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Embracing counseling and psychotherapy in Kenya

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Embracing Counseling and Psychotherapy in Kenya

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Abstract

This paper looks at the status of mental health in Kenya with specific focus on counseling and psychotherapy. It looks at the history of counseling and psychotherapy in Kenya, counselor education programs, accreditation, licensure and certification, current counseling and psychotherapy theories, processes and trends, and research and supervision. Its purpose is to examine how counseling and psychotherapy is developing in Kenya. It explores how Western methods of psychotherapy are being incorporated in treatment of individuals with mental illness. It also looks at possible ways in which traditional methods of healing can be incorporated into the treatment of mental illness. This study is a literature review of recently published works by various professionals involved in mental health research and training in Kenya. The counseling profession in Kenya is in its formative years, but a lot of research and training is being implemented to meet the mental health needs of Kenyans.

Embracing Counseling and Psychotherapy in Kenya

Brief History of Mental Health in Kenya

Kenya is a sovereign state that obtained independence from Britain in 1963. It is one of five East African countries in the East African Community and a member of the Commonwealth. Kenya's population currently stands at 39 million. The population growth in 2009 was estimated to be at 2.69% with the median age being 18.7 years. English and Kiswahili are the official languages but about 40 other indigenous languages are spoken within the country. There are four main religions: 45% Protestant, 33% Roman Catholic, 10% Muslim, and 10% of other indigenous beliefs (Republic of Kenya, 2014).

Kenya is one of the poorest countries in the world. The population is 39 million and life expectancy is 54 years. More than one in ten children die before the age of five and four women out of every 1000 die in childbirth. Nine percent of women and 5% of men have HIV, with rates of 10% or higher in urban areas and 6% in rural areas.

Inequality is high and Gross National income per capita in 2006 was 580 USD, lower than the Sub-Saharan Africa (SSA) average 842 USD (Kiima & Jenkins, 2010).

Although Kenya is one of the poorest countries in the world, Kenya boasts the largest economy in East Africa, with horticultural farming, tea farming, and tourism historically bringing the largest amount of income. In spite of this, the unemployment rate stood at 40% in 2009, with job opportunities concentrated in urban areas (Oketch & Kimemia, 2012). Consequently, there is a high level of rural-urban migration as large numbers of people move to the cities in search of employment opportunities. The systemic disruption of families and communities, and the disintegration of traditional support

systems are two of the factors that have created a need for professional mental health services in both urban and rural areas (Oketch & Kimemia, 2012).

The Health Service in Kenya is broadly structured into six levels: National referral hospitals (Level six), provincial general hospitals (Level five), district general hospitals (Level four), health centers (Level three), dispensaries (Level two), and volunteer community health workers (Level one). Mental Health in Kenya is primarily government funded (Kiima & Jenkins, 2010). Mental health services began with the establishment of Mathari Hospital in 1910, then called the “Nairobi Lunatic Asylum,” which is to date the only mental health hospital in Kenya. It was not until after independence in the 1960s that attempts were made to decentralize mental health services to the provincial (regional) level. Provincial Psychiatric Units (PPU’s) were established in the provincial general hospitals. These were basically 22-bed wards for the admission of psychiatric patients, but the services they provided were mainly custodial and otherwise limited because of lack of resources, especially human resources. In an attempt to further decentralize mental health services, seven district psychiatric units (DPU’s) have since been established in busy district hospitals nationwide (Kiima, Njenga, Okonji, & Kigamwa, 2004).

In 1982, Kenya adopted mental health as the ninth essential element of its Primary Health Care provision. Five years later, a division of mental health was created within the Ministry of Health. The Mental health Act of 1989 was enacted in parliament and the post of director of mental health at the Ministry, the Kenya Board of Mental Health and the district Mental Health Councils were all established. In 1991, the Mental Health act was first implemented in May. Despite these early developments in mental health, very

little implementation has since occurred. In principle, mental health care is integrated into general health care at the district level and community mental health care services developed alongside other primary care activities (Kiima et al, 2004). Indeed, people with mental disorders have been attending primary care, but apart from those with psychosis, which is relatively easy to diagnose, those with depression, anxiety and other common mental disorders are usually diagnosed as having a physical illness (Kiima et al, 2010).

The counseling profession in Kenya is, therefore, in its formative years. The professional development of counseling and psychotherapy can be traced back 20 years. This rapid growth came about from a number of factors. First and foremost, the spread of HIV/AIDS led to an emergence of Voluntary Counseling and Testing (VCT) centers that served to provide free testing and counseling with the aim of reducing the spread of HIV/AIDS. Second, the 1998 bombing of the American embassy, which left 800 people dead, led to the realization that there was need for crisis and trauma counseling. The counselors who took up this duty during this disaster realized just how under-prepared they were. Third, the government instituted Kenya National Youth Policy, which identified a key obligation to the youth of the country as the “Provision of guidance and counseling in social and academic settings” (Oketch & Kimemia, 2012 p107).

Other factors that led to a need for the development of psychotherapy have been the massive unrests in high schools and colleges, and the Post-Election Violence (PEV) that left about 1000 people dead. With the recent terrorist attack and the subsequent

trauma associated with that, there has been a demand for more services to attend to the trauma needs of the clients involved.

Although the “talking cure” is hardly new among Kenyans, the contemporary Western concept of a counselor is new and one that the wider Kenya community has been slow to embrace (Oketch & Kimemia, 2012). Most Kenyans would frown on the notion of approaching a stranger to talk about personal issues. Their approach to addressing individual and family problems has always been to seek assistance from a respected relative, village elder, or pastor. In very extreme cases, a family would seek the intervention of a traditional healer.

History of Counseling and Psychotherapy in Kenya

Historically, traditional medicine men and healers practiced caring interventions in local communities. They focused on psychosocial and spiritual matters, in addition to physical ailments. Given this cultural tradition, the introduction of applied psychology into the community was received with skepticism or denial. This attitude is rapidly changing due to the intensification of problems caused by corruption, HIV/AIDS, poverty, and the general inefficiency of the social service system. These realities underscore the urgent need for psychosocial interventions (Koinage, 2004).

Formal counseling and psychotherapy in Sub-Saharan Africa began as educational psychology with teacher training and student career counseling in a bid for human resource development. Then came pastoral counseling through churches, counseling and clinical psychology in the general public, and finally community counseling that offered Voluntary Counseling and Testing (VCT) in response to the AIDS pandemic (Mwiti & James, 2013).

The growth of counseling in Kenya has been fueled largely by events in the social educational, economic, and political arenas. Beginning in the late 1970s, the Catholic Church in Kenya embarked on a massive campaign to educate people on natural family planning methods (African Forum for Catholic Social Teachings, 1979). During this period, the practice of counseling was closely linked to the population debate; counselors were perceived as professionals who provided guidance on natural methods of family planning (Oketch & Kimemia, 2012).

In 1979, the establishment of Amani Counseling Center and Training Institute (ACCTI) also contributed to the early development of counseling in Kenya. The center was established as a voluntary organization to provide counseling services for people with emotional and psychological problems, as well as training counselors (ACCTI, 2014). For about ten years the center served as the sole training institution for counselors in Kenya, offering various certificate courses. Additionally, ACCTI offered a range of clinical services, from individual, group and family counseling to crisis interventions. As one of the oldest counseling agencies in the country, ACCTI set a precedent in its operations that has been emulated by several other counseling agencies and professional counseling organization (Oketch & Kimemia, 2012).

Another event that contributed to the development of counseling in Kenya was the first diagnosis of HIV/AIDS and the Kenyan government declaring HIV/AIDS as a national disaster in 1999. This was because after the first diagnosis was made, much of the country was unaware of the gravity of HIV and its potential impact socially and economically, leading to high death rates due to AIDS. Since then, there have been many initiatives to combat the epidemic. In 2003, the US-led Presidents Emergency Plan for

AIDS relief (PEPFAR) that provided funding to Kenya and many other African countries led to the mushrooming of Voluntary Counseling and Testing Centers (VCT) around the country. Services at the VCT centers were geared toward obtaining demographic information that was required by the funding entities; the counseling element often consisted of a brief pretest session about what one could expect during the testing procedure, actual testing, and a brief posttest counseling session (Oketch & Kimemia, 2012). Individuals conducting these sessions were often health or social workers who had very limited training in counseling interventions. Even for the trained workers, the training would likely have consisted of brief workshops and seminars with an end goal of educating individuals on the implications of the HIV test result (Oketch & Kimemia, 2012).

Since 1999, many “counseling” centers have opened their doors with little regard for specialized training requirements for counselors. This trend causes confusion in the public about what counseling really entails because it can take as many forms as there are people offering the services (Oketch & Kimemia, 2012).

Counselor Education Programs, Accreditation, Licensure and Certification

Kenya has six public universities and 11 private universities. Seven of the private universities are fully accredited by the Commission for Higher Education, a body charged with the responsibility of inspecting institutions of higher learning for the purpose of maintaining standards. The other four private universities are partially accredited (Koinange, 2004).

The counseling profession’s significant development in Kenya over the last 20 years has occurred in the absence of regulatory oversight for either the practice of

counseling or the training of counselors. As a result, counselors can now be found in virtually every sector, with the largest numbers being in HIV/AIDS VCT centers, hospitals, child protection agencies, and primary and secondary schools (Oketch & Kimemia, 2012).

The first graduate counseling-related program was established in 1988 by the United States International University (USIU Africa), a private institution based in Nairobi, Kenya (Oketch & Kimemia, 2012). USIU spearheaded high quality degree programs leading to a Bachelor of Arts in psychology and a Masters of Arts in counseling psychology. The university's vice chancellor, Dr. Frieda Brown, is a clinical psychologist whose accomplishments have contributed to the department of psychology's reputation for academic excellence (Koinange, 2004).

Masters degrees at most universities require coursework, a thesis involving a supervised research project, and a practicum or supervised field placement. Many universities have also initiated graduate programs that culminate either in a master's diploma or certificate; these programs aim to train guidance and counseling personnel. A few doctoral programs in educational psychology are also available. It has, however, been difficult for universities to mount doctoral programs in psychology because the country lacks qualified faculty in the discipline to train and supervise such advanced graduate students (Koinange, 2004). The University of Nairobi (UON) recently established a MSc and PhD clinical psychology program, though they struggle to find enough clinical psychologists to teach the program and have ended up with more psychiatrists as lecturers and a doctoral program that tends to focus on research more than clinical practice (Mwiti & James, 2013).

Unlike in the United States where counseling is clearly defined and has formalized its identity, the counseling profession in Kenya is still forming its identity. The counseling profession in Kenya continues to struggle through a maze of training options, standards of practice, and professional organizations with similar but separate missions of serving the same population (Oketch & Kimemia, 2012).

Currently, there are two major professional organizations for counselors in Kenya, namely the Kenya Association for Professional Counselors (KAPC) and the Kenya Counseling Association (KCA). The KAPC has adopted a definition of counseling used by the British Association For Counseling and Psychotherapy that describes counseling as intervention with clients “in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps their dissatisfaction with life or loss of a sense of direction or purpose” (Oketch & Kimemia, 2012 p.109). On its website, KAPC (2013 Para 2) outlines its vision as “to be the leading organization in professional counseling and adolescent behavior change through the provision of training, information, research and membership activities in sub-Saharan Africa” and its mission as “to promote opportunities for change and empower and support individuals during the process of change.” In addition to member services, KAPC also offers a number of courses in counselor education. They include a certificate in counseling, a diploma in counseling, and a bachelor’s in counseling. KAPC has also collaborated with the University of Manchester in the United Kingdom to offer a master’s degree and a doctorate degree in counseling. KAPC also offers an annual conference in counseling that brings together counseling professionals from local and regional universities, agencies, non-governmental organizations, and professionals from other African

Countries, the United States, and the United Kingdom. KAPC has recently introduced a chartered counselor designation that is legally registered and grants its holders recognition of their academic qualifications (Oketch & Kimemia, 2012).

KCA, the other prominent professional counseling organization, is consistently engaged in advocacy for the profession, encouraging its members to seek and work under supervision during their initial years of independent practice. KCA's standards of counseling and supervision credentials closely mirror state licensure requirements in the United States. KCA also offers institutional accreditation in addition to seven different accreditation levels for its members based in the member's professional training which ranges from level one, ordinary membership to level seven, senior supervisor (Oketch & Kimemia 2012).

Current Counseling and Psychotherapy Theories, Processes and Trends

The majority of psychologists and counselors in Sub Saharan Africa (SSA) have been trained to follow major models of psychotherapy developed in the Western countries such as Carl Rogers's Person-Centered Therapy, Albert Ellis's Rational Emotive Therapy and the Existential Therapy that includes Victor Frankl's Logo therapy. Play therapy is also gaining popularity due to the large numbers of children experiencing bereavement and loss related to war and AIDS (Mwiti & James, 2013).

Individual counseling is gaining popularity especially in urban areas where there is a higher concentration of trained helpers, although this service may be out of reach for individuals in poor communities (Mwiti & James, 2013). The person centered approach had gained popularity because of the client-therapist relationship as the basis for change and emphasis on qualities of the therapeutic relationship such as unconditional positive

regard, warmth, empathy, respect, and genuineness that resonate with African value systems (Okun, 1982; Mwiti & James, 2013). Cognitive behavioral therapies have been effective for substance abuse. Family systems therapy works well for African Families although factors like underdevelopment and poverty have extremely compromised the family fabric (Nwoye, 2004; Mwiti & James, 2013). Psychodynamic therapies find relevance in exploration of issues of early childhood, especially from families of origin (Shacham et al., 2008; Mwiti & James, 2013).

Many psychotherapists and counselors in SSA realize that since human needs are as unique as the individual seeking help, flexibility in the selection of an appropriate theoretical model and the wisdom to exercise integration should be the practical therapeutic approach (Mwiti & James, 2013).

Indigenous and traditional healing methods

Africa is a continent that is culturally diversified. Although there are cross-cultural and ethnic differences in Africa, there is nonetheless a general belief that both physical and mental diseases originate from various external causes such as a "breach of a taboo or customs, disturbances in social relations, hostile ancestral spirits, spirit possession, demoniacal possession, evil machination and intrusion of objects, evil eye, sorcery, natural causes and affliction by God or gods" (Idemudia, 2005 pp 11).

According to Taussing (1980), the most important thing about society is the relationship between people, and as a result we need to recognize the human relationships embodied in symptoms, signs, and therapy. Pearce (1989) also argued that "it is too simplistic to see disease as something physical, which attacks the body". According to him, disease causation can be due to "things we see and things we don't see". Many of the things we

don't see are included in African belief systems, cultural and social values, philosophies, expressions, etc. (Idemudia, 2005)

In Kenya, reinforcement of appropriate behaviors occurs through social sanctions, approvals, rewards and punishments. Fathers stayed close to their sons and modelled appropriate behavior while girls' education differentiated their roles from those of boys (Kenyatta, 1965; Mwiti & James, 2013). To this end, psychopathology, healing and wholeness are understood within a developmental perspective. The cycle of life birth, child naming, growing up, marriage and death is marked all through life with communal observances that reinforce stage to stage maturation. From a psychological perspective, positive elements of community-based puberty rites of passage form identity and belonging (Mugambi & Kirima, 1976). For individuals who deviate from the norm in terms of graduating through the age group rites of passage (M'Imanyara, 1992; Mwiti & James, 2013) the family would seek a shaman's wisdom to deal with the pathology. He might prescribe appeasing ancestral spirits, herbal treatment for development delays or family reconciliation (Mwiti & James, 2013).

In an article in the BBC, Dr. Monique Muthuru, one of the 25 psychiatrists in Kenya, reports that she sometimes refers patients she sees in her medical practice to traditional healers and thinks that particular types of mental distress might be especially suitable for treatment with traditional approaches. Cultural beliefs around the causes of mental illness, such a spirit possession or failure to honor forefathers, can sometimes fuel psychological distress, and giving patients the option of seeking traditional help can prove beneficial. However, she does not believe that treatments should be an either-or choice. She refers patients undergoing biomedical treatments to healers when they feel

that they need cleansing or additional reassurance. But, she emphasizes, they should continue taking their prescribed medication whilst they see traditional healer. The idea is to work together (BBC, 2013).

Spiritual Healing

McGuire (1997) argued that religion remains an important factor in an individual's societal integration. For one thing, it establishes unity among the group, represents a communion of believers, and contributes to consensus and moral values. For another, it wields powerful negative sanctions for noncooperation, and these appear to be more potent than earthly punishments (Ronald Marshal, 2005).

In Sub-Saharan Africa, spirituality also plays a major role in shaping communal living and psychotherapy (Mwiti & James, 2013). Many believe that life without religious observance is akin to self-excommunication from the entire life of the society. The worldview is that faith in God ensures individual and group identity and that communal worship creates spiritual connections that enhance social support and resiliency (MaMpolo, 1994; Mwiti & James, 2013). Another worldview is communal ownership of pathology. Just as healing is shared, psychopathology is also collective, and the bearer of the illness is taken care of by the group. To this end, no psychopathology is strong enough to cause excommunication of an individual. Instead, the community would share the care of the patient and together seek help for the same. Excommunication happens only in cases where there was blatant disregard for life and communalities, for example: murder, incest, or witchcraft (Mwiti & James, 2013).

Research and Supervision

Research and publishing are encouraged, especially in institutions of higher learning and among members of professional bodies, such as associations of psychologists, psychotherapists, and pastoral counselors. Findings are published locally and internationally in journals of psychology or medical practice. Most psychological research is carried out in universities, since institutions attract a larger portion of donor funding (Mwiti & James, 2013).

Supervision in sub-Saharan Africa is part of counselor and therapist training curricula and a minimum number of supervised clinical hours is mandatory for licensure by professional associations. In Kenya, the Kenya Psychological Association requires 25 hours for personal therapy and a minimum of 500 supervised client contact hours for MA Counseling Psychology, MA Clinical Psychology, and MA Marriage and Family practitioners. Holders of PhD in Counseling Psychology must have a minimum of 1,000 supervised clinical hours while Doctor of Psychology (PsyD) and PhD Clinical Psychology require a minimum of 1,500 supervised clinical hours. For example, At Oasis Africa, an active clinical location, practicum and internship students receive personal therapy as well as individual, peer and group supervision for rotations where they practice individual and group therapy (Children, Adolescent and Adults) (Mwiti & James, 2013).

There is very minimal information on how supervision and mental health research is conducted in Kenya. Students seeking a practicum site are severely handicapped by the lack of trained psychologists able to offer supervision, and those doing research are hampered by lack of funds and near total lack of equipment. Although the universities

have computer laboratories with statistical packages available to students and faculty, there is no access to laboratory space, to computers that can be programmed to present stimulus materials, or to imaging techniques or training in their use (Kariuki, Kimamo & Ginsberg 2006).

Currently in many nations in SSA, there is a scarcity of quality counseling and psychology training programs, poor integrative approaches, inadequate mental health policies, and absent or low national budgeting for service provision. These inadequacies are closely linked with poverty of research, professional practice, and supervision, all in the face of major challenges that are fast compromising mental health (Jenkins et al, 2010; Mwit & James 2013).

Future Directions

Significant effort is being made to improve the state of mental health care in Kenya. The SSA holds the capacity to set foundations for scholarship, research, practice, and innovative psychotherapies. Some civil society organizations seem to be taking advantage of this capacity. BasicNeeds, the Institute for Legislative Affairs (ILA), and the Africa Mental Health Foundation (AMHF) are emerging as leaders for the community mental health agenda in practice policy and research. BasicNeeds is doing pioneering work, bringing people together to create community-level services, raise awareness, and petition for much needed changes. The ILA is spear-heading reform to mental health policy, coordinating civil society stakeholders. The AMHF is leading important research on the effectiveness of training lay health workers in counseling skills (De Menil, 2013).

As much as SSA is endowed endless opportunities towards the development of authentic indigenous psychology and counseling models, funding for research and

affordability of treatment do not exist. Part of the reason is that to many African governments, mental health provision and research are not budgetary options (Kiima and Jenkins, 2010; Mwititi & James, 2013). In addition, following hard on the heels of colonialism, the perception of mental health is influenced by the colonial bio-medical model that emphasizes psychiatry over counseling and psychotherapy. With the absence of mental health policies in many countries in this region, the need for quality research-driven practice will continue to suffer (Mwititi & James, 2013).

Hopefully, this might change for Kenya with the implementation of the Mental Health Bill 2013 which went before the Kenyan Parliament in 2013. The new legislation will replace the Mental Health Act 1989, which mainly relates to hospitals and the circumstances in which someone can be hospitalized. The new version of the bill includes provisions for prevention and addresses recovery as a notion- both important steps which reflect a change of approach. It also makes reference to human rights and establishes a Mental Health Board that could be an important structure in overseeing the provision of mental health care (De Menil, 2013). There is hope that the same enthusiasm for resources for research and interventions that have gone into psychiatry training and mental illness programs will be shown in the field of counseling and psychotherapy, since the two are co-dependent (Mwititi & James, 2013).

For a society continuing to experience many psychosocial challenges, SSA is coping relatively well due to resiliency created by strong indigenous values, the African family, the community fabric, and reliance on faith and spirituality. This is the hope that emerging therapists need to explore (Garcia, Pence, & Evans, 2008; Mwititi & James, 2013). However, a major threat is the encroachment of a global value system through

social networks, media, music, and mobility, aspects that tend to dictate values that are more illusion than reality. Implications exist for counselor and therapist training to keep pace with the volatile populace. Informed by African indigenous worldviews of wholeness and integration, counselors and psychotherapist in SSA will need to assume a vocational perspective of an integrated mentor, teacher, and trainer with a bio-psycho-social-spiritual-relational perspective cognizant of individual and group survival (Mwiti & James, 2013).

Conclusion

Counseling and psychotherapy in Kenya is a very young profession that is still in its formative years. It is facing many challenges in terms of counselor training, research, and practice. However with these challenges comes an opportunity for enrichment and advancement of the field. Most of the mental health research seems to be basically focused on psychiatry and psychology. For there to be advancement in the field of counseling and psychotherapy, institutions that focus on training of counselors need to be actively engaged in mental health research on best practices.

Kenya is a diverse community with over 42 ethnic communities. These indigenous communities have rich traditions that influence and will continue to inspire new approaches to mental health. It is important to realize that psychotherapy is an ethnocentric practice cultivated mainly in Western societies, which was then exported to SSA. So, it is still unfamiliar with local communities who may rely on traditional healers for treatment of mental illness and emotional discomfort. Hence, there is a need to figure out appropriate ways of integrating traditional healing methods into counseling and psychotherapy. Cultural dimensions cannot be ignored.

In SSA traditional healers are typically contracted by local communities to both diagnose and treat illnesses. Depending on the diagnosis, traditional healers would use herbal medication or traditional rituals. An example of a popular herbal medication that has been used by traditional healers is a plant with psychiatric medicinal properties and has been used for treating severe psychotic conditions going back to 1925 is *Rauwolfia* which is rich in reserpine. This plant in many parts of Kenya and Tanzania especially around the Mt. Kilimanjaro area where it also grows in the wild. It is known for the treatment of 'madness', which is psychosis regardless of the cause or type (ATPS, 2013). These traditional healers could be included in the treatment of mental illness by informing them of how to identify an illness and how to effectively manage it. Traditional rituals such as appeasing ancestors who might have been wronged and hence cause an individual to be ill-can also be incorporated in treatment.

Hence, it is important for counselors within SSA to be knowledgeable about the cultures of their clients and to operate from the perspective of the realities their clients understand. It may be difficult to transfer one culture or one way of being into another; however, common elements and principles can be identified and integrated, even though other concepts and methods may not. For instance, although practices of rituals are not expected to be incorporated into conventional psychotherapeutic practices, their underlying principles such as ensuring high level activity, physical exercises, emotional arousal, and interpersonal exchanges-all of which make for personal empowerment and are health promoting - can be incorporated into counseling (Bojuwoye, 2005).

It is also important for counselors in the SSA to be aware of how a certain community conceptualizes mental illness. For example, what ideas and beliefs do family

members use to understand the delusional beliefs of a loved one? How do they talk about this behavior? What specific words and ideas do they employ? How does the local understanding of the illness impact the beliefs, behaviors and self-conception of the ill family members?

This integration can be achieved through research and training. Culture specific research and training will inform core activities that are the best clinical practices that will enhance the delivery of mental health services.

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