CHAPTER 5

LITERATURE REVIEW:
EXPLORING AN AFRICAN PERSPECTIVE ON PSYCHOPATHOLOGY

5.1 Introduction

This chapter is the second part of the literature review and further explores those aspects which were introduced in Chapter 4. The chapter explores African perspectives on psychopathology at great length. The review utilises the foundational ideas explored earlier in the chapter as pointers within the discussions on psychopathology. Certainly, the discussions precede context-specific areas of interest, such as idioms of distress and culture-bound syndromes. Some of these are specific to traditional African populations, while others are introduced as comparative views. Research regarding illness may certainly lead to discussions related to healing. It is for this reason that the review includes research on traditional healing. However, as the temperament of the research appears to take on an African-specific flavour, the reviewer introduces discussions relating to ethnocentricity and cultural diversity. The chapter makes its way towards an exploration of prototypal pathologies in Africa, as well as the way in which the research applies to the South African context. The literature review is concluded with studies which were closely related to the investigation, but had to be excluded from the current review for a number of reasons.

5.2 Psychopathology

This section explores the clinical view on psychopathology. The section lays the foundation for discussing subsequent literature which related to perspectives from traditional Africans. These demarcations appear to be social and academic constructions and are therefore relayed in a similar fashion.

The view that diagnoses and experiences are constant among cultures is reasonably imprecise, as constant taxonomies and definitions of psychopathologies suggest an ideal, not realistic, state. This is especially evident in the way that the same conditions have varying operationalised functions in differing diagnostic systems (World Health

Organization, 1992). One of the consequences of psychopathology includes the production of significant immobilisation (Patel & Kleinman, 2003). It is important to comprehend that a symptom is a constituent of a condition that is evidenced by the patient. A syndrome, however, is the sum of the symptoms that make up a clinical condition (Tseng, 2006).

Emotions mediate the individual, social, and political bodies. Emotions serve to influence the manner in which psychopathology is experienced by the individual body, and is then projected in images of the perceived performance of the social and political bodies (Scheper-Hughes & Lock, 1987). Toldson and Toldson (2001) are of the opinion that the fundamental standards of diagnoses and treatment in psychopathology theory stem from clinical and general psychology. These standards are usually universalistic in nature and thereby susceptible to cultural bias. In this regard, Toldson and Toldson suggest that the definition of abnormal behaviour be context-specific.

The question that needs be clarified when considering culture-related psychopathology is whether the phenomenon is culturally induced, culturally modified, or culturally labelled. Clearly, these dimensions suggest that some phenomena warrant little psychiatry-specific differentiation (Tseng, 2006). Behavioural scientists without psychiatric knowledge and experience find it complex to appreciate the nature of culture-related psychopathology in a suitable and meaningful way. As culture-related disorders stem from cross-cultural psychopathology, contemporary transcultural psychiatry is attuned to appreciate this position (Tseng, 2006).

Clinicians must guard against characterising atypical behaviours as psychopathological conditions. Proponents of the etic framework (discussed later) have exhibited noteworthy examples of discrepancies in classification. The anxiety-related disorder *latah*, for example, is perceived to be a social behaviour by anthropological behavioural scientists, but is classified as hysterical dissociation and hysterical psychosis by psychiatry (Tseng, 2006). This disorder is explained later in the review. Obtaining clinical data via observation is invalidated, to a degree, by major shortcomings. This includes that collective intercommunicative facets which

impinge on the clinical picture must be unravelled. These facets comprise interpersonal, economic, political, and subjective dynamics (Draguns, 2000).

Clinical inquiry is used to identify and explore psychological distress. The objective is to detail a comprehensive, accurate account of psychopathological symptoms and the context thereof. In addition, clinical inquiry necessitates that the clinician document variations in the patient's symptomatology and general condition. These variations and its relation to the context allow the clinician to determine the factors which resulted in the distress. The clinical approach is essential in investigating psychopathology, particularly during the early stages of the illness (Draguns, 2000).

Psychosis and depression have been part-and-parcel of the human condition since the dawn of time (Pilgrim, 2007). The World Health Organisation indicates that vegetative symptoms of depression appear to be universal, while subjective experiences relating to pathology appear to pertain to cultural dynamics. Examples of the cultural dynamics suggested by the World Health Organisation include collectivism-individualism, and belief systems (Draguns, 1997). Tomlinson et al. (2007) advise clinicians that depression may remain undetected due to one's naiveté as regards the diverse forms of presentation which include somatic, spiritual, and interpersonal dimensions.

From a Western perspective, the central indicator for schizophrenia includes interruption(s) in the premier stages of integration of neuropsychological functions. Thus, frequently observed indicators include disturbances in social communication due to errors during the processes of encoding and decoding data, faults in higher-order data processing, and difficulties in differentiating the external world from the self (Jablensky, 1987). The diathesis-stress model suggests that individuals possessing a constitutional vulnerability to schizophrenia become exposed to peripheral, exogenous stressors which precipitate an aberrant neurophysiological response. An alternative view suggests that schizophrenia comprises a pool of syndromes, as opposed to being a distinct disorder, and pursues patterns congruent to the diverse syndromes which form the clinical picture (Jablensky, 1987).

Jablensky (1987) views schizophrenia as a syndrome of ambiguous origin, the diagnosis of which relies almost entirely on clinical judgment and clinical impressions. This suggests the clinician's employment of inferential diagnostic and classification approaches. This line of reasoning as regards schizophrenia includes much support for the four groups of disease theory. Thus genetic loading such as family history often validates the schizophrenia diagnosis; the course and outcome, such as personality change to the extent that catamnestic substantiation becomes valid; treatment response, especially the psychopharmacological activity on the brain's dopaminergic systems, often suggest that the diagnosis of schizophrenia is accurate; and cerebral pathology which indicates that structural brain irregularities are closely associated to the diagnosis of schizophrenia.

5.2.1 Psychopathology and being Black

Bhugra and Bhui's (2001) observation of early literature regarding psychopathology within the African American population suggested a popular notion that this population, particularly within the context of slavery, rarely experienced psychopathological conditions due to the supposed lack of exposure to psychologically-strenuous situations. This fairly oblique view clearly lacked scientific and moral grounding and inadvertently reinforced Bhugra and Bhui's clinical observation that the adversities experienced by African Americans served to intensify psychopathology.

Perkins and Moodley (1993) indicate that Black African patients are likely to deny having psychiatric and/or psychological difficulties. But to suggest that African people do not experience psychopathology is false. To assume that the diagnosis of schizophrenia, for example, ceases to exist in the African population would be naive and inaccurate. The diagnosis may be, and has been, confirmed by clinicians who have conducted meticulous clinical interviews; applied culturally-contextual understandings of delusional phenomena; considered language differences, context-specific mood states and passivity phenomena; conducted neurological and physical investigations; and consulted third-party sources with regarded to symptomatology and cultural identity (Bhugra & Bhui, 2001).

5.2.2 Psychopathology in Africa

The appreciation of the manifestation of depression in South Africa has vastly transformed. In days of old, the disorder was thought to be urbane (Tomlinson et al., 2007). The typical Western notion of depression, from a psychiatric perspective, mechanically encompasses the syndromal framework which may not necessarily and legitimately enshrine the experience of depression in non-Western societies. It is unsurprising, therefore, that the applied diagnostic process is often adapted across and within societies (Bhui & Bhugra, 2001). While this may suggest that cultural considerations receive some accommodation in clinical practice, these ideas must be developed in order to serve the needs of local patient populations (see Trujillo, 2008).

5.2.2.1 *An African-specific perspective on psychopathology*

Research suggests that perceptual disturbances, such as hallucinations, vary across cultures and have virtually ceased to be considered an exclusively pathognomonic symptom of schizophrenia (Draguns, 2000). African perception serves as a foundation for a diagnosis in African-centred psychology. In essence, traditional African values precede urbanised values internalised by modern Africans (Kwate, 2005). Diagnostic administration must allow for influences relating to the environmental and socio-political arenas (Toldson & Toldson, 2001).

The genetic link, generally thought to be evident in psychotic operations, does not appear to apply to African-Caribbeans, for example. Environmental factors appear to play a significant role in developing psychotic symptoms in this population (Sharpley et al., 2001). African perception is influenced by a profound sense of oneness and spirituality (Kwate, 2005). In traditional African psychopathology, dysfunction implies collective and individual disequilibrium, particularly with regards to disparities in community, physical, and social functioning (Kwate, 2005).

More African-specific disorders need to be explored, so as to augment appreciation into African psychopathology (Kwate, 2005). Considered together, these disorders indicate the psychological, spiritual, historical, and social influences that compromise

the African's mental health in a society which represents universality and racial discrimination (Kwate, 2005).

Applying universalistic or misinformed notions to the African experience may yield scientific imperialism. As such, extraneous views are applied to local experiences. Discounting the authentic African experience is tantamount to imperialistic egotism (Adams & Salter, 2007). African consciousness shapes cognitive schemata, and in so doing influences perspectives regarding perceptual phenomena. As such, what is 'real' or 'bizarre' does not necessarily correlate with the Western perspective of perceptual phenomena (Toldson & Toldson, 2001).

Culturally-specific models of psychopathology are necessary as the Western nosological system appears to be ill-adapted to African individuals, often resulting in diagnostic bias. African-centred psychology queries the authenticity of Western ideology which itself employs a culturally-specific cosmology (Kwate, 2005). To address these constrictions, putative mental illnesses regarding African-related models have been identified (Kwate, 2005). These include African-specific syndromes such as alien-self disorder (discussed later).

Consider that local perceptions of typical illness do not necessarily conform to the Western nosological system. As a point of note, the people of Ruaha, in Tanzania, consider epilepsy to be a traditional African illness, signifying supernatural influence, and one that cannot be successfully treated with biomedicine (Jilek-Aall et al., 1997). However, if one maintains the opinion that epilepsy or epilepsy-like symptoms include tonic-clonic seizures, then certain associations become apparent. Persons suffering from chronic tonic-clonic seizures are particularly vulnerable to developing severe psychopathology, including aggressive and tactless behaviours (Jilek-Aall et al., 1997). Those who do not ascribe to the Western perception of epilepsy continue to observe similar prognostic features, but ascribe local perceptions of these features. For the Tanzanian Pogoro, for example, epilepsy is never discussed lest they offend the spirit Kifafa who will punish the family by continuously inflicting epilepsy upon them (Jilek-Aall et al., 1997).

In a similar vein, Okello and Musisi (2006) explored the way in which the Ugandan Baganda formulates psychotic depression. The Baganda formulate psychotic depression with mood-congruent delusions as a disorder called eByekika, which suggests pathology resulting from behaviours of the living towards those who have died. Furthermore, disregarding rituals, breaching taboos, or integrating traditional African and Western cosmological views are thought to initiate the illness. Traditional healers are favoured in terms of treatment because the population believes that the ultimate source of the disorder rests within the cultural domain (Okello & Musisi, 2006).

5.2.2.2 *Prototypal names*

A prototypal name is defined as a term given to the process of the pathological repudiation of traditionally African experiences. It is syndromal in nature and is characterised by beliefs and views that are dissonant with traditional African values (Kwate, 2005). The aim of including reviewed literature on prototypal names in the thesis is to afford the academic fraternity the opportunity to acknowledge the way in which some Black authors perceive acculturation processes as psychopathological. In a sense, these relatively recent publications suggest that denying traditional African views are a psychopathological condition. Further, that prototypal names are being explored as focused research areas may also suggest some dissatisfaction with mainstream definitions of psychopathology. Finally, as will be indicated in the reflexivity section of Chapter 6, including prototypal names may suggest that denying an African perspective on psychopathology equates denying aspects of the African worldview.

Ilechukwu (2007) investigated prototypal names for ogbanje and abiku. The Nigerian Igbo and Yoruba people believe that some people may rapidly cycle through birth and death. The affected people are referred to as ogbanje/abiku and are perceived to be infants that are born and die repeatedly. The names ogbanje and abiku relate to subcultural perceptions of the syndromes. Five prototypal names for ogbanje have been identified by the Nigerian Igbo. Ezimma literally means ‘genuinely pretty.’ The emotional tone associated to the literal meaning is denial. Nonyelum means ‘please stay with me.’ Here, the emotional tone is supplication. Onwukiko denotes ‘death, I

beg you,' and the corresponding emotional tone is also supplication. 'Death may please itself' is the literal meaning for onwuma, and the emotional tone is resignation. Finally, ozoemezina means 'may it not happen again.' The emotional tone associated to this prototypal name is hope. Ilechukwu suggests that six prototypal names have been identified by the Yoruba in Nigeria. Apara literally means 'one who comes and goes.' The emotional tone associated to the literal meaning is apathy. Biobaku means 'if he does not die.' Here, the emotional tone is reservation. 'Stay with me' is the literal meaning for durotimi, and the emotional tone is supplication. Ikudeinde denotes 'death has come back,' and the corresponding emotional tone is dread. Hope is the emotional tone for ikujore, which literally means 'death leaves him.' Finally, kokumo means 'not dying again.' The emotional tone associated to this prototypal name, like ikujore, is hope.

Other prototypal names of African-specific syndromes were identified by Kwate (2005). These include alien-self disorder, anti-self-disorder, individualism, mammyism, materialistic depression, self-destructive disorder, and theological misorientation, and will be discussed below.

5.2.2.2.1 Alien-self disorder

Persons with alien-self disorder have been conditioned to aspire to materialist goals. Achievement and prestige are actively pursued and the person exhibits indifference and/or dissent with regards to social occurrences, including the dynamics of race and subjugation. These individuals often imitate the oppressive group (Kwate, 2005).

5.2.2.2.2 Anti-self disorder

Individuals with anti-self disorder adopt the authoritarian's projected aggression and disapproval towards Africans. Consequently, they apply behaviours that are disadvantageous to their communities and become focused on securing out-group approval endorsement (Kwate, 2005).

5.2.2.2.3 Individualism

Persons suffering from individualism abide by Western-centred ideals of individualism. They place emphasis on individual goals and aim to be inimitable.

Typically, these individuals rebuff communal needs for personal needs (Kwate, 2005).

5.2.2.2.4 Mammyism

Mammyism relates to the behaviours that some Africans had to adopt during colonisation and/or slavery. During these times, the African person was expected to be altruistic, supportive, and non-threatening. S/he was also expected to exhibit affection and dependability towards the intimidator. Nowadays, some African people continue to display redundant slave-like behaviours such as radical altruism in order to benefit White authority (Kwate, 2005).

5.2.2.2.5 Materialistic depression

Persons with materialistic depression evaluate themselves and/or others according to material worth. They therefore aim to accumulate financial prosperity and status (Kwate, 2005).

5.2.2.2.6 Self-destructive disorder

Engaging in self-defeating behaviours characterise self-destructive disorders, and includes behaviours such as negative health behaviours, violence, and substance abuse. Although these behaviours are perceived as coping mechanisms in a frustrating society, they impinge on normal development and growth (Kwate, 2005).

5.2.2.2.7 Theological misorientation

With theological misorientation, the person focuses on theological beliefs and practices which are discordant with African cosmology. These beliefs often overlap European cosmology, were proliferated during colonisation and/or African oppression, and appear to be maligned to African spiritual systems (Kwate, 2005).

5.2.2.3 *From then to now*

Prince (1967) reviewed reports relating to depressive syndromes in Africa. The reports were written between 1895 and 1957. The populations assessed in the reports included patients from mental health hospitals, as well as local villages. The population consisted of patients from Gold Coast (in Australia), Kenya, Nigeria,

South Africa, and Tanganyika (now known as Rwanda and Burundi). A second review of depressive syndromes in Africa was conducted between 1957 and 1965. The patient population was from psychiatric units in Guinea, Liberia, Nigeria, and Senegal. Reports between 1895 and 1957 suggest that psychotic depression was uncommon in Africa. The rare occurrences of psychotic depression were short-lived and moderate. Furthermore, self-castigation was unusual, as was suicide. In addition, if such pathology did occur, the episode was not as extreme as those in Western countries, and was probably active for a brief period of time (Prince, 1967).

However, Swartz (1998) indicates that depression is, and was, similarly frequent in Africa as the rest of the world. However, the manifestation, and perhaps the experience, of depression in Africa are distinct to the prevalent notion of depression as promoted by Western views (Swartz, 1998). Interestingly, recent research in sub-Saharan Africa indubitably suggests that the presentation of affective disturbance is comparable to the presentation of depressive disorders in Western countries (Tomlinson et al., 2007). Tomlinson et al. indicate that a South African variation of the manifestation of depression is often reflected in the patient's experience of guilt. These views, therefore, are suggestive of comparable worldwide rates regarding affective disturbances, with minor nuances reflected in the presentation of the disturbances.

To reinforce the previous observation, literature indicates that approximately 20% of patients who attended primary healthcare clinics in Kenya experienced noticeable psychopathology (Ndetei & Muhangi, 1979). South African research indicates that approximately 25% of rural South Africans exhibited serious psychological distress and depression in 1991 (Gillis, Welman, Koch, & Joyi, 1991), with an increasing rate of approximately 27% in 1994 (Rumble, 1994), and a reduced rate of 18% in 1996 (Rumble, Swartz, Parry, & Zwarenstein, 1996). These fluctuating percentages may indicate the experiences of a shifting political climate in South Africa during these years (Tomlinson et al., 2007), or may even suggest methodological flaws with the research.

In Nigeria, the rate of Major Depressive Disorder is three times as high for women as it is for men, while the rate of Dysthymic Disorder is twice as high for women as it is

for men (Gureje, Obikoya, & Ikuesan, 1992). In Uganda, mood disorders, especially depression, are frequent (Okello & Musisi, 2006). The urban setting in Zimbabwe poses much similarity to many urban areas in South Africa. It is interesting, therefore, to take note that at least 30% of women in Zimbabwean urban areas displayed anxiety and/or depressive pathology (Abas & Broadhead, 1997). The implication is that these prevalence rates may be more applicable to the South African community than was originally thought.

Although reports of depression were scarce during the colonial period in Africa, the historical and political revolutions across time have also fostered a shift in the criteria for depression. More recently, and referring to cultural variation, it has been noted that the experiencing of a sense of guilt appears to be a manifestation of depression (Draguns & Tanaka-Matsumi, 2003; Tomlinson et al., 2007). In this regard, Sow (1980) suggested that guilt feelings may be experienced by the African patient, but was rarely spontaneously reported. Sow accredits this to attributions regarding exogenous discrimination. However, in terms of the manifestation of pathology, these were reported with seemingly atypical symptoms when compared to Western universalistic symptoms. Draguns and Tanaka-Matsumi (2003) suggest that the African population exhibits depressed states via somatic complaints. These include general malaise, which is often associated to neurasthenia. In order to communicate these experiences, African patients often present with symptoms of pain.

Depending on the cultural influences in operation, depression is often reported either as a psychological representation, such as guilt, or it may be represented as a somatic complaint, such as a headache (Trujillo, 2008). Guilt is less prevalent in African patients that underscore social acquiescence and unity (Draguns, 2000). If the clinician is unfamiliar to the patient, the African patient may feel extremely uncomfortable in sharing psychological experiences. Certainly this may apply to all people, but one must not discount the way in which the manifestation and outcome of psychopathology may differ for various populations. For this reason, consider the significance of the way in which physical distress becomes a significant channel for communicating emotional disturbances in many non-Western populations (Draguns, 2000). However, somatic complaints do not necessarily suggest depression. These complaints may suggest anxiety and psychosis, among other disorders. In addition,

somatic complaints are hardly ever the only form of expressing depression or other negative affective disorders (Draguns, 2000). Often, reporting somatic symptoms may be perceived as equivalent to physical illness, thereby allowing the patient the opportunity to communicate the exigency of the psychological distress (Draguns, 2000).

Since many traditional African languages appeared not to possess the lexicon parallel for depression, Marsella (1980) was of the view that a universal theory of depression did not exist. Marsella found that even those non-Western cultures which did not have equivalent terminology to express specific symptoms or syndromes, nonetheless had variants similar to those in Western cultures.

Roelandt (2001) agrees with Marsella's (1980) view that many African cultures appear not to have a dictionary-equivalent term for depression. However, Roelandt appends Marsella's view by indicating that even if such a term may have been available in some of the indigenous languages it appeared that many individuals within the cultural population seemed to be unfamiliar with such terminology. In this regard, and corresponding to Roelandt's view, Tanaka-Matsumi and Marsella (1976) stated that many cultures consigned variable connotative value to the experience of depression.

5.2.2.4 *Contemporary trends in the manifestation of psychopathology*

Miller and Pumariega's (2001) review suggests that Black Africans are beginning to exhibit more negative eating attitudes and behaviours, particularly within South Africa. In many African countries where obesity is considered to be sexually attractive, anorexia nervosa is less common (Miller & Pumariega, 2001). The vulnerability to develop eating disorders is greater in urbanised societies where personal success is overemphasised. Conversely, traditional societies that value acquiescence, respect, and unassertiveness experience lowered susceptibility to developing eating pathology (Miller & Pumariega, 2001). Similarly, Western views regarding body image and ideal weight have become increasingly dominant in the Middle East (Miller & Pumariega, 2001). This observation suggests that cultural overlapping is becoming more frequent.

A study regarding eating disorders in South Africa recently affirmed that eating pathology is equally common among Black and White female students (Le Grange, Louw, Breen, & Katzman, 2004). The more industrialised societies become, the more prone to eating disorders they appear to be. This was evident especially in countries such as Malaysia and India, where the population appears to be tending towards overvaluing thinness (Miller & Pumariega, 2001).

The way in which some African patients appear to prefer somatic complaints to psychological complaints (Draguns, 2000), appears to be dynamically apparent in the way that HIV is perceived in some populations in Africa (Campbell, 1997). The prevalence of HIV infection is elevated among the migrant population in sub-Saharan Africa (Campbell, 1997). Africans may detach themselves psychologically from HIV-related experiences due to the perception that supernatural processes influence the symptomatology. Possessing traditional perceptions allows the African patient to become more susceptible to infection due to his/her perception of being at a lower self-risk. Furthermore, the patient is vulnerable to fostering social isolation by sharing HIV-related experiences due to the community's negative perception of the illness (Peltzer, Mpofu, Baguma, & Bolanle, 2002). Certainly, HIV is not a psychopathological condition, however, the process of detaching oneself from a threatening experience (e.g. symptomatology and stigma) may suggest psychological distress.

Apart from HIV, sex in relation to psychopathology has been researched in Africa. Akinnawo (1995) was particularly concerned in understanding how Nigerian women became interested in the sex industry, their experiences of potential occupational risks, the coping strategies employed to deal with their perceptions, and maintaining factors of both their coping mechanisms as well as occupational roles. He aimed to provide academia with a psychological examination of the dynamics at play, as well as to review the degree and incidence of psychopathological symptomatology among the sex workers. Unsurprisingly, socioeconomic difficulties such as unemployment, financial trouble, marital separation, and peer pressure were found to dominate the picture of instigating an occupation in the sex industry. Furthermore, poor self-concept was relatively high and possessed the potential to subvert diverse areas of the sex industry. The incidence of psychopathology among Black Nigerian sex workers

was extremely high, but the hypothesis that psychopathology existed prior to the individual's initiation into the sex industry was ruled out by evidence proposed in an investigation conducted a year earlier (Orubuloye, Caldwell, & Caldwell, 1994). It therefore appeared more likely that the psychopathology developed as a result of engaging in the sex industry. Thus, the induction of psychopathology may be appreciated as an occupational hazard (Akinnawo, 1995), so to speak. In his exploration of the possible dynamics at play, Akinnawo suggested that African women who engage in commercial sex experience adverse effects on psychological well-being. I contend that this applies to anyone, not particularly to African women. Similarly, sex work is not detrimental to everyone.

In Kenya, psychosis is conceived in very similar ways to Western perspectives of psychosis, and includes behaviours such as aggression, inappropriate laughing, speech and thinking disturbances, memory impairments, and delusions, for example. This is true for the Xhosa culture as well (Patel, 1995).

Bhugra and Bhui (2001) found high percentages of psychopathology in the African-Caribbean population in the U.K. The prevalence rates of mental illness in this population was closely associated to genetic influences, gestational and perinatal complications, the experience of discrimination, poor economic situations, social inequity, racial persecution, and population miscellany. They therefore suggest the appraisal of empirical investigation using an interactional model considering psychological and environmental factors. This may also aid in understanding the phenomenon of improved outcomes in developing countries.

The negative stigma associated with psychopathology is reinforced by media messages which often suggest that mental illness and aggression occur simultaneously (Sieff, 2003). Lay persons often confound deviant behaviours as professional diagnoses. This reinforces the negative perception of psychopathology (Penn et al., 1994). The negative stigma associated with psychopathology becomes internalised within cultures and by individuals (Rogers et al., 1998).

Patel and Kleinman (2003) reviewed literature from 11 community studies published from 1990 to 2003. The studies centred on the relationship between poverty and

common psychopathology. They define common psychopathology as anxiety and depressive disorders listed in the World Health Organisation's International Statistical Classification of Diseases, 10th Revision (ICD-10). The study investigated whether the poverty-psychopathology link was common in collective, non-Western cultures, where the majority of the population experienced socio-economic difficulties. The countries included in the study included Zimbabwe, Lesotho, Pakistan, Indonesia, Chile, and Brazil. This review found that individuals possessing low formal education were at a great risk for developing psychopathology. Furthermore, the experience of swift social transformation, low self-confidence, despair, ill-health, and/or exposure to interpersonal aggression increased the incidence of psychopathology. Similarly, Patel, Araya, de Lima, Ludermir, and Todd (1999) conducted research in five developing collective-orientated cities, including Harare, Pelotas, Goa, Olinda, and Santiago. Their findings suggest that the experience of poverty increases one's vulnerability to developing mental illness. Furthermore, being female and experiencing poverty further increases this vulnerability.

Hundt, Stuttaford, and Ngoma's (2004) ethnographic study indicated that Black South Africans did not perceive their stroke-like symptoms as their chief complaints. Instead, they perceived poverty, joblessness, and water shortages as their most important health concerns.

Discussing deep-seated emotional trauma is perceived to be threatening for many African patients. The discomfort of sharing private experiences with an outsider in an unfamiliar venue leaves the patient feeling vulnerable. Often, presenting somatic complaints appear to be less threatening because the symptoms relate to the outer self (Draguns, 2000). While these dynamics may be true for many patients in general, one may wonder about the difficulty some African patients experience in dealing with the woundedness of the inner world. This will be further explored in Chapter 6.

5.2.2.5 *Context-specific modes of expression*

The consideration of local modes of illness is crucial for clinicians working in non-Western societies. This is particularly significant if one aims to understand the dynamics of the experience of the illness. The Shona people of Zimbabwe, for

example, hold that symptomatology is instigated by supernatural forces (Patel, Abas, Broadhead, Todd, & Reeler, 2001). This is in stark contrast to the biological model of mental illness. The Rwandans attribute symptoms of suicidal ideation, a sense of worthlessness and/or hopelessness, and depressed mood as supernaturally inflicted syndrome identified as guhahamuka (Bolton, 2001).

Sharpley et al. (2001) are of the view that it is erroneous to describe psychotic illness in African-Caribbeans as classical schizophrenia. Although this population does exhibit a surfeit of psychotic illnesses, the pathogenesis and taxonomy of the illnesses appear to be unclear. From an African perspective, not all misfortune requires an explanation. If no cause can be found, it is accepted as such (Nsamenang, 1992).

Amongst traditional Africans, illness is also the result of human malevolence, castigation for engaging in evil, natural, and/or induced by the spirits for transgressions of moral codes of conduct (Nsamenang, 1992). Spiritual causes are usually regarded as adequate explanations for psychopathology (Patel, 1995).

With regard to the spiritual dimension, not performing the correct rituals when a person dies may dispossess the vital source from the transformation it requires in order to enter the higher spiritual realm and thereby become an ancestral spirit. The vital source, forced into supernatural exile, remains in the physical world where it persecutes its family for not performing the rites and rituals defined by the ancestors. The persecution inflicted by the vital source often manifests as illness (Nsamenang, 1992). Illness may be the result of spiritual degradation and is perceived to be sinful. Sinners must be purified in order to placate the ancestral spirits (Nsamenang, 1992). As such, if the subjective experience of the individual, whether it is a personal view or based on the diagnosis of a traditional healer, includes the need to be purified, pharmacotherapy may probably be devalued by that individual.

Diseases which are not considered to be biomedically treatable often include psychopathology, infertility, epilepsy, and nightmares, to name a few. These diseases are believed to be caused by supernatural phenomena. Traditional healing is often preferred to Western treatment in this regard (Nsamenang, 1992). The ancestors act as intermediaries between people and God. Rituals and festivals are conducted with the

hope that people may move closer towards a distant God. These rituals and festivals also serve as a catharsis for the African population (Nsamenang, 1992).

Traditional psychiatrists in Tanzania acknowledged five psychotic disorders. Mbepo included aggressive behaviour and perceptual disturbances. It was a result of witchcraft and could only be cured by a skilled mbombwe (traditional healer). The traditional psychiatrist had to be extremely competent to deal with mbepo as it was presumed that the witch could easily target the mbombwe who attempted to obstruct the curse. Kuhavila was similar to mbepo, but the aggressive behaviours were more violent and coerced people into abusing and/or killing others. The disorder was so severe that these patients often ate faeces, neglected to wear clothes, and attacked people at random. The disorder appeared to have a supernatural foundation and was perceived as a form of magic acquired by a woman involved in incestual sexual activities with her father. The continued incestual relationship increased the woman's power and she sometimes passed this power to her offspring who naturally had the ability to impose kuhavila on others. Traditional psychiatrists who were able to identify the witch, provided the patient with supernatural protection, and administer the correct medication, were able to cure the disorder easily (Edgerton, 1971).

Lisaliko was very similar to mbepo, but the disorder was presumed to be natural. Causes therefore included genetic susceptibility, actual poisoning, or excessive anxiety. Traditional psychiatrists were only able to cure this disorder if it was correctly identified and treated during the early stages of its course. Litego differed from the three preceding disorders. Patients with this disorder never exhibited perceptual disturbances and only rarely displayed unusual behaviours. Often, these patients experienced a depressed mood, as well as guilt. Affected persons also experienced severe headaches and fever. The cause was also seen to be supernatural, but was not attributable to witchcraft. The supernatural cause in this disorder was perceived as retributive magic, and was often the result of transgressing moral codes of conduct. The mbombwe was unable to treat this condition pharmacologically or s/he too would have had to endure retributive magic. Atonement, in the form of apology, confession, and material compensation, was the only cure. Failure to atone was presumed to be fatal (Edgerton, 1971).

The fifth psychotic condition acknowledged by traditional psychiatrists was called Erishitani. It is believed that only Muslims were capable of creating these malevolent spirits. The view was that the spirit entered the patient's body and squeezed the blood out of the victim's body, thereby inducing psychosis. Typical symptoms included affective blunting and mental vacuity. In a sense, then, the person was rendered empty. The condition was regarded as one that could only be cured by another Muslim (Edgerton, 1971). Research regarding the treatment of erishitani could not be located.

For the Ugandan Baganda, disease categorisation falls within four assemblages. Eddalu refers to aggressive psychosis, ensimbu is the Bagandan term for epilepsy, obusiru suggests idiocy, and kantalooze refers to a sense of severe vertigo (Patel, 1995).

Edgerton (1966) investigated psychopathological conditions in four African populations, namely the Sebei in Uganda, the Kamba in south central Kenya, the Pokot in north-western Kenya, and the Hehe in southwest Tanganyika. The research included assessing values via a picture test, administering and interpreting data using the Rorschach inkblot test, the application of various projective assessments, and asking almost 90 general questions, some of which addressed psychosis. Where applicable, the author explored local terminology for specific phenomena, particularly psychosis. The study unambiguously ascertained that Africans did not habitually ascribe all psychosis and adversity to supernatural causes. It ought to be noted that these findings are dated, and also used the Rorschach inkblot test which is not culture-free (Dana, 2000). However, the study remains useful in that it explicates that African perspectives do not routinely suggest a supernatural perspective.

Edgerton's (1966) findings suggested that the Sebei and Pokot people held a natural perspective of psychosis, believing that the afflicted individual possessed a worm in the frontal cortex of the brain. Both cultures assume that the affliction occurred for no particular reason. The Kamba and Hehe people maintained that supernatural causes accounted for psychotic states, often being inflicted during the process of sorcery or witchcraft. These views diverged from the perspectives of the Bantu people across Africa. The Bantu tribes believed that some psychotic states may be due to witchcraft,

while God was implicated for other psychotic states and/or possible genetic causes. The Kamba, however, asserted that stress, fear, and grief may precipitate psychosis. Frequently, the Kamba perspective of psychosis was referred to as the malfunction of a tired brain (Edgerton, 1966).

Edgerton (1966) was candid in asserting that the four tribes considered multiple causation of psychotic states and that local modes of illness causation was dependent upon the context of the individual and family. When probed to explore evidence of psychosis, the Sebei were of the view that persons who scream, collect garbage, wander aimlessly, consume dirt, and defy the social norms of covering one's body, were indicative of an active psychotic state. In addition, aggressive actions such as murder and violence were also considered to be indicative of a psychotic process.

According to Edgerton (1966), Kamba and Pokot views of psychosis corresponded to the Sebei view, as did the Hehe view. Although, the Hehe believed that the psychotic person also exhibited evidence of social withdrawal. While the Sebei people viewed the majority of psychotic individuals as either thoughtless or riotous, the Hehe believed that most psychotic persons became either overtly inert or violent. Additionally, Hehe doctors described psychosis as beginning with aggressive unrest, followed by bewilderment, docility, and nudist exhibitionism, culminating in social isolation and living alone. The only explicit difference of psychosis between the Sebei and Pokot perspective included the Pokot view that psychotic persons often engaged in actions suggesting arson.

Edgerton (1966) indicated that the overall perceptions of psychosis were surprisingly similar among the four tribes, save for a diminutive number of differences. While these African conceptions appear similar to Western conceptions of psychosis, a few stark differences become immediately palpable. The prevalent difference, of course, appears to be the uncommon incidence of visual and auditory hallucinations. Edgerton's study, for example, explored data from a few East African hospitals and found that hallucinations occurred, but were relatively rare. Ultimately, psychotic behaviour in Africa may be considered to be psychotic behaviour in the Western world. However, as Edgerton (1966) implied, the converse may not necessarily be valid.

In a more recent study, Dzokoto and Adams (2005) analysed 56 media reports of genital-shrinking epidemics in six West African countries between 1997 and 2003. They compared the symptoms suggested in the West African experiences to those of the culture-bound syndrome, koro. Koro is a well-known syndrome in Asia, characterised by the fear that one's genitals will retract into the body. This study indicates that culture plays a role in the experience of genital-shrinking, and also influences psychopathology.

The genital-shrinking epidemic began either in Cameroon or Nigeria in 1996. Ghana reported several cases of the syndrome in 1997, as did Senegal and Cote D'Ivoire. The reports were spread across the countries, suggesting that both inland and coastal locations were affected (Dzokoto & Adams, 2005). The most familiar symptom was reported by males, who indicated the subjective experience of a shrinking penis. Women reported the subjective experience of shrinking breasts and/or alterations to their genitalia. It was apparent that the onset and experience of the episode was acute and transitory, with no recurrence (Dzokoto & Adams, 2005).

Investigation conducted by police and medical personnel suggested no changes to genitalia. Patients, however, described perceived differences in the size and functioning of genitalia (Dzokoto & Adams, 2005). Dzokoto and Adams could find no evidence that any of the cases were treated psychologically and/or psychiatrically. Instead, the affected individual, often assisted by the community, treated the incident as a different form of criminal activity. Further considerations of the dynamics involved in the genital-shrinking epidemics in Africa reflect those dynamics reflected in the local societies at the time. As such, genital thieves represented the perceived elevated levels of corruption and crime in society (Dzokoto & Adams, 2005). There is little evidence that social tensions accounted wholly for the genital-shrinking epidemics (Dzokoto & Adams, 2005).

5.3 Somatisation

It is a well-established view that somatisation occurs more frequently in non-Western societies, especially Africa and Asia (Gaw, 1993). Depressed patients from non-Western cultures do not present with depressive symptomatology, but rather with

somatic complaints. This is also a prevalent occurrence in China and Taiwan (Dein & Dickens, 1997).

Somatisation, or somatic complaints, is often a vital coping strategy for intrapsychic conflict in people from non-Western cultures (Somer & Saadon, 2000). That culture is extraorganismal, interorganismal, as well as intraorganismal does not indicate a paradox, but rather a misapprehension. Hence, culture includes occurrences within the extrasomatic context, and is not restricted to consisting of extrasomatic occurrences (White, 1959).

Kirmayer and Young (1998) suggest that culture-related disorders demonstrate the manner in which ethnophysiological indicators regarding bodily distress can yield somatic symptoms which are specific to cultural perspectives. These culture-related symptoms and syndromes have not been incorporated into standard psychiatric nosology and have experienced insufficient epidemiological research.

The body-mind association enjoyed particular attention in a recent study (Walker, Odendaal, & Esterhuyse, 2008) which found that increasing levels of perceived physical pain elevated one's risk to developing and experiencing mental illness. This finding endured irrespective of whether the pain was attributable to a medical condition, the consequence of an injury, or if no reasonable physical cause could be found.

Although somatisation appears to occur more frequently in non-Western cultures, the presentation of somatic distress is ubiquitous and occurs worldwide. As such, somatisation should not be confounded as a culture-bound syndrome (Isaac, Janca, & Orley, 1996).

Kirmayer and Young (1998) are of the view that somatisation is expressed in various ways in diverse cultures. Somatisation may function as an idiom of distress, an ethnomedical belief system, or a pathway to care with regards to the healthcare system in context. According to Scheper-Hughes and Lock (1987), to assume that metaphors and social symbols encompass the entire relationship between social bodies and the individual would be naïve. This relationship also includes aspects of

control and power. When the social body is threatened, supernatural influences become a symbol of the culture's idiom of distress. It is not uncommon for a number of bucolic South Africans to justify states of mental illness as witchcraft (Tomlinson et al., 2007).

5.4 Psychopathology from a cultural perspective

All cultures experience psychopathology. Pfeiffer's (1994) review of anthropological data suggested that even individuals from minority cultures are not exempt from experiencing anxiety and often express anxious states as extreme avoidance and alarm. Appreciating culture's position in mental health is imperative to thorough and precise diagnoses, as well as the treatment of psychopathology. This is due to psychopathology and culture being rooted in one another (Sam & Moreira, 2002).

Psychopathology, particularly psychotic phenomena, is momentous for, and to, cultural realities (Bullard, 2001). Culture provides people with the insight to generate mechanisms to process and integrate psychological distress (Wilson & Drozdek, 2004). For example, while depressive pathology is highly prevalent in Uganda, the symptoms, features, sub-type, and manifestation of the pathology is aligned to cultural perspectives (Okello & Musisi, 2006). This implies that the disturbances appear to be aligned with cultural content. Pakaslahti (2001) is of the view that mental illness is fashioned by culture, but may also be subjected to replication and endemic distribution. In addition, culture influences the meaning of psychopathology and assigns either interpersonal, biological, spiritual, or paranormal reasons as its cause. Culture also influences the way in which people exhibit psychopathological symptoms, their approaches in conveying symptoms, coping strategies employed when faced with psychological distress, as well as their motivation to ascribe to help-seeking behaviours and their perceptions of healing (Eshun & Gurung, 2009).

In essence, psychopathological conditions are influenced by culture in a number of various ways. First, culture may affect the development of the disorder. This is referred to as the pathogenic effect. Alternatively, culture may define the way in which the person copes with stress. This is referred to as the psychoselective effect. Third, the way in which culture modulates the clinical manifestation of the syndrome

is referred to as the psychoplastic effect. If culture structures psychopathology into a distinctive form, this denotes a pathoelaborating effect. Furthermore, the psychofacilitating effect suggests that culture may facilitate the prevalence of a disorder. Finally, culture defines the subjective reaction to a clinical manifestation. This is referred to as the psychoreactive effect (Tseng, 2001).

Mio, Barker-Hackett, and Tumambing (2006) are of the opinion that there are four frequent frameworks which address the way in which psychopathology is influenced by culture. These include the sociobiological approach, the ecocultural approach, the biopsychosocial approach, and multiculturalism. From a sociobiological point of view, evolutionary and biological features have an effect on culture, and culture evolves in order to sustain the survival of society. Proponents of the ecocultural approach centre on the ecological-cultural relationship and pay specific attention to the manner in which actions and opinions affect the environment, and vice versa. The biopsychosocial view considers the interaction between biological, psychological, and social factors. This approach regards the influence of culture on psychopathology with regards to the influence of the trimodal framework (bio-psycho-social) and its dynamic interplay on social interaction. Multiculturalism is a postmodern-endorsed approach and highlights the significance of equity and approval of all cultural views. Proponents of this approach aim to expand awareness into the dynamics of all cultures so as to promote positive interaction between all societies (Mio et al., 2006).

Research conducted by Draguns and Tanaka-Matsumi (2003) demonstrates a substantial influence of culture upon psychopathology. The various facets of culture in producing idiosyncratic symptoms of psychopathology have yet to be discovered. From an etic framework, prospective researchers may explore collective views regarding antecedents in relation to the emergence of psychopathology. From an emic orientation nuances may be explored with regards to culturally shared premises and concerns. Draguns and Tanaka-Matsumi request that prospective studies explore the generic association between culture and psychopathology, as well as identifying relationships between psychological distress and cultural features.

Canino and Algería (2008) found that research validating diagnoses among various cultures is deficient. According to McCrae (2001), the reconceptualisation of

personality traits suggests a new construction for research into personality and culture. One of these constructions includes intercultural research which considers cultural and subcultural traits in relation to traits from other cultures. Intracultural research, on the other hand, examines the discrete manifestations of traits in a particular culture. The third construction includes transcultural studies which focus on universal variables such as development and trait structure (McCrae, 2001).

Culture affects psychopathology by way of the patient's subjective experience of the distress. Furthermore, patients exhibit symptoms of distress in accordance to the standard and context defined by their cultures. The expression of the manner in which symptoms are exhibit are then interpreted by a clinician and diagnosed accordingly. Understanding the cultural dynamics at play, with regards to symptom manifestation, determines treatment options and has an influence on prognostic factors (Castillo, 1997). Language is also influenced by culture, thereby influencing the way in which illness is understood. Both the experience of illness and the conceptual understanding of illness depend on language (Hahn, 1995).

Every culture possesses personalised knowledge with regards to the perception and interpretation of illness (Feierman, 1985). Although anxiety disorders are prevalent in many cultures, the disorders are expressed differently across cultures (Draguns, 2000). Clinicians must never ignore the correlation between cultural and psychopathological characteristics (Draguns, 2000). All clinical impressions are negatively influenced if the clinician is unfamiliar with the patient's culture. This is due to the verbal and non-verbal discrepancies between cultures (Trujillo, 2008).

The dissimilarities in psychopathological expressions across diverse cultures are extraordinary (Draguns & Tanaka-Matsumi, 2003). The experience, and interpretation, of hallucinations depend by and large on the cultural construal attached to it. This is most notably evident in cultural interpretations of hallucinations as either pathological or supernatural. It is therefore of great consequence to appreciate that hallucinations transpire in context, are related to antecedent and consequential events, and only develop into a symptom when they are regarded as such (Draguns & Tanaka-Matsumi, 2003).

Stompe's (2001) summary of patterns of delusions in culture covered over 100 years of research. This précis suggested that the more rigid the community's religious perspective, the more religious delusions they would experience. The subjective experience of the patient as either a noble or ignoble follower defined experiencing proportionally good/bad delusional content. How, then, do these ideas affect the psychotherapeutic context?

According to Beiser (2003), it is difficult to conceptualise and operationalise psychotherapy from a cross-cultural perspective. Pope-Davis et al. (2002) aimed to explore the competencies needed by psychotherapists to work cross-culturally. Their findings did not address their key concern as to whether or not cultural competence intersects general competence. It may be valuable, therefore, to revisit this focus area further on in the thesis.

Cultural perspectives shape the expression of psychopathology. These perspectives are anchored in constructs such as race, ethnicity, acculturation, individualism-collectivism, and nationality (Eshun & Gurung, 2009). Culture regulates perceptions of normal and abnormal. In so doing, it endorses some behaviour and stems others. This dynamic allows the structure of the psychological threshold to be developed, thereby defining the parameters for intrapsychic conflict and psychological distress (Trujillo, 2008).

The aptitude for adaptations in the phenomenological experiences of psychopathology, as well as the associated effects, becomes evident if appreciated from both historical and cultural contexts (Okello & Musisi, 2006). Many cultures experience psychopathology, or many diseases for that matter, to reside outside of the control of the person. In African cultures, control belongs to unseen entities such as God, the ancestors, and/or spirits (Santino, 1985). Not to acknowledge these influences suggests fostering a ceaseless process of cultural misunderstandings.

Cultural misunderstandings result in deficient assessments, flawed diagnoses, and inapt treatment (Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003). That a cultural perspective regarding psychopathology exists is evident in the many culture-bound syndromes. The idea that specific cultures experience specific syndromes is

significant to the current review – particularly in establishing the validity of an African-specific view on mental illness. Certainly, investigation in this regard may suggest the authenticity of an African perspective on psychopathology.

5.5 The theory of culture-bound syndromes

Research into cultural perspectives allows the understanding of psychopathology to exceed the scope of culture-bound syndromes (Somer & Saadon, 2000). Various psychopathological conditions are specific to particular cultures and therefore are better accounted for from a sociocultural perspective (De Jong & Van Ommeren, 2002). *Culture-bound syndromes* may be inaccurately interpreted to mean *traditional*. It is important to note that culture-bound syndromes appear to be equally prevalent in urbanised African societies (Adams & Salter, 2007). This may possibly be explained as being due to the remnants of traditional perspectives in urbanised African cultures (see section 1.7.1).

Draguns and Tanaka-Matsumi (2003) are of the view that culture-bound syndromes are emic disorders. Thus, these syndromes are infrequently subjected to quantification and are normally investigated from an explorative stance at their particular cultural locations. Notwithstanding, proponents of culture-bound syndromes often suggest that these disorders become part of the central body of psychiatric classification of the American Psychiatric Association (Tseng, 2006).

There has been a temporal advancement from culture-bound syndromes to culture-related specific syndromes (Tseng, 2006). Culture-related specific syndromes are clusters of psychopathological symptoms that are associated with cultural characteristics in terms of their development and manifestation. The clinical manifestation is at variance with conventional psychopathological syndromes and is more prevalent in specific cultural contexts that share cultural characteristics (Tseng, 2006).

Several culture-related syndromes are fairly uncommon, even within the specific cultures. This applies especially to those psychopathological conditions that arise by way of pathogenic cultural stimuli, including frigophobia, koro, and voodoo death. As

a result, including these syndromes into the current classification system would be of little value from an applied perspective. Psychiatry is of the view that diagnoses should reinforce clinical utility for the majority of, if not all, psychiatric conditions (Tseng, 2006).

Culture-related specific disorders are dynamic and evolve or dissolve depending on the dynamics of the culture (Tseng, 2006). Appreciating culture-related specific syndromes from social and behavioural perspectives, devoid of clinical perception, may exhibit bias (Tseng, 2006). It appears that culture-bound syndromes and culture-related specific syndromes are often used interchangeably.

In order to develop meaningful insight in the metamorphosis of culture-bound syndromes, one must explore the sociocultural climate of the patients. In line with these views, therapists must regard the geopolitical, ideological, and socioeconomic context over and above individual psychodynamics (Tseng, 2006).

5.6 Culture-bound syndromes in Africa

During the early 20th century, Westerners colonised non-Western countries. The colonisers discovered that some of the local populations exhibited unusual behavioural and psychopathological conditions which were atypical to Western conditions and subsequently labelled *peculiar phenomena.* The peculiar phenomena were classified by the locals as folk illnesses (Tseng, 2006).

More recently, psychology and psychiatry have experienced a remarkable increase in cultural approaches, and there has been significant focus on cultural diversity (Miller, 1999). To address the observation that specific populations exhibit discrete syndromes, differing vastly to the clinical picture of typical syndromes, the DSM-IV-TR has added a new spectrum of disorders called culture-bound syndromes (APA, 2000). Syndromes, symptoms, idioms of distress, and modes of expression ought to be conceived as a product of interpersonal interaction and transaction (Draguns, 2000).

Yap (1967) originally used the term *culture-bound syndrome* to refer to syndromes that appeared to be limited to particular cultural and ethnic populations. As research into these syndromes progressed, it appeared that similar disorders manifested in various other cultures, and were therefore not wholly limited to one specific cultural entity (Tseng, 2006). At this point, it appears prudent to highlight two obvious constraints of the term. First, that similar disorders appear in other cultures suggest that the syndrome is not exclusively bound to a specific culture. The clear predicament with this interpretation is that the definitional prowess of a culture-bound syndrome is compromised by not accounting for variables such as acculturation and multiculturalism. Second, the term culture-bound syndrome funnels the utility of the term in that culture is assumed to filter the pathology. In other words, utility of the term denies personal, intrapsychic, and biological variables by placing significant emphasis on culture as the defining mediator of the distress. These constraints were not left unnoticed by the academic fraternity, as may be observed in the forthcoming discussions. It is for this reason that the researcher suggests revising culture-related psychopathological phenomena by recommending a new technical term. This is discussed in Chapter 6.

Culture-bound syndromes reflect culturally-created adaptations of psychopathology, culture-patterned mechanisms for managing stress, behavioural responses informed by culture, pathological forms of cultural experiences, and culture-specific versions of particular psychopathological conditions (Tseng, 2001). A culture-bound syndrome is a sequence of symptoms exclusive to, or typical of, a disorder within a particular region, culture, and/or ethnic group (Draguns, 2000). The syndrome is thus a mental or psychiatric cluster of symptoms in which the incidence and/or expression of symptoms are associated with cultural features and accordingly necessitate culture-fit intervention (Tseng, 2006).

If culture does not suggest an essential role in the condition, there is very little value in referring to the disorder as a culture-bound or culture-related specific syndrome (Tseng, 2006). Psychopathological disorders differ from one culture to another, either in manifestation or in expression (Canino & Algería, 2008).

According to Tseng (2006), evidence from various academic medical sources suggests that over 12 separate culture-specific psychopathological conditions were reported during the period between 1890 and 1970. During this period, non-medical researchers also reported similar conditions in academic journals (Tseng, 2006).

Tseng (2006) was particularly interested in exploring the taxonomy of culture-specific syndromes. Understanding, as a conceptual frame, may be considered as either taxonic or nontaxonic. The former refers to understanding an occurrence as a discrete class, while the latter refers to the degree of differentiation in mode or manifestation (Skilling, Quinsey, & Craig, 2001). In their investigation, Skilling et al. found that certain behavioural pathologies suggested an underlying personality taxon. They also found evidence that taxonicity applies to an increasing range of psychopathology. These included a taxon for endogenous depression, a latent taxon for specific eating disorders, and a schizotypy taxon which underlies schizophrenia. While their analysis was based on disorder-specific investigations, it may be useful to conduct similar research in the exploration of taxonicity in cultural perceptions of illness and culture-bound syndromes.

Culture-related syndromes cannot be assimilated into the panoptic classifications of mood, somatoform, and/or anxiety syndromes, as culture-related syndromes possess particular aetiological, prognostic, and remedial consequences, over and above its social course (Kirmayer & Young, 1998). There may appear to be some resemblance between typical disorders and culture-bound syndromes. However, culture-bound syndromes are inimitable because specific cultures recognise those symptoms and syndromes as psychopathological (Eshun & Gurung, 2009).

Kirmayer and Young (1998) are of the view that culture-bound syndromes epitomise emotional, somatic, and cultural meanings. If the aim of the clinician is to ascertain whether the diagnosis is a culture-bound syndrome, the clinician must explore the meanings of the symptoms according to cultural standards (Trujillo, 2008).

Russel (1989) indicates that pathological anxiety states become culturally structured into these syndromes. These processes are evident in syndromes such as ataque de nervios in Latin America (Guaranaccia, Rivera, Franco, & Neighbors, 1996), taijin

kyofusho in Japan (Russel, 1989), and koro in Southeast Asia (Tseng et al., 1992). The sections that follow explore various culture-bound syndromes in the DSM (APA, 2000) that relate to African cultures, but also communicate the propensity of culture-bound syndromes that emerge in various cultures. Once more, one ought to draw attention to the idea that the term culture-bound syndrome may be oversimplifying the way in which it is applied, as well as the possibility that the syndromes may suggest dexterity in universalism, thus being human-centred and not necessarily culture-centred. Bear in mind that a potential explanation for the intersection of psychopathology across cultures may also suggest the fusion of cultures. As will become apparent, these views are not always applicable, as some of the culture-bound syndromes appear to be localised to specific cultures.

5.6.1 Amafufunyane

The South African syndrome of amafufunyane, a common form of bewitchment, generally corresponds to the criteria for depression (Swartz, 1998). However, Mkize (1998) suggests that the affected person also experiences severe perceptual and somatic disturbances. Mkize's view is that amafufunyane has not been adequately addressed in academic literature. From the literature search during the current investigation, Mkize's view appears to be accurate more than a decade later.

5.6.2 Amok

Amok is a brief dissociative episode. This episode precedes a state of severe depression and intermittent aggressive outbursts. The episode frequently includes automatism, memory loss, fatigue, and persecutory delusions. The most commonly reported precipitating factor is a perceived attack, however, many patients also report being affected by amok as a result of exposure to traumatic events. The patient often returns to his/her premorbid level of functioning. In rare situations, amok includes overt psychotic symptoms. Typically, this suggests a poorer prognosis and sometimes implies the commencement of a chronic psychotic process (Hall, 2006; Trujillo, 2008).

Amok and mal de pelea are common syndromes in Laos, Malaysia, Papua New Guinea, Philippines, Polynesia, and Puerto Rico. The two names refer to the same syndrome (Saldaña, 2001). The Malaysian syndrome amok is also similar to hwa-byung in Korea, and boufée deliriante in West Africa and Haiti (Hall, 2006). Similar disturbances have been reported in Navaho, where it is called iich'aa, and in Polynesia, the disorder is referred to as cafard (Hall, 2006). Amok has also been reported in various areas of the United States (Tseng, 2006).

5.6.3 Brain fag

Every so often, students in Nigeria experience a familiar syndrome called brain fag. This syndrome includes the feeling of heaviness, or subjective experience of intense heat in the head and is often associated with the exertion related to studying. Comorbid disorders include anxiety disorders, affective disturbances, and/or adjustment disorders. Classical cases include patients with formally-uneducated families, and who have endured mental and environmental disconnection from families and native communities. Their distress is largely focused on the social quandary they experience (Guiness, 1992). High-school and university students in West Africa are particularly vulnerable to the syndrome (Hall, 2006).

The term *brain fag* was originally used in West African settings to indicate the difficulties some students experienced during their studies. Persons affected with brain fag experience concentration difficulties, poor memory, and difficulties in thinking. Somatic complaints are common in this syndrome and generally include discomfort in the head and neck areas. Brain fag is also prevalent among students throughout sub-Saharan Africa (Prince, 1990).

5.6.4 Roast breadfruit syndrome

Roast breadfruit is a Caribbean dish. *Artocarpus altilis* (Zerega, Ragone, & Motley, 2004), commonly called breadfruit, is roasted until the flesh becomes black. The inside of the fruit, however, remains white. The appearance of the roast breadfruit dish is used to name, and shame, Black people who adopt White values (Hickling & Hutchinson, 1999).

Technically, roast breadfruit syndrome refers to Black people who embrace Eurocentric perspectives (Hickling & Hutchinson, 1999). Symptoms of the roast breadfruit syndrome include experiencing one's indigenous culture as embarrassing, a great desire to be accepted by Western societies, rejecting traditional norms, and attempting to change one's skin colour and thereby appear more White.

Roast breadfruit psychosis is an exaggerated version of roast breadfruit syndrome, and includes psychotic features. The psychotic features are indicated by the psychotic phenomenology which relates to self-identity crises, as well as the significant affective disturbances exhibited during the psychosis (Hickling & Hutchinson, 1999).

5.6.5 Koro and genital-shrinking

The word *koro* appears to come from Malaysia. This syndrome is characterised by sudden and severe panic that the penis will withdraw into the body and bring about the person's death. In women, the same fear concerns the vulva and nipples. Genital-shrinking panic refers to acute anxiety experienced as a result of the experience that one's genital are being magically stolen by another person (Adams & Salter, 2007). The diagnosis of koro is complicated by the fact that genital retraction symptomatology may be due to organic pathology such as substance abuse, cerebral syphilis, and brain tumours. To confirm the diagnosis of koro, all organic pathologies must be ruled out (Trujillo, 2008).

Koro has a high incidence rate in Malaysia (Hall, 2006). Genital-shrinking psychopathology has become fairly common in West Africa (Mather, 2005), and is rife in many Asian communities (Saldaña, 2001). The syndrome is also familiar in China where it is known as shook yong or suo yan. Although rare, koro has been reported in a few Western countries. Koro is very similar to jinjinia bemar in Assam, and bears some resemblance to genital-shrinking epidemics in West Africa (Mather, 2005; Trujillo, 2008). Hall (2006) suggests that many experience the same syndrome in Thailand. The Thai refer to the disorder as rok-joo.

Genital-shrinking has not been included in the DSM-IV-TR (APA, 2000), but bears some semblance to koro (Dzokoto & Adams, 2005). Often, a conscious, physical

attempt is made to prevent the retraction. If all of the criteria are not met, the diagnosis is classified as partial koro syndrome (APA, 2000). Genitial-shinking would therefore be classified as partial koro syndrome because the affected individual does not use mechanical means to forestall the retraction. Dzokoto and Adams (2005) also indicate that atypical symptoms of koro include the fear that other organs, such as the ears or tongue, may recede into the body. They also indicate that koro-like symptoms have been reported in Tanzania, South Africa, Israel, Hungary, France, Canada, Britain, and America. Research in this regard could not be located during the literature search.

One of the major differences between koro and genital-shrinking appears to be based on the effects of the disturbance. With koro, the affected individual believes that the retraction will result in death, while persons affected with genital-shrinking believe that they will lose the capacity to reproduce and/or experience loss in sexual functioning (Dzokoto & Adams, 2005).

The African perception that genital-shrinking results in the inability to reproduce has significant implications as local conceptions suggest that becoming a parent allows one to achieve full personhood, as well as the opportunity to become an ancestor (Dzokoto & Adams, 2005; Nsamenang, 1992).

Local understandings of genital theft suggest that the thief will demand money to return the genitalia, or s/he may use the genitalia to manufacture substances that may bring the thief wealth (Adams & Salter, 2007). Persons accused of genital theft endure *instant justice*. Here, the affected individual calls upon bystanders in the area to physically attack the alleged thief. The immediate violence unleashed upon the supposed thief may bring about the thief's death if s/he is not rescued from the situation (Adams & Dzokoto, 2007; Dzokoto & Adams, 2005). Adams and Salter (2007) have the idea that many reports of genital theft received media attention for entertainment purposes rather than to underscore the pathological phenomenon.

5.6.6 Zar

Various reports in North Africa and the Middle East have indicated the occurrence of zar. The affected person is said to become possessed by a spirit. Symptomatology includes excessive crying, singing, laughing, and shouting. Possessed persons are also said to hit their heads against the wall, become unusually introverted, experience a decline in eating, and fail to carry out daily activities. These persons may also engage in enduring relationships with the spirits (Hall, 2006). The syndrome is similar to hsieh-ping in China, and shin-byung in Korea. According to Trujillo (2008), the syndrome is fairly common in Egypt, Ethiopia, Iran, the Middle East, North Africa, and Somalia. Apathy and social withdrawal are common. Interestingly, Zar is not considered to be pathological in communities where the syndrome is most prevalent.

5.6.7 Boufée deliriante

Boufée deliriante is characterised by the rapid onset of explosive and violent behaviour, significant bewilderment, and psychomotor excitement. The disorder occurs mostly in West Africa and Haiti (Hall, 2006). Boufée déliriante is similar to a few affective, somatoform, and anxiety disorders (Trujillo, 2008). Less frequent symptoms include hallucinations and paranoid delusions. Boufée déliriante is easily mistaken as a brief psychotic disorder (Trujillo, 2008).

5.6.8 Falling out / blacking out

People of the Southern region of the United States of America and the Caribbean have reported a syndrome called falling out, or blacking out. The affected person collapses and becomes unconscious, followed by frantic episodes of time-limited blindness (Hall, 2006). African Americans appear to be quite familiar with falling out. People affected by falling out are vulnerable to experiencing seizure-like episodes in response to a traumatic experience (Saldaña, 2001).

Ordinarily, the person reports brief episodes of sightlessness, even though his/her eyes remain open. In addition, the person becomes immobilised, but is able to comprehend

events in his/her immediate environment. This syndrome resembles dissociative disorder and conversion disorder (Trujillo, 2008).

5.6.9 Hex, rootwork, voodoo death

These syndromes suggest a process whereby disease and death are imposed upon people through supernatural forces. It is assumed that witches recruit evil spirits to harm others, thereby creating chaos and inflicting unnatural disease upon others. The affected persons are thought to be victims of hex, rootwork, or voodoo death (Saldaña, 2001).

Many people in the southern U.S. and the Caribbean believe in rootwork (Hall, 2006). Rootwork refers to a collection of cultural explanations regarding the cause of illness. Within this frame, the cause is perceived to be fundamentally evil. Common symptoms include the fear of being murdered through acts of voodoo, the fear of being harmed by poisonous substances, vertigo, weakness, gastrointestinal difficulties, and anxiety. Other common disturbances include a variety of psychological disturbances. The spell, called the root, is eradicated when a traditional healer, called a root doctor, offsets the spell by counter-cursing the adversary. The syndrome is common in the southern African American population, certain European populations, and in the Caribbean population. Latino cultures refer to the disorder as brujeria or mal puesto (Trujillo, 2008).

5.6.10 Spell

Spell is a trance-like state which allows individuals to dialogue with spiritual ancestors, or other spirits. The syndrome is prevalent in the southern U.S. (Hall, 2006).

During the hypnotic-like process of a spell, the person experiences time-limited personality changes during these episodes. The disorder occurs mainly amongst European Americans and African Americans. Due to the seemingly cataleptic state, the affected individual may appear to be experiencing a brief psychotic episode (Trujillo, 2008).

5.6.11 Ogbanje / abiku

This syndrome was briefly introduced in section 5.2.2.2. The word ogbanje suggests oscillation and literally means 'come and go.' The syndrome is perceived to be malignant re-embodiment (Ilechukwu, 2007). To appreciate ogbanje, one must be aware of the Igbo cosmology. Chiukwu is God and rules Elu-Igwe, heaven. The world consists of two parallel worlds. The physical world is called Ala mmadu, and the spiritual world is called Ala mmuo (Ilechukwu, 2007).

The Igbos are of the view that ogbanje is the effect of rebellion and human fate by strong partnerships between the infant and deities who guard the crossing point between birth and pre-birth existence. The pre-birth existence is thought to be a spiritual existence (Ilechukwu, 2007).

The Youba people believe that abiku is due to mischievous spirits, known as emere, who occupy a pregnancy. Once born, the emere exhibit many psychopathological symptoms, including dreams of water, a dramatic fantasy life, orgiastic play with strange children, and contact with Nne-miri, a water deity also known as mammy water. The affected children are perceived to be histrionic, calculating, and dissociative. They also exhibit either maladaptive or talented behaviours. The community's reaction to these children is contradictory and symbolise the celebration of life, as well as the fear of death. Psychiatric symptoms of ogbanje include aggressive behaviour, visual hallucinations, histrionic personality traits, dreams about water, conversion disorder symptoms, and dissociative disorders (Ilechukwu, 2007).

Traditional healers suggest that ogbanje is almost a female-exclusive disorder and that successes in life jeopardise the relationship with Nne-miri and/or the spirit deities who aim to cause disturbances (Ilechukwu, 2007). Similar to shamanic traditions, it is possible that talented people endure ogbanje illness because Nne-miri beckons them and they deny her call. The illness is then perceived to be Nne-miri's punishment for refusing her. Ogbanje may then be cured if the affected person returns to Nne-miri as a healer (Ilechukwu, 2007).

The bonding between the ogbanje child and mother is expected to be fragile. In earlier times, at the death of an ogbanje child, the father would bury the child in a shallow grave or simply throw the body into a forest. The father would also cut off or burn a small piece of the child's body so that the ogbanje child would be recognised if s/he returned as a newborn child. Grieving and bereavement processes were forbidden, and the mother would be expected to continue with normal, daily living after the child had died. The rationale behind this apathetic response was to divest possible elation that the ogbanje might experience for having caused sadness (Ilechukwu, 2007).

If a patient were to present with ogbanje symptoms to Western psychiatry, s/he would probably receive a differential diagnosis of conversion disorder, bipolar mood disorder, and dissociative disorder (Ilechukwu, 2007). A differential diagnosis is a list of possible diagnoses which are considered until further evidence suggests a final diagnosis.

Traditional healers in Lagos indicate that abiku is characterised by recurrent physical illnesses, the prevalence of which may be moderated by modern medicine. The abiku has a short life-span. Furthermore, traditional healers indicate that they are capable of diagnosing and treating abiku illness in utero. Traditional beliefs suggest that the illness is caused due to parental moral and social indiscretions (Ilechukwu, 2007).

The characteristics of emere, according to traditional healers in Lagos, include visual hallucinations, participating in cult activity during childhood, causing others to have bad luck, experiencing a sense of joy when others suffer, fainting, experiencing trance-like episodes, involvement in Nne-miri cults, and social deviance. The local community believes that parental involvement in sorcery contributes to being affected by emere (Ilechukwu, 2007).

The ogbanje chooses death instead of admitting that s/he is mistaken (Achebe, 1986). Even though the person inflicted with ogbanje hurts his/her mother emotionally, the mother continues to love and take care of her child with the hope that her love will exorcise the evil (Ilechukwu, 2007).

5.7 Traditional healing

The World Health Organisation (1978) defines traditional healers as individuals who make use of mineral, animal, and vegetable substances to doctor various severe or persistent disorders and are distinguished as healers within their communities. Traditional medicine is circumscribed as the understanding and employment of treatments used in the identification, prevention, and eradication of social, physiological, or mental disequilibrium and depends wholly on practical knowledge and experience passed on from one generation to another, either orally or through traditionally-related literature (WHO, 1978). Local and traditional therapies are often successful as they originate from, or directly relate to, the perspectives of the community (Santino, 1985). Like Santino, Mpofu (2006) indicates that the significance of traditional healing is extensively recognised. Mpofu does, however, suggest that further research be conducted in this area, particularly with regards to the characteristics of traditional healing which cause them to be effectual. Traditional healers may be skilled in the practice of traditional remedies, divination, and/or may act as spirit mediums (Swartz, 1998).

Mpofu (2006) is of the view that traditional healing's characteristic feature is that it operates at the grass-roots level. According to Koss-Chioino (2000), traditional healing has yet to endure extensive psychological investigation. One discipline that has a long-standing body of research on traditional healing is anthropology. In anthropology, traditional healing is often referred to as ethnomedical systems (Koss-Chioino, 2000).

Although traditional healing runs parallel to biomedicine, and has come to be viewed as 'alternative' treatment, it precedes the arrival of Europeans in Africa. As a result, these healing practices are preserved in the psyches of African people (Kale, 1995). Therefore, traditional healing in South Africa is well established and enjoys deference in the minds of African people (Pretorius, 1999). Moodley (1999) is of the view that in order to stimulate non-Western patients to engage in psychotherapy, multicultural counsellors will have to incorporate discourses regarding traditional healing practices into the therapeutic space.

5.7.1 On becoming a traditional healer

Traditionally, healers in South Africa are often called *inyangas*. Some inyangas correspond with ancestral spirits using a traditional custom of throwing bones. Through this spiritual consultation, the inyanga can assist in defending a person from misfortune and remedy harmful external effects such as witchcraft. Other curative techniques employed by inyangas include severing the skin in order to interleave herbal preparations, or suggesting and/or administering emetics and enemas in order to divest the body of contamination (Hundt et al., 2004).

An inyanga is consulted when spiritual dilemmas are suspected. Engaging these services suggests voluntarily engaging a bond between spiritual and physical surrender. The healing process is often extremely intense, and focuses on reconstructing the patient's relationship with the spirit world. Often, negative elements are purged from the body using emetics, enemas, purging, cupping, and sweating. The healing process is meant to strengthen the patient's faith in the traditional healer and improve his/her perception of the power of supernatural forces. During treatment, the inyanga plays the role of doctor, cleric, and educator. By embracing these roles, the inyanga is able to re-establish the patient's disconnected link with the ancestors and also teach the patient the rituals s/he may conduct after treatment. Avoiding errors during this process is crucial, as offending the ancestors may result in the inyanga and/or patient receiving the full wrath of the ancestors. Treatment is considered to be successful if the inyanga deems it as such, and the patient is said to have been cured of the curse. However, if the patient continues to experience the difficulties, these suggest the patient's personal limitations, and are not perceived to be an effect of the curse (Ashforth, 1998).

The source of healing may be due to heredity, a divine endowment, or through education (Nsamenang, 1992). From this framework, traditional healing ought to be appreciated as multivocal. Traditional healers tap into various dimensions and their noncodified healing practices have improved due to communication with other healing practices, such as biomedicine. Traditional healing has significance for communities in terms of their representations for both healers and patients (Koss-

Chioino, 2000). It appears that the role of the patient is as deeply entrenched as the role of healer.

Traditional healing, in fact the art thereof, is a gift from the ancestors (Wreford, 2005). Typically, traditional healers are thought to be imbued with supernatural talents that allow them to heal others (Santino, 1985). Traditional healers and witches receive their powers from direct communication with ancestors and/or spirits, they may inherit powers from ancestors, and/or they may be trained by skilled experts (Ashforth, 2005). In order to become an inyanga, the tyro must be exposed to *ukuthwasa*. During this process, an ancestor visits that apprentice in dream and instructs him/her to follow specific rituals. S/he may also be advised as to which gourds to employ as inyanga. To deny the call to ukuthwassa implies denying the highest authority, repercussions of which may be fatal (Ashforth, 1998).

Many prospective traditional healers stem from a family of mbombwes (healers) and undergo apprenticeships with the traditional healers in their families to qualify as traditional healers (Edgerton, 1971). Apprenticeship in traditional healing is extremely practical, and students are taught the process of observation, diagnosis, and healing. These may include genetic, environmental, and/or supernatural illnesses. Furthermore, the apprentice experiences practical training in the collection and indications of botanical medicines. Occasionally, the traditional healer inherits a talisman from his/her instructor. This talisman is of great value as it is thought to be imbued with God’s curative power (Edgerton, 1971). The cosmology of spiritual and ancestral power serves as the foundation to substantiate traditional healing practices (Noel, 1997)

5.7.2 Types of healers

In the main, there are three types of traditional healers in South Africa. These include inyangas, sangomas, and faith healers. Inyangas focus on remedies produced from herbal and animal origin. The majority of inyangas are male. A sangoma is a diviner and therefore communicates with the ancestors in order to determine the source of the pathology. The majority of sangomas are female. Faith healers are referred to as

umthandazi. These are healers rooted in Christianity and use prayer, sacred water, or a healing touch to treat inflicted individuals (Kale, 1995).

Certainly, African patients also consult prophets. Prophets differ from inyangas and are associated with the African Apostolic churches. While prophets may also medicate patients with herbal infusions and suggest enemas, they pray to God. God, from this perspective, correlates to the Christian view of God. A preferred technique employed by prophets includes decanting substances onto heated rocks and allowing the patient to inhale the vapour. Their worldview differs somewhat to that of the inyanga's worldview, and prophets are often antagonistic to the notion of witchcraft. All of the prophets' treatments accompany prayer (Hundt et al., 2004). Some of the African churches restore health with combined treatments, using prayer and herbal teas (Hundt et al., 2004).

While traditional healers are often seen as spiritual community leaders, prophets are also seen as leaders but emanate from indigenous Christian basilica. The identification and healing of mental illness, however, occurs through biblical norms such as prayer. The administration, or recommendation, to access Western medical resources is often dependent on the view of each independent church (Mpofu, 2001).

Magic and religion differ. More often than not, magic is impersonal. The magician commands occult forces to influence the world. Spells are commands. On the other hand, religion uses personalised intelligences. The object of worship is revered and supernatural influence is invoked through prayer. Unlike a spell, a prayer is often a request (Hammond-Tooke, 1998).

5.7.3 The difference between traditional healers and witches

Sorcery and witchcraft are often assumed to be equivalent. This is incorrect. In anthropology, sorcerers make use of substances to bring misfortune, while a witch possesses an inherent talent to manipulate supernatural forces to do his/her bidding. As a point of note, African beliefs regarding witchcraft and sorcery appear to suggest that sorcery resembles magic, while witchcraft is superficially similar to religion (Hammond-Tooke, 1998).

Sangomas, igqirha, and Yombe diviners are healers and work towards the greater good (Bond, 2001). Traditional healers are benign, while witches are proponents of evil (Wreford, 2005). The secret to successful witchcraft or healing is knowledge. The more one learns, the better witch or healer one will be (Ashforth, 2005). While traditional healers are able to discuss the sources of their powers, witches are unable to do this. To do so would rob the witch of his/her powers, rendering him/her ineffectual (Ashforth, 2005). According to many African people, the difference between witchcraft and traditional healing is anchored in the domain or morality. Depending on the intended use of supernatural forces, the craft is perceived as either good or bad. In general, witchcraft is perceived as bad, and traditional healing is perceived as good. Both pursuits operate within the auspices of 'African science' (Ashforth, 2005).

5.7.4 Traditional healing processes

Traditional African perspectives regarding the origin of psychopathology, or what may be perceived as psychopathology, suggest that these are either a product of proximate or ultimate causes. A proximate cause refers to the way in which the pathology develops, while the ultimate cause refers to answering the question as to why the pathology developed (Liddell et al., 2005). Traditional African patients and healers often find more value in targeting both proximate and ultimate causes, rather than focusing primarily on one cause. However, it appears that many traditional African healers and patients would opt for targeting the ultimate cause, if they had an option to only focus on one cause (Okello & Musisi, 2006).

Traditional healers are of the opinion that psychopathology may be classified into eight segments: mystical, genetic, puerperal psychosis, neurosis, mental retardation, antisocial behaviour, epilepsy, and brief psychosis (Odejide et al., 1978). Causal explanations include scientific and non-scientific views. Traditional healers suggest that non-scientific, that is personal, explanations are necessary in traditional healing. Non-scientific explanations regarding illness, for example, will begin with questions such as 'why?' and proceed to questions such as 'whom?' Answers are expected to address the specific offence, which entity has brought the illness, and which rituals

must be performed to reverse the illness. Hypothesis testing, and retesting, takes place within the confines of African divination (Kudadjie & Osei, 1998).

Traditional healing, by implication, necessitates that one surrender oneself to the healer in order to be healed (Santino, 1985). Treatment is considered to work only if the patient has faith in the capacity of the healer as an effective and competent healer (Edgerton, 1971). In traditional Tanzanian societies, for instance, catharsis through atonement facilitates healing (Edgerton, 1971).

Belief systems influence the way in which people seek help. In many collective cultures, traditional healing is favoured to Western health services (Dein & Dickens, 1997). Because traditional healers use a holistic approach to healing, African patients prefer to consult them. Traditional healers include medical, sociological, and cultural information before diagnosing and treating the patient (Nsamenang, 1992). Traditional healing remains ever popular in South Africa (Leclerc-Madlala, 2002).

Although many Western practitioners do not encourage traditional healing, people at the grass-roots level acknowledge supernatural process as a reality (Wreford, 2005). Traditional healing is often favoured in preference to professional care (Toldson & Toldson, 2001). Traditional African patients experience traditional healers as a valuable source of insight, fostering holistic and beneficial therapeutic processes (Okello & Musisi, 2006).

An inyanga's career relies on primarily positive feedback from the local and spiritual community. The local community has the ability to allow the inyanga's practice to continue on a practical level, while the ancestors allow the inyanga to retain his/her powers and thereby maintain his/her reputation. Poor feedback may result in the local community perceiving the inyanga as a witch, and s/he may consequently be severely harmed by the community (Ashforth, 1998).

There appears to be a good deal of Black South Africans who have faith in traditional healers, particularly based on positive experiences. However, there also appears to be many who harbour bitterness towards these healers. Many, for example, appear to be disappointed that traditional healers have not protected their communities from evil

forces (Ashforth, 1998). Ashforth experiences Sowetans as having faith in traditional healing and witchcraft, while concurrently maintaining a jovial cynicism of specific diviners. It is unfortunate that while Ashforth spent a significant amount of time living among Sowetans in order to obtain data, he did not obtain a statistically representative sample. His in-depth ethnographic study, therefore, provides insight into the daily experiences of some Sowetans.

5.7.4.1 *Muthi*

The participants in Ashforth's (1998) study regard witchcraft as acts of malevolent persons who make use of dangerous substances called muthi. Muthi, however, is also used by benign healers in order to alleviate a patient's physical, psychological, and/or spiritual distress (Ashforth, 2005).

Muthi, or muti in Xhosa, stems from the Nguni root *thi*, which means 'tree.' In its English translation, the term *muthi* means medicine or poison. Muthi is the combined product of substances, manufactured by a skilled person, and fashioned to heal, cleanse, rejuvenate, protect, wound, or cause death (Ashforth, 2005).

Every so often, local newspapers report on legal action against those involved in the trade of human body parts that may be used to manufacture black muthi (Ashforth, 1998). Black muthi is harmful, while white muthi is curative in nature. Although manymuthis are literally brown in colour, 'black' and 'white' refer to potentially evil or therapeutic effects respectively (Ashforth, 2005).

Although healing muthi is considered to be benign, it has the potential to bring about death. To elucidate, healers often inform patients that by counteracting witchcraft, their remedies will bring out the death of the witch. These aggressive responses are not frowned upon in traditional African culture, as the killing is perceived to be a form of self-defence (Ashforth, 2005).

Depending on the manufacturer of the muthi, as well as the agency of the healer or witch, muthi is thought to cause and cure all afflictions – irrespective of whether these are physical, psychological, social, or spiritual. Thus, muthi acts on and with people.

Supernatural forces, such as spirits, are thought to activate the power of the muthi. However, some believe that setting the muthi alight also triggers its powers (Ashforth, 2005). Muthi enters the body through edible substances, by breathing, through physical contact, during sexual intercourse, or via the anus. In addition, muthi may be activated from distant locations, or through dreams (Ashforth, 2005).

Discovering the medicinal properties of muthi is complex as many substances are infused to manufacture the substance. While the therapeutic value may be evident in terms of a patient's response to the treatment, modern scientific methodology would find it virtually impossible to ascertain general health-sustaining interactions (Ashforth, 2005).

5.7.4.2 *Traditional healing and psychopathology*

Many traditional Tanzanian's perceive psychopathology as illness which stems from supernatural forces (Edgerton, 1971). However, traditional healers whose interests lie in psychopathology, regard themselves as pharmacologists. This highlights the necessary link between the supernatural and scientific in some traditional cultures (Edgerton, 1971). Prophylaxis, therefore, must include supernatural intervention and requires the skill of a healer or prophet (Ashforth, 2005).

Edgerton's research in Tanzania with a traditional Hehe psychiatrist suggested that placebo effects may play a role in treating certain patients. However, Edgerton also found that botanical and pharmacological empiricism are equally significant. Edgerton's observation that suggestibility plays an important role in traditional healing has some validity, but cannot be generalisable. Certainly the use of substances which change colour when heated, the use of natural substance to induce psychological changes, and the dependable results achieved from purgatives and emetics may amplify the patient's sense of suggestibility (Edgerton, 1971). However, as Ashforth (1998) suggests, suggestibility and cultural perceptions should not be confused. The cultural perception that the supernatural process is real for the patient makes it real.

In many instances, traditional healers only accept payment after the patient has recovered from the illness (Edgerton, 1971). Since treatment often includes administering purgatives and emetics, once the patient's body has been purged of potentially obtrusive physical elements, appropriate medications are identified and/or prepared. This is based on the traditional healer's analyses, or if necessary, the patient may have to act as oracle and select his/her own medications. Many medications are brewed into a tea, but they may also be applied as an ointment to the skin or inhaled (Edgerton, 1971).

Many Africans believe that a grand mal seizure is inflicted upon them by another person. Some also believe that they may have offended the ancestors, or that a family member has broken a taboo. The family experiences a great deal of anxiety and guilt when a family member develops epilepsy and they consult traditional healers in order to identify the perpetrator, or to appease the ancestors. However, the traditional healer may indicate that the cause of the epilepsy is witchcraft, and may only be cured with ritualistic processes and/or counter-magic. Some Europeans also believed in this etiological perspective of epilepsy, but abandoned this belief when biomedicine offered an alternative understanding (Jilek-Aall et al., 1997).

Traditional healers systematise ambiguous information with the aim of classifying the disease according to a traditional diagnosis (Feierman, 1985). Time plays a significant role in diagnostic practices in traditional healing. As such, the diagnosis may change depending on the course of the disorder (Feierman, 1985). For example, a diagnosis of 'witchcraft' may change to a diagnosis of 'natural illness' if the medication does not heal a specific illness (Ashforth, 1998).

Traditional healers apply holistic and scientific healing practices. This applies to the diagnostic and treatment process, as well as their appreciation for natural and supernatural influences. As the spiritual and physical are indivisible, so too are the natural and supernatural (Kudadjie & Osei, 1998). Traditional healers do not divide healing into psychological, spiritual, and physical constituents. These delineations are unnecessary and alien to African perspectives (Edwards, 1998). Similarly, ethnomedical systems pretermit, and often take no notice of, what is often referred to as the body-mind division (Koss-Chioino, 2000).

Traditional healing is dynamic. The diagnosis and treatment depends on the context. Thus, in general, specific illnesses will not suggest specific treatments. Each person, even if they share symptoms with others, will require individualised treatment (Wreford, 2005).

Traditional healing is person-centred, not only in an individual capacity, but particularly in terms of focused attention on the family system. Informality and individualised explanatory and exploratory diagnostic and treatment processes define the traditional healing encounter. As a result, the holistic approach to healing moderates the subjective experience of anxiety (Toldson & Toldson, 2001).

In traditional healing, enemas and emetics are preferred above most other forms of treatment (Kale, 1995). Spiritual causes are usually regarded as adequate explanations for psychopathology (Patel, 1995), and the lack of symptoms suggests that the patient has been healed (Wreford, 2005). Due to the material and spiritual kinship ties in African culture, traditional healing may include addressing difficulties in worldly and spiritual relationships (Gualbert, 1997). Traditional healers operate within spiritual kinship networks called impandes. The micro network is traced to a gobela, the trainer of traditional healing practices. The gobela is part of a meso network associated to his koko, the gobela's initiator. The koko is part of a macro network linked to his/her initiator, traditionally called kokokhulu (male) or kokogasi (female) (Green et al., 1995).

An impande refers to a network of healers, types of medications, and ritual processes as defined by the senior gobela. Trainee healers, referred to as initiates, in the same impande refer to each other as siblings. Senior healers are referred to as koko, meaning great-grandparent, or gogo, meaning grandmother (Green et. al., 1995). Following the style of the oral tradition, the size of an impande is unknown. The exponential growth of an impande occurs because upon completion of the training, each healer may train new initiates. This occurs to such an extent that thousands of initiates may become part of an impande in one generation (Green et al., 1995).

Although African tribes share similar views regarding the manifestation of psychosis, the tribes often diverge in treatment regimens. Edgerton (1966) indicated that the

Sebei and Pokot people preferred to treat psychotic individuals severely, often imposing punitive measures to curb psychotic behaviours. The Hehe and Kamba people preferred that the patient engage in a process of therapy, ordinarily with traditional therapeutic interventions. These two divergent views point to the belief systems presumed within the tribes. Thus, and as evidenced within the investigation, the Hehe and Kamba tribes perceived psychosis as curable, while the Pokot and Sebei tribes perceived psychosis as incurable. The differential reaction of each of these systems correlates strongly with the beliefs regarding prognostic indications. The Kamba traditional doctor often treated psychotic patients with medications and supernatural healing processes. However, the Kamba traditional doctor also employed extremist interventions, such as allowing the patient to sit in water which is rapidly and intensively heated until he deemed the patient to be cured (Edgerton, 1966).

The Kamba indicated that they preferred treatments aligned to Western psychotherapy or extremist techniques which they termed *shock therapy*. Conversely, the Hehe treatment process gave emphasis to chemotherapy, employing a combination of magical and pharmacological treatments. This did not imply the administration of Western pharmacology, but rather the utilisation of a remarkable traditional pharmacopoeia which had significant pharmacological activity (Edgerton, 1966). Edgerton was also of the opinion that the treatment methods employed by the Sebei traditional doctors show resemblance to treatment regimens applied in Medieval Europe. To defend this view, Edgerton cited examples of Sebei treatment techniques such as the traditional doctor applying a scorching tool to the patient's forehead in an attempt to destroy the worm in the brain, or tying the patient to a centre post and forcing him/her to inhale assorted liquids.

The traditional psychiatrist in Edgerton's (1971) research became interested in psychopathology in the early stages of his training. During his apprenticeship, he experienced an auditory hallucination and experienced great anxiety in this regard. He was diagnosed as being the victim of witchcraft and was subsequently cured by a traditional healer. The participant suggests that he had not experienced any hallucinations thereafter. His interest in mental illness increased during the times when he witnessed his wife's psychosis, and later his sister's psychosis. He indicates that he cured both women and this led to his reputation as a proficient psychiatrist.

Traditional psychiatric nosology includes a diverse array of illness categories. Diagnosis is dependent on the patient's personal and medical history, nature of the present illness, and possible antagonists who may be willing to curse the patient. The total social context is used to reach a diagnosis (Edgerton, 1971).

Traditional healers often find that psychopathology occurs without reason. The lack of evidence as regards supernatural causes often implies that the disorder is a result of natural causes (Edgerton, 1971). Traditional healers acknowledge various illnesses. These include sterility, impotence, respiratory illness, venereal diseases, fevers, and stomach infections, among others. Other illnesses which they treat include particular disorders such as malaria (Edgerton, 1971). Traditional psychiatrists differ from traditional healers in that the former focuses on treating psychopathology. These psychiatrists presumed the mind to be the locus of the disorder (see Edgerton, 1971).

While this section appears to cite Edgerton to a large extent, a scarcity in context-specific literature was available during the research process. Much of the available literature focused on contrasting traditional and modern psychiatric nosology, with a profound deficiency in research relating to traditional African psychopathological treatment processes.

5.7.5 Harmony and balance

Social constructions define the customs of identifying traditional health and healing, and these reveal the African perspective (Mpofu, 2006). Synchronicity and equilibrium form the crux of the African worldview, and any deviation thereof often necessitates processes required to re-establish equilibrium (Bojuwoye, 2005). In endeavouring to foster balance, healing is assumed to influence affect, cognition, and behaviour. Healing, therefore, is collective and holistic (Mbiti, 1970). In African cosmology, *spirit* represents wholeness. Disturbances in wholeness perturb the spirit and manifest as psychopathology. The goal of African-centred approaches is to placate the spirit and restore balance and wholeness (Toldson & Toldson, 2001).

From a cultural standpoint, enemyship in Africa is assumed to be embedded in any relationship and is endemic to social reality (Adams & Salter, 2007). Greed,

resentment, aggression, vengeance, and hatred result in witchcraft (Wreford, 2005). Adams (2005) defines enemyship as interpersonal relationships characterised by hate and malevolence where at least one individual yearns for the destruction and/or failure of another individual. In Ghana, for example, it is usual to hear that enemies cause adversity for others. The identities of enemies often remain undisclosed. In conventional psychological theories, enemyship is interpreted as indicators of suspicion, aberration, and psychosis (Adams & Salter, 2007).

5.7.6 Traditional and modern collaboration

There appears to be a need for more correspondence between modern practitioners and traditionally-inclined patients. The population subgroups in Janse van Rensburg's (2009) study comprised Xhosa, Zulu, Zionist religious subgroups (e.g. ZCC), Indian, and Tswana/Sotho populations. The researcher found that traditional healing and psychopathology required further investigation in the areas of language barriers between traditional patients and modernistic practitioners; that those patients being treated by traditional and modernistic healers experienced conflict between the two paradigms and that synthesis could benefit the patient; that traditional and modern perspectives of normality and abnormality differed; and that a cultural formulation of psychopathology would be significant to patients if the formulation met the patient's worldview.

In an effort to collaborate traditional and modern paradigms, a national program in South Africa was established in 1992, focusing on HIV prevention. Traditional healers were recruited to be trained in the program, and these healers were then asked to train other healers. The idea was that as an important source of healing in the community, traditional healers would be able to access a large majority of the population and assist with HIV prevention strategies (Green et al., 1995). However, for various reasons, this endeavour did not appear to encourage disciplinary collaboration.

One of the reasons that traditional and modernised health care providers ought to collaborate is to ensure that the patient does not suffer the negative consequences of contraindicated pharmacopoeia. Dialogue and collaboration between traditional and

modernised practitioner will probably be better attuned to meeting the patient's health care needs (Kale, 1995).

One of the foremost difficulties with regards to the integration of traditional healing and modern clinical care is that the assimilation of these two areas appears to be financially costly to execute (Janse van Rensburg, 2009). However, assimilation may occur within the therapeutic space.

In terms of accommodating the traditional perspective, psychotherapy ought to include extended family members. Extended family therapy acknowledges and embodies the real-life experience of African patients (Wohl, 2000). The term 'extended family therapy,' may be used as a definitional phrase to identify family therapy that includes extended family members together with nuclear family members (Carlson, Sperry, & Lewis, 2005).

In family therapy, it is necessary to take cognisance of cultural perspectives and to acknowledge familial roles as defined by the culture. Consider, then, that initial acquiescence as regards traditional roles in the family may develop rapport within the family process. This may suggest awareness into the fact that the father is perceived as head of the family, that a seemingly symbiotic mother-child relationship should not be assessed as over-reliant, or that each sibling is expected to fulfil specific duties (Wohl, 2000).

5.8 Western perspectives on psychopathology

Application of Cartesian perceptions in the social sciences was defined by mechanistic formulations of the body and employed disappointing attempts at exploring mindful causation of somatic symptoms. Psychoanalytic psychiatry grappled for a long time in conceptualising these processes. The eventual progress of psychosomatic medication in the 20th century, together with evolving views in psychoanalytic psychiatry, initiated the task of reintegrating body and mind in clinical theory and practice (Scheper-Hughes & Lock, 1987). Here, one comes to appreciate the precarious position of psychiatry's relationship to medicine. Medicine is based on the biological reality of pathogens. Psychiatry, on the other hand, proposes that the

personalised experience generates the disordered reality (Littlewood, 2004). The psychiatric position has focused largely on a Western epistemological stance.

In Western epistemology, mind/body contrasts are linked to other supposed contrasts such as culture/biology, passion/logic, and personal/collective (Scheper-Hughes & Lock, 1987). Western epistemology often tessellates with the biomedical model. The biomedical model has situated the origin of psychopathology in biochemical pathogens and/or a breakdown in physical, individual structures (Adams & Salter, 2007). Biomedicine boisterously reinforced the notion of linear causality, depriving professional healing systems of further exploring *mindful causation* with regards to illness (Scheper-Hughes, 1987).

The reductionistic perspective suggested by the biomedical paradigm inhibits a cultural basis as explanation for wellbeing and disorder. While conventional health psychology acknowledges that culture may influence the experience of psychopathology, it often assumes that culture's influence on physiological processes is diminutive (Adams & Salter, 2007). Medicine and healing are constructed by culture. Biomedicine's focus on the physical body is produced by a Western perspective (Lupton, 1994). However, the biological theory is inept in providing a clear, comprehensive explanation for psychotic processes and the complex dynamics contained within the content thereof (Sharpley, Hutchinson, McKenzie, & Murray, 2001). From the biomedical approach, it appears that koro and partial koro syndrome, for example, is the same psychopathological syndrome, but that aetiology and culture mediate the experience thereof (Dzokoto & Adams, 2005).

There is a tendency in psychiatry to continue to use classificatory systems which account for Euro-American perspectives. However, many factions in psychiatry fail to explore the validity of Western systems in non-Western societies (Hickling & Hutchinson, 1999).

In attempting to explore these cultural dynamics from a professional's perspective, Yen and Wilbraham (2003) conducted a discourse analytic study with psychologists, psychiatrists, and traditional healers. The investigation revealed that professionals diverge in terms of diagnostic categorisation. At the one extreme, psychiatric

universalism was favoured. On the other extreme, cultural relativism was favoured. Often, in defence, professionals revert to professionalist discourse (Yen & Wilbraham, 2003). These processes suggest that professional discourses may be in jeopardy of transgressing imperative ethical responsibilities toward their patients.

Biomedical ethics refers to the critical examination of behaviours and views in medical and biological settings. The aim is to reinforce responsible and morally acceptable norms within these settings (Toldson & Toldson, 2001). To reinforce biomedical ethics, mental health care must accommodate worldviews, sociocultural norms, and context-specific experiences (Toldson & Toldson, 2001). Although collaboration between psychologists and psychiatrists is common, virtually no collaboration exists between traditional healers and the remaining two disciplines (Yen & Wilbraham, 2003).

While biomedical and traditional healing practices may possess opposing views, dialogue between these disciplines may bridge the gap in healing interventions. This is not an alien view as traditional African healing practices have accommodated various contemporary medical perspectives (Liddell et al., 2005).

5.9 Africa in relation to the West

Mafeje (1971) was of the view that difficulties in understanding African behaviour stem from ideological discrepancies, particularly with regards to tribalism as an ideology. In this regard, European colonialism constructed African reality as tribal, which made it difficult for numerous Western societies to view African society from a different perspective. Many Western views of the supposed tribalism in Africa have endured, notwithstanding political and economic modification in Africa over the last century. Mafeje was also of the view that considering the ideology of tribalism as being exclusive to the traditional African population is a Western construction. In this regard, Mudimbe (1988) was of the view that usually, training institutions and professional organisations have been promoting the application of logic, conceptualisation, and categorisation that corresponds to Western culture.

Kwate (2005) is of the view that psychopathology as reflected in African-centred theories signifies a heretical confrontation to Western models of psychopathology. Heresy, here, refers to denying the ideology of African perspectives of psychopathology in lieu of the predominant views publicised by Western perspectives. Although African-centred theories parallel Western psychiatry and clinical psychology in terms of diagnosis and formulation, unequivocal rejection of the ideological basis of illness characterisation is evident.

In general, Western society perceives hallucinations as pathological. However, non-Western cultures assign value to the hallucinations and regard them to be part of the real world. A hallucination, therefore, is not a distortion, but an actual experience of the real (Al-Issa, 1995; Sharpley et al., 2001). Furthermore, a few Western perspectives often regard enemyship as abnormal, while enemyship plays a part in everyday occurrences in African societies (Adams & Salter, 2007).

Edgerton's (1966) review of previous literature indicated that severe psychopathology in African societies was easily confounded as antisocial conduct. This appears to have stemmed from bigoted views of Africans as being primitive. Aged views of psychosis implied that Europeans experience more complex forms of psychopathology due to their perceived advanced evolution (Bullard, 2001).

Mpofu (2006) is of the opinion that Western imperialist views of traditional healing have been predominantly negative, and often associated with savageness. Cross-generational communication has allowed patients to appreciate the existence of historically negative undertones regarding the use of traditional healing. It has therefore become apparent that patients exhibit less candidness with regards to using these services.

Do these views imply a tacit tussle between proponents of modern or traditional healing practices? Mpofu (2006) finds this line of reasoning incongruous. In this regard, he indicates that the masses of the world's population experience negative health outcomes due to limited access to modern medicine. Furthermore, those who are able to access modern medicine exclusively, are at jeopardy to be overmedicated and do not have the opportunity to experience the advantages of traditional healing

services. According to Ilechukwu (2007), sometimes, patients do not obtain medical treatment because they believe that modern interventions are inept to treat specific disorders. An example of one such occurrence is the Igbo's belief of treatment regarding ogbanje; that is allowing the child that forged a pre-birth spiritual contract, to return to the contracted spirit deities.

The dichotomies created by exploring differences in cultures have fostered a West-against-the-rest frame of mind (Hermans & Kempen, 1998). For example, while homosexual experimentation is known to occur amongst traditional African boys, adults are thought to engage only in homosexual behaviour when they are deprived of heterosexual intimacy. Furthermore, traditional views of African homosexual males suggest that homosexuality is a negative behaviour divorced from African traditions. Traditionalists often indicate that these persons have been influenced by Western culture (Green et al., 1995).

It appears that many researchers continue to perceive African psychiatry as having limited importance to Western psychiatry. Some have even criticised African psychiatry as being detrimental to the scientific field (Edgerton, 1971). African cosmology and spiritual beliefs are no more fantastical than believing in the divine. From this point of view, the African psychopathology of genital-shrinking ought to be as acceptable as faith healing, for example (Dzokoto & Adams, 2005).

Traditional healing and biomedicine share communal sources, yet each view of illness characterisation has furcated (Horton, 1993). While biomedicine determines 'what' the illness is, traditional healing responds to the questions 'why me?' and 'why now?' thereby offering the patient an explanation which resonates with his/her worldview (Pretorius, de Klerk, & van Rensburg, 1993). Wreford (2005) suggests that traditional healers are disheartened by biomedicine's negativistic attitude towards them. They also appear to re-experience apartheid wounding as a result of this perception. To illustrate this, the mandatory relationship between healer and witch appears to foster Western disapproval of traditional practices (Wreford, 2005).

It is a Western postulation that the loci of all psychopathological conditions reside in the brain (Marsella, 1998). Western epistemology experiences contradiction as primary constructs. The epistemology fosters separation in constructs such as real and

unreal. One of the victims of this epistemology is undoubtedly biomedicine, conscientiously seeking internal, neurochemical changes erroneously perceived as accurate causal explanations (Scheper-Hughes & Lock, 1987). Biomedicine, as well as Western progression, has done much in terms of physical healthcare and advancement in areas such as travel. However, while deaths appear to be postponed, and lives saved, humanity is somewhat undermined (Scheper-Hughes & Lock, 1987).

In researching cultural diversity, cross-cultural psychologists have depended upon cross-national methods to contrast cultural perspectives, particularly between non-Western and Western cultures. In these cases, individuals within each sector (either Western or non-Western) are perceived to be from a single cultural unit, sharing static, internalised values and norms. This hampers appreciating behaviour-in-context (Schönpflug, 2001).

If the cause of disease cannot be ascertained, patients will often use a combination of traditional and Western healing (Nsamenang, 1992). Western and traditional perspectives and healing practices should be afforded equivalent value as both suggest the cultural construction of illness characterisation (Patel, 1995).

Wreford (2005) is of the view that Western-trained professionals and traditional healers should work collaboratively in order to benefit the African population. Since 1997, the WHO and UNICEF have advocated that Western professionals and traditional healers collaborate in order to improve community health (Green et al., 1995). South African health, for instance, is characterised by a pluralist provision comprising African traditional healing and Western healing. The two provisions, however, do not operate side-by-side (Wreford, 2005).

Collaboration between African and Western healers may have an important, and positive, effect on the African population. Certainly, the combined effort will be more relevant and meaningful to traditionally-inclined Africans (Wreford, 2005).

The immense influence of Western medicine on society has facilitated a somewhat unfair distribution of referral processes between the formal and informal sectors. Mpofu (2001) indicates that prophets and traditional healers often refer patients with

complex illnesses to the formal sector. However, it appears unlikely that the formal sector will undoubtedly refer patients to the non-formal sector, including traditional healers. In a diabolical conundrum of metaphorical alphas and omegas, Mpofu indicates that the traditional healer is often both an initial port of call, as well as a final alternative for many Africans. He consequently questions the justification of continuing to enable the lack of a referral system between the two sectors.

Inequality features in every society. This extends to degrees of inequality sanctioned or endured within each society. In this regard, power distance influences help-seeking behaviours, treatment, and especially prevalence rates. If a clinician or his/her related industry are perceived as being superior and/or intimidating, they may come across as being unapproachable or intimidating. The clinical sector may therefore experience limited exposure to particular populations and pathologies because the sector is perceived to be unapproachable (Eshun & Gurung, 2009). This may suggest resistance.

Resistance is the reaction a patient has to perceptions of psychological danger within the therapy process. Although resistance occurs with all patients, specific considerations must be observed when working with non-Western patients. To regard all uncertainty, disinclination, vacillation, doubt, cynicism, or distrust as resistance would be erroneous. Intrinsically fixed defensive norms, as a result of cultural influence, may be a preliminary response to an atypical healing environment (Wohl, 2000).

If a clinician elects to discriminate between internal and external hurdles, particularly as regards resistance and resistance-like devices, then it is necessary to explore the source of these influences. Here, culture may provide rich clinical material, as well as inform the clinician on particular cultural influences which may be operating. In return, the clinician is able to ascertain which therapeutic models may benefit specific patients. It ought to be noted that this process should be applied to all patients, and most specifically to those who appear to have different worldviews (Wohl, 2000).

5.10 On universalism, relativism, and absolutism

Many assume that psychological growth is universal and can consequently be appreciated independently of culture. This approach to psychological development accepts that environmental dynamics may assist or impede development. Nonetheless, sociocultural experiences are presumed to occur universally and produce common results (Miller, 1999). The ICD-10 (WHO, 1992) and DSM (APA, 2000) classifications of psychopathology fall within the scope of the universalistic approach. The assumptions of these systems include the idea that primarily Western-researched syndromes may be applied to all populations. This assumption is not necessarily accurate. The DSM-IV-TR attempted to address this limitation by incorporating culture-focused data, but agrees that further research is required in this regard (Eshun & Gurung, 2009).

Canino, Lewis-Fernandez, and Bravo (1997) are of the view that a number of scholars in psychopathological epidemiology remain faithful to the universalistic perspective. The foundation of this perspective rests on the idea that psychopathology is universal among all human beings and, as a result, may be subject to universally patterned clusters of symptoms. The only divergence accepted from extremists in the universalistic school is that culture regulates the manifestation of psychopathological indicators, as well as the parameters that define normality and psychopathology. For these proponents, the locus of pathology rests exclusively within the individual (Canino et al., 1997).

Panksepp (1998) views the universalistic position as regarding the biological manifestation of emotions. The universalistic stance therefore regards emotions as the outcome of neurophysiologic activity located in the limbic system. Kleinman and Good (1985) indicate that the universalistic position attends to the classification and tagging of symptom clusters, anchored exclusively in the domain of biomedicine.

Multiculturalism appears to relate strongly to the universal approach. This is due to the idea that all forms of counselling are generic and therefore multicultural in nature (Patterson, 1996). The assumption that a universal conception of family therapy is sufficient may be less positive than anticipated. Bear in mind that the spigot in family

therapy has two primary areas. The first addresses the qualities of the pathology, while the other centres on understanding the context of the pathology (Wohl, 2000).

Higher education institutions, implicitly or explicitly, generally promote the view that a universal 'attitude' to learning and behaviour equips prospective clinicians to become competent in working with traditional African populations (Airhihenbuwa & DeWitt Webster, 2004). An enriching observation is that many social science students do not appear to appreciate information which they perceived to be stereotypical. They seem to prefer information suggesting that people and culture be placed into context, so as to understand the personal experience of the person (Tomlinson-Clarke, 2000).

Diagnostic discourses compartmentalise relativism and universalism. In this way, specific conditions are perceived to be psychopathology, while others are perceived to be culture-illnesses (Yen & Wilbraham, 2003). According to Kleinman and Kleinman (1991), proponents of the relativistic perspective are of the opinion that classificatory systems, such as the DSM-IV-TR, afford culture an extremely limited position in diagnoses and therefore produce a category fallacy, as well as unjust homogeneity in pathology across cultures.

The idea that the locus of the pathology resides within the person is strongly contested by relativists, specifically with regards to the way that culture appears to influence psychiatric symptoms, as well as the experience of psychological distress devoid of evidence regarding biological dysfunction (Wakefield, Pottick, & Kirk, 2002). In this way, the opinion that psychopathology is universal is doubted by relativists (WHO, 1992).

Lutz (1985) is of the opinion that the relativistic stance defends emotional expression as collectively conceived and is consequently exclusive to cultural, social, and historical systems. Proponents of the relativistic position are of the view that assessment measures applied in specific settings do not depict distinctive qualities expressed in other settings. This is due to proponents of the universalistic position often discounting lived experience, context, and culture-specific manifestations of psychopathology (Kleinman & Good, 1985).

The relativistic position also assumes that culture determines the definition of normal and abnormal, including the degree and length of pathological indicators required to necessitate a diagnosis suggesting pathology. Furthermore, phenomenological facets of the disorder influence the aetiology of the disorder, as well as the way in which individuals respond to the pathology. These dimensions, according to relativists, are mainly dependent on cultural identification and norms (Hughes, Simons, & Wintrob, 1997; Lewis-Fernandez & Kleinman, 1995). However, by and large, the universalistic view does not negate that extraneous factors may precipitate psychopathology. In the same way, the universalistic view assents that risk and protective factors affecting the pathogenesis of the pathology have the propensity to influence the manifestation of the pathology. The DSM-IV-TR, for example, makes references to the ways in which various cultures and identity-related factors influence the manifestation of certain disorders (Canino & Algería, 2008).

Universalists centre on slight levels of dissimilarity in general global groupings and dimensions. Relativists emphasise depth in cultural variation by highlighting the interpenetration of psychological distress and culture. Relativists, therefore, focus on the inimitability of each culture, and contend that the study of psychopathology with regard to culture be understood in terms of that specific culture (Draguns & Tanaka-Matsumi, 2003).

Smit, van den Berg, Bekker, Seedat, and Stein (2006) are of the view that both positions have limitations. Kirmayer (2001) suggests that the observation of these limitations become overtly evident in reviewing ethnographic studies. Often, these studies explore insight into cultural differences, but seldom inform academia on probable similarities.

Berry (1995) suggests that the absolutist view (that is, exclusive favourability of either approach) does not consider cultural dynamics in the articulation of psychopathological symptoms. Thus, the presentation, manifestation, and implications of psychological distress are regarded as invariable amongst all cultural groups. The relativist view posits that all psychopathological symptoms be observed within cultural frameworks, and the universalist view strikes an attempt to find the middle-ground between the absolutist and relativist positions by regarding mental illness as

universal in its course, but regards culture as having some influence on the pathology. Any absolutist perspective, whether rooted in the universalistic or relativistic approach, poses limitations (Patel, 1995).

The universalistic and relativist position overlie the etic and emic approaches respectively. On the one hand, the etic approach signifies an explanation of occurrences, independent of the attached connotations. On the other hand, the emic approach signifies the connotations attributed to specific occurrences, by a particular faction (Draguns & Tanaka-Matsumi, 2003).

The universalistic position extends beyond the etic orientation, focussing upon supposedly common rubrics and continua of experience. In contrast, the relativistic position extends beyond the emic orientation, focussing upon ideas and labels originating within specific cultures (Draguns & Tanaka-Matsumi, 2003).

The word *etic* stems from 'phonetic.' Phonetic represents the full range of sounds used in human linguistics. Etic, therefore, refers to a universal approach. In contrast, the word *emic* stems from 'phonemic.' Phonemic is representative of sounds that are consequential in specific languages. Emic, therefore, refers to a relative approach (Achenbach et al., 2008).

The etic approach suggests that psychopathology is analogous across cultures and that psychopathological taxonomy, assessment tools, and health care prototypes are universally acceptable. As previously discussed in this section, the etic view precipitated the argument regarding 'category fallacy' (Kleinman, 1988).

Jablensky (1987) suggests that long-standing ethnopsychiatric views suggested that schizophrenia would not be universally dispersed across various cultures, and that each culture would produce dissimilar prevalence rates of the disorder. This certainly suggested a close link to the etic approach, particularly as the specific pattern of symptoms could be reliably identified in various cultural settings (Jablensky, 1987). Furthermore, relativistic-orientated clinicians may find it difficult to account for the identical symptomatology evident in urbanised, Western populations and rural, traditional populations. These symptoms, reflecting anomalous experiences which

almost instinctively fall within the ambit of schizophrenic disturbance, include thought broadcasting, for example. The challenge, as a result of these observations, is for relativistic-orientated researchers to vindicate the universalistic experiences of specific symptoms of schizophrenia across diverse populations globally (Jablensky, 1987).

Lin and Kleinman (1988) conducted a literature review to assess schizophrenia and its effects in non-Western countries. The reason for conducting this investigation was to evaluate the legitimacy of statements suggesting improved prognosis in developing countries. These researchers took into consideration the substantial influence of sociocultural factors in terms of affecting the clinical course of schizophrenia. Their review indicated that non-Western societies often experience better prognosis due to their sociocentric positioning, thus allowing for additional emphasis on social support. Furthermore, the process of incorporating the extended family in the family therapy process served to provide additional support to schizophrenic patients.

Lin and Kleinman (1988) also found that allowing schizophrenic patients to continue to work, as is common in non-Western societies, even though the nature of work may be revised, improved their prognostic status. In addition, the incidence of schizophrenia in non-Western countries appeared to be lower than Western countries. Due to perceptions in traditional societies that psychopathology is often expressed as somatic complaints, spiritual idioms of distress, and symbolic interpretations, patients are often not perceived as culpable for their illnesses. This is distinctly converse to popular Western psychiatric theories which subsume psychopathology as psychodynamic or personality flaws integral to the person. These views certainly facilitate peripheral rejection and stigmatisation, as well as personal self-blame and self-attribution. The demands placed on the person by self and others in Western societies are viewed as more pessimistic thereby diminishing the prognostic status. The review, however, left Lin and Kleinman with more questions than answers. These questions allowed them to develop recommendations for future research, such as the need for longitudinal studies, investigations focused on specific populations and their specific sociocultural characteristics, the need for more research exploring soft neurological signs, and cross-cultural differences in terms of the manifestation and experience of schizophrenia.

The biomedical model has been described as an etic approach in that it defends what appears to be a scientific and universal outlook. The ethnomedical model, however, has often been described as an emic approach because it endorses what appears to be a contextual and relativistic outlook (Koss-Chioino, 2000). The emic approach assesses phenomena in terms of the cultural perspective, and aspires to appreciate the importance of culture and its affiliation with various other intracultural factors (Okello & Musisi, 2006). There is a great need in clinical psychology and psychiatry for the development of emic-inclined assessment tools (Patel, 1995).

Considering multiculturalism in psychopathology is consistent with the etic approach (Achenbach et al., 2008). This view is aligned to the previously discussed opinion by Patterson (1996). It is fairly accurate to state the emic approach is not exactly a cross-cultural system, because it is more attuned to monocultural focus. The etic approach, however, naturally evaluates phenomena in more than one culture (Nsamenang, 1992).

Atypical investigations are beginning to combine etic techniques with emic models, suggesting a novel approach to research which appears to be a cut above employing either of the approaches exclusively (Draguns & Tanaka-Matsumi, 2003). It is crucial that academia and practitioners begin to assimilate both emic and etic perspectives (Okello & Musisi, 2006). The etic and emic approaches are not exclusive to each other. They may be used in chorus (Achenbach et al., 2008).

5.11 Ethnocentricity

If one recognises that culture exists, then centrism is conventional (Mabie, 2000). However, ethnocentrism is formed when one applies his/her norms as the benchmark for assessing others. This often fosters stereotypical attitudes between clinicians and patients (Eshun & Gurung, 2009). The view that aspects of society may be influenced by a single person is a pitfall of ethnocentrism. All people experience sociocultural stimulation, and all actions are a function of a group, as well as of an individual. However, the group as the source of action precedes the individual as perpetrator of action (White, 1959). Ethnocentric views have been influential on people, but the

most apparent outcome of ethnocentric dynamics has been evident in the anxieties caused by uncertainty avoidance (Hofstede, 1986).

Hofstede defines uncertainty avoidance as the degree of anxiety imposed on specific populations by exposing them to ambiguous circumstances. In order to elude the uncertainty, they employ concrete and absolutist cultural codes to minimise the effects of this experience. According to Eshun and Gurung (2009), dominant views become deeply entrenched and may be complex to identify. For a clinician, the best counterattack is to acknowledge diverse views and to systematically explore a comprehensive range of perceptions before reaching a clinical decision (Eshun & Gurung, 2009).

According to Mabie (2000), Afrocentric refers to repossessing the privilege, liability, and licence to classify oneself with one's African ancestry. Communalism is underscored in traditional African society as much as it is accentuated in African American society (Black, Spence, & Omari, 2004). The common experience of these groups assisted in precipitating the African American endeavour to celebrate Afrocentric perspectives. Soon, the efforts of African American psychologists encouraged the intensification of Afrocentricism. Some are of the view that the discipline of psychology has benefited due to this process. However, there appears to be an explicit constructive aspect to the Afrocentric view. The view places a major emphasis on spirituality (Black et al., 2004).

In practice, afrocentricity may entail the implementation of varied theories of personality, psychopathology, therapy, and treatment. Afrocentricity may suggest deviating from the current ontological slant of international clinical psychology. Certainly, this suggests generating an Afrocentric volume of literature. While some welcome this process, others oppose the Afrocentric position vehemently. Nonetheless, arguments in clinical psychology, with regards to culture, appear to be fundamentally directed at the Eurocentric or Afrocentric perspectives and its associated meanings (Eagle, 2005).

5.12 Comparative views

It may be extremely valuable to consider comparative views of cultural psychopathology as these suggest an explicit divergence from universal perspectives. In terms of fortifying the integrity of science in the future, it may be valuable to position African spirituality beside Eastern spirituality (Edwards, 1998). Spiritual practice, from an Eastern worldview, is thought to be scientific because it includes inspection and trialling. The cause-and-effect observations are repeatable. Eastern cosmology, African spirituality, and Western science agree that authority is a consensual accreditation. However, while Eastern worldviews overlap African spirituality to a large extent, Eastern perspectives are perceived to be similar to Western science (Edwards, 1998). Analytically, then, acceptance of an Eastern perspective suggests implicit acceptance of an African perspective.

Human governance of nature is typical of Islamic cosmology, but is often buffered by a supernatural world that focuses on the equilibrium of all occurrences. The belief in one God transcends purely religious dogma and symbolises monistic subsistence of all existence. All people are answerable to God, and strive to achieve unity through the complementarities of body/spirit, work/hereafter, meaning/substance, and natural/supernatural (Scheper-Hughes & Lock, 1987). In the past, the Muslims were of the view that psychosis was in fact spiritual transformation and touched only God's most beloved people (Bullard, 2001). The Muslims believe that spirits, commonly called jinns, exist in the physical world, but are normally invisible. They appear to exist between objective and unseen reality (Bullard, 2001).

Buddhist cosmology, however, suggests that the world exists in the mind. A universal mind exists, and individual minds are able to merge with the universal mind through meditation. Analytic approaches to perception are superficial in Buddhist cosmology, and the person is encouraged to learn to understand experience through an instinctive, insightful synthesis attained during periods of transcendence. These periods defy the barriers of language, speech, and writing (Scheper-Hughes & Lock, 1987).

The Japanese application of philosophical systems, such as Buddhism and Shintoism, allow the Japanese individual to disengage from earthly desires and/or attempt to

attain feelings of submersion in nature. The adoption of these philosophical systems, however, has not reinforced the Western-focused notion of individuation in Japan (Scheper-Hughes & Lock, 1987).

It appears that Littlewood's (2007) work may be applicable to the urbanised South African population. Academic debates regarding African heritage of Trinidad have been noted. Yet, experiences at community level exemplify African worldviews, as well as interpersonal dynamics reflected in many African countries. Contemporary interactional patterns suggest negotiating patterns between Black and White, as well as urban and rural. Trinidad also shares collectivistic views with the African continent, as well as views pertaining to culture-related psychopathology (Littlewood, 2007). Genetic disposition is frequently considered to be a cause of psychopathology in Trinidad. Other causes considered to be equally common include severe anxiety relating to the social context, being cursed, and having beckoned the spirits (Littlewood, 2007). Local Trinidad people attribute psychopathology to peripheral causes. Genetic predisposition plays a role, but precipitating factors are perceived as the cause (Littlewood, 2007).

Littlewood (2007) indicates that possessing the evil eye regulates personal agency. Trinidadian and Albanian people perceive possessing the evil eye as similar to being able to perform witchcraft. This implies an unconscious and innate propensity to willingly or unwillingly harm others. Littlewood also indicates that Albanians protect themselves from evil eye by wearing blue or black talismans. Trinidadians, on the other hand, believe in cosmic retribution and anticipate equal harm to be caused to the perpetrator. In Trinidad and Albania, adult females are said to automatically know specific phrases to alleviate the negative effects of evil eye.

In both Albania and Trinidad, defiling moral codes of local society is seen to be psychopathological. Specific acts which transgress these moral codes are specifically perceived as madness and include, but are not limited to, bestiality, homosexuality, sexual abuse of children, sadistic behaviours towards family, and culturally-prohibited adultery (Littlewood, 2007).

5.13 Cultural diversity

Many views suggest that social behaviour is extremely diverse and is difficult to comprehend (Mafeje, 1971). Exploring diversity is terrifying for some, although it need not be. Diversity has been ever present, but does not imply that groups of people remain constant eternally. Cultures adapt, people change. Families are groups which operate at the micro level, while cultures are groups which operate at the macro level (Mabie, 2000).

Education in cultural diversity affords counselling students a window into experiencing different worldviews. This appears to facilitate counsellor self-development, but also gives the student the opportunity to examine personal assumptions and biases (Tomlinson-Clarke, 2000). South Africa is not alone in its struggle with issues relating to marginality, diversity, and multiculturalism. These issues have been broadly considered in many countries (Modood & Ahmad, 2007).

For Wohl (2000), clinicians must be wary of a universalistic approach to family therapy. As patients appreciate their differences, so should clinicians. To be able to contend with variations among the cultures, yet appreciate the similarities of humanness implies not just acknowledging universality, but also embracing the courage to confront relativism. These dynamics, therefore, must be confronted in order to acknowledge the value of a potential African perspective.

The observation that Black patients find it difficult to communicate subjective experiences with White counsellors is incorrect. It appears that some people may not be comfortable with communicating personal information with others, and has very little to do with race (Patterson, 1996). Abridging differences to its most simplified form appears to be a basic human tendency and creates us-them disjunctions. A focus on difference has the potential to foster stereotypes and/or to separate 'us' from 'them' to the extent that the other is placed at a disadvantage (Achenbach et al., 2008).

In terms of stereotypes, psychology has depended upon, and thereby reinforced, the stereotype of African people as being homogenous. This allows psychologists to

evade theoretical and cognitive dissonance, particularly when engaged in therapy with these patients. As a result, cultural similarities are amplified with little regard for cultural differences (Moodley, 1999).

Africa's earliest links to extrinsic influences was with Arabian, Persian, and Greco-Roman citizens. The cultural, linguistic, and racial attachments are incontrovertible, especially in the Horn of Africa. In addition, external influences have been spiritual. Christianity and Islam have undoubtedly been spliced into the African framework (Nsamenang, 1992). Africa has been the largest beneficiary of extrinsic influences, particularly due to colonisation (Nsamenang, 1992). Many researchers emphasise the resultant Western influences operating within Africa. This is especially applicable in literature focused on urbanisation and modernisation in Africa. However, the exploration of traditional African culture allows the world to become aware of a less-researched process. Inasmuch as the West has had an influence on Africa, Africa has influenced the world. Furthermore, African perspectives have had an influence on the cultures of all persons who came to settle in Africa (Nsamenang, 1992). It is for this reason that cross-cultural research will benefit all people in Africa.

Cross-cultural psychology endured neglect for many years (López & Guarnaccia, 2000). Although cross-cultural research is not new to academia, a focus on difference has been employed (Hermans & Kempen, 1998). Researchers who focus on differences, in lieu of similarities, often jeopardise 'diversity' by disregarding potential influences of cultural integration and acculturation (Swartz, 1998). Cultural groups are not disconnected, and overlap other cultures. As a matter of fact, individuals from all cultures absorb facets of other cultures into the perception of self (Patterson, 2004). This appears to apply to subcultural groups as well.

Divisions are fostered by human, not spiritual, processes. Consider that the ancestors decide which gobela will train the would-be initiate. In this way, initiation does not occur within the confines of ethnic boundaries. It is possible, therefore, that a gobela from one ethnic group train an initiate from a different ethnic group. In this way, an impande becomes a multi-ethnic group. Weaving the ethnic groups together, this dynamic process suggests an underlying unity between ethnic groups, as well as the way in which plural societies fuse diverse facets of culture (Green et al., 1995).

Certainly, discord based on ethnic differences occurs within impandes. However, from a functionalist analytic perspective, reconciling the discord within the impande serves as a template for reconciling discord in the larger society. This promotes integration in larger social systems (Green et al., 1995).

5.14 Multiculturalism

Students in the social sciences express a great need for in-depth training in multiculturalism (Tomlinson-Clarke, 2000). Achenbach et al. (2008) are of the view that the expression 'multicultural' is preferred to the term 'cross-cultural' during the examination of group distinctions.

Multiculturalism is becoming a common process across the world, particularly as immigration increases globally (Van der Vijer & Phalet, 2004). Since the 1970s, training has become more attuned to multicultural issues, fostering the development of multicultural, intercultural, transcultural, cross-cultural, and Afrocentric approaches, amongst others. Many of these approaches, however, are based on Eurocentric and ethnocentric perspectives resulting in either lack of participation, or early termination of therapy among the non-Western population. Many proponents of culture-sensitive counselling have recommended that clinicians include socio-economic and political constructs in therapy so as to allow counselling to be more valid to the non-Western population, but also that these considerations be included in the definition of multicultural counselling so as to broaden its horizon. The definition will therefore include aspects relating to cultural hegemony, racism, gender schemas and issues of power (Moodley, 1999).

In its development, multicultural therapy represented a universal, transcultural, pluralist, and humanistic approach. The evident dilemma appeared to be that multicultural therapists did all they could to bring in aspects of race and culture in such a way so as to avoid being perceived as racist. Then, and now, many continue to attempt to cater for non-Western patients, but preserve Western foundations in therapeutic process and diagnosis (Moodley, 1999).

Cabral (1974) was of the view that research ought to focus on human beings in general. In fact, Cabral suggested that the focus on a single population, such as Africans, would be worthless. In line with this reasoning, Patterson (2004) proposes that the entire spectrum of counselling is multicultural as everybody lives in a multicultural social order. In addition, developing different systems of counselling would be impractical and superfluous as a universal basis of counselling ought to prepare a therapist to work with most patients. The inverse should also be appreciated, namely that no counsellor will be adequately prepared to counsel every patient.

Patterson (2004) suggests that first-hand experience with patients from diverse cultures allows psychotherapists the opportunity to increase insight into cultural dynamics. It is a faulty assumption that technique and theory alone may facilitate appreciation of culture, although these may augment the process. Another faulty assumption includes the notion that the celebration of diversity is more important than the celebration of similarities. Here, it seems pertinent to introduce the influences of acculturation and enculturation on multiculturalism in Africa.

The African renaissance implies that Africans be in command of their role as Africans in the global village. The renaissance is a vehicle of empowerment, motivating Africans to transform a history of hardship into present and future successes (Makgoba, 1998). Celebrating being African requires validating the current cultural process in Africa. Due to the widespread psychological acculturation in Africa, African values have come to overlap, and sometimes conflict, with foreign values (Nsamenang, 1992).

On the one hand, acculturation is defined as the way in which a person responds to a second, or dominant, culture. In acculturation, as a result of contact with a different cultural group, the person’s worldview becomes transformed (Aponte & Johnson, 2000). According to culture-reactive theory, acculturation may result in culture-change if the person’s cultural values are not deeply entrenched (Caradas, Lambert, & Charlton, 2001).

Enculturation, on the other hand, takes place when a person is socialised into his/her own culture (Aponte & Johnson, 2000). Successful enculturation implies that the

person acquires the necessary competencies to operate efficiently in her/her cultural group (Aponte & Johnson, 2000).

People who adopt facets of different cultures, those who possess various cultural identities, are said to be multicultural. Airhihenbuwa and DeWitt Webster (2004) prefer to use the anthropological term, hybridity, to refer to these persons. Many African Americans embrace a Western culture, as well as a traditionally African ethos. In this sense, they appear to be bi-cultural (Toldson & Toldson, 2001).

For some, culturally-sensitive and culture-specific therapy is clearly needed (Hickling & Hutchinson, 1999). It is not necessarily negative that many students would like to learn more about skills and techniques to use with diverse clients. This concrete, cognitively-based approach is perceived as less threatening for students, but allows them the opportunity to explore more complex dimensions later in their training and/or during practice (Tomlinson-Clarke, 2000).

The *multicultural man* described by Peter Adler in 1977, was a person with self-consciousness who was adept at working with people from diverse cultures (Sparrow, 2000). Adler indicated that working with diverse populations requires an appreciation of identity development which is interactive, context-specific, and anchored in ethnicity, gender, race, and religion (Sparrow, 2000).

Psychotherapy, in general, must be equipped to deal with issues of culture. However, clinicians adopting a culturally-specific slant may benefit populations where culture-related psychopathology is dominant (Wohl, 2000). Most notably, Patterson (1996) is of the view that the limitations experienced in clinical settings with regards to providing adequate services to diverse groups, stem from the apparent scarcity of multi-lingual counsellors. To fortify multicultural appreciation and integration, therapists and patients will benefit from being able to communicate via linguistic multiculturalism.

5.15 Epistemology and science

The historical arguments questioning what is, or is not, science varies (Nsamenang, 1992). Science does not belong to specific cosmological systems. Consider that science is science. Not African, or Western, or Asian science. Science is associated with technology and includes worldviews. In this way, perceptions of science differ. For example, linear progressive cultures perceive science in a way that differs to those who hail from cyclical cultures (Du Toit, 1998). Cross-cultural research has formed the reputation that science is psychological erudition because it becomes conventional in literature. While the data may become 'scientific' data, it does not necessarily represent the 'reality' as it occurs in context (Nsamenang, 1992).

Even the scientific worldview adaptations, such as Newtonian and Quantum views, maintain the core laws of science. Therefore, science is constant, but subject to perceptual reinterpretation and re-evaluation from diverse perspectives (Du Toit, 1998). Lay people determine the influence of science, by either accepting or rejecting scientific views. African cosmology may be seen as a significant antecedent for science. Local worldviews lay the foundation for prospective science students (Du Toit, 1998).

If scientific thinking is characterised by the exploration of causal relationships, investigation through empirical observation, and testing hypotheses, then traditional African views are competent in being scientific (Kudadjie & Osei, 1998). It appears that many traditional Africans would approve of investigations into the medicinal properties of muthi. For them, the fact that muthi works, plainly indicates that the dynamics of science are in operation. For this reason, many traditional Africans refer to traditional healing and witchcraft as 'African science,' 'indigenous medicine,' and 'indigenous knowledge systems' (Ashforth, 2005). As science failed to incorporate Western spirituality, there is little reason to believe that science will attempt to incorporate African spirituality (Edwards, 1998). This is especially significant in terms of African perspectives of science in relation to ontogeny.

Ontogeny relating to the social dimension, does not rebuff biology. However, biogenetic development necessitates ecocultural strictures. As the physical body is

insignificant when compared to the human spectre contained therein, the body is perceived to be merely a manifestation of the vital source (Nsamenang, 1992). As such, science and experience in Africa are not divorced from spirituality and cosmology. Regardless of the Christian Church's stance, much of the Black African population disputed this view, electing to maintain beliefs in traditional spiritual influences (Niehaus, 2001).

The existence of a scientific ethos in non-Western traditional healing does not eliminate the existence of magical phenomena in Western healing. In line with this view, every clinician ought to bear in mind that the focus on the supernatural in non-Western healing does not prevent traditional beliefs from being extremely significant to Western science (Edgerton, 1971).

5.16 Psychiatry and clinical psychology

The original conception of depression suggested psychosis (Pilgrim, 2007). The evolution of psychiatric systems has changed over time. In the past, Kraeplin suggested three features of modern, Western psychiatry. As follows, psychopathology was perceived to be naturally occurring; was probably due to a predisposed genetic tendency with a foreseeable prognosis; and was the result of dysfunction in the brain and/or nervous system (Pilgrim, 2007).

In the 20th century, Adolf Meyer challenged Kraeplin's three features and instead chose to support dynamic holism. As a result, he developed the psychobiological perspective, and later remodelled the approach to become what is currently known as the biopsychosocial approach. The approach favoured contextual meanings and surpassed purely diagnostic categorisation (Double, 1990; Pilgrim, 2002).

Psychiatric conditions were identified and classified according to North American and European Anglo-Saxon patient populations. Those syndromes that did not manifest primarily in these populations were regarded to be atypical adaptations of the Anglo-Saxon syndromes. This suggests that prevailing classificatory syndromes were based on the Western ethnocentric perspective of psychological distress. All psychopathological phenomena that were unusual to the Western ethnocentric

perspective were regarded to be peculiar. Nonetheless, many mental health practitioners became conscious that culture influenced psychopathology. Soon, the domain of cultural psychiatry developed. Put differently, peculiar phenomena became the underpinning of cross-cultural psychopathology (Tseng, 2006).

Cross-cultural psychopathology aside, psychopathology in non-Western cultures has perpetually been debated in psychiatry (Hickling & Hutchinson, 1999). Psychiatry's status as an authentic biomedical science relies on its conformity to nosological systems based on seemingly objective assessment measures, stemming from the view that mind-related constructs are measurable. Psychopathology is therefore regarded as an organic disease, suggesting brain dysfunction that may be treated with medication. Students in psychiatry are erroneously trained in viewing psychological distress as bodily disease (Kwate, 2005).

A large proportion of current conceptualisations in psychiatry, as regards causal determinism, employ a Newtonian model (Thomas & Bracken, 2004). Psychiatry's main drawback is its attempt to apply positivism to lived experience (Thomas & Bracken, 2004).

Many evaluators of the DSM have suggested that the current diagnostic standards appear to be inappropriate for the African context (see Mezzich et al., 1996). The DSM-IV-TR addressed culture in psychiatry in three ways. First, influential cultural factors regarding the articulation, evaluation, and prevalence of particular syndromes are included. In addition, an attempt is made to outline cultural conceptualisations in order to supplement the multiaxial diagnosis. Finally, a list of culture-bound syndromes is included (López & Guarnaccia, 2000).

However, the DSM does not provide adequate data relating to the dynamic nature of culture's influence on mental health. The exploratory information on cultural expression of symptoms, as well as the influence of signs of distress, is insufficient to allow clinicians to make a comprehensive, accurate diagnosis (López & Guarnaccia, 2000).

The idea that a culture-bound syndrome relates to non-Western populations, as implied in the DSM, is erroneous. The DSM Task Force suggested that it may be necessary to include Western syndromes, such as chronic fatigue syndrome, in the culture-bound classification system. In this way, non-Western psychopathologies would not be marginalised in the DSM. The developers of the DSM, however, disagreed with this view and suggested that culture-bound syndromes are efficiently accounted for in the DSM body, but that the culture-bound syndromes represented variations thereof. While this view disappoints true appreciation of culture and psychopathology, it certainly suggests progression in cultural psychiatry (López & Guarnaccia, 2000). Trujillo (2008) is of the opinion that cultural conceptualisation is one of the greatest assets of the DSM-IV-TR.

Unfortunately, the biogenic view of schizophrenia, for instance, has alienated varied conceptions over the past twenty years. As a result, psychosocial research enquiry has waned in scale and preference (Draguns, 2000). The current state of affairs suggests that the family framework is receiving increased attention as a culturally-specific facet of schizophrenia (Draguns, 2000).

Clinical psychology embraces sociology, physiology, and neurology. Mostly, clinical psychologists adhere to psychiatric nosology (Pilgrim, 2007). Each discipline depends on the other in order to preserve the scope of each practice. Clinical psychology needs psychiatry in order to demonstrate that many psychopathological syndromes require psychotherapy to deal with deep-seated intrapsychic conflict. Similarly, psychiatry needs clinical psychology in order to demonstrate that many psychopathological syndromes require biomedical intervention (Kwate, 2005). Kwate is also of the opinion that many patients who experience psychological distress often meet the diagnostic criteria for a psychiatric condition, thereby allowing medical schemes to pay for psychotherapeutic services. In this way, to some extent, clinical psychology relies on psychiatric diagnosis. Adopting this process in practice suggests assenting to the universalistic approach of psychiatry. Rejecting this position exemplifies African-centred psychology’s vista, but also suggests the potential appreciation of psychiatry for the person.

Psychiatry for the Person encourages that people be appreciated holistically, and within context. It underscores human dignity and respect (Mezzich, 2007). This view appears to approve the philosophy of biomedical ethics and should be embraced in various psychopathological treatment fields, such as psychopharmacology.

5.17 Psychopathology in South Africa

South Africa is a democratic state, reflecting modern political norms. Its reintegration into the international community comes after a difficult apartheid period (Ashforth, 1998). In terms of the considerable variations between communities, one must reflect on the circumstances inherent in the relational processes between the South African groups. Presuming that cultural groups differ in their socio-political and socioeconomic foundations, groups differ in their experiences. Additionally, the experiences of societies that have endured socio-political rule by ethnic minorities differ from those societies where majority, indigenous rule ran sovereign (Lieberson, 1961). In this regard, the South African experience is interesting due to the transformations in socio-political governance. This was evident in disparities of race relations in countries experiencing similar dynamics. The apartheid era in South Africa exhibited extremely tumultuous race and ethnic relations. In contrast, countries such as Brazil experienced relatively harmonious relationships under their old governance. Factors and processes such as those in Brazil and South Africa, foster great challenges in describing a nation’s so-called foreseeable social development with regards to race and ethnic interaction (Lieberson, 1961).

Many are of the opinion that historically divided societies, such as South Africa, make it difficult to develop a multinational or multiethnic society. Often, in these societies, people find it easier to relate to their own racial, ethnic, and religious groups (Mattes, 2002).

5.17.1 A reconciled South Africa

Former president Thabo Mbeki’s *two nations thesis* suggests that South Africa consists of a fairly prosperous, mainly White population, and a fairly impoverished, mainly Black population (Mattes, 2002). As the majority of the South African

population is Black (Puttergill & Leildé, 2006), it is reasonable to assume that the majority of the population is impoverished. It was 1996 and in the presence of the Constitutional Assembly. “I am an African,” said Thabo Mbeki, who was the president of South Africa at the time. Four words, six syllables, the key phrase in unifying South Africa with Africa (Vale & Maseko, 1998).

South Africa has experienced a fairly successful shift from apartheid to democracy (Gibson, 2004). Reconciliation in South Africa suggests disdaining racial typecasting and appreciating people as individuals, instead of as racial constituents. Furthermore, tolerance of dissimilarities is encouraged. To assist the reconciliation process, South Africans are expected to promote human rights, and accept the authenticity of the country’s political institutions (Gibson, 2004).

In South Africa, apartheid generated a valid discourse with regards to African identity. This led academia to contend that the study of African identity, in context, is confounded. Academics grapple with what the dominant identity actually is, and what the dominant identity should be (Puttergill & Leildé, 2006).

It is my view that Nesbitt’s (1998) research with the British-Hindu population provides valuable consideration for identity issues, particularly with regards to the South African experience. In suggesting that the British-Hindus experience various identity structures, it appears that a similar process be afforded to South Africans. The South African identity structure may therefore consist of a tri-axial gamut relating to African-ness, South African-ness, and religion. Nesbitt indicates that all people differ in terms of their subjective perceptions relating to their core identity, but that many people prefer defining their identity according to these axes. In this regard, consider that the British-Hindu regards British-ness as a civic identity, Asian as a cultural identity, and Hindu as his/her core identity (Nesbitt, 1998).

Stone, Kaminer, and Durrheim (2000) found that distressing perceptions of political events were linked to the onset, maintenance, and severity of psychopathology. Collective memories which operated in the apartheid era include, for example, the Black view that Whites were generally dictatorial, and the White view that Blacks were a Communist threat (Gibson, 2004).

Many views of the Truth and Reconciliation Commission (TRC), at grass-roots level, suggest that the TRC re-traumatised communities by rehashing disturbing historical memories (Gibson, 2004). In order to shape the future of South Africa, the TRC allowed South African nationals to comprehensively confront its past (Gibson, 2004). Many are of the view that the TRC was successful in many ways (Gibson, 2004). The establishment of truth commissions, similar to South Africa's TRC, is becoming a worldwide trend. These commissions are constructed with the hope that they may reinforce reconciliation within societies. Whether this happens, or not, is anyone's guess (Gibson, 2004).

An interesting outcome of South Africa's TRC was that people began to reassess the apartheid era, discovering that blame was not unilateral. Undue victimisation occurred across the board. Opening up this awareness, the TRC allowed blame to be shared and created the foundation for dialogue (Gibson, 2004).

5.17.2 South Africa: The present tense

Stevens and Lockhat (1997) have observed the mounting presence of Western ideologies at numerous echelons such as popular prose and fashion in Black South African adolescents. They contend that the integration of Western identity systems, such as values, has facilitated a change from African collectivism to Western individualism. While this process alleviates some of the stressors associated with engaging in a contemporary sociohistorical ambit, it also marginalises and disaffects them from their fundamental, traditional reality. Stevens and Lockhat refer to their observation of this process as the materialisation of the *Coca-Cola kids*, a generation inflicted with conflicting identity integration processes, negotiating their identity between individual and collective values, as well as between pre- and post-apartheid.

Le Grange, Telch, and Tibbs (1998) found high prevalence rates of eating disorders in the South African population, with female subjects more prone to disordered eating attitudes than male subjects. African males, however, scored much higher than male subjects from any other group. This suggested that African males were almost equally as prone to eating pathology as African females. Unfortunately, this investigation was conducted on samples with increased exposure to Western pressures, suggesting that

these participants were possibly adapting and ascribing to Western-syntonic perceptions in a country experiencing swift transformation. Similarly, Szabo and Allwood (2004) assessed eating attitudes in Black South African girls and found that their potential risk for developing eating disorders was steadily on the rise, although the current prevalence rate of 3% for abnormal eating attitudes was somewhat lower than previously suggested.

Walker et al. (2008) found that the Afrikaans population were exceedingly troubled by seemingly benign physiological occurrences and often mistook these as symptoms of pathology. Their over-concern with physical health necessitated a high prevalence of depressive and anxiety disorders.

In using the Western model of psychiatry, Muris, Schmidt, Engelbrecht, and Perold (2002) found that Black African children in South Africa exhibited extremely high levels of anxiety. The authors posed the following explanations for this finding. It may be that Black African children report anxiety more often than other racial groups; or that observed parenting styles differ depending on cultural contexts and that these styles were indicative of overprotection, rejection, and/or anxious rearing. Specific indicators in this investigation suggested that African girls appear to be more anxious than African boys, and that environmental difficulties such as exposure to violence, poverty, and dispossession increase the potential to experience higher levels of anxiety.

May et al. (2000) found a higher rate of Foetal Alcohol Syndrome in South Africa than in the United States. While diagnostic traits were similar in Africa and the rest of the world, they also found that rural Africans, in South Africa, had a significantly higher prevalence rate of Foetal Alcohol Syndrome than the rest of the South African population. As alcohol consumption is often considered a comorbidity of other psychopathologies, this has some bearing on the prevalence rates of psychopathology in rural Africans. The proposition entailed herein is for further research to be conducted in this area in order to identify potentially under-diagnosed or undiagnosed psychopathology in rural Africans.

Harris (2002) suggests that post-apartheid South Africa has experienced elementary modifications in terms of the democratic process. Although the country has established major laws relating to equality, Harris views many of these theoretical propositions as falling within the umbrella of satirical democracy. To defend this view, Harris's (2002) investigation considers the grass-roots exhibition of xenophobia, which is described as a new pathology for South Africa. Delimiting xenophobia as a psychopathological disorder includes the individual perceiving the foreigner as bad. The individual therefore exhibits anomalous and harmful attitudes and/or behaviours towards the foreigner and, in so doing, impedes on healthy social functioning (Harris, 2002). Harris goes on to say that the media, too, portrays Black foreigners negatively by suggesting the following: foreigners filch employment opportunities from South Africans; they are illegal immigrants; and they have transmuted the social fabric of the country into an asylum for Africa's conflicts.

5.18 Excluded studies

The following studies were excluded from the review. Some of the literature did not meet the present investigation's inclusion criteria, while others met the exclusion criteria.

- Literature by Nagata (1974) regarding polyethnic societies focused exclusively on the Malay population, without much focus on plurality as was suggested in the title. The information contained within the literature did not, therefore, facilitate comparative views, as well as insights in cultural perspectives on psychopathology.
- Crane's (1991) sociological study regarding epidemic theory in poor communities may apply to many populations, but does not lend itself to the appreciation of African perspectives.
- Nickerson, Helms, and Terrell (1994) explored whether African American students exhibited trustful/distrustful attitudes towards White clinicians.
- The investigation by Burnett et al. (1999), on African-Caribbean patients' pathways to care, researched the reasons surrounding the population's resistance to voluntarily be admitted into psychiatric care. Unfortunately, the study did not focus on the experiences of patients.

- Slone, Durrheim, Kaminer, and Lachman's (1999) research into comorbid psychopathology and mental retardation was excluded from the current review. Although the study focused on multiculturalism, it lacked exploration into perspectives and experiences. The study also pertained to predominantly psychiatric data.
- Dzama and Osborne (1999) found that many African students perform poorly in science due to the conflicting views between science and traditional beliefs.
- Carter and May (1999) investigated poverty, livelihood, and class in rural South Africa.
- Susser and Stein's (2000) research regarding culture, sexuality, and women's role in circumventing HIV/AIDS in Southern Africa was excluded from the current review.
- Research conducted by Chick (2000) focused on the construction of multiculturalism in South African schools. Chick's study emphasised the constitutional rights of all South Africans, but did not elaborate on cultural perspectives of psychopathology.
- The eating pathology study conducted by Caradas et al. (2001) focused on psychiatry-specific data, failing to consider African perspectives on psychopathology. Furthermore, the population sample represented a mixed cohort group, an explicit exclusion factor for the current investigation.
- An interesting investigation concerning the relationship between psychopathology and adverse life events was conducted by Tiet et al. (2001). The study, nonetheless, did not focus on a population applicable to the current review, nor did it highlight psychological insight into the experiences of life events, as well as the dynamics of the pathologies under investigation.
- While the study conducted by Ward et al. (2001) is valuable to the South African research domain, the study focused on violence as a precipitating factor to psychopathology. The data exhibited extremely limited perceptivity into the psychological dynamics of patients.
- Research conducted by Schech and Haggis (2001) appears to pose significant value to the difficulties in defining identity in a multicultural society. However, the study focuses exclusively on specific processes in Australia. It may be argued that cultural diversity issues in Australia are similar to diversity issues in African countries. However, the investigation centres on what is

described as Australia's re-emergence of racism and perspectives which relate distinctively to the current political climate in Australia.

- The study conducted by Diala et al. (2001) aimed to determine the attitudes of African Americans towards mental health services, as well as to establish whether these services would spontaneously be sought out. Unfortunately, the study did not meet the inclusion criteria of the current review.
- Liang, Flisher, and Chalton (2002) conducted an investigation into the mental health of South African school-aged children who did not attend school. This study plainly assessed if there was a surplus or shortfall in rates of mental illness without attending to African perspectives of mental illness. While their conclusion, that poverty is probably particularly important in this population not attending school may say much about the socioeconomic climate of a large population of inhabitants in South Africa, it offers little perception into the related psychological distress exerted upon this population.
- A fairly recent investigation by Jewkes and Abrahams (2002) appeared in the online literature search several times. The study focuses on sexual abuse in South Africa but could not be included in the current study.
- The study on gender, poverty, and postnatal depression in India by Patel, Rodrigues, and DeSouza (2002) focused more on prevalence rates rather than cultural perspectives.
- Research into culture and psychiatry in New Zealand, by Chowdhury and Wharemate-Dobson (2002) did not meet the inclusion criteria.
- Ackermann and De Klerk's (2002) research focused on the social factors that make South African women vulnerable to HIV infection.
- Guindon, Green, and Hanna's (2003) investigation on developing diagnostic criteria for homophobia, sexism, and racism appeared several times during the literature searches. Their investigation focused exclusively on psychiatric data and only referred to a subdivision of an African perspective, by mentioning the phrase *apartheid*. Regrettably, the acuity into the dynamics of apartheid on the African perspective was superseded by amplifying racial discrimination as a cause for including a psychiatric syndrome called 'intolerant personality disorder' into predominant psychiatric classification systems.
- Prince, Acosta, Chiu, Scazufca, and Varghese (2003) attempted to develop an assessment measure to test for dementia with as little cultural and educational

bias as possible. The investigation evidenced limited attention was paid to cultural perspectives on psychopathology.

- Minsky, Vega, Miskimen, Gara, and Escobar (2003) conducted research into the diagnostic patterns of African American, European American, and Latin American psychiatric patients.
- Le Grange, Louw, Breen, and Katzman (2004) explored the increasing incidence of eating disorders in Black South African adolescents. However, this investigation failed to address African perspectives on psychopathology. Furthermore, a contextual analysis of the adolescents investigated suggested that the poverty within which they live could have severely influenced the outcomes of the assessment measures used in the study.
- Olley et al. (2004) conducted research into psychopathology and coping in HIV+ patients in Cape Town (South Africa). While this investigation assessed the percentages of psychiatric syndromes prevalent among the researched population, the investigation centred on data specific to psychiatric rates. The information, therefore, provided little insight into the dynamics of the disorders, nor did it explore the experiences of psychological distress.
- The study of anorexia nervosa in subcultures in Curacao (Katzman, Hermans, Van Hoeken, & Hoek, 2004) did not meet the inclusion criteria for the current review.
- Olley, Zeier, Seedat, and Stein (2005) investigated post-traumatic stress disorder traits in newly diagnosed HIV-positive patients in South Africa. The study pertained to psychiatry-specific data and focused on prevalence rates as opposed to subjective experience.
- Cantor-Graae and Selten (2005) conducted a meta-analysis and review to investigate the relationship between migration and schizophrenia. While the ideas surrounding may have suggested some association with the process of acculturation, therefore somewhat relative to the African experience, the study lacked qualitative depth.
- Smit, Myer, et al. (2006) conducted one of the foremost investigations assessing the association between mental illness and sexual risk in sub-Saharan Africa. In their cross-sectional study, they found that 13% of participants reported Posttraumatic Stress Disorder (PTSD), 17% reported substance abuse, and 33% reported depression. This data suggested high

incidence of psychopathology. While the investigation may be useful in understanding sexual risk behaviours and its relationship to psychopathology, it leaves little room to explore African perspectives. Furthermore the research focus was on prevalence rates of psychiatry-specific data.

- Smit, van den Berg, Bekker, Seedat, and Stein (2006) conducted an investigation into translating a mental health battery into Xhosa. They aimed to develop a 'culture-free' assessment battery, but did not lay a great deal of emphasis on African perspectives of psychopathology.
- The study conducted by Subramaney (2006) could not be included in the current review as the data centred on information which lacked insight into perspectives and psychological dynamics.
- Angermeyer and Dietrich (2006) explored public beliefs and attitudes towards people with psychopathology. While the investigation provides recent insight into the current state of perceptions towards these persons, it provides little insight with regards to the scope of the current literature review.
- Robertson (2008) investigated the prevalence of Gilles de la Tourette Syndrome in sub-Saharan Africa and found decreased rates in comparison to the rest of the world. This investigation addresses psychiatry-specific data, with inadequate attention to African perspectives on psychopathology.
- Carey, Walker, Rossouw, Seedat, and Stein's (2008) investigation into the psychopathological risk factors as a result of sexual abuse in South Africa is of great value to South African research. The investigation found high rates of sexual abuse and probable comorbidity, such as depression, adjustment disorders, and anxiety disorders, among others. The study, however, did not focus on perspective and experience.
- Wilbraham's (2008) research regarding HIV and parent-child communication in South Africa did not meet the scope of the current literature review.

5.19 Conclusion

This chapter explored African perspectives on psychopathology, and required a review on areas such as idioms of distress and culture-bound syndromes. In order to comprehensively consider these ideas, African-specific data and comparative views were introduced. The chapter then addressed the ways in which these areas were

considered by traditional healers. As the temperament of the review appeared to foster an African-specific slant, the reviewer introduced discussions on ethnocentricity and cultural diversity. However, emergent views in the literature also necessitated that areas such as prototypal pathologies in Africa be discussed. This aided the discussion in terms of re-evaluating psychopathology nosology in the South African context. The literature review was concluded with studies which were closely related to the investigation, but were excluded from the review for a number of reasons. Chapter 6 will explore conceptual themes in the literature, as well as process the findings of the literature review using psychological theory.