African socialisation: the application of cross-cultural methodology

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An African socialisation model is presented considering three dimensions and different levels of acculturation (traditional, transitional and modern). The tri-dimensional model (authority, group and body-mind environment) is detailed in a complex matrix of conceptual categories on person or object-oriented interaction and explicated in two detailed case vignettes of culturally different healer-patient interactions.

Keywords: acculturation, culture, healer-patient interaction, psychopathology, psychotherapy, social interaction, transitional African

Introduction

For the construction of an African socialisation model, variations in contemporary African populations need to be included, following three distinctive components of the people inhabiting present-day sub-Saharan Africa: (1) traditional persons who are as yet little affected by modernisation and who are functioning within the established and seemingly timeless framework of their culture; (2) transitional persons, often living in, and shuttling between, the two cultures in the course of their daily round of activities e.g. between work and home or between the temporary urban dwelling and the ancestral traditional village where their extended family continues to reside; and (3) modern individuals, participating fully in the activities of the contemporary, industrial or post-industrial world. As yet, these important distinctions have not been taken into account in most empirical studies of personality in Africa. If it is assumed that this trichotomy is relevant to personal experience and functioning, its disregard may then have contributed to the error variance in the studies extant and may have distorted the resulting findings. In the case of the transitional person especially, overlooking these distinctions may have increased the share of unaccounted for intra-individual variation and complicated and misshaped the results obtained (Peltzer 1995).

The socialisation of traditional and transitional persons can be illustrated in the form of a model in three dimensions: the authority dimension (vertical, diachronic, historic); the group dimension (horizontal, synchronic, social); and the body-mind-environment dimension.

The traditional person is always newly constructed through situational variables of the authority, group and body-mind-environmental dimensions, whereas for the Western personality an assumption of continuity is made which is oriented towards primary socialisation. For example, the causes of the brain-fag syndrome, which is prevalent in African students, can be explained through a disorder in the authority, group and body-mind-environment dimensions.

In the authority dimension the ancestors are ‘unhappy’ because the student denies his/her tradition by ‘worshipping’ foreign ‘gods’, in the form of the Western, formal and abstract education based on achieved and not ascribed status.

In the group dimension the student is in a conflict between his/her present individualistic and competitive educational culture and his/her past collective and co-operative culture of childhood. The fusion with the group from primary socialisation can no longer be practiced in secondary socialisation, since the student’s activities are aimed at the ideology of achievement and independence from the group.

In the body-mind-environment dimension, the student faces conflicts between the microcosmos (body-mind) and the macrocosmos (environment), and between body and mind. During primary socialisation, there has been an emphasis on socialisation by people in the authority and group dimensions (microcosmos), whereas during secondary socialisation there is an emphasis on socialisation of the environment (macrocosmos) with objects like books. As a result, the one-sided acquired technological intelligence separates the body-mind unity of primary socialisation and leads to increased body and affect control (unpleasant head symptoms, fatigue and sleepiness in spite of adequate rest, and visual difficulties), and disorders in the mind (inability to grasp the meaning of printed symbols and sometimes spoken words, and poor retention).

A cross-cultural socialisation model

The different variables shown in Table 1 indicate, according to the differential person and object-oriented interaction,
As in most cross-cultural studies, the applied constructs of the three dimensions and the conceptual categories serve as both descriptive and explanatory variables. Therefore, further conceptual-empirical and methodological aspects need to be considered, so as to avoid false conclusions. The indicator ‘person/object-oriented interaction’ requires further analysis on different levels and in different contexts to avoid false inferences. ‘Person/object-oriented interaction’ can be differentiated on the following levels of analysis: (1) culture; (2) individual orientation; and (3) social interaction. On the conceptual-empirical side, the construct ‘person/object-oriented interaction’ is less dependent on the variance of analytic main effects than on the reciprocal interaction, with regard to personality and situational effects. It has been shown that differences in psychological dimensions among members of different cultures cannot be depicted without considering inter-individual differences within a particular culture and the specific situations triggering certain behaviour.

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Person-oriented and object-oriented interaction tendencies are not exclusive, but psychologically inclusive. In order to identify these effects more precisely, the construct ‘person/object-oriented interaction’ includes relatively independent factors like age group, peer group and body/emotion-mind.

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### Table 1: Cross-cultural socialisation model

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Conceptual category</th>
<th>Person-oriented interaction</th>
<th>Object-oriented interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group (vertical/</td>
<td>Time frame</td>
<td>- cyclic</td>
<td>- linear</td>
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<tr>
<td>diachronic)</td>
<td></td>
<td>- episodic</td>
<td>- continuous</td>
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<td></td>
<td></td>
<td>- processual</td>
<td>- structural</td>
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<td></td>
<td>Time focus</td>
<td>- present</td>
<td>- past/future</td>
</tr>
<tr>
<td>Role model</td>
<td>authority/control/punishment as:</td>
<td>- care</td>
<td>- sanction</td>
</tr>
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<td></td>
<td>- clear-cut</td>
<td>- ambiguous</td>
<td></td>
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<tr>
<td>Peer group (horizontal/</td>
<td>Gender focus</td>
<td>- separated</td>
<td>- mixed</td>
</tr>
<tr>
<td>synchronic)</td>
<td></td>
<td>- distinct</td>
<td>- diffuse</td>
</tr>
<tr>
<td>Gender identity</td>
<td>- strong</td>
<td>- weak</td>
<td></td>
</tr>
<tr>
<td>Age and peer group</td>
<td>Identification</td>
<td>- person-centred</td>
<td>- object-centred</td>
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<tr>
<td></td>
<td></td>
<td>- multilateral</td>
<td>- unilateral</td>
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<tr>
<td>Control focus</td>
<td>- external</td>
<td>- internal</td>
<td></td>
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<tr>
<td></td>
<td>- public</td>
<td>- private</td>
<td></td>
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<td></td>
<td>- shame</td>
<td>- guilt</td>
<td></td>
</tr>
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<td></td>
<td>- formal</td>
<td>- informal</td>
<td></td>
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<tr>
<td>Defence/coping</td>
<td>- projection</td>
<td>- introjection</td>
<td></td>
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<tr>
<td></td>
<td>- identification</td>
<td>- reaction formation</td>
<td></td>
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<td></td>
<td>- avoidance</td>
<td>- isolation</td>
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<td></td>
<td>- denial</td>
<td>- undoing</td>
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<td></td>
<td>- somatisation</td>
<td>- displacement</td>
<td></td>
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<tr>
<td>Core relationship</td>
<td>- hierarchical</td>
<td>- egalitarian</td>
<td></td>
</tr>
<tr>
<td>(parents-children)</td>
<td></td>
<td>(husband- wife)</td>
<td></td>
</tr>
<tr>
<td>Adult-child relationship</td>
<td>- united</td>
<td>- separated</td>
<td></td>
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<tr>
<td>Libido/respect</td>
<td>- age group</td>
<td>- peer group</td>
<td></td>
</tr>
<tr>
<td>Aggression</td>
<td>- peer group</td>
<td>- age group</td>
<td></td>
</tr>
<tr>
<td>- unity</td>
<td>- dualism</td>
<td></td>
<td></td>
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<tr>
<td>Body/emotion-mind</td>
<td>Focus</td>
<td>- body/emotion</td>
<td>- mind</td>
</tr>
<tr>
<td>Cognitive/emotional style</td>
<td>- consensus-centred</td>
<td>- conflict-centred</td>
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<tr>
<td></td>
<td>- co-existence of opinions</td>
<td>- disagreement of opinions</td>
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</tr>
<tr>
<td></td>
<td>- narrative</td>
<td>- monoeausal</td>
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</table>
the cultural level 'intercultural variations', on an individual level 'intra-cultural variations' and on the therapist-patient interaction level, 'situation-specific variations' can be depicted.

In order to demonstrate basic cultural differences between a traditional and transitional African person, two case vignette examples of the first interview in a therapist-patient consultation are described below: (1) the traditional healer with a traditional patient, and (2) the Caucasian author with a transitional Kenyan client.

**The traditional healer with a traditional patient (see Peltzer 1987)**

Traditional healer (TH): When you write, you sometimes feel as though there is darkness in your eyes – especially when you are writing. (directive, no question; clear cut role model) Patient (PT): Yes (multilateral identification, respect towards authority or age group)

TH: Also when you are reading you have tears coming from your eyes – does that happen? (episodic time frame, present time focus)

PT: Yes. (consensus-centered cognitive/emotional style, no real (only somatic) self-disclosure)

TH: And when you sit somewhere you find that you start perspiring – sweating too much, is it true? [The following is summarised] Sometimes you feel very cold. Sometimes after you have eaten, you suddenly feel hungry. Your leg feels sometimes as though it is paralysed. (body focus, episodic time frame, somatic defence)

PT: Yes. (coexistence of opinions)

TH: You sometimes feel as though you are alone – although there may be people chatting to you, you still do not talk; you remain silent. Am I lying? (public/shame locus of control)

PT: No. (respect towards authority, age-group)

TH: Vyanusi [spiritually caused acute confusional state] is in the background but foremost is vimbuza [spirit disorder: conversion or dissociation disorder or depressive neurosis], it is not witchcraft. Your uncle used to look for medicine for you – ages ago – he used to help a lot of people. Am I lying? (hierarchical core relationship [ancestors-parents-children], external control focus, multirelational concept of illness [vyanusi, vimbuza, witchcraft], united ancestors-adults-children relationship, multilateral identification [the healer and the uncle], narrative cognitive/emotional style [your uncle. ...ages ago... he used to], projection as method of defence [supernatural etiology: vyanusi, vimbuza, witchcraft])

PT: No. (consensus-centered cognitive/emotional style)

TH: Sometimes when you wake up in the morning you feel pain in your arms when you stretch them. Am I lying? (cyclic, episodic time frame, body focus)

PT: No. (respect towards authority, etc.)

TH: Sometimes when you wake up you feel as though you want to fall when you stand up. Then you say that you want to remain standing or seated for a long time before you walk – there is some witchcraft involved – jealousy – that money – they feel you have a lot of money and your fellow villagers feel they want to fix you. At work there is little cooperation – that is where it all starts from. But then when you have the money, you do not know how to spend it wisely. Something goes wrong inside your head. You cannot hold your capital. You have a big vimbuza problem, that is why you sometimes feel dizzy. Anything else – any complaints? (patient focused, the healer does generally more of the talking, external/public locus of control, etc.)

PT: No, none. (clear cut/caring role model, method of defence: avoidance [since he does not voice disconsensus, which does exist]

Healer-patient interactions like this one are generally shorter and less continuous than Caucasian therapist-patient interactions, which refer to the present time focus, multilateral identification, external/public locus of control and the hierarchical core relationship (ancestors-parents-children) (cf Table 1).

**The Caucasian author with a transitional Kenyan client**

Therapist (T): Can you tell me something about your problem? (patient and not therapist focused)

Client (C): My problem, I would really like to know myself more, I don’t think I understand myself. (monocausal cognitive/emotional style, avoidance as defence [since he does not approach his problem])

T: Yes (client centered)

C: There are times when I am strong and have faith in myself but there are times when I am not strong at the same time, I am almost certain that I must be having a complex. I have an inferiority complex. (processual time frame [changes over time], past-future time focus [inferiority complex])

T: Like how? (mind focus, directed towards self-disclosure)

C: Maybe I am invited for lunch and you opt not to go for that lunch because you are new in a company and you don’t know what is going on in this strange environment. (episodic time frame, public locus of control)

T: What is your profession? (clear-cut role model, therapist centered)

C: Professionally, I am a teacher in a secondary school. (present time focus)

T: What subjects are you teaching? (past-future time focus, conflict-centered cognitive/emotional style)

C: Chemistry and biology, that is up to March this year. Then I started with a consulting firm. (ambiguous role model)

T: You did this because of the money, or why did you change the job? (monocausal/conflict-centered cognitive/emotional style)

C: Hm, as I have told you sometimes, I do something that I am not very sure of, if I try to trace as to why I did this, the cause; originally, I knew I wanted to be a surgeon, when I was in school, and after some time I had a chance, I didn’t make it very well to do medicine, so I had an option of joining veterinary medicine or teaching but I opted to go for teaching. Why I didn’t go for animal health I don’t know. It was close to the field I have actually taken, I decided for teaching. Now, as I try to trace it, I can see the heart was not really in teaching, maybe there is a lot of time to do other money making things, the desire was there to pursue education. (conflict-centered cognitive/emotional style, client centered)

T: What else, any other problem? (hierarchical core relationship: therapist-client)

C: Those are the major ones. Sometimes I do things on impulses because when I try to analyse some of the things I do, okay, I just see people suffering and I feel I ought to give, I mean, if I don’t give I feel guilty and sometimes I just give too much. (respect towards authority, narrative cognitive/emotional style, public/shame and guilt locus of control)
T: Give me an example of the suffering. (monocausal cognitive/emotional style)
C: When I am walking along the street, I might just look at a beggar on the street, maybe look at a child and sometimes I feel very bad, I am just moved by the situation. (external locus of control, narrative cognitive/emotional style)
T: So you would give the beggar too much. (monocausal cognitive/emotional style)
C: Sometimes I would give too much, it will depend on the situation. (cyclic time frame)
T: How much was it last time? (linear time frame, monocausal cognitive/emotional style)
C: Last time I gave 50 Kenyan Shillings (about the fare of 20 times for 10km distance by bus). (consensus-centered cognitive/emotional style)

[In the following text two more examples are given of situations where the client gives in over-easily to help people in need. His body and sleep is okay. Dreams he cannot remember, he is single and 28 years old. He is the only son who has gone as far as university education. On exploration about the father it came out that he had a car accident when the client was in Form 3.]

I met my brother crying and he told me that he had an accident. In 1974 he was released momentarily. I remember I came back from school. I just looked at the legs, the plaster and I cried.

[He remembered that people went to donate blood, the father got paralysed and still has a wound that does not heal.] (client centered self-disclosure)
T: When you were in Form 3 attending school, were you concerned and worried about your father at that time? Did it affect your studies? (past-future time focus, introjection as method of defence)
C: I never thought much about the problems at home (at that time he only knew his father was in the hospital but had not seen him). I was conscious of them.
T: Did you do well in school? (mind focus)
C: Yeah, I used to do very well; actually I used to lead the class in Form 3 and Form 4. (mind focus)
T: How was it in Form 5 and 6?
[after he had seen the father the first time when he was on home visit from the hospital after three years admission] (monocausal cognitive/emotional style)
C: The performance was not very good. I dropped a bit. Actually, I should have gone for the arts, but actually I just pressed for the sciences. That is when the problem came. I used to be very good in history and literature. (past-future time focus)
T: So you wanted to do sciences and become a surgeon in order to help your hospitalised father, and now when you see people suffering like your father you would not like to be reminded of your father (your performance in history became worse in class) but you still want to help your father. Not being able to help him, you have the urge of helping people who are suffering like your father in order to appease your guilty conscious. (conflict-centered cognitive/emotional style)
C: Yes, I think so. (consensus)

T: [Makes reference to a case who suffered from symptoms following the ‘denial’ of the death of his father] (narrative)
C: [Reveals that he fears to die himself and has heart palpitations and palm sweating when talking in public and in strange places]
T: [Before it was revealed that the family including the father and the client had supper prior to the accident of the father] Now it may become clear why you avoid going for lunch on invitation. You may be unconsciously reminded of the ‘last supper’ with your father before his accident but also of your own possibility to die and thus developing heart palpitation. (past-future time focus)
C: Yes. (consensus)

T: [Prescribes specific tasks like identifying and recording of situations of helping excessively, fear, and dreams] (clear-cut role model and locus of control, present time focus)

The first part is clearly client-centred, whereas the last part of the interview is more therapist-centred — giving interpretations, making reference to cases, explaining about psychotherapy, the use of behavioural tasks etc. In this case there is no body focus, as is often the case, but some of the depressive or anxiety symptoms are not expressed as much in terms of feelings but in regard to specific rituals in human interaction. The client uses both modes of interaction, person- and object-oriented interaction; however, there is an emphasis on categories pertaining to the ‘person-oriented interaction group’, whereas the Caucasian therapist uses predominantly categories pertaining to the ‘object-oriented interaction group’, but a number of categories from the ‘person-oriented interaction group’ are also used (cf Table 1).

Note
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References