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Health Psychology in African Settings

A Cultural-psychological Analysis

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Abstract

African settings provide an important context in which to examine the relationship between cultural beliefs and health. First, research in African settings helps illuminate the sociocultural grounding of health and illness: the idea that beliefs play a constitutive role in the experience of distress. Second, research in African settings helps to illuminate the cultural grounding of health sciences: the idea that theory and practice reflect particular constructions of reality. We examine these ideas in the context of three research examples: the prominent experience of personal enemies; epidemic outbreaks of genital-shrinking panic; and fears about sabotage of vaccines in immunization campaigns.

Keywords

- *enemyship*
- *genital-shrinking panic*
- *health beliefs*
- *mass psychogenic illness*
- *polio vaccination*

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THIS ARTICLE addresses the topic of health psychology in African settings from the meta-theoretical perspective of cultural psychology (Shweder, 1990). Although popular understandings equate a cultural perspective with exploration of diversity, the goal of the article is *not* to describe how health and illness beliefs vary across African cultures. Instead, the goal is to illuminate a more general process that is typically invisible in more mainstream scientific approaches: the extent to which the health and illness experience is grounded in particular constructions of reality associated with different cultural worlds (Adams & Markus, 2004).[1] Applied to the case of African settings, this perspective can serve two important purposes.

Understanding health and illness in African settings

The first purpose of a cultural perspective is to provide a more adequate understanding of health and illness in African settings. The reigning paradigm in mainstream health science is a biomedical model that locates the ultimate sources of illness in biochemical pathogens or structural malfunctions operating at the level of the individual body. Recent contributions to this journal have criticized this model for propagating an individualistic account of health and illness that deflects attention away from the socioeconomic and political context (e.g. Campbell & Murray, 2004; Hepworth, 2006). This shortcoming is particularly serious when one considers health and illness in African settings, which are consistently rated among the least healthy in the world (see United Nations Office of the High Representative for the Least Developed Countries, 2006). An adequate health psychology for African settings requires that scientists locate the ultimate sources of well-being and disease beyond the behaviors, beliefs and physiological processes of individual bodies, and instead in the broader socioeconomic and geopolitical structures that contribute to the production (and reproduction) of health-threatening environments.

The present analysis considers another way in which mainstream health science suffers from an overly individualist account. Specifically, we propose that the atomistic worldview implicit in the biomedical model deflects attention away from the cultural grounding of health and illness. Although mainstream health psychology does not deny the role of belief in health and illness experience (indeed, one might regard this topic as its raison d'etre), it often treats belief as a thin layer of interpretation that moderates the more basic, physiological processes of health and illness. In contrast, a cultural perspective holds that beliefs are often *constitutive* of health and illness (Good, 1994). They are not merely epiphenomenal attempts at post-hoc explanation, but instead play an inseparable role in the production and experience of well-being and distress. By emphasizing the constitutive role of belief, we hope to promote a better understanding of (and more productive response to) suffering in African settings.

The focus of this analysis is both specific beliefs such as spiritual causation or sorcery (see de-Graft Aikins, 2004; Geschiere, 1997; Meyer, 2003; Mullings, 1984) and more general constructions of reality that include the material *realization* of beliefs in institutions, practices and artifacts (Berger & Luckmann, 1966; Moscovici, 1984). With respect to the latter, a guiding concept is what Markus and her colleagues (Markus, Mullally, & Kitayama, 1997) have referred to as *selfways*: beliefs, cultural models and social representations that both afford and promote particular habits of mind regarding experience of self and social reality.

Discussions of the selfways that inform experience in many African settings appear in work by Africa-based psychologists (e.g. Naidoo, Olowu, Gilbert, & Akotia, 1998; Nsamenang, 1997), Black psychologists within the African Diaspora (e.g. Nobles, 1986) and ethnographers working in African communities (e.g. Piot, 1999; Riesman, 1986; Shaw, 2000). Common to these discussions is an emphasis on the ontological experience of inherent connection not only to other people (both living relatives and dead ancestors), but also to place, spiritual forces and a sense of built-in order (Geschiere & Gugler, 1998; Tengan, 1991). Another relevant feature of these selfways is an interdependence of cognition and affect or mind and body. In contrast to mainstream psychological approaches that privilege rational mind over emotional body, the selfways that are prevalent in many African settings promote a relatively holistic experience that integrates mind and body (or cognition and affect; Parham, White, & Ajamu, 1999).

Revealing the cultural grounding of mainstream health psychology

The second purpose of a cultural perspective is to help reveal the typically invisible, cultural grounding of mainstream health psychology. A cultural perspective helps to reveal how accounts of health

and illness in mainstream health science are not a simple reflection of objective reality, but instead are grounded in particular constructions of reality that also require explanation. Again, the reference here is to both specific beliefs and general constructions of reality like selfways. Rather than pre-existing fields of relational force, the selfways that typically inform mainstream health science locate the foundations of experience in the internal properties of inherently separate individuals. Rather than a sense of inherent connection, these selfways promote an ontological experience of inherent insulation from social and physical context. Rather than an experience of mind–body integration, these selfways promote an experience of mind and body as relatively separate phenomena (Markus et al., 1997). The investigation of health and illness in African settings helps to illuminate these constructions of reality and their influence on health science.

Empirical examples

The sections that follow consider these ideas in the context of three empirical examples: the prominent experience of personal enemies (Adams, 2005), epidemic outbreaks of genital-shrinking panic (Adams & Dzokoto, 2007; Dzokoto & Adams, 2005) and fears about sabotage of vaccines in immunization campaigns (Clements, Greenough, & Shull, 2006; Obadare, 2005). Although typical accounts construct these phenomena as a pathological mixture of paranoia and superstition, our account emphasizes the normality of these phenomena. More important, our account considers how health scientists' reactions to these phenomena are not neutral observations of objective facts, but instead reflect particular constructions of reality that are themselves open to question.

Example 1: prominent experience of personal enemies

Our first empirical example comes from research on *enemyship*: personal relationship of hatred and malice in which one person desires another person's downfall and attempts to sabotage that person's progress (Adams, 2005). The view within mainstream health science is that normal people in normal circumstances do not have personal enemies, especially not within close ingroup spaces. Indeed, within mainstream psychological science (and the worlds that it reflects), the claim to be the target of enemies is a sign of paranoia, delusion and lack of contact with reality.

Although characterized as abnormal in mainstream psychological science, concern with personal enemies tends to be prominent in many African worlds. This concern is explicit in painted vehicle slogans that express ideas like 'No [person] without enemy' (Kyei & Schreckenbach, 1975), calendars that advertise and celebrate divine protection from enemies (Adams & Dzokoto, 2003) and stickers with messages like 'I am afraid of my friends, even you!' (Adams, 2005). It is implicit in practices like *divination*, an investigation technique that frequently locates the sources of misfortune in the mischief of enemies (cf. Kirby, 1993; Tengan, 1991); *infant seclusion*, the practice of hiding mother and newborn child for several days to protect against harm from envious observers; and *sorcery* or *witchcraft*, a rough category of techniques for sending magical harm to enemies or defending oneself against such harm (Assimeng, 1989; de-Graft Aikins, 2004; Field, 1960; Geschiere, 1997; Mullings, 1984).

Besides these observable representations, the prominent concern with personal enemies also extends to private experience. Across diverse settings in the West African country of Ghana, the proportion of people who claim to be the target of personal enemies ranges from 60 percent to 92 percent (compared to 12–25 percent of people across diverse settings in the USA; see Adams, Anderson, & Adonu, 2004). Moreover, roughly half of the Ghanaian participants who report personal enemies also report that the identity of these suspected enemies remains hidden (Adams, 2005). A typical response goes like this: 'I don't know my enemies, but I know that I have them. One day something will happen to me, and then I will know that this person has been after me all along.' Responses like these reveal the extent to which the prominent concern with personal enemies is a collective representation—an expectation based on local cultural models—rather than a conclusion based on personal experience of an enemy relationship. However, even when participants claim unidentified enemies, they typically have in mind certain social locations—if not always specific people—from which they anticipate enemies. These locations include such intimate spaces as family and relatives, and participants often cite proverbs like '*Otan fi fie*' (i.e. 'Hatred comes from the house'; Kyei & Schreckenbach, 1975) to express this idea.

How is one to explain apparent differences in the experience of enemies? By treating the prominent concern with enemies as the thing that requires explanation, most accounts imply that the source

of differences lies in something pathological about African worlds. For example, noting its association with practices like sorcery, many observers assume that concern with enemies is a manifestation of ignorance or superstition (see related discussion by Meyer, 2003). Noting its association with the concept of paranoia, other accounts propose that concern with enemies reflects collective psychopathology (Parin, Morgenthaler, & Parin-Matthey, 1980).

A *cultural perspective: enemyship and embeddedness*

Rather than ignorance, paranoia or some other distortion of reality, a cultural perspective links the prominent concern with enemies to a more neutral source: the experience of embeddedness associated with local selfways. Everyday life in many African communities promotes an experience of embeddedness in which enemies, like any other relationship, are a more-or-less inevitable fact of social existence.[2]

Evidence for a link between local selfways and the prominent experience of enemies comes from a variety of sources. One source is the explicit remarks of interview participants who link this concern to the embeddedness of everyday life, particularly in the context of family and relatives (Adams, 2005, Study 1). A second source is questionnaire responses: specifically, positive correlations between indicators of the experience of embeddedness and the concern with personal enemies (Adams, 2005, Study 2). Finally, evidence for a causal link between local selfways and enemy experience comes from an experiment in which the investigator randomly assigned Ghanaian students to write about ways in which they were inescapably connected to other people (Adams, 2005, Study 3). Participants in this *embeddedness treatment* condition completed ambiguous word stems (e.g. _ IN and HA _ _) with more family-relevant words (e.g. *K*IN) and enemy-relevant words (e.g. HA*TE*) than did students in a *no-treatment control* condition. Results of this experiment suggest that, at least among students at the University of Ghana, the experience of embeddedness can be sufficient to promote a construction of relationship in which *family* and *enemyship* are highly accessible and related concepts. From this cultural perspective, the prominent concern with enemies does not reflect lack of contact with reality-in-general (i.e. individual psychopathology), but instead reflects contact with particular realities that promote the experience of embeddedness.[3]

Even if the prominent concern with enemies is not the reflection of individual pathology, one might consider it a form of *social* pathology to the extent that it fosters harmful consequences like suspicion, distrust, hoarding, secrecy and witch hunts (Foster, 1961; Jackson, 1975; Mullings, 1984). Without denying that the prominent concern with enemies can have such harmful consequences, a cultural perspective provides a more nuanced account that frames these consequences as one side of more neutral constructions that also have a positive side (Geschiere, 1997, p. 7). For example, the same selfways that promote concern with enemies also provide such benefits as 'assurance of membership and support' (Bohannan, 1971, p. 55). Indeed, the concern with enemies may serve a positive social function by enforcing obligations of material support and motivating well-off people to redistribute resources as a means to avoid the envy and resentment of their less fortunate relatives and neighbors. In short, rather than frame concern about enemies as unambiguous evidence of social pathology, a cultural perspective locates this phenomenon in broader constructions of reality that have both positive and negative aspects.

Turning the lens: sense of freedom from enemies

By emphasizing the prominent concern about enemies in many African worlds, the explanatory focus of the previous section resonates with the constructions of reality that inform scientific imagination. However, this focus also reveals a subtle bias. It treats the prominent concern about enemies in African worlds as the deviant phenomenon that requires explanation, while implying that the sense of freedom from enemies in science-exporting spaces is unremarkably normal and without need of explanation.

Against this background, a second way in which a cultural perspective contributes to understanding is to turn the analytic lens away from an exclusive focus on African settings to a focus on science-exporting spaces as the object of analysis. Rather than the unfiltered expression of context-free human nature, our research locates the sense of freedom from enemies in particular constructions of reality: namely, selfways that promote an experience of relationship as the discretionary product of inherently insulated selves. Like the selfways that promote experience of enemies, these selfways have both positive and negative correlates. On the positive side, these selfways afford a sense of freedom to avoid personal enemies; however, on their

negative side lies the potential for social isolation (among other possibilities; cf. Baumeister, 1997).

In this way, the strategy of turning the lens provides an alternative response to pathologizing interpretations of concerns about personal enemies. Specifically, one can admit that these concerns have pathological aspects but hold that these are no more pathological than the sense of freedom from enemies that passes for normal in mainstream psychological science. With respect to individual psychopathology, one can admit that beliefs about enemies may have some irrational elements, but hold that they are no more irrational than beliefs that intimate spaces are free from enemies or that one is unilaterally capable of preventing negative connection.

With respect to collective realities, the sense of freedom from enemies in science-exporting spaces has two negative consequences for health in African settings. The first concerns models of social support and caregiving.[4] Informed by cultural models of relationship as the discretionary product of inherently insulated selves, psychologists tend to emphasize such benefits of personal relationship as companionship and assistance in times of need while downplaying the ways in which relational connection can be a cost or burden. Yet, rather than an unambiguously positive resource upon which people draw in times of stress, relationships themselves can be a significant source of stress (Rook & Pietromonaco, 1987). Rather than a safe space in which to find social support, intimate relationships are often a place of risk and danger (Spitzberg & Cupach, 1998).

A cultural perspective suggests that the construction of intimate relationship as an unambiguously supportive space operates in mainstream health psychology as an 'imposed etic' (Berry, 1969): a culturally particular construction of reality that becomes adopted by scientific institutions and applied across settings as a context-general law of human nature. This imposed etic blinds psychologists to the dark side of relationship, even within the 'western' settings that inform scientific imagination. However, the consequences of this imposed etic may be especially problematic in African settings, where it clashes with constructions of intimate relationship as a potential source of malice and hatred. Constructions of intimate relationship as a supportive space may blind health professionals to the suffering of people in many African settings who—because their healthcare decisions often occur in the context of family relationships—must seek support from spaces that they perceive to be fraught with danger.

The second way in which the sense of freedom from enemies has consequences for health and illness in African settings concerns the notion of 'social pathology'. Although suspicion of enemies may promote 'social pathologies' associated with distrust and envy, a cultural analysis suggests that these are no more pathological than social pathologies associated with the sense of inherent insulation from negative connection. In particular, the sense of social insulation may afford people the peace of mind to consume scarce resources and appropriate collective goods, happily oblivious to the broader social consequences of their activity. Framed in this way, the sense of freedom from enemies constitutes one cultural belief—albeit of people in high-consumption, science-exporting societies—that contributes to suffering in African settings. By directing attention to the impact of these beliefs and associated consumption patterns on health in African settings, the present analysis resonates with recent critiques of mainstream health psychology as an overly individualist enterprise that ignores the broader geopolitical context of health and illness (e.g. Campbell & Murray, 2004; Hepworth, 2006). A cultural analysis emphasizes that public health and community development require not only programs that educate people in African settings about health behaviors, but also programs that educate people in 'developed' societies about the potential effects of their behaviors (including patterns of consumption) on health and community development in African worlds.

In this way, a cultural analysis extends the focus of health psychology to consider the collective construction of health and illness realities. Far from a neutral or objective rendering of events, the biomedical model—with its corresponding focus on internal bodily processes and individual behavior—constitutes a politically consequential construction of reality that obscures the broader structural and geopolitical forces that pose an ongoing threat to public health in African settings. Whether intentional or not, this individualistic construction of health and illness helps to ease the collective conscience of outside observers who witness health crises in Africa and justifies their relative inaction in response to these crises. In contrast, a cultural perspective serves the purpose of liberation from oppressively unhealthy circumstances to the extent that it helps to reveal the invisible ideologies that frame issues of health and illness in African settings as the sole responsibility of

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African communities. We return to this idea in the conclusion to this article.

Example 2: genital-shrinking panic

Our second empirical example comes from research on the phenomenon of *genital-shrinking panic* (GSP), several episodes of which have occurred periodically throughout the West Africa region in recent years (Dzokoto & Adams, 2005; Mather, 2005). In its typical presentations, GSP refers to the mass occurrence of distress in which people experience disappearance or shrinking of 'genital organs' and attribute this experience to magical theft by an acquaintance or passerby. Local accounts explain the motivation for this theft as either: (a) an attempt to extort money by holding stolen genitalia for ransom; or (b) a desire to procure ingredients for the production of *money medicine*: magical rituals or substances designed to bring wealth to the user. In either case, the accusation of genital theft places the accused person in mortal danger. Bystanders often administer 'instant justice' in the form of beatings that can result in death of the accused unless police or rescuers intervene (Adams & Dzokoto, 2007; Dzokoto & Adams, 2005).

It is important to note that not everyone in settings where GSP occurs fully believes this *genital theft* account, at least not as an explanation for every incident. The official explanation favored by government personnel attributes incidents of GSP to criminals who intentionally make false accusations of genital theft so that members of their gang can engage in more ordinary forms of theft during the ensuing confusion. Interview participants suggest yet another explanation that resonates with the discussion of enemies in the preceding section. In particular, they report a reluctance to engage in normal social interaction during incidents of GSP not so much due to fear of genital theft, but instead due to fear that a previously hidden enemy will falsely accuse them of genital theft as a means to perpetrate malicious harm (Adams & Dzokoto, 2007).

We suspect that this feature of GSP incidents, rather than their importance for understanding health and illness in African settings, is what led international media to report them in the first place. Against the background neglect of more newsworthy phenomena, the purpose of reports about GSP seems less to inform readers than to entertain them with stories about the ridiculous behavior of (supposedly) superstitious Africans. At the same time that international media gravitate toward material like GSP, locally grounded scholars tend to avoid the topic due to the justifiable concern that attention to these episodes will reinforce stereotypes of African experience in terms of ignorance, superstition and exotic otherness (Ciekawy & Geschiere, 1998). Indeed, for people in highly educated or 'modern' worlds, the phenomenon of GSP seems like exactly the sort of 'superstitious nonsense' that biomedical science helps societies overcome (Hesse, 1997; Jackson, 1998).

A cultural perspective on GSP In contrast, a cultural perspective suggests that outbreaks of GSP are not evidence of ignorance or superstition, but instead reflect a general process: the grounding of health and illness in particular constructions of reality. In part, the reference here is to specific concepts or institutions. For example, a prevailing construction of reality that underlies local experience of both genital theft and concerns about false accusation is the set of concepts referred to in English as *witchcraft*, *sorcery* or *juju* (see, for example, Assimeng, 1989; de-Graft Aikins, 2004; Geschiere, 1997; Meyer, 2003). Although the specifics vary across communities, the ideas associated with these concepts not only propose magical means through which genital theft and shrinking might occur, but also propose the existence of malicious enemies who seek to do harm through both magical and non-magical means. Widespread awareness of these concepts means that they are readily available for people to appropriate, regardless of whether or not they typically 'believe in' these phenomena.

Beyond specific concepts, the phrase 'constructions of reality' also refers to more general psychological tendencies or habits of mind, like local selfways, that promote genital-shrinking experience. Translating into terms of mainstream psychological science, one might use the label *interdependent* to refer to selfways that are prominent in many African settings (Markus et al., 1997; cf. Greenfield, Keller, Fuligni, & Maynard, 2003). Research from a variety of cultural spaces has associated the concept of interdependent selfways with several habits of being that afford or promote GSP (Dzokoto & Adams, 2005). First, the sense of pervasive connection associated with interdependent selfways is in turn associated with a sense of openness to interpersonal forces like enemies or genital tampering (Adams, 2005; Jackson, 1990; Riesman, 1986). Second, interdependent selfways are associated with 'holistic' perceptual habits that direct attention to contextual sources

of experience (see Nisbett, Peng, Choi, & Norenzayan, 2001). By increasing attention to the social context, these habits of mind render people more open to the sorts of social influence alleged in genital-shrinking episodes (Mesquita, 2001). Third, interdependent self-ways are associated with *somatization*: the tendency to experience negative affect in bodily rather than psychological forms (e.g. Ryder, Yang, & Heine, 2002). By promoting interpretation of negative affect in terms of bodily experience, this tendency promotes experience of anxious arousal in terms of physical symptoms (e.g. vanishing organs) rather than psychological symptoms (e.g. anxiety).

Turning the analytic lens　A second way in which a cultural perspective contributes to understanding the phenomenon of GSP is to reveal the typically invisible constructions of reality that inform understanding in mainstream health psychology. The difficulty that mainstream health science has in explaining GSP suggests the extent to which prevailing understandings rest upon selfways that promote an experience of abstraction from social and physical context. Although these constructions of reality have produced advances in human health by affording understanding of the biochemical nature of disease, they have simultaneously obscured phenomena—for example, placebo effects (Harrington, 1999), mass psychogenic illness (Colligan, Pennebaker, & Murphy, 1982) or GSP—in which belief plays a large role in shaping bodily experience. In contrast, one suspects that phenomena in which belief plays a large role in shaping bodily experience would receive greater attention if scientific imagination were grounded in the selfways that are prominent across diverse African worlds.

Besides the individualist roots of mainstream health science, a cultural perspective on GSP also helps to illuminate another construction of reality that informs understanding in mainstream health psychology: a lingering ethnocentrism, bordering on racism, that portrays the experience of African peoples as somehow backward or pathological. Although few scientists would endorse the relatively explicit racism found in media accounts of GSP, scientific ethnocentrism does appear in more implicit forms. A particularly salient example is the standard international reference for mental health: the DSM. Noting that the publisher of the DSM is the *American* Psychiatric Association—not the *African* Psychiatric Association or even the World Health Organization—critics suggest that this allegedly standard reference may be inappropriate when applied to mental health in settings that differ substantially from mainstream American worlds. In response, producers of the DSM have actively considered how best to incorporate culture to improve the DSM's relevance and capture the full range of mental health issues in the global community to which it is increasingly applied (Mezzich, Kleinman, Fabrega, & Parron, 1996).

We certainly applaud the efforts of the DSM's creators to be responsive to issues of mental health in a global context. However, the discussion of GSP provides an opportunity to emphasize an important concern. To the extent that mainstream health practitioners have considered GSP within the DSM framework, it has been as a possible variant of *koro*: a culture-bound syndrome, found mostly in Southeast Asian settings, characterized by 'an episode of sudden and intense anxiety that the penis (or, in females, the vulva and the nipples) will recede into the body and possibly cause death' (American Psychiatric Association, 1994, p. 846). Indeed, some authors have even referred to genital-shrinking episodes in African settings as *koro-like* cases (Ilechukwu, 1992).

Despite their superficial resemblance, episodes of GSP in African settings and *koro* in Southeast Asian settings differ in several aspects, the most important of which concern beliefs about etiology (Dzokoto & Adams, 2005). Although sufferers from GSP in African settings attribute genital-shrinking distress to interpersonal tampering (and attack people suspected of such tampering), sufferers from *koro* in Southeast Asian settings attribute genital-shrinking distress to contamination (and therefore do not attack other people). Given such differences, one might fruitfully ask why health practitioners would assimilate African cases of GSP to the DSM category *koro*. Implicit in this tendency is a distinction, rooted in the biomedical model of disease, between allegedly basic, physiological manifestations of disease and secondary, psychological representations of physiological experience. From this perspective, presentations of genital-shrinking distress may vary across Southeast Asian and African settings; however, these differences in presentation simply mask the underlying source of culture-invariant disease. In contrast, rather than a superficial difference in presentation of the same underlying disease, the present analysis suggests that differences in beliefs about etiology in Southeast Asian and West African settings represent essential components in different forms of distress. They are not

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merely superficial window-dressing applied after the fact, but instead play a constitutive role in genital-shrinking distress such that mass episodes would not occur *at all* without the fertile cultural ground that these models and representations provide (Good, 1994).

More generally, the potential problem with the idea of 'culture-bound illness' is that it appears to limit the role of cultural belief to a few syndromes in so-called 'traditional' societies. In contrast, the present perspective emphasizes the cultural grounding of health and illness—particularly, the constitutive role of belief in production of bodily experience—as a basic process that also operates within the modern spaces that inform scientific imagination. Here again, the phrase 'constitutive role of belief' refers to both specific concepts—for example, efficacy of chemical agents (Johnson, 1945; Kerckhoff & Back, 1968) or the possibility of abduction by space aliens (Clancy, 2005)—and broader constructions of reality like local selfways. A globally relevant health psychology must recognize how cultural processes underlie the experience of health and illness in any setting rather than imagine that cultural processes are limited to a few culture-bound syndromes that operate in 'other' societies.

Example 3: suspicion of polio vaccination campaigns

Our third empirical example concerns a global immunization campaign launched in 1988 to eradicate the poliomyelitis virus (Global Polio Eradication Initiative, 2006). The campaign originally projected full global eradication by the year 2000, and it was successful in eradicating the virus from all but a few countries. However, the campaign stalled when it encountered strong resistance in the predominantly Muslim states of northern Nigeria. The primary source of this resistance was the belief that the vaccinations had either been contaminated with HIV or were designed to render female children infertile as a means of population control (Ajiya, 2003). As a result of these suspicions, community and religious leaders demanded suspension of the vaccinations until proper investigation by Nigerian scientists could deem them safe (UN Integrated Regional Information Networks News, 2003).

This resistance to vaccination drives forced the global campaign to postpone its projected target date for full eradication. As of 1 May 2006, there were still approximately 309 polio cases worldwide, with 245 of these cases located in Nigeria

(Global Polio Eradication Initiative, 2006). Even more troubling for the eradication campaign was the discovery of new cases of polio in countries (e.g. Indonesia) that the WHO had previously declared polio-free. Investigators traced these strains of polio virus to Nigerian sources, and speculated that transmission of the virus occurred in the context of a pilgrimage to Mecca (Clements et al., 2006). Thus, concern about safety of vaccinations has jeopardized the success of the polio eradication campaign not only in Nigerian settings, but also for the entire human community.

The response of international health institutions has been to deny allegations of vaccine tampering. They imply that community leaders who advocate resistance to campaigns irresponsibly endanger the lives of their constituents 'over unfounded concerns about the oral vaccine's safety' (WHO News, 2004). Donor organizations like the European Union impatiently threatened to remove funding for other health-related programs in communities that did not cooperate with the eradication campaign (Musa, 2003).

Underlying these responses is a construction of resistance as ignorant superstition, collective paranoia, political manipulation or some other pathological feature of African settings. Further evidence of this construction comes from training guidelines for UNICEF vaccinators:

Make the point: vaccinators do more than just put OPV [Oral Polio Vaccine] drops in children's mouths and mark tally sheets. Vaccinators are *educators* as well, they are the front line workers … it is critical they have accurate information about OPV. (UNICEF, 2002, emphasis in original)

Here again, the training manual portrays resistance to vaccination campaigns as uneducated suspicion—yet another case of superstitious or paranoid belief that constitutes evidence of African backwardness—that can be alleviated by exposure to 'correct' knowledge.

A cultural perspective: collective memory of racism   Without advocating the practice of vaccine refusal, a cultural perspective offers an alternative construction of this resistance. In contrast to the construction of suspicions about vaccination campaigns as 'unfounded concern', a cultural perspective suggests that these suspicions may have a foundation in collective memory about historically documented events.

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One source of suspicion is a more general mistrust of western-dominated international agendas that has its foundation in collective memory of recent conquest and exploitation:

No matter how short the memory of an African is, it sometimes re-vibrates—forcing him to be suspicious of donations from a power that refused to help un-claim him from the shackles of colonialism and other forms of economic exploitations … Where was the donor country or body that is now dishing out free of charge polio vaccines when we were crying at the United Nations for the complete decolonization of the African continent? (Galadima, 2003)

Given that one can hardly deny the fact of recent conquest and exploitation, who is to say whether suspicion of western agendas is unfounded?

Besides collective memory of conquest and exploitation, another source of suspicion about polio vaccination campaigns comes from past incidents of racism in the domain of public health institutions themselves. The reference here is to cases like the Tuskegee Syphilis Study, in which mainstream health scientists withheld information and treatment from syphilis-infected men of African descent so that they could study the progression of the untreated disease (Freimuth et al., 2001). The reference here is also to the use of practices in African settings—for example, randomized trials of a known, effective drug treatment against a placebo or no-treatment control (see Lurie & Wolfe, 1997)—that people in science-exporting settings would deem unethical if done in their own research hospital. Add to these facts the awareness of eugenics research and sterilization practices designed to control population growth among people of African descent (e.g. in Puerto Rico, Barbados and Jamaica; Mass, 1977), and one might come to different conclusions about whether concern about racism in public health interventions is unfounded.

Turning the analytic lens: collective forgetting of racism among mainstream scientists

Besides providing an alternative account of African resistance to immunization campaigns, a cultural perspective also directs attention to the typically invisible constructions of reality that underlie mainstream health science. From this perspective, mainstream reactions to vaccine campaign resistance are not based on a neutral or objective reading of events, but instead reflect an equally 'irrational' tendency to deny the extent of racism in health science.

Evidence for this account comes from a program of research that examines group differences in perception of racism in the USA, including beliefs about deliberate racist harm within the public health system. A consistent finding across studies is that White Americans tend to report less racism in American status quo than do people from a variety of historically oppressed groups (e.g. Adams, Tormala, & O'Brien, 2006; Operario & Fiske, 2001). Our research links this tendency to two sources. First, evidence suggests that White Americans are motivated to deny the extent of racism in American society in the service of collective identity concerns, the desire to avoid the experience of collective guilt, or the desire to preserve the perceived legitimacy of the social order (Adams et al., 2006; Powell, Branscombe, & Schmitt, 2005). Second, evidence suggests that White Americans are less aware of historically documented cases of racism—including events, like the Tuskegee experiment, that reveal racism in the public health system—than are Americans of African descent. In turn, this group difference in knowledge of past racism partly accounts for group differences in perception of present racism, even after one controls for identity-related motivational concerns (Adams & Nelson, 2006).

Translating to the present topic, this research portrays suspicions about racism in vaccination campaigns in a very different way than prevailing accounts in mainstream health science. Rather than portray African suspicion of racism as the sole phenomenon that requires explanation, this research illuminates denial of racism in mainstream science as an equally problematic phenomenon that also requires explanation. From this perspective, the mainstream framing of vaccine suspicion as wildly irrational is not self-evident. Instead, this framing may partly reflect: (a) the motivation to deny the significance of past oppression in order to preserve the legitimacy of the international order, coupled with; (b) ignorance of relevant, documented cases of racist malpractice in recent history of international health science.

Conclusion

To conclude our discussion, we emphasize that the goal of our analysis is not to promote refusal of polio vaccination (nor, for that matter, to advocate greater watchfulness for personal enemies and genital-shrinking *juju*men). Indeed, if people were to ask us for advice, we would strongly urge them to

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take their children for vaccination. Instead, our goal has been to highlight a level of analysis that is typically obscured in mainstream accounts: the grounding of health psychology in particular constructions of reality.

We highlight this level of analysis for two reasons. The first reason is to provide a more adequate account of health-relevant phenomena in African settings. We share with mainstream health scientists the goal of alleviating suffering—whether from suspicion of enemies, experience of GSP or diseases like polio—and we find a cultural perspective useful for that goal. The second reason is to provide a necessary corrective to mainstream accounts of health and illness. By neglecting the cultural grounding of experience, mainstream accounts reproduce a distorted understanding of health psychology that locates the structure of mind exclusively in genetically evolved, brain architecture without appreciating the extent to which the structure of mind—and its consequences for health— also resides in the historically evolved affordances of particular, sociocultural worlds.

Weaving through our account is an attempt to illuminate the cultural grounding of psychological science (Gergen, Gulerce, Lock, & Misra, 1996). Contrary to prevailing ideology and self-conception, scientific accounts of health-relevant phenomena do not represent an objective 'view from nowhere'. Instead, scientific theories and concepts are grounded in particular constructions of reality that typically remain invisible in mainstream accounts.

The cultural grounding of science can contribute to misunderstanding in any case. However, its consequences are particularly severe when scientists and health practitioners appropriate the culture-particular apparatus of mainstream health science and apply it as a culture-general framework to settings—like many African spaces—where different constructions of reality shape experience. This misapplication can result in a form of *scientific imperialism*: the imposition of foreign practices and concepts to explain local experience. Despite the undeniable success of global health science in alleviating suffering in African (and other) communities, the unreflexive imposition of foreign models, combined with an almost arrogant disregard for local understanding, renders efforts of health practitioners less effective than they might otherwise be.

In contrast to a lurking imperialism in global health science, the present analysis resonates with the meta-theoretical perspective of liberation psychology (LP;

Martín-Baró, 1994). As with the meta-theoretical perspective of cultural psychology, the guiding principle of the LP perspective is a self-conscious strategy to adopt local perspectives. The rationale for this principle comes not from humanistic values and an idealistic desire for solidarity with the masses, but instead from scientific values and a desire for truth. An LP perspective suggests two important tasks for health psychology in African settings. The first task is to expose the ideological constructions of reality that: (a) portray African experience in pathological terms; and (b) mask the ongoing reproduction of health-threatening environments. The second task is to propose alternative constructions of reality that are more conducive to human development and alleviation of suffering. This article constitutes a small step in these directions.

Notes

1. Associated with this goal is a less reifying conception of culture than that which typically informs mainstream social psychology. We define culture as *explicit and implicit patterns of historically derived and selected ideas and their embodiment in institutions, practices, and artifacts* (see Adams & Markus, 2001, 2004; based on Kroeber & Kluckhohn, 1952, p. 357). This definition de-emphasizes the association of culture with bounded groups or geographic spaces and instead locates culture in more diffuse models or social representations.

2. The phrase, 'everyday life' refers not only to religious practices, residence patterns and other forces that are typically regarded as 'cultural', but also includes forces, like economic insecurity or interactions with global capitalism, that are often regarded as 'non-cultural'. From the present perspective, what qualifies a force as 'cultural' is not a link to some defining group tradition, but instead its status as a collective construction of reality that informs experience, regardless of an individual's position in the social structure. For example, evidence indicates that concern with personal enemies is stronger among people in more impoverished settings (e.g. Northern Ghana) than less impoverished settings (e.g. former students of the University of Ghana). However, this evidence also suggests that any effect of poverty on experience of personal enemies is not the consequence of individual differences in wealth. Instead, the effects of poverty operate as a cultural-psychological force: an atmosphere of economic insecurity that applies to both rich and poor inhabitants of a setting, regardless of their individual wealth or poverty (Adams, Anderson, & Mensah, 2006).

3. What might these particular cultural realities be? Again, the idea here is not that either the experience of embeddedness or the prominent concern with enemies has its ultimate source in some invented, imaginary

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'African' tradition. Instead, the ultimate sources of both the experience of embeddedness and prominent concern with enemies are likely to lie in such forces as kinship structure (Geschiere, 1997), historical residue of the slave trade (Shaw, 2000) or an atmosphere of economic insecurity (Mullings, 1984). In any case, evidence reviewed in this paragraph indicates that the experience of embeddedness functions as a proximal source of concern with enemies, whatever the more distal sources of these phenomena.

4. We thank an anonymous reviewer for suggesting this consequence.

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