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The Heresy of African-Centered Psychology

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This paper contends that African-centered models of psychopathology represent a heretical challenge to orthodox North American Mental Health. Heresy is the defiant rejection of ideology from a smaller community within the orthodoxy. African-centered models of psychopathology use much of the same language and ideas about the diagnostic process as Western psychiatry and clinical psychology but explicitly reject the ideological foundations of illness definition. The nature of the heretical critique is discussed, and implications for the future of this school of thought are offered.

KEY WORDS: African Americans; African-centered psychology; cultural psychiatry; heresy; nosology.

For some time, African American scholars have written about the need to incorporate issues of race and culture into the practice of psychology. [2] In addition, some psychologists have applied cultural concepts to specific groups within the Diaspora, such as Caribbean Americans.[3] Initially, there was a great deal of resistance to accepting these ideas. Indeed, psychological models of theory and practice that emphasize cultural concepts regarding African Americans, Asian Americans, Latin Americans, and Native Americans are still not considered "mainstream," but rather, "ethnic minority psychology." However, over time, these challenges to the orthodoxy have been tolerated within what Wolpe calls a controlled cultural space for noncomformist thought.[4]

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[2] Though this work is too voluminous to review in detail here, the reader is referred to Boyd-Franklin, Carter, and Greene's, "Considerations in the Treatment of Black Patients by White Therapists."
[3] See Brent and Callwood, and Gopaul-McNicol.
[4] Wolpe, "The Holistic Heresy," 913–923.

African-centered psychology has pushed the cultural psychology envelope by making the cultural foundation more stringent: psychological theories in this school rest more strongly upon traditional African cultural thought and behavior. In this regard, African-centered theories of psychopathology are unique to individuals of African descent and do not use the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM)* as the diagnostic foundation. In African-centered psychology, mental disorder does not refer solely to individual intra-psychic malfunction but includes a larger context of social and political reality. Mental health is defined by that which promotes the survival and liberation of people of African descent, both individually and collectively. In turn, dissonance from traditional African value systems and collective survival is what constitutes disorder. Brought to the fore is a richer matrix within which to conceptualize and treat dysfunctional behavior.

This paper argues that African-centered models of psychopathology are a form of heresy to North American Mental Health (NAMH). Heresy occurs when a subgroup attacks the orthodoxy from within, using much of the same language, but reinterprets reality and reframes values in novel terms. Heresy also includes a component of defiance, as this is what defines the position as something other than ignorance or error.[5] In addition, heresy can only come from someone without the power to define ideological orthodoxy, not from the ruling elite. It is important to note that other challenges take place in science, but not all of them are heretical. For example, challenges to knowledge products (whatever the professions "sell" to the public) and to authority (i.e., the right of the profession to define its jurisdiction) are not heretical but simply dissent and rebellion, respectively.[6] Heresy attacks ideology itself, calling into question the linguistic constructs and legitimacy of the orthodox cultural model.

African-centered models of psychopathology exemplify these characteristics of heresy. First, the models are proposed by psychologists of African descent, a subgroup of NAMH; these models did not originate outside psychological discourse. In addition, this subgroup is not part of the power-wielding elite that categorizes and defines mental illness in society. Second, African-centered models are defiant, in that they ardently reclaim the power to define illness rather than allowing that power to remain solely in the purview of orthodox psychiatry. Akbar cogently argues that the ability to decide who is sane or insane is one of the ultimate measures of power and community integrity.[7] African-centered models explicitly reject orthodox notions of mental illness from within NAMH by: 1) using communal rather than individualistic reference points for diagnosis; 2) openly acknowledging and integrating the politics inherent in diagnosing abnormality;

[5]Wolpe, "The Dynamics of Heresy in a Profession," 133–1148.
[6]Ibid.
[7]Akbar, "Mental Disorder Among African-Americans," 18–25.

and 3) referencing traditionally African, rather than European, cultural thought and behavior.

This paper will examine the heretical challenge of African-centered psychopathology by articulating the boundaries of African-centered heresy, reviewing the ideological tradition of orthodox NAMH and discussing the implications of a heretical stance on the growth of African-centered diagnosis and treatment. Here, NAMH refers to clinical psychology and psychiatry collectively. Although the two disciplines focus on different aspects of mental illness (e.g., psychotherapy vs. pharmacotherapy), they share several fundamental similarities. First, both agree that mental illness is an individually-defined construct. That is, illness occurs within the psyche or within the neurobiological substrates of the brain. Second, both disciplines generally reject an emphasis on societal processes. Third, both disciplines presume the universality of illness, such that illness constructs are presumed to be applicable to all human beings. Thus, depression is depression, wherever and in whomever it might occur; there is no such thing as a gender-specific depressive disorder, for example. In addition, both disciplines use the same nosology of mental illness, the *Diagnostic and Statistical Manual for Mental Disorders (DSM)*.[8] Finally, both disciplines are founded on Eurocentric values and behaviors.

It is also important to recognize that each discipline relies on the other to maintain the boundaries and legitimacy of the profession. Psychiatry needs clinical psychology in order to show why some disorders require biomedical intervention and to reify the categorization of psychiatry as a medical science. In turn, clinical psychology needs psychiatry to show why not all mental disorders can be easily cured with pharmacotherapy; deep-rooted intra-psychic conflict is best solved by talk therapy. Also, because psychologists do not have the power to define illness categories, they can only treat those who meet criteria for mental disorder as given by psychiatry. Psychologists may see patients in their private practices that have "Messed Up Disorder NOS," but any treatment that takes place in the context of reimbursement by the health care system requires a *DSM* diagnosis. Thus, clinical psychology is not only wedded to but also dependent on the maintenance of the diagnostic orthodoxy. This includes the acceptance of the apolitical, universalistic stance underlying psychiatry. African-centered psychology's heresy lies in the rejection of this stance.

AFRICAN-CENTERED PSYCHOLOGY

One could make the claim that culturally-specific models are necessary because, when the standard nosological system has been applied to individuals of

[8]American Psychiatry Association, *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed. (Washington, DC, 1994).

African descent, diagnostic inequities have resulted.[9] These studies reveal that NAMH has not provided culturally-appropriate care for individuals of African descent. African-centered psychology goes further, into heresy, by calling into question the legitimacy of the fundamental orthodox ideologies using a culturally-specific cosmology and survival thrust and arguing that traditionally African worldview and behaviors best represent "normal" or optimal behavior. Conversely, deviance from traditional African cultural thought and behavior, over-reliance on Western ideology, or negativism towards the African/African American collective is categorized as disordered. Putative disorders in this framework are described below.

Alien-Self Disorder

Individuals with this disorder have been socialized to be other than themselves, resulting in primarily materialistic goals, such as social affluence and prestige, and membership in "exclusive" organizations. There is a denial and/or indifference of social realities, particularly as they relate to race and oppression, and an emphasis on imitating the dominant group.[10]

Anti-Self Disorder

Individuals with this disorder add the dominant group's projected hostility and negativism toward African Americans to the characteristics of alien-self disorder. As a result, these individuals may engage in behaviors that are detrimental to their communities and are more attentive to outgroup approval.[11]

Individualism

Individuals with this disorder adhere to European-centered "rugged individualism." Value is placed on the desire and practice of being unique or different and primarily "looking out for number one," and a communal orientation is rejected.[12]

Mammyism

This condition refers to certain behaviors thatAfrican American women exhibited during slavery as a means of survival, including the presentation of being

[9] See, for example, Adembimpe, et al., "Racial and Geographic Differences in the Psychopathology of Schizophrenia," 888–891; Fabrega, Mezzich, et al.; Neal-Barnett, Smith, et al.; Strakowski et al. "The Effects of Race on Diagnosis and Disposition"; Strakowski et al., "The Effects of Race and Information Variance on Disagreement Between Psychiatric Emergency Service and Research Diagnoses in First-Episode Psychosis"; and Whaley.

[10] Akbar, "Mental Disorder," 18–25.

[11] Ibid.

[12] Azibo, "African-Centered Theses," 173–214.

non-threatening, nurturing and selfless, with demonstrations of love, devotion and loyalty to the oppressor rather than to the women's own families. Today, some African American women practice defunct slave-like social behaviors such as taking ownership of authority figures' troubles (e.g., employers), demonstrating self-sacrifice and self-denial in order to benefit the White power structure, and succumbing to Eurocentric ideals of beauty. These behaviors, which are no longer adaptive, are considered Mammyism.[13]

Materialistic Depression

Individuals with this disorder use material goods (or the lack of them) as a major criterion for judging themselves and/or others. These individuals seek the accumulation of money and status symbols that they regard as having some intrinsic value above and beyond their economic value.[14]

Self-Destructive Disorder

Individuals with this disorder engage in self-destructive behaviors such as substance abuse, violence, and negative health behaviors. These behaviors are seen as attempts to survive in a society which frustrates efforts at normal growth and development.[15]

Theological Misorientation

Individuals with this disorder hold beliefs or allegiances to and engage in the practice of a theology or religion-related ideology incompatible with Afrocentricity or the African cosmology.[16] These beliefs have often historically been used in the service of African oppression. Azibo asserts that Africans throughout the world possess other people's holy books, and that these other people now possess the previously African-owned resources. Theologically misoriented behaviors can include depicting the Divine as of European descent or denigrating traditional African spiritual systems.

Taken together, these "illnesses" reflect many of the psycho-spiritual and socio-historical forces that threaten the well-being of individuals of African descent in a society powerfully underlined by racism and cultural hegemony. By marking a reference point for judging deviance rather distally (i.e., a traditional African ethos), African-centered psychology describes an idealized African self. Gaines states that "classifications are less attempts to classify disease than to articulate an idealized cultural-, age- and gender-specific self";[17] the *DSM* is indeed

[13] Abdullah, 196–210.
[14] According to Braithwaite and Taylor as cited in Azibo, 1989.
[15] Akbar, "Mental Disorder," 18–25.
[16] Azibo, "African-centered Theses," 173–214.
[17] Gaines, 19.

an articulation of an idealized *European* self. African-centered psychology rejects the Eurocentric self and, with it, behaviors that embrace self-negation. Abdullah states it plainly: "to devalue one's culture is a disorder."[18] The heterodoxy of such an assertion is easily seen. However, a review of basic tenets of orthodox NAMH is necessary to illuminate fully the heresy of African-centered psychology.

THE ORTHODOX IDEOLOGY OF NAMH BIOMEDICAL EPISTEMOLOGY AND DISEASE CLASSIFICATION

In 1968, Erwin Ackerknecht described psychiatry as the youngest branch of medicine, one which suffered from the hostility directed against the mentally ill patients it treats.[19] Alexander and Selesnick also claimed that in psychiatry's early days,

> . . . while psychiatry was considered a part of medicine, it was kept in a marginal position. The psychiatrist was primarily a custodian and not a healer. And, were it not for mental disturbances that apparently were due to physical causes, the psychiatrist would have had no contact with his fellow physicians or even a common language with them . . . in our century a scientific revolution has taken place: psychiatry has come of age. On the strength of substantial achievements, it has ceased being medicine's neglected stepchild and become one of the most prominent fields in medicine.[20]

Today, psychiatry consistently ranks near the bottom in prestige hierarchies among physicians and/or medical students, and psychiatrists are often not recognized as medical doctors by lay people.[21] As a result, psychiatry continues to resist stepchild status via a rigid epistemology of biomedical constructs that exclude sociopolitical concepts. Once practiced primarily from a model of psychoanalytically-oriented treatment, psychiatry has become increasingly focused on pharmacotherapy and biological substrates of disorder. Psychiatry tends to operate from a defensive and dogmatic adherence to the ideology of modernism and displays a fetishized preference for science.[22]

Psychiatric training is largely oriented towards treating psychopathology as brain dysfunction, as an organic disease process to be uncovered and treated with medication. Psychiatric residents are taught to conceptualize mental anguish as if it were cardiac disease, whereby psychosis and depression become written on the body. Much is at stake in maintaining such a position. Psychiatry's very status as a legitimate medical specialty is dependent on its adherence to a nosology of disorder based on the mind and measurable, "objective" treatments such as drug therapy.[23] Indeed, Gaines argues that *DSM*-III's move from psychological

[18] Abdullah, 205.
[19] Ackernecht.
[20] Alexander and Selesnick, 4.
[21] Rosoff and Leone, 321–326.
[22] Lewis, 71–84.
[23] Fernado.

to biological explanations of mental disorders is a result of psychiatry's need to rationalize and justify the increasing use of pharmacological treatments.[24]

As psychiatry has fought a long battle to become respected as a "hard" science so, too, has psychology. In 1913, Watson argued that the proper focus of psychology should be on objective, observable behavior rather than the "unscientific" introspection paradigm.[25] Similarly, Helmholtz is credited as being a great pioneer of psychology for revealing that neurological processes could be subject to rigorous laboratory experimentation, as well as for integrating "lawful and mechanistic" principles of sensation.[26] Piaget is also lauded for stressing the organic and biological nature of the mind. As psychology moved away from a psychophysics paradigm, an emphasis on mental process with an attendant disconnection to the body became prominent. Descartes is thought to have created the groundwork for modern psychology,[27] and he is famous for stating, "I think, therefore I am."

Today, treatment in NAMH is firmly bound by Cartesian mind-body dualism. For example, treatment focuses on "mental" problems and observes when patients are "somatisizing." Gaines makes a stronger point: the very existence of psychiatry as a discipline reveals the dualism in U.S. medicine; without it, the disease classifications for psychiatry and medicine would be the same.[28] Although psychiatry uses a different classification schema than the rest of medicine, it relies on the same methods and boundaries in characterizing illness.

For example, a fundamental notion in NAMH is that psychiatric illnesses are discrete entities that are "discovered" in nature. Moreover, neurobiological correlates (e.g., neurotransmitter activity) are taken as evidence that psychiatric constructs are analogous to the diseases typically treated by allopathic medicine. However, even medical disease categories shift historically; in seventeenth century England, individuals were classified as dying from such varied afflictions as "itch," "cut of the stone," "grief," "Mother, rising of the lights," and "Stopping of the stomach."[29] Too, understanding the etiology of classified diseases has changed from a moral valence emphasizing sinfulness to present day secularized biomedical paradigms. Yet, NAMH acts as if psychiatric classification systems are scientific truths, rather than culturally constrained rules, which are not naturally occurring phenomena.[30]

The fluidity of psychiatric nosological rules reveals that disorders are, in fact, constructed rather than discovered. For example, Passive-Aggressive Personality Disorder was a diagnostic label in *DSM*-III and *DSM*-III-R, but upon the publication of *DSM*-IV, it was only a "criteria set under further study." By the time *DSM*-V is released, it may well be again defined as a mental illness. Blashfield

[24]Gaines, 3–24
[25]Fancher.
[26]Ibid.
[27]Ibid.
[28]Gaines, 3–24
[29]Bowker and Star.
[30]Szasz.

and Fuller found that the number of pages associated with each edition of the *DSM* has steadily increased.[31] And, as the number of pages and words has increased, so have the diagnostic categories. In *DSM*-I, there were 128 total disorders; in *DSM*-IV, there are 357. The authors contend that the growth process associated with the *DSM*s has passed reasonable bounds, and scientists should begin sorting out which of the existing categories represent valid diagnostic concepts. The growth of putative mental disorders reflects the reality that these diagnostic categories do not represent naturally occurring diseases; even schizophrenia, the most "serious" mental disorder, has no symptoms that are unique to it as a syndrome.[32]

It is ironic that NAMH has yet to explicate what is "normal" functioning. In the final analysis, normality can only be described as whatever is *not* in the *DSM*.[33] In any case, psychiatric classification is often defined by the symptoms themselves. For example, a child who *acts* oppositional is said to *have* Oppositional Defiant Disorder, a supposed discrete mental disorder. In pediatrics, a child who vomits would not be diagnosed with "Vomiting Disorder"; this symptom would be investigated for any number of disease processes. NAMH's narrow focus on symptoms neglects socio-cultural determinants of illness and relies on psychiatric "truth" being revealed in abstract, depoliticized concepts. Psychiatric disorders are routinely shorn of cultural epiphenomena,[34] precluding a contextualized understanding of behavioral dysfunction.

EUROCENTRISM AND CULTURAL FOUNDATION

At worst, NAMH reflects deeply racist ideologies that are cloaked in scientism and objective truth. For example, in 1913, Evarts argued that slavery was, in fact, beneficial to Africans because imitating European slave owners ameliorated their lacking mental initiative.[35] This "scientific" view was consonant with the social mores at the time, which saw Africans as more animal than human. A few years prior to the publication of this paper, Africans from the continent were being displayed at the St. Louis World's Fair with monkeys.[36] Evarts' paper is ostensibly a scientific treatise on the mental status of Africans but is clearly little more than rationalization for the racist behavior that governed the United States–what Fairchild terms scientific racism.[37] Indeed, Western science has often attempted to support what Thomas and Sillen describe as two basic themes of racism.[38] The

[31] Blashfield and Fuller, 4–7.
[32] Gaines, 3–24.
[33] Haley.
[34] Fabrega, "Culture and History in Psychiatric Diagnosis and Practice," 391–405.
[35] Evarts, 388–403.
[36] Guthrie.
[37] Fairchild, 101–115.
[38] Thomas and Sillen.

first theme is that Black people enter the world with inferior brains and limited capacity for mental growth; the second is that the Black personality is abnormal, whether by nature or nurture.

As recently as 1973, Henry Garrett, a past president of the American Psychological Association, stated that the Black man's brain is on average smaller and less complex than those of Whites; this was given as supporting evidence against racial integration.[39] An oft-cited problem-solving heuristic is Thomas' "missionary-cannibal" problem where "three missionaries and three cannibals stand on one side of a stream, with a boat capable of carrying just two people. All six people are to be transported to the other side. At least one person must be in the boat during each crossing. Cannibals must never outnumber missionaries on either side of the river."[40]

At best, the Eurocentric worldview underlying NAMH tends to see culture as a separate category of human experience which generally "complicates" one's understanding of people[41] and conceptualizes individuals of European descent as the normative standard. For example, a case book published soon after *DSM*-IV did not include the terms "race," "culture," or "ethnicity" in the index at all, and case studies list only the sex, age, and occupation of the patients described.[42] The *DSM*-IV itself failed to incorporate adequately culturally-based text, resulting in a "Cultural Formulation Outline" being placed in the Ninth Appendix rather than the Introduction, as was proposed.[43] Other sections on cultural considerations were also omitted entirely.[44] In addition, references to culture throughout the book were scarce, superficial, and disguised or enmeshed with age, gender, and socioeconomic factors.[45]

Gaines argues that the *DSM*s represent a Northern Germanic, adult male voice and that the *DSM*s reflect particular cultural-historical processes by which certain ethnic Western selves comment on themselves or others.[46] The "self" in European thought has been described as enclosed by boundaries of individualism, personal control, and a self-concept that excludes other persons.[47] By extension, the theoretical foundations of psychotherapy include Eurocentric values, such as individualism, rational and scientific thinking,[48] action orientation, status and power, and the Protestant work ethic.

These values are viewed as catalysts for scientific progress and healing. In psychiatry, emotion is an insult to the ideal self; it is distinct from rational

[39] Guthire.
[40] Cited in Baron.
[41] Hays, 309–315.
[42] Frances and Ross.
[43] Mezzich, et al. "The Place of Culture in *DSM*-IV," 457–464.
[44] Mezzich, et al., "Culture in *DSM-IV*," 407–419.
[45] See Alarcon, 260–270 and Kleinman, 343–344.
[46] Gaines, 3–24.
[47] Dana.
[48] Comas-Diaz and Greene.

thought and the enemy of balance and control.[49] Emotion is generally an insult to the structure of the European scientific process which underscores "objectivism." Modern medicine itself is founded on a disregard for the personal sentiments of the researcher.[50] Thus, a synergy of science and spiritual concerns is viewed with suspicion and skepticism, if not outright hostility. Oshodi states that American psychology maintains alliances with the framework of natural sciences such as physics and chemistry, and that a distinct element shared by these areas of science is antispiritualism.[51] He also points out that what are viewed as scientific revolutions in psychology, in fact, represent different periods of myth. Psychoanalysis, for example, though couched in the lingo of empiricism is, in essence, a mythological system; indeed, Watson reportedly called it, "voodoo."[52]

In summary, the ideological understructure of NAMH is founded on Eurocentric values of individualism, hierarchy, rational thought, and anti-spiritualism and is realized in a biomedical approach to illness. These values stand in stark contrast to an African-centered worldview,[53] and thus are inappropriate as a diagnostic fulcrum for individuals of African descent. Here, core values such as collectivistic and spiritual orientations are salient among varied groups throughout the Diaspora, as briefly reviewed below.

AFRICAN CULTURAL THOUGHT AND BEHAVIOR

A deep sense of spirituality and oneness with nature is focal in African cultural thought and behavior. Mbiti argues that he has not come across a single African people who do not have knowledge of God.[54] Among the Yoruba, the presence of divine spirit is felt to be constant, and in all undertakings, individuals put divinity first and call upon spiritual blessing, support, and succor.[55] An emphasis on a higher life-force and connectedness to spirit also affects other aspects of life, such as concepts of time. Because time is seen as inseparable from the life force, the rhythm of time is not seen as quantifiable and constant. Rather, time is simply part of the natural essence of actual experience. A spiritual orientation also translates into a harmonious relationship with nature.

The value of collective orientation rather than individualism is well documented in African historical and anthropological literature. Mbiti states that:

> . . . in traditional life, the individual does not and cannot exist alone except corporately. He owes his existence to other people, including those of past generations and his contemporaries. He is simply part of the whole . . . only in terms of other people does the individual

[49]Gaines,3–24.
[50]Gursoy, 577–599.
[51]Oshodi, 172–182.
[52]Ibid.
[53]See Azibo, "Articulating the Distinction," 64–97; and Baldwin, 216–223.
[54]Mbiti, "Man in African Religion."
[55]Bolaji Idowu.

> become conscious of his own being, his own duties, his privileges and responsibilities towards himself and towards other people.[56]

He discusses the ways in which African fables stress the value in group solidarity and the danger in individualism.[57] Finally, an ethnographic account of the Zhun/twasi (!Kung), a hunter-gatherer group in southern Africa, illustrates the importance of collective responsibility and acknowledgment of the group. Among the !Kung, when obtaining food, most hunters alternate hunting with long periods of inactivity, in order to allow others to receive praise and attention from the group.[58]

In the African worldview, relationships with others also extend into the past and future, and concepts of health are imbued with this notion of extended self. Ogbonnaya states that the idea of "a single self constricted within a physical prison called the body, whose only health is to remain monolinearly focused, can hardly be said to be African."[59] In classical and traditional African medicine, disease is viewed as personal and collective disharmony, wherein the afflicted is out of balance physically, spiritually, and with the community.

In traditional African societies, the concept of kinship is paramount in social organization and sense of self, both individual and collective. Mbiti describes kinship as controlling social relationships and determining the behavior of one individual toward another.[60] Indeed, this sense of kinship is even extended to cover animals, plants, and non-living objects. Wright describes the ways in which kinship networks were carried over to North America during the slave trade,[61] and Boyd-Franklin illuminates how these networks continue to serve as a fundamental way of being in African American communities.[62]

Because African value systems center on interpersonal and spiritual connectedness, there is a consequent lack of focus on materialism. Opoku states that an Akan proverb recounts, "Onipa ne asem. Mefre sika a, sika nnye me so; mefre ntama a, ntama nnye me so. Onipa ne asem," which translates to, "It is the human being that counts. I call on gold, gold does not respond; I call on drapery, but it does not respond. It is the human being that counts."[63] This proverb illustrates that the centrality of wealth is derived by human contact and quality of relationships rather than possessions. Moreover, whatever material wealth one acquires is expected to be shared amongst others. Owomoyela describes the protagonist of Yoruba trickster tales as being incomparable in his miserliness, a trait that is shown to be a character deficit in these tales.[64]

[56] Mbiti, *African Religions and Philosophy,* 106.
[57] Boateng.
[58] Shostak.
[59] Ogbonnaya, 79.
[60] Mbiti, *African Religions*.
[61] Wright.
[62] Boyd-Frabklin.
[63] Opoku, 10.
[64] Owomoyela.

Taken together, these core values serve as the starting point for a diagnostic normative reference point in African-centered psychology and are thought to be applicable to all individuals of African descent. This means that although Africans who lived through the particular cultural epochs of America faced very different circumstances from those who lived in the Caribbean or on the continent, these traditional core values are thought to supersede the idiosyncratic context of the new environments Africans faced. As a result, the significant variation in the African experience is not addressed, despite the fact that African-centered "diagnoses" are based on experience and interpretation of that experience. The literature on African personality assumes that Africans were all taken from the mother continent and sent to varied geographical locations, but that the core facets of expressed personality are derived from the original place of origin. Thus, the concept of an African-centered psychopathology assumes that personality dysfunction for African descendants can be assessed using the same deep cultural structure as the original reference point, despite the fact that these values are not static, unchanging systems.

Still, there is utility in thinking broadly about what it means for an individual to come from a heritage in which these values have historical weight. Just as terms such as "Eastern philosophy" may paint a broad brush across a number of ethnocultural groups but still retain some useful heuristics in thinking about worldview, the same is true for "African culture." It is also important to note that peoples of African descent are not the only groups who are oriented towards collectivism; certainly, there is voluminous literature documenting such a worldview among many cultures. The critical factor here is that *because* African culture does tend to cohere around these values, a diagnostic paradigm which is founded on a set of opposite Western values and ignores relevant sociopolitical concerns, is less useful in this population.

THE FAILURE OF ORTHODOX NAMH

The *DSM*-IV diagnostic criteria of Antisocial Personality Disorder (APD) are illustrative of why orthodox constructions of mental disorder can misrepresent maladaptive behaviors among individuals of African descent. The primary criteria for APD center on failure to conform to social norms with respect to lawful behavior, such as aggressive/assaultive acts, lying, stealing, destroying property, or pursuing illegal occupations. Other features of Antisocial Personality Disorder include "irresponsible work behavior" (e.g., significant periods of unemployment despite job opportunities) and "financial irresponsibility" (e.g., failure to provide child support). Associated features such as "history of many sexual partners," failure to sustain a monogamous relationship, spending many years in penal institutions, and a greater likelihood of dying prematurely by violent means are also given. Finally, Antisocial Personality Disorder is stated as "associated with low

socioeconomic status and urban settings" and is reportedly "much more common" in males than females.[65] The euphemisms above essentially refer to poor, Black, urban males, the most criminalized segment of American society.

Criminal and sociopathic behaviors have historically been attributed to Black people, particularly males.[66] It is interesting to note that "white-collar" crimes are not seen as "antisocial." Indeed, Nuckolls argues that "the prototypical antisocial person whose behavior does not invoke criminal sanctions is powerfully equipped to function in the world of consumer capitalism."[67] What is missing from the APD diagnostic schema is any contextual understanding of how and why these "antisocial" behaviors originate and are maintained.

For African-Americans, many of the terms and features that are used to diagnose APD have long-standing historical roots. For example, Akbar discusses work in the African-American community and its connection to the forced labor of slavery. He points out that during slavery, work was not only a chore but also a punishment, which began in early childhood and continued until death or disability.[68] Moreover, this work was entirely to the benefit of the slave owners. As a result, Akbar argues, work is often equated with enslavement and freedom with the avoidance of work. Clearly, these factors alone do not explain patterns of work or unemployment among African Americans. Factors such as institutional racism, educational inequities, job availability and economic conditions are real obstacles. However, when taken together, these factors remind us to consider social context, both present and historical, in diagnosing "mental disorder."

The associated features of sexual and parenting behaviors in APD are also clearly related to broader forces. Akbar's discussion also reveals the enduring legacy of slavery on the African-American family.[69] During this time, African-American manhood was systematically denied. Rather than providing for and protecting his family, the African man was evaluated by his ability to withstand strenuous work and to impregnate women to create more slaves. Any attempts to assert himself as a man or to engage in more appropriate representations of manhood were punished severely, potentially by death. Today, in many communities, some African-American men continue to express their manhood through fathering children. Akbar points out that men seeking to be men through sexual or physical exploits is, in fact, predictable when natural avenues to manhood have been systematically blocked.[70] Similarly, many African-American women, including adolescents, evaluate their own worth by being "breeders."

Finally, in terms of criminal behavior and tendency to experience violent crimes and incarceration, we again see that *DSM*-IV's conception of illness is

[65] American Psychiatric Association, 647.
[66] Greene, "Considerations in the Treatment of Black Patients," 389–393.
[67] Nuckolls, 45.
[68] Akbar, *Chains and Images*.
[69] Ibid.
[70] Ibid.

artificially abstracted and centered on individual character flaws. The diagnostic criteria ignore the fact that even law-abiding Black males are systematically profiled by law enforcement as criminals, and that Black men are more likely to be prosecuted and to receive harsher sentences than White men for the same crimes. As a result, the etiology of criminal behavior remains to be articulated in the diagnostic features of APD. Wright questions why African-American men commit crimes in their own communities and die in violent ways; in other words, why they are programmed for self-destruction.[71] Wilson contends that "the violent Black-on-Black narcissistic criminal in his triumph reveals his self-contempt, cowardliness, and contempt for his people. His violent narcissism reveals that he cannot believe his real self to be truly lovable . . . The Black-on-Black violent criminal hates in other Blacks those characteristics he hates most in himself."[72] This analysis reveals an alternate way of conceptualizing violence, one that is informed by culturally relevant life experience.

African-centered conceptions such as Self-Destructive or Anti-Self Disorder more fully illuminate the scope of many of the maladaptive behaviors described by APD. Still, it is interesting to note that African-centered conceptions of disorder are not at odds with the core *DSM*-IV definition of mental disorder. The *DSM*-IV defines mental disorder as "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress . . . or with a significantly increased risk of suffering death, panic, disability, or an important loss of freedom."[73] African-centered theorists would agree that individuals of African descent who operate with anti-self values are more likely to engage in behaviors that are destructive to themselves and their communities, resulting in increased risk of death, disability, or loss of freedom.

In addition, the essential diagnostic feature of personality disorders in *DSM*-IV is described as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifested in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control."[74] African-centered personality disorders simply use African cultural thought and behavior as the reference culture, and disorder is defined accordingly. Personality disorders defined in *DSM*-IV can also "be complicated by the fact that the characteristics that define a Personality Disorder may not be considered problematic by the individual (i.e., the traits are often ego-syntonic)."[75] The same is true for African-centered disorder. Indeed, Kambon argues that, by and large, culturally misoriented Africans do not experience anxiety or confusion around their identity because the Eurocentric

[71] Wright, 15–17.
[72] Wilson, 75.
[73] American Psychiatric Association, xxi.
[74] Ibid., 630.
[75] Ibid., 630.

social system in the United States generally fosters and reinforces a Eurocentric worldview.[76]

AFRICAN-CENTERED PSYCHOLOGY'S HERETICAL CHALLENGE

Despite these areas of concordance, the heresy inherent in the African-centered paradigm is clear. African-centered psychology represents an attack on the orthodoxy both in rhetoric and in failing to maintain the institutionalized self of NAMH. In terms of rhetoric, the deconstruction of universal mental illness is heretical. As previously noted, NAMH is founded on a biomedically-constructed definition of illness whereby all people can become afflicted by any illness. African-centered psychology rejects that premise and contends that individuals of African descent can be diagnosed with disorders that are contained solely within the group. When we imagine the idea of a *DSM* categorizing "American" mental illnesses, the heresy of African-centered psychology is evident. Indeed, attempts at defining Western culture-bound syndromes in the *DSM* have been rejected by the orthodoxy of NAMH.[77] Kleinman points out that 90% of *DSM* categories are, in fact, culture-bound to North America and Western Europe, but the "culture-bound" label is only applied to "exotic" syndromes outside Euro-American society.[78]

By offering culturally-specific models, African-centered psychology unifies varied ethnic groups of African descent as a whole, an unorthodox concept in the social sciences generally. Soyinka highlights the sense of "Africanness," or continental unity various African groups share.[79] For example, the Yoruba refer to themselves and their descendants in the Diaspora as *enia dudu*, the black peoples. African-centered psychology is informed by this Pan-Africanist worldview and proposes that African people throughout the Diaspora could be diagnosed with any of the African-centered disorders.

The parameters of disordered behavior in African-centered psychology and the distinction of a "natural order" make a definition of normal behavior explicit. As one example, Azibo describes the ultimate goal of intervention with a client as fostering Africentricity.[80] In other words, "normal" behaviors are those that evidence a strong cultural identity and promote the sustenance of the group. NAMH resolutely refuses to define normal behavior, and, in any case, would not use group-based norms as the criterion.

African-centered psychology's illness definitions are heretical because they are informed by social constructs located outside the scope of NAMH's supposed scientific objectivism, individualism, and apolitical theory. By including

[76] Kambon.
[77] Mezzich, et al., "Culture in DSM-IV," 407–419.
[78] Kleinman, 343–344.
[79] Soyinka.
[80] Azibo, "Treatment and Training," 53–65.

concepts such as identity, spirituality, community, and sociopolitical well-being, African-centered psychology has redefined the scope of science, and thus questioned the institutionalized self. In addition, Wolpe suggests that a defining characteristic of a profession is the use of a common language that is only partially understood by outsiders.[81] Disorders such as Alien-Self Disorder are framed in everyday language and can be understood and even "diagnosed" by lay people. This linguistic shift breaks the ritualized secrecy surrounding NAMH.

Most importantly, an Africentric conception of mental health questions the very legitimacy of psychiatry. As Wolpe contends, heretical beliefs divest the orthodoxy of its cultural prerogatives.[82] In this case, African-centered models are heretical because they debate who ought to have the power to define what is adaptive and what is maladaptive behavior. As noted earlier, the construction of illness definition has heretofore been solely the province of medicine (psychiatrists). Here, psychologists have entered the forbidden city, and constructed illness definitions that are not easily reduced to biomedical ephemera.

IMPLICATIONS OF A HERETICAL AFRICAN-CENTERED STANCE

What is the future of African-centered psychology's heretical challenge? Holistic medicine has been described as a heretical movement in biomedicine, and although it was dismissed as quackery by the orthodoxy, "today, biomedicine not only tolerates these cranks and magicians, it finds itself incorporating their philosophical positions into its medical model and their alternative therapies into its medical regimen."[83] This outcome can be conceptualized as co-optation; adopting the practices of a group without accepting them as practitioners.[84] This process is one of several that may be used by the orthodoxy to force conformity by the heretic; others can include isolation, subjugation, absorption or suppression.

Perhaps most relevant to African-centered psychology is suppression, the first instinct of the orthodoxy.[85] Heretics who go too far or press too hard can be "excommunicated." That is, because journals, university posts and funding sources are controlled by the orthodoxy, scientists who make heretical challenges can be isolated from orthodox institutional practices and find their work suppressed.[86]

The African-centered literature has tended to appear within the relevant flagship journal, *Journal of Black Psychology*, or within other related, specialized journals such as the *Journal of Black Studies*, or the *Western Journal of Black Studies*. The end result is extremely limited visibility, significantly reducing the

[81] Wolpe, "Holistic Heresy," 913–923.
[82] Wolpe, "Dynamics of Heresy," 1133–1148.
[83] Ibid, 1134.
[84] Ibid.
[85] Ibid.
[86] Ibid.

chances of a powerful heretical movement. Nagayama Hall and Maramba showed that there is a paucity of cross-cultural and "ethnic minority" research published in American Psychological Association journals, and African-centered psychology is no exception.[87]

Sue reviews research that shows that few empirical articles have been published on African Americans.[88] If "mainstream" research on African Americans is wanting, it is logical to expect that a heretical subgroup of literature would be given even less visibility. The orthodoxy regularly engages in defensive, ethnocentric perspectives when confronted with challenges to the cultural ideology and makes it difficult for cultural heretics to gain footing in the scientific discourse.[89] More recently, several scholars have begun to question the utility of "race" in scientific research,[90] further reducing the likelihood of race-based notions of mental disorder being widely accepted. When we also consider that the Academy tends not to be receptive to psychologists of African descent who practice African-centered psychology, we are faced with a number of obstacles to a successful heretical challenge.

While a heretical stance has the potential to revolutionize the knowledge base and practice of a field, it appears that even within the larger umbrella of Black psychology, African-centered psychology has perhaps been too heretical for its own good. That is, with the exception of relatively new work by preeminent scholars in the field, African-centered models of psychopathology have entered into a deep slumber and are relatively invisible even among psychologists who emphasize culturally appropriate treatment.

Treatment models that are informed by Africentric thinking are abundant,[91] and some writers have proposed alternative, culturally-specific *DSM* diagnostic paradigms. However, a fuller articulation of putative African-centered disorders has yet to appear in the literature. Such an exposition might include finely tuned criteria directly translatable to clinical practice and empirical/epidemiologic investigation of the constructs. Without such work, scholars who seek to employ these models are asked to base their work on theory alone. It is perhaps this state of affairs that has left African-centered mental disorders out of current discourse.

It is also true that in order to conduct psychological research and practice from an African-centered perspective requires exposure to cultural concepts during training. NAMH has not made this a priority. For example, the American Psychological Association's task force on the "Delivery of Services to Ethnic Minority Populations" was not established until 1988, after the APA had been in

[87] Nagayama Hall and Maramba, 12–26.
[88] Sue, 1070–1077.
[89] See, for example, Fowers and Richardson, 609–621.
[90] See Helms and Tallyrand, 1246–1247; Oppenheimer, 1049–1055; and Thomas.
[91] For instance, Belgrave, et al., 386–401; Franklin and Pack-Brown, 237–245; Longshore, et al., 319–332; Cherry, et al., 319–339.

existence for ninety-six years, reflecting the tendency to avoid examining issues of difference, particularly due to discomfort.[92] As late as 1994, 74% of programs did not require even one course on diverse populations for completion of the doctorate, and 48% of programs preferred "generic" training. More recently, scholars have commented on the minimal integration of culture into curricular plans. Not surprisingly, clinicians often do not view themselves as competent to serve a diverse clientele. It is clear that the integration of culture is not a priority of NAMH.

African-centered psychology should look to other models of cultural psychiatry for strategies in broader implementation. For example, Latin American psychiatrists have a longstanding history in creating culturally viable diagnostic systems for Latino populations. Described as local glossaries, nosologies such as the *Cuban Glossary of Psychiatry* and the *Latin American Guide for Psychiatric Diagnosis* provide culturally-specific formulations of mental disorder that are based on the everyday experiences of users.[93] This work has been extended to such orthodox institutions as the World Health Organization (and its diagnostic system, the *International Classification of Diseases*). Whether African-centered psychological concepts will be implemented on this scale remains to be seen. However, in the final analysis, it is clear that African-centered psychology must in some way broaden its scope to a larger stage or risk permanent suppression.

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[92] Greene, 389–393.

[93] Berganza, 443–446.

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