and managing human behavior. While Western psychology was written, the African version was oral. For example, scholarly developmental psychopathology is based on the norms of maturation, evaluating divergence, and mandating treatment to revert to standard behavior for anyone born without a disability. Norms of development are assessed by growth across stages of development. With the coming of Western education and Western psychology, Africa faces the problem of assumptions. To identify pathology, western-oriented psychology assumes that Erikson's eight Stages of Psychosocial Development are global and can be utilized by mental health providers when diagnosing and treating any patient facing complex adjustments or turning points in life. Indeed, there is an argument that an individual can understand themselves better by evaluating personal progress against Erikson's understanding of development from early life (Orenstein & Lewis, 2020) [16]. Malone *et al.* (2016) [17] argue that such assessment yields awareness of cognitive, executive, and emotional functioning into late life. The authors add that such conceptualization of psychopathology informs treatment planning, psychotherapy, and prognosis. However, it would be presumptuous to assume that societies like the Maasai of Kenya, with three developmental stages, can have Erikson's understanding of developmental pathology superimposed upon their community. This is psychological colonialism.

Western colonialism sought to impose paternal authoritarian thought through curriculum, disregarding indigenous training and teaching systems. African

psychology should be contextualized through dialogue and integration with the shared evolution of evidence-based psychotherapies to create Afro-centric counseling and psychotherapy. Psychotherapy in Africa should be perceived as something other than alien. Africa-sensitive psychology will interrogate DSM-5-TR into various community definitions of psychopathology and healing modalities. The same interrogation needs to be applied to psychometrics—to encourage empirical evidence in validating and standardizing clinical assessments using African populations and their languages, metaphors, clichés, and pearls of wisdom.

4. Results

4.1. Psychology and Mental Health in Africa—Status and Interventions

More and more universities offer psychology training, but mainly with curriculum influence, textbooks, research, and psychotherapies from the West, mostly the USA and Europe. This is primarily because many African countries still do not have government-sponsored mental health regulatory bodies. For example, in Kenya, we still do not have a Board of Psychology to regulate the practice, accredit training institutions, and inform training content. Therefore, the quality of clinical psychology and counseling psychology in the university curriculum is managed by the Commission for University Education, which uses panels of psychology professors and practitioners to moderate proposed psychology syllabi for all new psychology programs. This, at least, has helped to standardize the quality of programs. Without a Board, professional psychology bodies license their members and ensure that a Code of Ethics is followed with regular Supervision and mandatory Continuing Education. The problem is that punishing defaulters is not easy because, beyond exclusion, litigation for any offender is not possible. After all, societies have no legal mandate.

For many years and following the medical model, African education has emphasized mental illness rather than mental health. This is because the control of the university mental health curriculum emphasizes psychiatry versus psychology. The distinction between psychology and psychiatry has not been made very well, and many psychiatrists do not refer clients for psychotherapy. Psychopharmacology is chosen above counseling and psychotherapy, leading to more stigma and labeling of anyone struggling with emotional challenges and relational conflict. Psychoeducation is increasing slowly, educating people that mental health challenges are typical and that psychotherapy should be the first option before medication. In such situations, diagnosis is necessary. However, another challenge is the lack of doctoral-level psychologists trained in psychometrics and assessment instruments validated and standardized in Africa. This vacuum encourages the persistence of the medical model in diagnosis, leading to more people on psychotropics than necessary. Many more lack the help they need to break free from emotional and relational deficits that encourage various

conditions—anxiety, depression, marital conflict, relationship breakdowns, and substance abuse as individuals self-medicate when helplessness takes control.

4.2. Mental Health Policies in Africa

African nations need mental health policies, national mental health plans, guidelines, and budgeting for mental health services and interventions. According to a global 2014 WHO Mental Atlas Survey, 24% of countries reported that they did not have or have not implemented mental health policies. This percentage rose to 46% for Africa (Sankoh *et al.*, 2018) [18]. The authors add that between 2000 and 2015, Africa's population grew by 49%, and the number of years lost to disability due to mental and substance use disorders increased by 52%. The same report confirms this scarcity of mental health services by stating that the proportion of Africans who receive treatment for mental health problems is deficient—at 14 per 100,000, while the global annual rate of visits to mental health outpatient facilities is 1051 per every 100,000 people. In addition, the dearth of research reflects the weakness of mental health services on the continent and that many African governments [as well as humanitarian groups] disregard this need.

This neglect is reflected in the reality that many African governments do not recognize the need to create systems for the practice and protection of counseling and psychotherapy. For example, since the onset of the COVID-19 pandemic, WHO has advised that mental wellness should take precedence in intervention planning and that all countries should have COVID-19 mental health strategies and plans. WHO also called for the care of medics on the Covid-19 front lines. However, nations like Kenya went through 2020 without any mental health plan (Jaguga & Kwobah, 2020) [19]. And then released one in early 2021 (MOH, 2021) [20]. However, the strategy has been critiqued for lack of a preventive approach and poor multidisciplinary sensitivity as recommended by WHO.

4.3. Community-Based, Indigenously-Sensitive Counseling and Psychotherapy in Africa

Many development initiatives for Africa do not include counseling and psychotherapy in their programs. The emphasis is on education, health, agriculture, governance, and so on, with few initiatives including mental health and trauma recovery. This reality has remained the same, although many know that factors such as AIDS, wars, the refugee situation, and poverty contribute to the heavy burden of mental illness. Besides Western individual and miniature models of counseling and psychotherapy, WHO has recommended that where there are few professional mental health helpers, especially during mass crises like COVID-19, nations should adopt *task-shifting*. In this model, multidisciplinary teams work together to provide need-based counseling services (WHO, 2008 [21], Mwiti, 2017 [22], Mwiti, 2021 [23]). Besides increasing the efficiency of mental health services, task-shifting reduces the prevalence of severe mental health problems through psychoeducation and the multiplication of gras-

roots-based lay counselors, especially during wars and pandemics. Orkin *et al.* (2021) [24] add that task shifting fills the economic gap between the need and supply of essential mental health services.

Task shifting has limitations. Competition between individuals serving at various levels of care can create ego clashes and overpass limit levels of responsibility beyond their level of training (Okyere *et al.*, 2017) [25]. Each care group must recognize its limits and practice the mutual referral system, such as counselors, psychologists, case workers, psychiatrists, mental health practitioners, and religious leaders. Empowering partnerships and recognizing the power of synergy decreases ego-based competition. Malpractice, omissions, and compassion fatigue have been reported in task shifting. Continuous professional supervision, retraining in professional ethics, and continued education enhance confidence, emphasize self-care, and prevent compassion fatigue. There is weak evidence regarding task shifting's efficacy. However, even as the evaluation of service impact continues, WHO believes this deficiency should not be an excuse for the non-implementation of this urgently needed program (Saraceno, 2004) [26].

5. Case Study

Application of Task Shifting.

Community-based task shifting prevents stigma, discrimination, and human rights violations related to mental disorders. It can create a safe place for psychoeducation and healing conversations. This was the experience of Oasis Africa as we trained and mobilized over 1000 lay trauma counselors to work in all parts of Rwanda soon after the 1994 genocide (Mwiti, 2021) [23]. Tasked with essential skills to identify levels of need, we encouraged the counselors to create a referral list of clergy, professional counselors, and doctors to whom they could refer anyone in the community who indicated complicated grief reactions and critical mental and behavioral health conditions. Besides running community discussion and Bible Study groups on critical areas of functioning, for example, anger, grief, traumatic stress, forgiveness, and mutual care, they used our book, *Crisis and Trauma Counselling* (Oasis Africa, 1994) [27] which was translated into their language—Kinya-Rwanda, to train other helpers and send a message of healing and reconciliation through community meetings, radio, and television. Pastors used our sermon outline booklets—*Kairos for Rwanda*, to preach messages of healing and restoration from their pulpits.

Oasis Africa's task-shifting created a Ripple Effect that spread through the grieving nation. Another decisive outcome of this three-year program was a wave of reconciliation throughout the country through the discussion and Bible Study Groups, where, after training a multi-ethnic group of leaders, we would assign them into groups to meet once a week over the next ten weeks. At the end of the ten assigned group studies, many clusters continued to meet—creating their agenda. Some started visiting one another. Others built homes for any among them whose houses had been destroyed during the genocide. Still, others started income generation activities—growing passion fruit, marketing the pro-

duce together, or keeping chickens and goats. Meeting together over the weeks, Hutus and Tutsis began talking and working together—a decisive outcome of community-based task-shifting.

Realizing the paucity of counselors in Africa, Oasis Africa was already practicing the Ripple Effect model through the *Annual Inter-Africa Lay Counselors* training we started in 1990. In the program, 40 Christian leaders, selected by their constituencies—churches, hospitals, non-governmental organizations, educational institutions, and hospitals, would gather in Nairobi for three weeks—equivalent to 120 contact hours, training in Basic Skills in Christian Counseling. Over ten years, 400 lay counselors representing 16 countries led community psychoeducation and lay counseling training of grassroots helpers in their nations. Countries covered included Kenya, Uganda, Tanzania, Rwanda, Burundi, Ethiopia, Zambia, Zimbabwe, Malawi, Cote d'Ivoire, Cameroon, Ghana, Nigeria, United Kingdom, USA, and India. Participants were already professionals in their countries of origin but volunteered their time in various church ministries or worked as hospital chaplains and counselors. The outcomes of this program, funded mainly by Tear Fund, UK, gave Oasis Africa the courage to train Lay Trauma Counselors for the 1994 Rwanda genocide, the 1998 Nairobi USA Embassy bombing, and the 2001 India Gujarat earthquake.

Oasis Africa used task-shifting in other community disaster interventions: the *Nairobi USA Embassy bombing* in 1998, where we trained 150 counselors, psychologists, and psychological clinics to serve over 2000 survivors. We also engaged psychiatrists, hospitals, community groups, mosques, and churches on a need basis. We repeated this model after the *Nairobi Westgate Mall Terror Attack of September 21, 2013*, where 71 people were killed, approximately 200 were injured, and over 2500 were affected. Dr. Gladys Mwiti once again led the intervention. The multidisciplinary team of 400 volunteers received training in *Psychological First Aid* (Wang *et al.*, 2021) [28]. Practicing psychologists received the equipment in *Skills for Psychological Recovery* (Berkowitz *et al.*, 2010) [29] and *Trauma-Focused Cognitive Behavioral Therapy* (Kliethermes *et al.*, 2017) [30] for those needing the package. We reminded the trainees of the need for contextualization, cultural sensitivity, and religious integration for all these packages. Over the next six months, these individuals offered services in a carefully choreographed plan guided by a leadership team, receiving ongoing supervision and retraining in self-care to avoid burnout.

6. Proposed Levels of Task Shifting

Mwiti (2021) [23] argues that task-shifting should be offered at four levels, according to expertise, after completing the initial Preparatory Phase. The tasks of preparation include: a) Determination of the need for the intervention; b) Setting up a multidisciplinary Intervention Coordination Team (ICT) that identifies policies needed to support the program; c) Writing the Psychosocial Support Plan; d) Identifying players; e) Preparing training materials; f) Setting up the leadership team—trainers, location for service provision, g) Other loca-

tion-specific tasks that meet the requirements of the intervention. The ICT team creates data on available community service providers—hospitals, medical and mental health clinics, rehabilitation and rescue centers, and children’s homes. The team also determines training modalities, areas of service, requirements for supervision, Continued Education, and program monitoring and evaluation.

Mapping needs and available human resources, followed by plans and budgets, anticipated gaps, and ways to manage them. For example, although the Oasis Africa Rwanda trauma healing program was funded, the local Church that hosted this national program decided that to get as many people trained as possible, apart from the training venue and hosting for the week-long program, there would be no pay for participants or their transportation. The sending churches and organizations undertook this cost as part of their contribution, commitment, and program ownership. The trauma lay counselors volunteered their time and brought food to share during their local training seminars.

The multi-level Training Phase follows the Preparatory Phase to standardize program delivery. Here, selected individuals at each level are identified and trained to train others and to carry out psychosocial interventions at their level of expertise. *Program Evaluators* are prepared to monitor and evaluate the outputs.

Level One includes *Lay Counsellors*—adults willing to serve by encouraging others and linking them with services. These individuals should do outside psychosocial support in other primary helping professions, e.g., as teachers, nurses, clergy, sociologists, etc. These, along with the different levels of care, receive training in Psychological First Aid (PFA, Wang *et al.*, 2021) [28] to standardize service provision. Using the PFA guidelines, the Counselor creates healing networks by normalizing trauma responses and then providing tips for recovery. The survivor is connected with needed resources, such as help tracing loved ones and friends. Grief reactions are managed with exceptional care for those indicating complicated reactions or suicidal ideation. Through PFA, basic need-based information is gathered with developmental, cultural, and spiritual sensitivity and provides what the client needs to hasten recovery and re-orientation.

Essential qualities for all levels of care include communication skills, listening skills, patience, confidence, respect, confidentiality, a non-judgmental attitude, and the ability to instill hope. In addition to PFA, Level One receives training in counseling micro-skills: active listening, rapport building, creating trust, communicating respect, attending, immediacy, use of silence, reflecting and paraphrasing, and questions to clarify and summarize. Clergy learns and teaches theological perspectives of suffering, loss and bereavement, healing, social support, maintaining hope in suffering, caregiving, and sustaining care.

Level Two involves training *Program Coordinators* and lay people in the mental health profession, but have the gift of program coordination and people mobilization. They should also be exposed to ethical practices and the protection of privacy. Level Two manages registration desks, maintains a service data bank, links the program to relief amenities, and manages the booking process for pro-

professional referrals. For all teams, trainers emphasize record keeping, reporting, self-care, limit setting, the need to maintain regular supervision, and maintaining an active referral system.

Level Three includes standardization of service provision by Professional Practitioners—Master and Doctoral levels in Clinical Psychology, Counselling Psychology, Marriage & Family Therapists, and Clinical Social Workers. These are reminded to offer evidence-based, culturally-sensitive psychotherapies and to exercise religious integration, mindful of client needs. All sign up and receive training in specific packages, for example, Skills for Psychological Recovery (SPR) and Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT). Besides receiving clients needing advanced services, this team manages referrals. It maintains Supervision for self and others, organized on a staircase model with each individual stretching their hand to be helped by someone above them and the other hand reaching down to help those on lower rungs. Level Three providers are reminded: a) to observe their Code of Ethics, b) the role of cultural and religious sensitivity with the integration of faith and practice where possible, c) to practice self-care, d) the process of receiving referrals from Levels One, and Two, and e) to offer organized supervision throughout the whole program, including peer supervision.

Level Four includes overall organizational coordinators who offer program administration, engage community leaders to support the intervention, and link the program with other resources, such as food banks, medical clinics, hospitals, schools, and policymakers. Level Four coordinators also organize outreach services where harmonized teams are needed in the media, schools, hospitals, and the wider community.

After training, the ICT can place Levels Two and Three helpers in service groups according to the needs to be addressed—marriage, family, youth, trauma, loss and bereavement, environmental stewardship and care, and parenting, each headed by a Level Three practitioner to guide the intervention, monitor referrals and provide Team Supervision. Level Three works in close collaboration with Level Four for program coordination. Level Two can also engage in psychoeducation and group discussions with active referral to the Level Three team so that each group works within its limits. Program Evaluators already identified in the Preparatory Phase carry out surveys, monitor and evaluate outcomes on the intervention's progress, write reports, and share regular reports on the intervention's progress at the regular ICT meetings.

Over the years, task shifting at Oasis Africa has introduced many people all over Africa to the need for community-based mental health and psychosocial support services. Today, several Ph.D. and PsyD psychologists in our region are second-career practitioners who began with Oasis Africa lay counselor training—a decisive outcome of task shifting.

7. Recommendations

Moving into the future, if humanitarian groups in Africa care for the wellness of

the continent, mental health should become a priority on the agenda. The budget should no longer be selectively focused on HIV and AIDS prevention and AIDS orphans' education, health, and nutrition without budgeting for robust interventions in the mental wellness of these populations. Money raised for refugee settlements should include research on trauma and resilience-building programs. Hospitals can offer medical support integrated with psychological testing and counseling programs because we cannot divorce physical illness from behavioural and stress-related factors. The standard medical model needs to be replaced with interdisciplinary modes of care.

There is an urgent need for government mental health policies and mental health plans to offer regulation and accreditation to guide university training curriculums to train professionals in counseling and psychology (Mwiti & James, 2012) [31]. The authors recommend integrating Western psychology, indigenous psychologies, and religious practices informed by the values, beliefs, and cultural healing modalities of the populations served. Similarly, humanitarian interventions should adopt a bottom-up approach, where the needs and wisdom of the people inform plans. Time has passed for cut-and-paste paternalistic programs and short-term solutions to endemic historical traumatic stress. Aid dollars without mental health interventions become blind programming and create a game without end (Hansen & Ainsworth, 2013) [32] and an error in social typing (Watzlawick *et al.*, 1974) [33]. Such approaches deny solutions that could end problems and create piecemeal resolutions, contributing to more complicated, endless predicaments. Recurrent suffering is a desired state for some donors to justify their presence, denying populations freedom to seek sustainable solutions to their problems.

8. Conclusion

Africa is a continent in between. Fast disappearing is the drumbeat of peaceful villages save for ethnic strife that would often be stifled with understanding and elder conflict resolution. African communities lie between age-old wisdom pearls quickly replaced by postmodern behaviours, global languages, short lives, and complicated mental health challenges [34]. Parenting and mentoring spelled out by tribal systems are being challenged by school learning and the global culture of the Internet. More and more global wars are being fought on African soil as rich nations fight to control the wealth of Africa. It is well-known that bloody, trauma-ridden tribal conflicts in places like DR Congo and Sierra Leon have nothing to do with warring people groups but that warlords seek to control the diamond and cobalt-ridden national reserves on behalf of international smuggling rings, leaving behind communities torn with conflict.

A humbling fact is that Africa existed long before the Western nations scrambled for the Continent, and Africa will continue to survive long into the future. In crowded slums and villages, without running water and no social distancing, and unable to afford the COVID-19 vaccines, Africa has survived COVID-19

(Chitungo *et al.*, 2020) [35]. This resilience needs research, affirmation, and inclusion into the Continent's mental health healing modalities. Such can seed proper transformational counseling and psychotherapy models that Africa can share with other nations.

Conflicts of Interest

The author declares no conflicts of interest.

References

- [1] Anderson, P., Jane-llopis, E. and Hosman, C. (2011) Reducing the Silent Burden of Impaired Mental Health. *Health Promotion International*, **26**, i4-i9. <https://doi.org/10.1093/heapro/dar051>
- [2] Ivbijaro, G. (2021) Mental Health in an Unequal World. World Federation for Mental Health. http://wmhd2021.com/template.php?file=news/21-03-19_about-the-theme.html
- [3] OCHA (2021) Mozambique. Analysis of the Context, Crisis, and Needs. <https://gho.unocha.org/mozambique>
- [4] ECHO (2021) Humanitarian Implementation Plan (HIP) Southern Africa and Indian Ocean. Directorate-General for European Civil Protection and Humanitarian Aid Operations (ECHO). https://ec.europa.eu/echo/files/funding/hip2021/echo_sf_bud_2021_91000_v2.pdf
- [5] Lee, J., Kim, S. and Kim, J. (2020) The Impact of Community Disaster Trauma: A Focus on Emerging Research of PTSD and Other Mental Health Outcomes. *Chonnam Medical Journal*, **56**, 99-107. <https://doi.org/10.4068/cmj.2020.56.2.99>
- [6] Chilewa, E. and Osaki, K. (2022) The Effectiveness of Guidance and Counseling Practices on Students' Career Development in Secondary Schools in Temeke Municipality. *Journal of Humanities and Education Development*, **4**, 160-181. <https://doi.org/10.22161/jhed.4.1.17>
- [7] Cook, S.C., Schwartz, A.C. and Kaslow, N.J. (2017) Evidence-Based Psychotherapy: Advantages and Challenges. *Neurotherapeutics*, **14**, 537-545. <https://doi.org/10.1007/s13311-017-0549-4>
- [8] Maguire, B. and Hagan, P. (2007) Disasters and Communities: Understanding Social Resilience. *Australian Journal of Emergency Management*, **22**, 16-20.
- [9] Armitage, D., Béné, C., Charles, A.T., Johnson, D. and Allison, E.H. (2012) The Interplay of Well-Being and Resilience in Applying a Social-Ecological Perspective. *Ecology and Society*, **17**, Article 15. <https://doi.org/10.5751/es-04940-170415>
- [10] Mwiti, G.K. and Al, D. (2006) Christian Counseling: An Africa Indigenous Perspective. Fuller Seminary Press.
- [11] Mwiti, G.K. (2005) Moving on Towards Maturity: A Manual for Youth Counseling. Evangel Publishing House.
- [12] Mwiti, G.K. (2016) Parenting with Purpose & African Wisdom. Arba Publications.
- [13] Chen, K., Lay, K., Wu, Y. and Yao, G. (2007) Adolescent Self-Identity and Mental Health: The Function of Identity Importance, Identity Firmness, and Identity Discrepancy. *Chinese Journal of Psychology*, **49**, 53-72.
- [14] Vulliez-Coady, L., Solheim, E., Nahum, J.P. and Lyons-Ruth, K. (2016) Role-Confusion in Parent-Child Relationships: Assessing Mother's Representations and Its Implications for Counselling and Psychotherapy Practice. *The European Journal of Counselling*

- Psychology*, **4**, 205-227. <https://doi.org/10.5964/ejcop.v4i2.62>
- [15] Peatrick, A.M. (2020) The New Frontier of Age Limits, or Youthhoods among Meru (Kenya). Traduction de Matthew Cunningham. *Ateliers d'Anthropologie*, **47**, 64-66. <https://doi.org/10.4000/ateliers.12684>
- [16] Orenstein, G.A. and Lewis, L. (2020) Erikson's Stages of Psychosocial Development. <https://www.ncbi.nlm.nih.gov/books/NBK556096/>
- [17] Malone, J.C., Liu, S.R., Vaillant, G.E., Rentz, D.M. and Waldinger, R.J. (2016) Mid-life Eriksonian Psychosocial Development: Setting the Stage for Late-Life Cognitive and Emotional Health. *Developmental Psychology*, **52**, 496-508. <https://doi.org/10.1037/a0039875>
- [18] Sankoh, O., Sevalie, S. and Weston, M. (2018) Mental Health in Africa. *The Lancet Global Health*, **6**, e954-e955. [https://doi.org/10.1016/s2214-109x\(18\)30303-6](https://doi.org/10.1016/s2214-109x(18)30303-6)
- [19] Jaguga, F. and Kwobah, E. (2020) Mental Health Response to the COVID-19 Pandemic in Kenya: A Review. *International Journal of Mental Health Systems*, **14**, Article No. 68. <https://doi.org/10.1186/s13033-020-00400-8>
- [20] MOH (2021) Kenya Mental Health Action Plan 2021-2025. <https://mental.health.go.ke/download/kenya-mental-health-action-plan-2021-2025/>
- [21] WHO (2008) Task Shifting. Global Recommendations & Guidelines. Rational Redistribution of Tasks among Health Workforce Teams. Global Recommendations and Guidelines. https://data.unaids.org/pub/manual/2007/ttr_taskshifting_en.pdf
- [22] Mwiti, G.K. (2017) Indigenous Christian Counseling in Africa: The Call of the Church to Care & Counsel as Mission. In: Giesekus, U., Smith, B.M. and Schuster, J., Eds., *Global Mental Health and the Church*, LIT Verlag, 51-62.
- [23] Mwiti, G.K. (2021) Trauma, Resilience and Task-Shifting: Leveraging on the Wealth of the Church for Healing and Thriving. Fuller Theological Seminary/Center for Missiological Research.
- [24] Orkin, A.M., Rao, S., Venugopal, J., Kithulegoda, N., Wegier, P., Ritchie, S.D., *et al.* (2021) Conceptual Framework for Task Shifting and Task Sharing: An International Delphi Study. *Human Resources for Health*, **19**, Article No. 61. <https://doi.org/10.1186/s12960-021-00605-z>
- [25] Okyere, E., Mwanri, L. and Ward, P. (2017) Is Task-Shifting a Solution to the Health Workers' Shortage in Northern Ghana? *PLOS ONE*, **12**, e0174631. <https://doi.org/10.1371/journal.pone.0174631>
- [26] Saxena, S., Jané-Llopis, E. and Hosman, C. (2006) Prevention of Mental and Behavioural Disorders: Implications for Policy and Practice. *World Psychiatry*, **5**, 5-14. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1472261/>
- [27] Oasis Africa (1994) Crisis and Trauma Counselling. Giant Printers.
- [28] Wang, L., Norman, I., Xiao, T., Li, Y. and Leamy, M. (2021) Psychological First Aid Training: A Scoping Review of Its Application, Outcomes and Implementation. *International Journal of Environmental Research and Public Health*, **18**, Article 4594. <https://doi.org/10.3390/ijerph18094594>
- [29] Berkowitz, S., Bryant, R., Brymer, M., Hamblen, J., Jacobs, A., Layne, C., *et al.* (2010) Skills for Psychological Recovery. National Center for PTSD and National Child Traumatic Stress Network. https://www.nctsn.org/sites/default/files/resources/special-resource/spr_complete_english.pdf
- [30] Kliethermes, M.D., Drewry, K. and Wamser-Nanney, R. (2017) Trauma-Focused Cognitive Behavioral Therapy. In: Landolt, M., Cloitre, M. and Schnyder, U., Eds.,

Evidence-Based Treatments for Trauma Related Disorders in Children and Adolescents, Springer International Publishing, 167-186.

https://doi.org/10.1007/978-3-319-46138-0_8

- [31] Mwiti, G.K. and James, N. (2012) Counseling and Psychotherapy in Sub-Saharan Africa (Kenya, Tanzania, & Uganda). Professionalism and Contextualization. In: Moodley, R., Gielen, U.P. and Wu, R., Eds., *Handbook of Counseling and Psychotherapy in an International Context*, Routledge, 55-61.
<https://doi.org/10.4324/9780203864906>
- [32] Hansen, P. and Ainsworth, F. (2011) Australian Child Protection Services: A Game without End. *International Journal of Social Welfare*, **22**, 104-110.
<https://doi.org/10.1111/j.1468-2397.2011.00859.x>
- [33] Watzlawick, P., Weakland, J. and Fisch, R. (1974) *Change: Principles of Problem Formulation and Problem Resolution*. Norton.
- [34] Nicholas, A. and Deji, O. (2023) Invisible Illness: The Consequences of Limited Health Insurance in Africa. *Health Science Reports*, **6**, e1313.
<https://doi.org/10.1002/hsr2.1313>
- [35] Chitungo, I., Dzobo, M., Hlongwa, M. and Dzinamarira, T. (2020) COVID-19: Unpacking the Low Number of Cases in Africa. *Public Health in Practice*, **1**, Article ID: 100038. <https://doi.org/10.1016/j.puhip.2020.100038>