UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

God

the Light

For

Rashida Hassim

Cor unum; intaminatus fulget honoribus

symbol of eternal inspiration

Your sacrifice has been beyond measure. You gave me life, dignity, and unconditional love. I could never repay you!

For

Fazul Hassim

Castrum doloris

symbol of eternal strength

Thank you for everything. From before the beginning until after the end.

A father, best friend, and an inspiration.

For

Kulsum Hassim

Castrum doloris

symbol of eternal virtue

Whose gentle soul carried a boy's aggressive search for meaning.

For

Fatima Hassim

Fortis facere; nunc scio quid sit amor

symbol of eternal connection

This achievement would have been impossible without you as my anchor.

For

Ebrahim & Amina Patel

AND

Amod Ismail

Ubi amor. Ibi dolor

symbols of eternal faith

Thank you for your legacies.

For

Mikhail

AND

Aadil Hassim

Nosce te ipsum; vive et vivas

symbols of eternal resilience

Joy and hope – personified.

Your father's treasures!

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

CRITICALLY QUESTIONING AN AFRICAN PERSPECTIVE ON PSYCHOPATHOLOGY: A SYSTEMATIC LITERATURE REVIEW

By

JUNAID HASSIM

Submitted in partial fulfilment of the requirements for the Degree

PHILOSOPHIAE DOCTOR

(PhD)

in the

FACULTY OF HUMANITIES

(DEPARTMENT OF PSYCHOLOGY)

at the

UNIVERSITY OF PRETORIA

Promoter:

Prof. C. Wagner

May 2012

I learned: the first lesson of my life: nobody can face the world with his eyes open all the time.

(Rushdie, 2008, p. 171)

All games have morals; and the game of Snakes and Ladders captures, as no other activity can hope to do, the eternal truth that for every ladder you climb, a snake is waiting just around the corner; and for every snake, a ladder will compensate. But it's more than that; no mere carrot-and-stick affair; because implicit in the game is the unchanging twoness of things, the duality of up against down, good against evil; the solid rationality of ladders balances the occult sinuosities of the serpent; in the opposition of staircase and cobra we can see, metaphorically, all conceivable oppositions, Alpha against Omega, father against mother… but I found, very early in my life, that the game lacked one crucial dimension, that of ambiguity – because… it is also possible to slither down a ladder and climb to triumph on the venom of a snake…

(Rushdie, 2008, p. 194)

Reality is a question of perspective; the further you get from the past, the more concrete and plausible it seems – but as you approach the present, it inevitably seems more and more incredible. Suppose yourself in a large cinema, sitting at first in the back row, and gradually moving up, row by row, until your nose is almost pressed against the screen. Gradually the stars' faces dissolve into dancing grain; tiny details assume grotesque proportions; the illusion dissolves or rather, it becomes clear that the illusion itself *is* reality…

(Rushdie, 2008, p. 229)

ACKNOWLEDGMENTS

My promoter, **Claire Wagner** was instrumental in guiding me throughout this process. Of course, there were times during this process when the odds were too large to bear alone. Especially for those times, thank you Claire for helping me to walk tall against the rain.

The **Research Committee** at the **University of Pretoria** provided me with constructive criticism. I mean this in the real sense of the term. David Maree provided me with insights into the depths of the research areas and certainly motivated me when the chips were down. Also, Anne Moleko, Nafisa Cassimjee, Terri Bakker, Ilse Ruane, and Assie Gildenhuys helped me refine the topic, as well as guide me towards research material which certainly benefited this study. Here, I must also thank Adri Prinsloo for her role in guiding me towards the right supervisor.

My colleagues at the **Department of Clinical Psychology** at **Weskoppies Psychiatric Hospital** not only assisted in supporting me during this process, but also motivated me with their enthusiasm. Their commitment to my personal and clinical process was invaluable. I would

therefore like to thank Nicole Schluep, Grant Statham, Marissa Morkel, Jenny Simpson, Melissa Fernihough, Isabelle Swanepoel, Jonathan Scholtz, Katerina Michael, Chantelle van Lelyveld, and Kobus Coetzee. Also, thank you to the Community Service and Intern Clinical Psychologists of 2010 and 2011 whose words of support were a pillar of strength.

Werdie van Staden, Ilse du Plessis, Debbie van der Westhuizen, **Heather Alison**, **Francois Esterhuizen**, and **Morongwa Mohapi**, your knowledge in psychiatry played a pivotal role in exploring the clinical aspects of my study. Thank you for the formal and informal resources you provided me with.

Often, people behind the scenes provide a service which allows intensive processes to run relatively smoothly. In this case, **Petru Woest** and **Janine White** helped to make administrative matters bearable. This research process would have been impossible without you.

My **family** provided me with supportive structures so that I could dedicate the necessary time to conduct this investigation. Thank you to my

sister, Farhana Hassim; my parents-in-law, Sikander and Julie Carrim; my grandparents-in-law, Ismail and Ayesha Cassim; and my uncle, Ismail Patel. However, many more family members played a role in facilitating ease (or as much ease as a PhD will allow) in supporting me. Thank you to: Feroz, Hajira, Faheem, and Aalia Ismail; Ashraf, Shirin, Fateen, Kaamila, Naeem, Zawaheer, Farhaan, and Farheen Ebrahim; Mohamed Akhter, Nashrin, and Naadir Suleman; Zaahir and Nazrana Kalla; Shamigh, Yasmeen, Farid, Fahim, and Rashaad Alli; Moosa, Julie, Nazeer, and Zaida Patel; Afzal and Rubeena Dhudia; Adam, Zohra, Zahira, Mohamed Ashraf, and Diyanah Patel; Shamim and Fareed Valley; and Tasneem and Basheer Motala. I would also like to acknowledge the supportive contributions of Yacoob and Hawa Bibi Noormohamed; Mohamed Fuad, Nazia, and Rumanaah Suleman; Haroon and Zahira Adam; and my brother-in-law Mohamed Carrim.

Adeeb and **Kashiefa Samodien**, my friends. Thank you for your continued support and encouragement.

Finally, I would like to extend my gratitude to **Elgiz Bal** at the University of Illinois (Chicago) for his assistance with psychiatric instruments and information while this investigation was in its earliest stages.

DECLARATION

I declare that this is my unaided work and has not been submitted to another university for any degree.

_____ _____

Junaid Hassim Date

ABSTRACT

This study aimed to collate and analyse academic literature with regards to possible African perspectives on psychological distress. The purpose of conducting the literature review was to explore thirty years of critical arguments supporting and refuting an African perspective on psychopathology. Literature (e.g. Bhugra & Bhui, 1997) appeared to suggest that some of the relatively recent views regarding psychopathology fail to adequately address psychological distress as it presents in Africa. A systematic literature review was selected as the methodology for this study, and the specific method of the review was research synthesis (Gough, 2004; Popay, 2005). Reviewed literature was sourced between the years 1980 and 2010. The theoretical point of departure was integrative theory, thus falling within the post-postmodern framework. As such, literature regarding psychological theory formed a substantial part of the research, including literature relating to psychodynamic theory, cognitive-behavioural theory, postmodernism, phenomenology, existentialism, critical theory, and systemic patterning (Becvar & Becvar, 1996). These theories formed part of the analysis, thereby allowing contextual analysis as the interpretive method. The review's themes highlighted the following outcomes: current psychiatric nosology employed a universalistic approach to diagnosis and intervention, thus limiting cultural conceptions of mental illness; holistic intervention requires the inclusion of traditional epistemological tenets; collaboration between modern practitioners and traditional healers would probably better meet the patient's needs; and that culture-fit assessment and treatment often indicated improved prognosis. The outcomes evidenced the operation of an African perspective on psychopathology. In fact, much of the reviewed literature also suggested culture-contextual perspectives on psychopathology. Furthermore, the way in which lack of cultural coherence appears to exist between patients and some clinicians suggested that diagnostic flaws may be a relatively frequent occurrence. Potential benefits of the investigation include increased awareness that culture-related conceptualisation be further explored in the clinical field; that future researchers use the current review as a foundational reference for primary investigations; that contemporary clinical classificatory systems be reviewed in terms of cultural applicability; and that clinicians reconsider the diagnostic process in terms of culture-fit manifestations of psychopathology.

Keywords

African perspective; clinical psychology; psychopathology; post-postmodern; systematic literature review; integrative theory; culture-bound syndrome; traditional healing; multiculturalism; South Africa.

CONTENTS

CHAPTER 3
RESEARCH METHODOLOGY

CHAPTER 4
LITERATURE REVIEW:
FOUNDATIONS FOR QUESTIONING AN AFRICAN PERSPECTIVE ON PSYCHOPATHOLOGY

CHAPTER 6
DISCUSSION

List of figures

CHAPTER 1

INTRODUCTION

1.1 Overview

This chapter serves as the foundation of the study. Background information is provided, followed by the justification for the study. Thereafter, the research problem is introduced, leading towards the presentation of the research question. The researcher then discusses the delimitation of the scope of the study as well as the research goals. A brief view on the theoretical orientation of the study is offered, in addition to a section dedicated to clarifying key terms. The researcher then provides a synopsis of the research methodology and a brief structure of the research report.

1.2 Background

The prelude to this investigation commenced early in my clinical training during research into clinical interviewing and evaluation. The training institution is a South African based tertiary healthcare institution offering evaluative, diagnostic, and treatment interventions to patients who are directly affected with severe psychiatric disturbances. Progressively, it became apparent during my practical training, and via direct observation, that culture-related material did not feature as prominently as one would expect in a country that comprises of diverse cultures. In fact, Bhugra and Bhui (1997) made a similar observation. In this regard, Sinha (2000) is of the view that discounting culture corresponds with the repudiation of subjectivity and context. This implies a depreciation of the lived experiences of the patient. In acknowledging culture, one fosters the humanisation of patients (Kazarian & Evans, 1998). As previously mentioned, South Africa comprises many diverse cultures, but traditional African practices form a substantial part of the Black South African cultural milieu (Chick, 2000). As culture mediates psychological process (McCrae, 2001), an understanding of the way in which African culture influences psychopathological responses and experiences would potentially promote further appreciation of the experiences of a large faction of the clinical population in South Africa (see Thomas

& Bracken, 2004). Further observation and interest in this regard prompted the initiation of this study.

The topography of mental health care is currently in a process of transformation. It has become apparent that patients yearn for more than a diagnosis. They have a great need to appreciate their experiences from a cultural and social perspective (Thomas & Bracken, 2004). Culture influences views and experiences during the course of one's life, which then has an influence on behaviour. Thus, persons of different cultures may express similar behavioural tendencies, but express them according to culturally-sanctioned norms (McCrae, 2001). The logical question here, then, is: do people experience psychological distress according to culturally-sanctioned norms? This certainly lays the foundation for investigation into the field of cultural psychopathology and therefore substantiates questioning an African perspective on psychopathology.

In traditional African cosmology, the symbiosis between the seen and unseen is unquestionably acknowledged (Chandler, 1998). Of significance is culture's capacity to modulate emotional regulation (Eshun & Gurung, 2009). Numerous theories focused on the composition of emotion do not illustrate the African experience effectively (Dzokoto & Okazaki, 2006). In an attempt to illustrate the African experience, there appears to be a need for thorough assessment into African views on psychopathology. However, the need for exploring African conceptualisations of psychopathology is not new. Edgerton (1966) expressed this view by requesting that research forage within the African domain so as to inform academia in this regard. Edgerton's primary concern questioned Western nosologies as misrepresenting the cultural and social veracity of authentic African experience. The current study aims to address Edgerton's request to explore the possibility of African conceptualisations on psychopathology.

1.3 Justification for the study

In particular, the current investigation emphasised the current status of African perspectives on psychopathology of which a similar investigation could not be located by the author. Conducting such an investigation corresponds with Wilkinson's (2005)

guidelines to conduct a study such as the present investigation. In terms of temporal trends regarding clinical processes, it appeared that more recent literature (Gorman et al., 2004; Luck et al., 2002; McLay, Rodenhauser, Anderson, Stanton, & Markert, 2002; Pfeiffer, Madray, Ardolino, & Willms, 1998; Williams & Heikes, 1993) indicated a greater appreciation of culture, diversity, subjective experience, specificity regarding the course of psychopathology, the humanisation of clinical interviews, and acknowledging the complexity of human participants. This was in marked contrast to archaic literature (see Prince, 1915) which focused on patients as subjects and mere recipients of treatment protocols. It is therefore logical to infer that clinicians are moving towards a more holistic (inclusive) approach to understanding patients, in preference to a primarily diagnostic (reductive) system. Haidet and Paterniti (2003) also agree with this view. As such, a more holistic approach to understanding patients remains fairly contemporary. It was therefore anticipated that a large volume of the literature used in this study would comprise mainly of fairly contemporary academic articles.

Additionally, during the preliminary literature review, it appeared that literature relating to the analysis of psychopathology in the African context is broadly diffused within a variety of spheres, such as anthropology, and across transnational peripheries. As a result, it was necessary to utilise multinational and multidisciplinary resources to develop a system which was applicable in this regard. It was, therefore, beneficial to the current review to include comparative studies of literature focused on cultures in developing countries and/or literature focused on collective cultures (Kamwangamalu, 1999). Glazer (1997) was of the view that people have become multicultural beings as their behaviours are shaped by various cultures irrespective of their regional location. One may therefore understand specific cultures by juxtaposing perspectives which have a historical and/or a contemporary influence on a specific culture. Therefore, focusing on multicultural perspectives operating in Africa was extremely valuable to the current investigation. This process also serves as a foundation for not separating *Africa* from the *Rest of the World*. With these ideas in mind, it was clear that there was a need for a study aligned to the current investigation.

Wassenaar, le Grange, Winship, and Lachenicht (2000) suggest that focussing one's attention on African perceptions is extremely important, specifically if future research aims to consider cross-cultural perceptions. This study aims towards pursuing this suggestion. In addition, as suggested by Prilleltensky and Nelson (2002), it is anticipated that the study will comprehensively delve into the prevailing debates with regards to the applicability and/or limitations of mainstream psychological perspectives. For Fox and Prilleltensky (1997), this appears to be necessary in order to examine the cultural, cross-cultural, and multicultural dynamics applicable to the African context.

From my observations at a practical level, it was also evident that psychologists who operate within specific paradigms focused on information that was applicable to their frame of reference, particularly with regards to information received as a result of the personal, cultural, and educational experiences. However, according to Miller (1999), the acknowledgement of culture is important to most of the applicable frameworks irrespective of the discipline or paradigm. The implication here is that the inclusion of the cultural dimension will probably allow for more comprehensive assessment, thus implying that more accurate diagnoses can be made (Bhugra & Bhui, 1997). Miller (1999) maintains that culture is essential to psychology. Theory in psychology is dependent on meaning-based analyses of culture. Furthermore, theory rests on the appreciation of culture as vital to individual psychological growth.

Conducting the present study may confirm or disconfirm the suitability of contemporary clinical practice and/or underscore a need for potential research. The foremost purpose of conducting such an investigation is to recapitulate research findings and, by this means, aid the audience in appraising both effects and potentialities of the research (Higgins & Green, 2008). In Trujillo's (2008) opinion, expanding the knowledge base of indigenous knowledge systems assists in the diagnostic and treatment process, particularly amongst traditional communities. Certainly, research into culture will aid the transformation of clinical formulation in its journey towards a more holistic approach. Thus the emphasis on a biopsychosocial model of psychopathology ought to become more holistic and therefore biopsycho-sociocultural (Trujillo, 2008).

Wohl (2000) reviewed literature regarding psychotherapy with non-Western patients. It appears that researchers and clinicians alike contend that therapists who work with various cultures must aim to attain as much knowledge about a culture as possible, so as to develop insight into a patient's cultural influences. The time is ripe for academia and clinicians to focus more on culture-fit care (Tseng, 2006). Canino and Algería (2008) implore mental health professionals to integrate culture more frequently into their clinical formulations. This study aims to accommodate this request.

1.4 Research problem

Ake (1993) suggests that Africa is faced with a dilemma in terms of considering ethnicity as a conception. He indicates that Africans are subjected to an integrated consciousness, but society has fostered a process whereby subdivisions are formed giving what he terms a false impression of the makeup of the unified African culture. He also points out that it is unrealistic to believe that differences in language, values, and beliefs preclude diversity in ethnicity and therefore suggests that an informed view of the differences and similarities within various cultures be explored. This implies considering the hegemonies of culture and is in harmony with the aims of the current investigation. Just as the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) may suggest a context-specific classification system (Western), it may transpire that many people in African societies appreciate psychopathology in culture-specific modes of expression (Guarnaccia & Rogler, 1999). The current investigation, however, aims to analyse literature in order to ascertain if an African perspective of psychopathology is necessary. In so doing, it is anticipated that diverse analyses of psychopathology be encouraged. Of concern in the current investigation would be to limit the opportunity of ethnocentrism within the study. Ethnocentrism is formed when one applies one's norms as the benchmark for assessing others. This often fosters stereotypical attitudes (Eshun & Gurung, 2009). The question remains whether Ake's and Guarnaccia and Rogler's views are in disharmony with the process of the world becoming a global village.

The idea of the world becoming a *global village* is exemplified in Eshun and Gurung's (2009) work. These authors suggest that frequent patterns of migration and voyaging have fostered a process whereby the world is becoming more global. Topics

such as acculturation, therefore, demand attention in any discussion relating to cultural perspectives. Acculturation may be defined as the shift experienced when an individual adapts to, and assimilates, qualities of a different culture (Eshun & Gurung, 2009; Reber & Reber, 2001). Eshun and Gurung indicate that integration, however, refers to the process whereby a person integrates the values and beliefs of the new culture, but simultaneously preserves his/her cultural values and beliefs. The person endeavours to maintain some form of equilibrium between the two cultures. In contrast, separation pertains to espousing the perspectives of a new culture in lieu of one's own cultural perspectives. Assimilation refers to the converse of separation and suggests that the individual actively attempts to preserve his/her cultural heritage, while simultaneously discounting the perspectives of the new culture. Finally, marginalisation is defined as neglecting to embrace one's own cultural perspectives, and/or new cultural perspectives. This process is understood to represent various adjustment difficulties (Eshun & Gurung, 2009). It would be of significance to consider these influences during the investigation, and may provide some understanding of the cultural dynamics affecting people on a daily basis. This is explored further on in the thesis.

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). Culture-specific groups may be becoming a rarity. The permutation of cultures within every society suggests that people, especially psychotherapists, are automatically developing the capacity to work with people from various cultures. Furthermore, attempting to generate specific theories and techniques to work with each culture and/or subculture would be impossible (Patterson, 1996). In addition, shared histories cultivate a shared culture (Ritchie, 1997). This is particularly significant in a continent such as Africa, defined by multicultural influences. One ought to also take note that the researcher is cognisant that some of the perspectives presented in this thesis will have little utility for some modern and/or acculturated Black populations. Adapting the scope of this study, for future research, may certainly be valuable in this regard.

Professor Asa G. Hilliard, the teacher, psychologist, and historian indicates that one should, at minimum, acknowledge the existence of culture (Mabie, 2000). Therefore,

while respect for multiculturalism will be exercised in this study, acknowledging the traditional African culture is equally important as it considers various aspects that may form part of the Black African perspective, including some perspectives of modernised Black Africans and those in the process of acculturation (see Mbiti, 1970). However, the motive behind focusing on the multicultural dimension is to promote the appreciation of cultural diversity (Grillo, 2007). A study that incorporates this dimension may facilitate introspection on the dynamics of the patient's distress, specifically on the clinician's part (Seixas, 1993), thereby allowing the practitioner to build a comprehensive history of facets which might otherwise have been ignored (Haidet & Paterniti, 2003). This seems to serve the purpose of reflecting on dynamic influences.

1.4.1 Research question

The research question stems from the need to develop a single point of reference for literature regarding an African perspective on psychopathology. Furthermore, the research question aims to address the debates regarding the utility of the cultural perspective in modern clinical practice, and in so doing encourage more culture-fit assessment. These areas were explored in detail in section 1.3. It appears that literature regarding an African perspective on psychopathology has increased from the year 1985. The researcher, however, decided to include literature from the beginning of that decade as a number of the sources between 1980 and 1984 seemed to contribute significantly to the scope of this investigation. Many of these sources appeared to debate the notion of African conceptualisation of mental illness, particularly with regards to modern/clinical psychiatric nosology.

It was during this observation process that the researcher developed the research question: In the academic literature, is there an African perspective on psychopathology from 1980 to 2010? The research question for this study thus addresses those aspects of literature which describe, or refute, an African perspective on psychopathology.

Sub-questions include the following:

- Are etic and/or emic perspectives on psychological distress favoured in Africa?
- Do the present diagnostic and classificatory systems serve the needs of African populations?

1.4.2 Delimitation of the scope of study

The scope of this study is based in the broad sphere of clinical psychology. Thus, the focus is on theory and practice relating to psychology and the assessment and treatment of abnormal behaviour (Reber & Reber, 2001). Literature regarding psychological theory forms a substantial part of the research. This includes literature relating to underlying dynamics (Sadock & Sadock, 2007), defensive operations (Sadock & Sadock, 2007), subjective experience (Farrell, 1994; McDowell, 2003), thematic extrapolation (Smith, 2008), and systemic patterning (Becvar & Becvar, 1996), to name a few. Based on these considerations, that is to say conducting substantially extensive analyses of the literature, the research is suitable for a doctoral study as the scope suggests adding new knowledge to the current body of knowledge in the field of psychology. New knowledge, in the context of this thesis, includes constructing a single reference point for literature adhering to the inclusion criteria, as well as conducting an overt extrapolation of the universalistic and relativistic perspectives on culture and psychopathology. In other words, the investigation integrates various literature sources, but in so doing identifies if psychopathology in Africa differs from universalistic approaches. For instance, Tomlinson, Swartz, Kruger, and Gureje (2007) are of the view that no universal differences exist save for minor differences in the presentation of psychopathological symptoms. It is valuable, therefore, that this investigation considers the psychological influences on the presentation of symptoms.

This is not to suggest that every psychological view was compacted into the study, but more so that pertinent aspects relating to the dynamics of the disturbance, together with culturally sensitive considerations, were critically appraised and justified as to

why (or why not) it should form part of the review. Higgins and Green (2008) indicate that this is not a simple task as information has to be procured which can inform, as well as challenge, research regarding the inclusion and exclusion of certain information.

1.5 Research goals

The goal of this investigation is to identify and analyse aspects of literature that suggest an African perspective on psychopathology. The discovery of an African perspective ought to fortify the appreciation of context-specific perspectives in relation to the theoretical constructs frequently used in clinical psychology. This would aid clinical practice in Africa, particularly within the South African context. This does not preclude developing ideas for future research into theory relating to the South African context. Furthermore, this study may augment awareness into the germaneness of classification and diagnosis in South Africa, as well as add to the ideas which need to be adapted for the local populace. The findings of this study have the potential to inform the process of clinical interviewing by describing possible African perspectives on psychological distress and may thereby afford the patient to be more carefully and more considerately assessed. This view is not intended to imply that patients are not carefully assessed, but to further accent the need for culture-fit care as suggested by Tseng (2006). This is consonant with research conducted by Vatrapu and Pérez-Quiñones (2006), whose study focused on the ways in which culture influences clinical interviewing, and may thereby allow for better interviewer-interviewee relationships (Ferguson & Candib, 2002). The aforementioned is also implied by Gabbard (2005).

1.6 Theoretical orientation of the study

This study's theoretical point of departure is post-postmodern integrative theory which proposes that the diverse facets of various theories form a desegregated approach to theory, as well as to practice (Brooks-Harris, 2008). This suggests that diverse schools of thought are deliberated on in order to provide a comprehensive understanding of various dynamics and propositions. As a result, the study exhibits a concerted effort to search for common variables in separate schools of thought,

employing a multidirectional stance to best explore specific dynamics, integrating various perspectives to understand personalised experiences, comparing perspectives from diverse schools of thought to challenge complex phenomena, and using a multitheoretical approach to conceptualise complex information (Norcross & Goldfried, 2005). This process allows for clinicians to become more aware of the diverse exploratory processes in the interviewing process (Brooks-Harris, 2008). Thus, from a psychological perspective, areas such as psychodynamic theory, phenomenology, postmodernism, and cognitive-behavioural theory were explored in order to explain the themes within the reviewed literature.

Furthermore, these areas accommodated an African epistemology so as to facilitate greater applicability with regards to the African context (see section 2.5; cf. sections 4.7 and 4.9.4). Kaphagawani and Malherbe (2001) define epistemology as enquiry into the characteristics, and range of erudition, the assumptions and foundations of wisdom, and the analysis of knowledge acquisition. While developing an epistemological stance is universal to the human species, knowledge acquisition varies among cultures as the socio-cultural situation moulds one's way of knowing. They further suggest that the question of the existence of an African epistemology has been argued for numerous decades. The result of these arguments indicates the authenticity of an African epistemology, as well as an African philosophy. A significant view on African epistemology was offered by Appiah (1992) who suggested the construction of the African epistemology as a pre- and post-Western phenomenon as imprecise. Instead, he suggested, traditional African history shaped African epistemology. Warranting the exploration of an African epistemology in the study may be fortified by defining the ways in which the term *African* will be applied within this thesis. This reasserts the need for this study to explore traditional perspectives (as discussed in section 1.4), but will also be further explored in section 1.7.1.

1.7 Clarification of terminology

In order to appreciate the context of this study, as well as to elucidate the delimitation with regards to the scope of the study, it seems fitting that a few concepts be clarified.

1.7.1 Defining African

South Africa comprises 11 official languages, with many African subcultures operating within the South African community. Thus, a cultural sensitivity to understanding patients in Africa appears to be adequately aimed at addressing a reasonable portion of the South African context. Furthermore, research into South African culture suggests that South Africans are on the journey to developing a multicultural national identity (Chick, 2000) and thereby suggests that universality may be more applicable than multiculturalism within the context of this study. An exploration of these dynamics will need to be further unpacked within the thesis. The roving debate as regards the definition of who is, or is not, African continues. In this regard, Nagel (1994) suggests that identity formation as an African is an individual process and cannot be answered with universal acceptance. The controversy is multidimensional in the literature, often based on various aspects including race and culture. Ndletyana (2006), for example, explores the manner in which middle-class Black individuals often come to be seen as less African. Therefore, being African may be a question which each person may need to ask him/herself.

Many have also argued whether the African American experience ought to be considered in research regarding traditional African perspectives. Mbiti (1970), for example, was of the view that an authentic African consciousness pervaded the African American experience and should therefore be included in African-focused research. Bhui and Bhugra (2001), in contrast, are of the view that African studies should not include African American data as the inclusion thereof limits the appreciation of authentic African data. If one considers the comprehensive explorations regarding the definition of African, the sine qua non of aged literature (Anise, 1974; Mbiti, 1970), as well as more contemporary literature (Nagel, 1994; Ndletyana, 2006), finds little consensus on who is African. The literature review, however, appears to suggest that many references to African perspectives appear to suggest that *traditional African* is often equated as *African*. However, the present investigation underscores traditional Black African perspectives on psychopathology, and invariably acknowledges those observations mentioned in section 1.2. As discussed in section 1.4, the researcher is certainly perceptive of the utility, and

limitations thereof, as regards traditional perspectives for modernised Black African people.

While race often coincides within various African cultures, Appiah (1992) provides evidence that genetic traits may be excluded from the definition of *African* as people from the same cultural group do not necessarily evidence diverging genetic constitutions. This is particularly significant for those persons interested in fostering a national identity, where mutuality and cultural merging is valued (Owomoyela, 1994). As a result, *African* in the present study should not automatically be assumed to imply non-Black, but rather implies persons that adhere to parallel practices as described hereunder.

Defining the term *African* may be applied in more than one way (e.g. all people that reside in Africa). However, *African* in this investigation is defined as those traditionally-inclined persons that share specific aspects such as epistemology, linguistic mores, and social practices. According to Kaphagawani and Malherbe (2001), traditionally-inclined Africans share and/or appreciate the philosophical significance of particular expressions, sentence construction, and linguistic tendencies, including axioms. Furthermore, analogous social practices are exercised, such as the way in which disputes are resolved, children are schooled, and the way in which knowledge about the world is explored and applied. Clarification of the term *African*, therefore, sheds light on the researcher's application of the term. This sort of clarification is applied to other dynamic terminology utilised in the thesis and is explored hereafter.

While published definitions were consulted, Farlex Incorporated provided apt definitions for specific terms as the organisation provides an online forum that is regularly updated with comprehensive general and medical definitions. Farlex Incorporated is a private company that supplies reference products, including online library services. To begin with, Farlex Incorporated (2008) defines a *perspective* as a way of considering an occurrence and its relative significance. Farlex Incorporated further defines *culture* as behaviour models which are conveyed within communities and are regarded as a representation of a specific society, populace, or era.

Eshun and Gurung (2009) suggest that culture, a quality which is environmentally acquired, ought to be viewed as containing beliefs, principles, standards, activities, and symbols. It therefore reflects mutual societal experiences, is conveyed cross-generationally, and transforms in due course. Culture is also self-sufficient, and consists of concrete and abstract components. Furthermore survival and acclimatisation of a population are dependent on culture. Many aspects of culture, such as cultural principles, impact the manner in which people perceive and react (Eshun & Gurung, 2009). This is explored within the literature review, and particularly in section 4.3.4.

1.7.2 Clinical terminology

In addition, it is anticipated, based on the view that culture and clinical psychology will interlace, that the term *culture-bound syndrome* also be clarified. A culture-bound syndrome is a cluster of symptoms relating to particular configurations in terms of behaviour and disturbances in experience. The experiences may be associated to specific psychiatric categories, but are deemed to be disorders in terms of local knowledge and understanding (American Psychiatric Association (APA), 2000). Kirmayer and Young (1998) are of the view that culture-bound syndromes epitomise emotional, somatic, and cultural meanings. The views regarding culture-bound syndromes will be comprehensively considered in section 5.7.

In considering culture-bound syndromes, it seems pertinent to define *psychopathology*. Farlex Incorporated (2008) defines this as the investigation of mental illness or anguish, or signs of behaviours and occurrences which may denote mental illness or psychological wounding. Hence, the terms psychopathology and serious psychological distress may be utilised interchangeably. The current investigation will focus on symptomatology and clusters of symptoms as is applicable during the investigation. The philosophical assumption here is that the aspects of psychological distress be afforded substantial weight of evidence within the review.

1.8 Research methodology

In my search for more comprehensive and culturally-sensitive clinical material, it became evident that information in this area ought to be more thoroughly investigated. This view is also shared by Bhugra and Bhui (1997); even though this source is more than a decade old, the paucity in literature specific to the African context appears not to have changed. Despite this obvious obstacle, even though the avenues for gathering data may be complex, some research exists in relation to any investigation. In terms of the current literature review, these avenues included consulting in-depth investigations, proposed theories, and even minor ideas which were alluded to incidentally. The avenues, therefore, delved into the formal literature networks such as libraries and academic journals; the informal avenues such as workshops, lectures, and reference tracking, and at times, flirted with grey avenues such as discussion groups so as to acquire leads with regards to both formal and informal avenues. It ought to be noted, nonetheless, that only literature that could be verified by formal avenues was included in the review itself. The dilemma was therefore not whether information exists, but rather in determining the data which was pertinent to the study at hand (Dane, 2010).

Constructive research will weave multiple studies together to allow clinicians the opportunity to further appreciate culture and psychological distress comprehensively (López & Guarnaccia, 2000). Draguns and Tanaka-Matsumi (2003) recommend that research focuses on linking discrete studies in such a way that greater understanding of psychological dynamics be available to academia. A literature review was selected as the methodology for this study based on the observation that studies regarding psychopathology are often dispersed and divided (Draguns & Tanaka-Matsumi, 2003; Dzokoto & Adams, 2005).

Cooper (1998) is of the view that literature reviewing offers the potential to propose much needed research in specific areas. He further indicates that theses focused on reviewing literature produce a wealth of data which serve as the academic nuclei for primary studies to be conducted in the future. As such, future research endeavours should aim to broaden the focus areas of primary research (Cooper, 1998). In this respect, literature reviewing appears competent in fulfilling this requirement. Upon

completion, the current investigation therefore has the potential to stimulate a host of empirical investigations.

The specific method of literature review will be research synthesis (Gough, 2004; Popay, 2005). Research synthesis entails outlining and integrating research (Oakley, Gough, Oliver, & Thomas, 2005; Sandelowski, Voils, & Barroso, 2006), in order to augment practice and policy (Gough & Elbourne, 2002). Given that academic knowledge corrals as research progresses, the resultant cornucopia of information defends a literature review as an efficient methodology to review recent research and structures an essential climate for further systematic knowledge construction and development (Cooper, 1989). A detailed discussion on the way in which the systematic literature review was applied as a method is available in section 3.3.

1.9 Structure of the thesis

Chapter 1 introduces the context of the investigation.

Chapter 2 centres on the theoretical and paradigmatic stance exercised in the investigation.

Chapter 3 focuses on the research methodology employed in the study, as well as the rationale for selecting the research methodology.

Chapter 4 serves as the first part of the literature review and includes the literature aimed at responding to the research question. However, this chapter focuses on the foundational aspect for critically questioning an African perspective on psychopathology.

Chapter 5 serves as the second, and final, part of the literature review. It contains literature which comprehensively explores those aspects of an African perspective on psychopathology. The chapter may be seen as a progression from Chapter 4.

Chapter 6 is the discussion chapter and provides an integrated account of the literature, including the implications thereof. Theory is also applied to the literature so as to further explore the reviewed literature.

Chapter 7 is the technical report, typical of systematic literature reviews. This section reports on the salient aspects of the investigation in an abridged format.

1.10 Conclusion

This chapter comprised of pertinent information relating to the foundation of the current investigation. Areas such as background information, the justification for the study, and the research problem were discussed. Furthermore, research goals were identified in harmony with the structure of the research report. The chapter concluded with a brief view of the structure of the thesis. Chapter 2 will comprehensively explore the theoretical orientation of the study.

CHAPTER 2

THEORETICAL POINT OF DEPARTURE

2.1 Introduction

This chapter highlights the way in which post-postmodern integrative theory considers an African perspective on psychopathology. By applying this theoretical framework, one may be better equipped to appreciate the dynamic catalysts suggested in the literatures, as well as appreciate the many ways in which views on psychopathology can be conceptualised. The chapter begins with a brief background to the development of integrative theory. The facets of integrative theory are explored and the discussion naturally tends towards a graphic portrayal of the study's theoretical orientation (Figure 2.1 in this chapter). Thereafter, an explanation on an African epistemology and its utility with regards to the scope of the present investigation is offered. Having explored the dynamic nature of the integrative approach, as well as an African epistemology, a brief discussion on theoretical transformation is offered. The chapter also highlights those theoretical aspects which concern the scope of the current investigation. As such, this chapter includes theoretical views on psychopathology, exploring race, and integrative therapies.

2.2 Background to integrative theory

As this investigation embraces post-postmodern integrative theory, it may be prudent to offer a brief background of integrative theory. Integrative theory suggests the synthesis of tenets across diverse schools of thought. It diverges from postmodern eclecticism in that it discourages the extemporised use of various techniques in a single process. Instead, a concerted effort is made to apply a structured, premeditated process to particular events and experiences (Norcross & Goldfried, 2005; Palmer & Woolfe, 1999). In addition, this post-postmodern stance repudiates certain aspects of postmodernism, and is often regarded as a reaction to difficulties experienced with postmodernism. As a result, the post-postmodern school of thought developed in order to re-embrace modernistic schools, without altogether abandoning postmodern utility (Vermeulen & Van der Akker, 2010). Additionally, to some degree, there is

less focus on areas such as Derridean deconstruction. In this regard, Brooks-Harris (2008) suggests that various underpinnings and assumptions are accepted without critical analysis.

Integrative theory is relatively intimidating for many academics. To illustrate this, Sandahl and Lindgren (2006) are of the view that psychology is not yet adequately prepared for an absolute integration of paradigms. Focused Group Therapy (FGT) is an example of an integrative model, but is predominantly psychodynamic although other paradigms may be incorporated into the model. FGT requires the person to focus on personal behavioural responses with a specific focus, such as learning and action, in mind. The theory is integrative in the way it focuses on underlying processes (psychodynamic) and remedial ways in which to adjust resultant behaviours (cognitive-behavioural therapy). However, as it appears, absolute integration will take much more consideration before an inclusive paradigm may be developed (Sandahl & Lindgren, 2006).

2.3 Integrative theory

This section elaborates the ways in which various psychological perspectives such as psychodynamic theory, phenomenology, cognitive-behavioural therapy and so forth are consulted so as to animate the findings of the review. Furthermore, an African epistemology is also accommodated (as discussed in section 2.4), where necessary, so as to facilitate greater applicability with regards to the African context.

In an attempt to (re)integrate theory and paradigm, establishing cognisance of the diffused interactions between ontological, epistemological, and disciplinal dimensions must be appreciated. Mutual systemic stimulation between disciplines in the clinical field, for example, appears to be an area of interest that may profit the scope of the current investigation. Essentially, one ought to consider those disciplines which are implicitly and explicitly identified within the literary discourses as having some persuasive impact. Certainly, defining the term *discipline*, will aid during the research process in identifying these fields.

The term *discipline* is an indistinct one. Disciplines suggest the allotment of knowledge in terms of discrete epistemology, as well as forms of authority and ways in which particular systems of control are employed to guarantee perpetual control (Hook, 2004a). According to this definition, disciplines relating to the clinical field are not exclusive of psychology and psychiatry, but may certainly include anthropology, philosophy, and indigenous views, among others. Consequently, the critical frame justifies disciplinary collaboration.

To support this, Hook and Howarth (2005) are of the view that one ought to disallow consternations associated with including the ambit of fiction, life narratives, cultural views, and common knowledge. Many of the essential perspectives, operating within cultures, appear to be underdeveloped, often denying disciplinary collaboration. Disciplinary collaboration allows one the occasion to comprehend the interchange between psychological subjectivity and subjectification (Hook & Howarth, 2005).

Integrative theory continues to be emergent and therefore challenging for many professionals and academics to imbibe. Grounds for this difficulty include the separatist vocabulary used in literature to secede psychological and neuroscientific expressions, for example. More importantly, modernistic sciences have been inclined to broach psychotherapy mainly on declarative, vocalised, and cortical levels. In this regard, a reduced amount of consideration has been afforded to those processes which are subliminal and indirectly inaccessible in conventional psychotherapy (Seltzer, 2005). While Sandahl and Lindgren (2006) do not explicitly proclaim the reaction of some academics as regards integrative theory, one is left with the sense that many opponents of integrative theory experience panaphobic anxiety due to the diversity suggested within the theory.

Perhaps preferential analysis is awarded to the collaboration of psychotherapy and the neurosciences in this exposition. However, it appears to adequately illustrate the intensities suggested in the ways in which collaboration is shied away from, irrespective of the paradigm or discipline. According to Seltzer (2005), literature that exhibits the interdependent nature between neuroscience and psychotherapy is currently in its early stages. While developing vocabulary to conceptualise pre-cognitive processes may expand the field of psychotherapy, the current state of affairs

as regards the coexistence of psychology and neuroscience has obstructed the practice of perceiving patients as phenotypical, genotypical, existential, and phenomenological beings (Seltzer, 2005). At this point, it may be valuable to reflect on similar dynamics as they interact with critical theory.

Critical theory centres on tacit wisdom and may therefore be placed alongside psychoanalysis. The two frames attempt to render unconscious dynamics into conscious awareness. Furthermore, both frames aim to translate perceptions of repression. These are illustrated as dissociating encounters of personal realities. In Freudian terms, one is made aware of the process of disengaging the quota of affect from the perception it epitomises. From this point of view, Freud's assertion on the authentic *groundedness* of seemingly unanchored angst is particularly significant as this view sheds light on the idea that one's perception of another's *groundlessness* stems from one's own irrationalisation of his/her anxieties by de-objectifying them. As such, the person employs mechanisms to encumber and alter that which the other person's truth proposes (Osterkamp, 2009).

Scientific and academic homily are in the field of, stimulated, and constructed by social configurations and interfaces. The structure, depiction, and vindication of theory are positioned in the socio-political domain and consequently intrinsic to the discourse analytical endeavour. As a result, such interaction must be examined in order to deepen insights into seemingly atypical views (van Dijk, 1998). Erudition in this regard amplifies the range of influences impacting on the psychological dynamics operating within, and between, systems.

Stetsenko and Arievitch (2004) provide an inclusive justification on this matter. Erudition is functional since it stems from dynamic revolutionary systems and is able to return to those systems. The function of this action is of great consequence as it accomplishes its functions within the ambit of expansive renovation rituals, such as political, ideological, and ethical systems of practice. In addition, erudition exemplifies historical perceptions in conjunction with prospective perceptions. These multifaceted configurations regulate the systems in concert with ethical and political opinions relating to the culture's aims and perceptions of realism. As such, erudition must be understood as a process that is active, productive, and greatly historical.

Knowledge, in all its animations, is permeated with human principles that network all three tenses of time. That knowledge is misrepresented to represent an abstraction of reality is evidence of the vestiges of authentic historical processes that fostered the mind/body divide. These same processes reinforced the perceptions of knowledge, action, individualism, and collectivity. These divides are anchored in deficient comprehension of systems that shape and cause this practice, since these dynamics are concurrently structured and generated by action in the uninterrupted course of collective living (Stetsenko & Arievitch, 2004).

The framework applied in this thesis is diagrammatically represented below in Figure 2.1. As the paradigmatic approach is post-postmodern integrative theory, diverse facets of psychological theories are embraced. Where applicable to the literature, existential, psychoanalytical/psychodynamic, phenomenological, cognitive-behavioural (CBT), critical, and postmodern views are applied. However, these views are contrasted with the African epistemology (Kaphagawani & Malherbe, 2001) so as to gauge potential strengths and limitations within the arguments under discussion. This framework, therefore, allows for fluidity in integrating diverse approaches, without discounting potentially constructive views. Here, a discussion on the psychological theories applied in integrative theory appears to be indicated.

Psychodynamic theory aims at illuminating unconscious material, with the intention of reducing psychological distress. Although classified as a form of depth psychology, the actual process of unearthing unconscious tension is via the relationship between the therapist and the patient (Sadock & Sadock, 2007).

The experiences of being human, as opposed to being exclusively thinking beings, are embraced within the existential school of thought. Largely influenced by the discipline of philosophy, existentialism regards the affective, behavioural, and experiential processes involved in being human. The focus area of existentialists is to search for meaning (Breisach, 1962; Kaufmann, 1956; Macquarrie, 1972; Solomon, 1974). A significant approach to excavating richness in experience and meaning is the break away from mechanistic and deterministic psychological principles, which were often associated with psychoanalytical principles (Yalom, 1980). Like existentialism, phenomenology embraces the discipline of philosophy (Giorgi, 1970). With

significant reference to philosophers such as Husserl and Merleau-Ponty, phenomenologists explore the process of being in the world and the associated qualities thereof. In the therapeutic space, the intersubjective experience becomes the arena where therapeutic process unfolds (Langdridge, 2006).

Cognitive-behavioural theory focuses on systematic processes which facilitate dysfunction in affective, behavioural, and cognitive processes. These systematic processes are often the result of deep-seated patterns of thought, and belief blueprints which are established and maintained within the person's environmental framework (Swift, Durkin, & Beuster, 2004).

Postmodernism is a school of thought that established itself as a result of the philosophical manacles created by modernistic paradigms. The major hindrance for postmodernists is the philosophical assumption regarding the existence of a universal truth. Furthermore, that reality is socially constructed lays the foundation for postmodern thinkers to critically evaluate the restrictions in the construction of language and power relations, for example (Anderson, 1998).

Blatner (1997) is of the view that an integrative approach is also congruent with postmodern philosophy. Within this framework, one considers the current epoch of the social structures which one investigates and appraises the transformations of the data based on local modes of expression in lieu of wide-ranging generalities (Lindlof & Taylor, 2002). The framework further encourages alternative understandings of psychological dynamics (Parker, 1999). This view is propounded in the current chapter. According to Blatner (1997), this position appreciates that culture and history exist in relation to assumptions which may not be unconditional. In employing postmodern theory, Blatner further recommends eight considerations. These include: creativity as a core quality; composing and understanding subjective reality; the transpersonal position as a foundation; an integrative, philosophical outlook; cultural appreciation; diverse perspectives; metacognition; and developing reflexivity. These considerations form a significant part of the theoretical point of departure, and are applied throughout the thesis. Additionally, such a philosophy is congruent with integrative theory as this viewpoint consistently builds a connection with diverse areas of knowledge (Brooks-Harris, 2008). Seltzer (2005) suggests that integrative

theory underscores the trends in psychological formulation. An example of a trend, although not a universal trend, includes the shift from classical postmodern theory to post-postmodern integrative theory. This chapter underscores these trends, and their applicability to the subject matter under investigation.

Finally, critical theory reviews and analyses mainstream psychology with the intention of recommending and applying progressive ideas to better explain certain phenomena. Often, the idea that social transformation facilitates the aptitude to inhibit and/or doctor psychological distress plays a significant role in communicating the philosophical schemata of critical psychology. Additionally, proponents of this school of thought emphasise the ways in which mainstream psychology fails to address the socio-political forces which impinge on the physical and psychological health of individuals and groups (Prilleltensky & Nelson, 2002).

2.4 An African epistemology

Epistemology signifies the character, condition, and creation of knowledge. It also refers to the way in which one perceives and appreciates his/her world (Harding, 1987). Epistemology ought to be viewed as a system of knowledge. The emphasis being on the word *system*, and is unreservedly associated with worldviews founded on the contexts within which people subsist (Ladson-Billings, 2000). Here, African epistemology is defined as the African spiritual-focused acumen, an explicit paradigm, valued in many African subcultures. In other words, the African epistemology may be referred to as African approaches to interpretation (Ngara, 2007).

This section is included in the theoretical chapter so as to accommodate Ngara's (2007) view that African ways of knowing denote a definite paradigm. As an extension to this view, inclusion of a discussion on epistemology may also assist in contrasting African and Western epistemology. As a result, one is afforded with the opportunity to explore the diverse ways in which illness is constructed.

In terms of Western epistemology, Western modernism refers to a system of extensive beliefs constructed by, and founded on, perceptions of the nature of being from the

Western cultural point of view (Foucault, 1979). To be aware of the idea that Western epistemology represents only a portion of available views, indicates a call for epistemological vigilance. To exercise epistemological vigilance means to object to the intimation that so-called Western perspectives are commensurate universal truths (Mudimbe, 1988).

Truth has many dimensions, as has rationality (Du Toit, 1998). That psychiatric diagnostic process universalises mental process is a truth that is not universally realised. The literature review will provide much evidence with regards to the way in which certain populations construct and reframe psychopathology. Psychiatric nosology suggests that the tenets of pathology are constructed, instead of uncovered. In so doing, psychiatry has come to construct symptoms of psychopathology (Draguns 1997; Lupton, 1994). Similarly, the diagnosis of pathology is based on symptomatology, and not on disease. Diagnostic criteria are therefore subject to revision, fortifying the observation that these disorders do not epitomise naturally occurring diseases. Due to the universalistic approach applied in Western classifications of psychopathology, cultural epiphenomena are often discounted in the assessment process thereby limiting a contextualised appreciation of the dysfunction as a psychopathological state. In this regard, it ought to be appreciated that *truth* does not equal *psychiatric truth*, particularly when *truth* comprises abstract conceptions such as psychological distress (Kwate, 2005). Psychiatric nosology, from a Western perspective, presupposes rationality, signifying the marginalisation of truth as it operates from alternative perspectives. Psychology has had a history which is comparable to mainstream epistemology in psychiatry. As a result, conceptualisations and formulations relating to psychopathology often fall within the Western epistemological framework (Kwate, 2005).

By and large, the discipline of psychology has overemphasised individualistic, psychological, and psychopathological phenomena in lieu of societal, historical, and economic influences. Within this process, psychology has fashioned sweeping oversimplifications, observably consistent with US and European theories and assumptions. As a point of note, it appears that Eurocentric approaches have employed universalistic genre to reassert itself in postcolonial frameworks. As such, culture- and context-specific perceptions are annihilated at the highest levels, often

being criticised as essentialist and often remaining, in the main, dissonant with universalistic and Eurocentric approaches (Hook, 2004a).

The critical realist epistemological view, as a component of integrative psychology, and as considered in this thesis, reunites the physical and abstract dynamics of experience, but also recognises the cultural and historical framework(s) within which significance is constructed (Ussher, 1997). Critical realism asserts physical and collective realities as justifiable areas of investigation, but appreciates that reality is mediated by language, culture, and politics (Bhaskar, 1989). The latter includes discourses regarding race and gender, for example (Pilgrim & Rogers, 1997).

At the outset, it appears fitting to state that the author is not oblivious to, nor will deny, those literary tensions which appear to sometimes be endemic to studies focused on areas such as African epistemology, Africanity, and the like. Owomoyela (1994), for instance, suggested that some researchers focusing on bringing African insights into the academic sphere would almost invariably propagate a distinctly pro-African picture. The author of this thesis is compelled, therefore, to categorically state that the seemingly pro-African stance in this study is in no way intended to suggest opposition to non-African views. In an attempt to supply the academic fraternity with a comprehensive picture of the ideas that deliberate on African perspectives on psychopathology, various contextual sources were consulted. However, that this stance constitutes specific challenges to non-African perspectives, and by implication may suggest methodological complexity, was certainly a consideration which was carried throughout the research process. This will be discussed towards the end of the thesis.

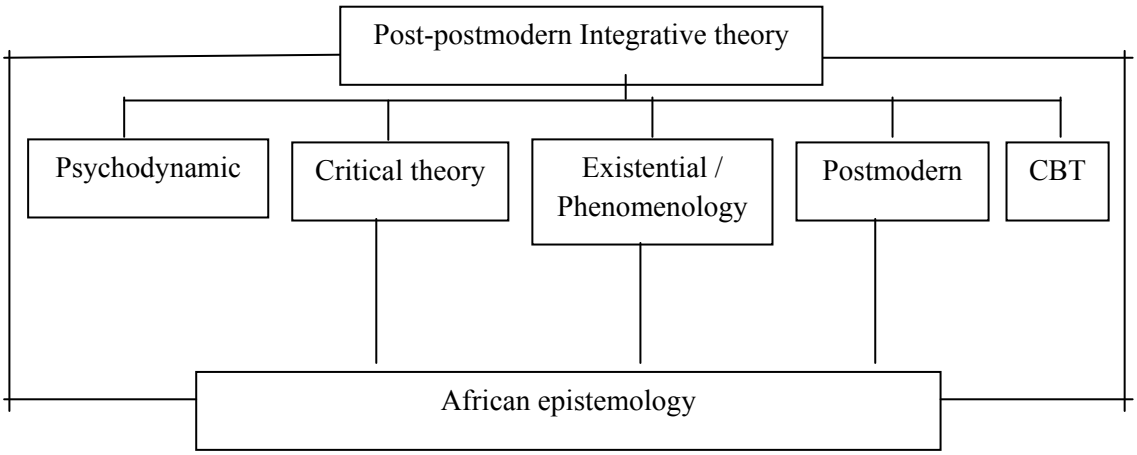

Figure 2.1. Theoretical framework employed in this study

2.5 Theoretical transformation

More recent inclinations in psychological theory have embraced more holistic modal frameworks. This is particularly useful in the context of the present study where the focus is on developing diverse insights with regards to a cultural perspective. The form and application of psychological descriptions are being continuously confronted by meaning-based approaches to culture. The context, therefore, requires the consideration of collective views as opposed to specifically objective limits. Psychological explanations of culture, from a meaning-based approach, may be appreciated trilaterally. This includes reflecting on the individual, the ecological context, and the culture (Miller, 1999).

However, meaning-based approaches to culture, such as ecological perspectives, have not adequately confronted the dualistic form, typical of psychological dynamics. Ecological perspectives have played a vital role in enlightening theory and research, particularly with regards to behavioural, genetic, environmental, evolutionary, and cross-cultural approaches. These views are based on practical requirements in the social structural and physical environment. Culture is appreciated as influencing a causal link to personal psychological dynamics as is the context to which these dynamics adapt. Furthermore, culture is acknowledged as a mode which in itself is adapted to personal psychological needs (Miller, 1999).

Proponents of social constructionism often offer fairly insipid approaches to the alteration of racial discrimination, for instance. While some appear less distressed due to the engrossment with meticulous analyses, others are consumed with *perturbing* the conventional models to the extent that other, perhaps more active, lines of attack are disregarded. Some of those who appear to confront the Marxist tradition display explicit antagonism to the so-called grand narratives. However, in favouring the expressive, descriptive, and discursive directives, social constructionism has the potential to be politicised as idealist, equal in measure to those mainstream contenders it often censures (Foster, 1999).

Nevertheless, some of the social constructionists appear to be enthusiastic with regards to the assimilation of progressive components of discourse and intergroup models, or at least with acumen derived from post-structuralism and Marxism (Parker & Spears, 1996). Structural approaches such as those proposed by Minuchin (1974), for example, appear to allow for such assimilation. In family therapy, the therapist draws attention to the interplay between the family context and the individual's perception. As the context adapts, so does the person's experience. These adaptations are recreated within the therapeutic process with a focus on reanimating alternative interactions and thereby facilitating altered interpersonal relating within the family therapy situation. The altered methods act as a catalyst within the family system and are transferred to systems outside the therapy context (Minuchin, 1974). By employing different modes of interaction, family arrangement is transformed at a foundational structural level (Wohl, 2000).

Integrating the strengths of these approaches appears to offer a more holistic view on the dynamics at play. Integrating systemic patterns into the interpretative process allows for attending to intergenerational conflicts, for example. This appears to be useful in light of patterns of interaction that occur from one generation to the next, but also by exploring perpetual patterns regardless of the possibility that a modernised, multicultural generation may be emerging.

Another framework that lends itself to meaning-based insight is the existential-integrative (EI) paradigm. According to Schneider (2007), James Bugental and Rollo May inspired EI. The EI paradigm allows psychotherapists to organise therapeutic

intervention within an overarching metaphysical and experiential framework. Under the umbrella of the EI framework, one may appreciate the integration of analytic, cognitive-behavioural, and pharmacological frameworks (Schneider, 2007).

Perceptual Control Theory (PCT) is also an integrative approach to understanding psychopathology. Within this context, psychopathology is precipitated from unresolved conflict involving personal ambition and negative feedback cycles that manipulate perception via control of the external world (Mansell, 2005). PCT presents a creative portfolio with regards to the functions of goal conflict, imagery, automatic processes, compromised psychological functioning, and perceptual disturbances (Mansell, 2005).

2.6 Integrative therapies

Psychotherapy is engrafted in cultural and historical contexts (Wohl, 2000). Schneider (2007) movingly reflects Rollo May's view that therapists work with people, not symptoms. Eagle (2005) found that most theoretical frameworks have strengths and weaknesses with regards to cultural appreciation and sensitivity. As such, no single model is idyllic in this regard. However, many continue to search for a framework that can effectively contain the influence and density of culture.

Although it may be appealing to consider novel, or seemingly culture-focused, approaches as beneficial to cultural communities, a clinician must not undervalue the potential of time-honoured therapies. Many Western psychotherapy models have been beneficial to non-Western populations (Wohl, 2000).

Psychotherapists work from various frameworks. In spite of this, each framework is composed of basic tenets that allow a clinician to be prepared to recognise and work openly with the inimitability of the therapeutic space (Wohl, 2000). Ultimately, therapy presupposes that the patient experiences a sense of liberation from the psychological shackles s/he is bound by (Schneider, 2007).

Patients who engage in long-term psychotherapy are subjected to healing processes which rise to a crescendo. At this point, the patient undergoes experiential liberation

(Schneider, 2007). Motivated patients may undergo experiential liberation through four dimensions. These dimensions are interconnected and include the immediate dimension, the affective dimension, the kinaesthetic dimension, and the cosmic or insightful dimension. These dimensions are accessed in such a way so as to allow the patient to explore his/her faculty in limiting, amplifying, and focusing energies (Schneider, 2007). In EI, the perception of amplifying psychophysiological faculty is referred to as expansion. Constriction, conversely, refers to the perception of limiting psychophysiological faculties. Extreme experiences that are called hyperexpansive signify chaos and confusion. However, extreme experiences that are called hyperconstrictive suggest entrapment and annihilation. Hyperexpansive and hyperconstrictive fears influence all classes of psychopathology. These fears may often be assumed to be unipolar, but the complex fusion of hyperexpansive and hyperconstrictive fears is endemic to most psychological disturbances (Schneider, 2007). Certainly, these experiences incorporate the spiritual dimension.

Experiential liberation, for example, endeavours to hone expansive and constrictive options in order to allow the patient to tap into the four dimensions with vivacity, inventiveness, and determination. This is especially significant for those who aim to explore the spiritual dimension (Schneider, 2007). Other modalities will be explored within the thesis. Cognitive-behavioural therapy (CBT), for example, may also be beneficial to diverse cultural populations (Eagle, 2005).

If cultural norms suggest that the clinician is directive, proactive, and an authority in the treatment relationship, CBT may be experienced as valuable to those patients. However, CBT may also be experienced as disempowering to those who are intimidated by exceedingly directive approaches (Eagle, 2005).

Cognitive and cognitive-behavioural approaches have demonstrated less restriction in terms of cultural influence. This appears to be due to the application of incorporating patient-specific pathogenic worldviews into its core praxis. The opportunity for cross-cultural research, in this regard, shows potential (Trujillo, 2001). Alternatively, although some may perceive psychodynamic approaches to be limiting, the psychodynamic frame also has constructive cultural components.

Psychodynamic theory reveres a person's subjective analysis and translation of experience (Sadock & Sadock, 2007). For this reason, psychodynamic perspectives have actively engaged the cultural dimension of lived experience. However, some have argued that certain views of psychodynamic approaches may be precarious if interpretations become overly reductionistic. Boundary maintenance, which appears to differ in systemic approaches, is an example of one such aspect (Eagle, 2005). Ecological theories, such as ecosystemic therapy for example, acknowledges the sociocultural context (Becvar & Becvar, 1996). However, some have argued that these frameworks overstate the social dimension by transforming interpersonal relationships into ecological symbols (Eagle, 2005).

Client-focused models, such as Rogerian therapy, are expedient in that the patient comes to experience the dynamics of interpersonal interaction (Sadock & Sadock, 2007). However, authenticity may become complex due to intercultural pressures within the therapeutic encounter (Eagle, 2005). Additionally, narrative therapy centres on cultural perspectives and aims to recognise the value of subjective views on culture, including culture's flexibility. In spite of this, the swathed temperament of power relations that could transpire during the course of co-constructing narrative adaptations may pose serious challenges to the therapeutic process (Eagle, 2005). Indeed, a few approaches to psychotherapy appear to correlate with African collectivism. The African appreciation of *oneness of being* resonates with group therapies (Toldson & Toldson, 2001). Systemic therapies, group therapies, and community-focused interventions are in harmony with the African appreciation of, and for, communalism and collectivism (Toldson & Toldson, 1999).

2.7 Psychopathology for the African

As the aim of the current investigation is to explore evidence confirming or disconfirming an African perspective on psychopathology, relevant theory relating to the clinical discipline (e.g. Goddard, Hoy, & Hoy, 2004; Masterson, 1985; Sadock & Sadock, 2007) will be continually consulted and reviewed to augment the study. Furthermore, the search for an African perspective on psychopathology inevitably suggests the juxtaposition of culture, race, and psychological distress. Ethnopsychiatry, as an example, is one of those areas which will feature in the thesis.

Ethnopsychiatry underscores the degrees in which sociocultural influences affect psychopathology (Bullard, 2001). However, history in Africa will also be explored so as to explore the way in which African history has influenced psychological distress.

In terms of colonial Africa, Vaughan (1991) contends that the mental health diagnostic taxonomies contributed to the functions of colonial control. Biomedicine, and those disciplines associated with the medical fraternity, operated in a way that objectified the African as an entity in need of study, thus having the ability to produce scientific knowledge. During this period, the meaning of pathology from an African perspective was eschewed in preference to issues regarding Africanness. *Africanness* therefore was a topic of greater interest to the academic body than *madness* (Mkhize, 2004). According to Vaughan (1991), the zeal espoused by the idea of Africanness implied that mental illness in Africa was fundamentally different from mental illness in the European world. And so, the reinforcement of *otherness* persisted. Being perceived fundamentally and unremittingly as the *other*, the African maintained the position of *normally abnormal*. The discourse of difference is yet to be thoroughly dismantled (Mkhize, 2004).

Regardless of race and/or culture, one ought to appreciate that psychopathology has much to do with the notion of *conflict*. A collection of control systems theory regarding psychopathology exists. These include explanations ranging from broad-spectrum implications to express conceptions of pathology (Mansell, 2005). The negative outcomes of unresolved conflict have been extensively explored within psychology (e.g. Freud, 2002; Mansell, 2005; Pavlov, 1941). Investigations aligned to the scope of the current study will certainly ply conceptual ideas. Thomas and Bracken's (2004) view in this regard is that the investigation of psychopathology is enhanced by conceptual analysis, and devalued by empirical analysis. Conceptually, then, psychological distress must be delimited within the scope of this investigation. Hook's (2004) definition of neurosis appears to exhibit sound correspondence with the conceptual definitions of psychopathology and psychological distress, as defined in Chapter 1.

Extending the definition of this malady to race, Hook (2004b) also provides a synopsis of Fanon's *neurosis of blackness*. Fanon's view of the neurosis of blackness

is equivalent to the *fantasy of becoming white*. This statement must be correctly interpreted to imply the desire for the degree of humanity, apparently enjoyed by white people, in bigoted/colonial settings. The conflict, therefore, arises as the experience of possessing a black exterior, living in a racially prejudiced social environment, and realising the hopelessness of this phantasy. From Fanon's perspective, the neurosis is unambiguously a social psychological occurrence, anchored in trans-historical and political frameworks created by colonisation (Hook, 2004b).

Does the exploration of an African perspective in psychopathology become one relating greatly to race? It appears that a more extensive exploration of *race* is required to clarify this point. The literature (e.g. Darder & Torres, 2000) suggests that the issue of race and psychology is largely affixed to psychopolitics and identity politics.

2.8 Exploring race – a process of humanisation

Awareness of race does not suggest, nor does it instigate, racism (Swartz, 2007). However, research (e.g., Sharpley, Hutchinson, McKenzie, & Murray, 2001) indicates that many African populations are of the view that strained race relations, particularly within the political domain, are responsible for a large proportion of their psychological distress. Sen and Chowdhury (2006) suggest that an important process in addressing these race-related concerns is to discuss racism and thereby challenge racist insinuations. This discussion is comprehensively explored in Chapters 4 and 5. In the interim, race is discussed from a theoretical perspective. It may be useful to begin with a brief introduction on psychopolitics and identity politics.

On the one hand, psychopolitics refers to the development of critical understanding with regards to the functions operating via political dynamics. Power relations, for example, when considered within the psychological sphere of influence are regarded as psychopolitics. As follows, an awareness of the way in which politics influences psychology, as well as the converse, falls within the field of psychopolitics (Hook, 2004c). Identity politics, on the other hand, refer to the hidebound conceptions of race

and discounts the diversity inherent in gender, culture, and so forth (Darder & Torres, 2000).

Scores of academic references suggest that postmodern, and some other, theorists may find critical race theory discomforting due to their conviction that the theory proposes essentialist views with regards to race, and tends to treat all people of the same race similarly. Essentialism, from this viewpoint, is grounded in identity politics derived from one-dimensional views of race (Brayboy, 2001). Critics equitably contend that the essentialism of identity is one-dimensional and prohibits the appreciation of the multitude of experiences that profile identity and epistemology (Bernal, 2002).

However, to appreciate the multidimensional views of race from a psychological perspective implies the appreciation of the trans-historical mechanisms that have influenced many areas of psychological functioning, and continue to do so at present. Information and/or dynamics that pervade the breadth of historical settings are referred to as trans-historical (Hook, 2004a). In the days of old, Western modernism reinforced a system of extensive beliefs constructed by, and founded on, perceptions of the nature of being from the Western cultural point of view (Foucault, 1979). The influence of this trans-historical process must be addressed by paralleling non-Western perspectives which were undermined due to the Western upsurge of recorded data.

In their focus of issues relating to race, critical race theorists analyse the apparatuses employed to exert authority, either physically or psychologically, and the influences these apparatuses had (and have) on various populations. An apparatus, in Foucault's view, refers to an assortment of discourses, establishments, authoritarian judgments, regulations, organisational measures, scientific records, and abstract devices applied in order to instigate relations of power (Hook, 2004a). Despite some of the criticisms relating to the focus on race in critical theory, critical race theorists have diversified the literature and discourses regarding culture and race (Solórzano & Yosso, 2001). Certainly, discussing race does not imply a lack of moral and humanistic responsibility (Guindon, Green, & Hanna, 2003; Hook, 2004b). Some of the focus areas addressed by critical race theorists relating to the moral dimension include their awareness of humanism, sovereignty, and moral orthopaedics, among others.

Humanism indicates structures of thought which attend to people, their principles, and abilities (Hook, 2004c; Mezzich, 2007). It also refers to human pursuits, desires, and welfare (Hook, 2004c). Humanisation refers to the process of instilling humanitarian deference and compassion. To humanise suggests a process of civilisation, in harmony with an attitude of humanity (Hook, 2004c). When minds and *souls* come to be viewed as the objects of dominance, they became the recipients of punishment. Certainly, within this process during history, the body became less of a container of castigation. As such, anguish was distributed via symbols throughout society as opposed to overt corporeal torture. Consequently, power themes such as objectification, individualisation, soul/mind, and humanisation surfaced from the era of humanist reformation (Hook, 2004c).

Sovereign refers to a monarch who implements dominion (Mbembe, 2000). For Foucault, use of the term *sovereignty* refers to pre-modern power styles organised in such as way so as to afford the sovereign the authority to chastise the offences of reprobates with fierce, bodily, and demonstrative energy (Hook, 2004a). In response, psychology's aim became that of disciplining the effects of sovereignty. Disciplining suggests endeavours to amend, restore, shape, or remodel the psychical and/or psychological aspects of the person, by employing therapeutic techniques to enhance the person's docility and capacity (Hook, 2004a). Disciplining, therefore, relates to moral orthopaedics. Foucault suggests that *moral orthopaedics* refers to the modification or deterrence of wounding or pathology of the psyche by means of recurring psychotherapeutic interventions and/or interest (Hook, 2004a). Alertness in terms of psychotherapeutic intervention and the dynamics associated therein may allow the clinician the opportunity to address these dynamics within the therapeutic process.

2.9 Conclusion

This chapter highlighted the theoretical composition of the present investigation. Here, the researcher built on the theoretical integrity of integrative theory and discussed the complementary ways in which epistemological constituents may be considered. Certainly, integrative theory was considered at length, culminating in a graphic illustration of the theoretical foundation of the study. This led the chapter

towards a discussion on the ways in which psychological theory is currently in a process of transformation. However, the discussion made a concerted effort to also consider the long-standing theoretical views on areas which significantly influence the scope of the current review. This chapter also highlighted the ways in which exploring race may be appreciated as a process of humanisation, as well as the ways in which psychopathology may be appreciated in the context of Africa. The next chapter will detail the research methodology applied in the present study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

The purpose of the research methodology chapter is to allow the audience the opportunity to appreciate the research process, thereby providing a view of the scaffolding of the study itself. In so doing, the research design is explored. The chapter also includes discussions on the structured, systematic process of literature reviewing applied within the study. Thereafter, technical aspects of the research process are explored, including the aims and principles of the methodology, as well as formulating the problem, collecting the data, evaluating the data, and analysing and interpreting the data. The researcher then provides a description of the way in which the data is presented, followed by the ethical ethos applied during the investigation. Finally, the researcher briefly describes the way in which the outcomes of the research will be disseminated.

3.2 Research design

The process of cerebrating the subject of this thesis was both intensive and extensive. While it may be possible to calculate the frequency of occurrences as regards African psychopathology in Africa, this view does not offer a comprehensive appreciation of exploring subjective views regarding psychopathology in Africa. The term *perspective* appears to feature at this stage (see section 1.7.1). Although the notion of perspective may be appreciated in diverse academic endeavours, the quality tacit to the experiential process of perspective appears best suited to a methodology competent in appreciating the verisimilitude of culture-specific reality. Thus, research methods aimed at providing exploratory and narrative perspectives regarding cultural views appear to highlight the diverse views contained therein.

While this transactional system was suggested in the theory of consensus, which underscores the sociocultural and political forces that construct socially accepted truths (Putnam, 1981), it appears to have experienced nominal research attention in

terms of African culture. The latter view is based on my personal observation concerning the limited academic material specific to the traditional African population in this regard. It appeared that literature (e.g. Nsamenang, 1992) suggested intra-cultural accord with regards to African perspectives of pathology, yet little formal research, specific to perspectives, appeared to have been available during the preliminary literature review.

Upon deliberating on a veritable methodological technique, it transpired that employing a specific research design would be of great consequence. As is often the case, diverse methodologies yield diverse observations. Agreement, therefore, should rest in which methodology is apt for specific types of research enquiry, as well as consensus with regards to the correct administration of the chosen methodology (Dane, 2010). The upshot of this intensive and extensive cerebration suggested a process whereby disparate and sparse data sources could be accrued and analysed (discussed in Chapter 1). Based on a process of elimination, it emerged that a systematic literature review with a methodological focus on research synthesis (Higgins & Green, 2008) would best suit the current investigation.

A systematic review of literature aims to gather as much research as possible, which corresponds to pre-specified eligible conditions, so as to respond to a particular research enquiry (Oxman & Guyatt, 1993). A literature review was selected as the methodology for this study based on the observation that studies regarding psychopathology are often disorder-specific rather than wide-ranging (Draguns & Tanaka-Matsumi, 2003), and region-specific rather than culture-specific (Dzokoto & Adams, 2005). Draguns and Tanaka-Matsumi (2003) recommend that research focus on linking discrete studies in such a way that greater understanding of psychological dynamics be available to academia. Literature reviewing appears competent in fulfilling this requirement (Cooper, 1998). This investigation therefore endeavoured to assimilate discrete studies in such a way so as to inform academia on the dynamics of traditional African culture, as a wide-ranging construct, in relation to psychopathology.

3.3 The systematic literature review

Practitioners, mental healthcare users, and investigators are suffused with excessive volumes of data and it is improbable that they will possess the resources, whatever these may be, to evaluate and analyse these sources and assimilate them into policy and/or practice. Systematic literature reviewing satisfies this need to an extent, by assessing, integrating and presenting research in a manageable format (Mulrow, 1994). Oxman and Guyatt (1993) further assert this methodology as employing unambiguous, systematic techniques which aim to reduce bias and thereby supply more dependable results from which findings can be prepared.

In systematic literature reviewing, Gough (2004) proposed that reviewed reports be methodically and critically appraised. This promoted an efficient administrative system where literature informed the research with regards to recording decisions to ensure that the data meet the scope of the review, describing and coding data so as to ensure systematic rigour, and analysing the data in such a way so as to warrant accurate reporting of the results. Higgins and Green (2008) indicated that, while this approach might appear somewhat simplistic, this process is extremely rigorous and laborious as the researcher employs a range of theoretical and scientific views to generate significance of the data. This process is best conducted using research synthesis (Thomas et al., 2004). In terms of research synthesis, Popay (2005) recommended that justification and in-depth analysis into the subject area be employed.

Vis-à-vis this systematic process, Hart (1998) suggested that the literature review be lucid, composed logically, and exhibit sufficient latitude of analyses within the investigation. In this regard, the researcher introduced an analysis of the researched literature. This was achieved by instituting awareness into the sequential topography of the subject so as to depict the manner in which the issue was typified and subsequently reconnoitred. Intrinsic to the sphere of PhD research is the notion that the thesis ought to be documented and tailored with an academic audience in mind (Hart, 1998).

In addition, literature reviews centre on hypothetical investigations, applied studies, research methods, and/or the results thereof. They also venture to integrate research findings, evaluate academic compositions, assess and develop networks of comparative topics, and/or uncover elemental ideas in research areas (Hedges & Cooper, 1994). At this stage, however, it appears pertinent to introduce the ideas of both integrative and theoretical reviews.

In the integrative research review, global conclusions regarding previous research are illustrated. This is achieved by analysing several independent studies that are deemed to attend to associated or duplicated premises. The reviewer resolves to expound on the current condition of literature, and also endeavours to underscore significant concerns which remain unresolved within the present body of research. The theoretical review is an alternative to the integrative review. This type of review expects to elucidate a specific occurrence and also to evaluate this occurrence with reference to the internal consistency, disposition, and breadth of the reviewer's academic forecast. A theoretical review includes a portrayal of key research which has been proposed or performed, reviews of applicable theoretical appraisals regarding well-established interactions, and occasionally the redevelopment or assimilation of conceptual ideas from diverse paradigms (Cooper, 1998). While the current study parallelled intimately with the integrative review accentuating the position of current literature, it also attached to the theoretical interface of dynamic influences. Both types of review are accommodated in systematic literature reviews that focus on descriptive material (EPPI-Centre, 2007). To gauge the worth of this thesis therefore suggested appreciating that the opus is based on the present body of literature as it expands knowledge based on employing logical reasoning, appropriate substantiation, and an analytical and reflexive position (Hart, 1998).

Furthermore, the literature review identified and evaluated appropriate data. This suggested exhibiting, comprehending, and evaluating all core ideas, assumptions, and methods. Thus, the review was not simply an uninterrupted composition, but rather a symphony of literature which systematically guides the audience through a collection of ideas towards the goal of the thesis (Hart, 1998). Implicit here was maintaining a connective thread through the research process. This connective thread extended beyond linear reasoning and implied adopting a philosophy of science.

A philosophy of science refers to any array of tenets which identify that which is regarded as satisfactory information/education. In science, as in life, there are several acknowledged philosophies. This is discernable as philosophy is emergent, variable, and germinating in nature – existing purely to expand the current knowledge base (Dane, 2010). From the vantage point of this methodological stance, a prerequisite in the scientific inquiry included profiling the components suggested in the investigation. Of necessity was to qualify conceptual definitions and therein exemplify the degree of abstraction, or frequency of events, to which they pertain. In an attempt to foster qualitative depth in research, the reviewer adjudicated which conceptual definitions represent the components of interest (Cooper, 2009; Savin-Baden & Major, 2009). An example of a component in this investigation included the notion that primary language was suggestive of culture. As a result, it was palpable that a review generated by a different researcher may be dissimilar based on the definitions s/he chooses, as well as the literature s/he has access to. This underscores the dynamic nature of literature reviewing and intimates the effect on research of the reviewed collection of data. While it is possible to repeat the investigation, or update the review, outcomes may vary based on the researcher's process of assigning significance to the data (Higgins & Green, 2008). This faculty of reasoning, convoluted with intellectual and talent-laden debates, often point to common discussions evident in critical philosophy and were germane to the current dialogue.

Cooper (2009) indicated that a familiar protestation to the presentation of methodological directives for literature reviews was that such systematisation may asphyxiate creative resources. This is farcical. Meticulous standards will not engender perfunctory and infertile research reviews. The knowledge and insight of the researcher would undoubtedly be confronted in such a way so as to capitalise on or construct openings to acquire, appraise, and study information exclusive to each topic (Cooper, 2009). Accordingly, Cooper indicated that the restricted focus implied in a literature review, that is to say by being confined to published literature, did not suggest the impingement on imagination. Indeed, the reviewer's resourcefulness and inventiveness became animated during the stages where sense-making (Abolafia, 2010) was applied to the data, and specifically when interrelated concepts were analysed in the literature. What becomes apparent during the analysis of a review is that the collective results of literature are often more composite in nature than

considered in a separate study. The reflexive process of discovering variables, which stimulate a relation or produces diverse plots, are imperative in research synthesis (Cooper, 1998). This description in itself did not lend itself to appreciating the process of selecting a literature review as the methodology.

Petticrew and Roberts (2006) summarise the stages of conducting the review. The first stage would be to define the type of study (i.e., the literature review). The second stage delineates the process for selecting literature to include in the review and thereby apply the search strategy (Higgins & Green, 2008). For this investigation, the electronic databases available to students of the University of Pretoria, Google Scholar, hand-searching for key resources, and asking personal contacts and experts in the field for relevant authors, was used to source literature. During the third stage, one screens the material based on the taxonomy of the review, as well as describes these studies in order to map and refine the literature review. Once the process of gathering and describing the research is conducted, the researcher begins the fourth stage of the review and appraises and synthesises the data. This included an appraisal of the quality and relevance of the data; synthesising the findings of the studies; drawing conclusions and making recommendations; and developing the final report (EPPI-Centre, 2007; Savin-Baden & Major, 2009). It is of critical importance to bear in mind that the current systematic literature review is descriptive in nature. Furthermore, the descriptive nature of the method is defined by a structured process as described by EPPI-Centre (2007) and Higgins and Green (2008). The systematic literature review may, therefore be appreciated as a methodology that synthesises research by utilising processes such as descriptive and structured reviewing.

3.3.1 Descriptive reviewing in systematic literature reviews

Studying an experience in order to copiously characterise it, or to discriminate it in contrast to discrete experiences, is identified as descriptive research. The aim is to encapsulate the essence of an entity and to depict the manner in which that essence transforms in due course, or based on the context of that entity. Descriptive research may also be employed to investigate variation in terms of progressive trends as compared with long-standing trends (Dane, 2010). This type of study illustrates characteristics of a populace, and highlights the health condition and/or specific traits

of a sample from a delimited population (Higgins & Green, 2008). Cooper (2009) further indicated the call for more interest in descriptive research reviewing. He affirmed that a research review is advantageous in that many social scientists experience time restrictions, thereby denying them the opportunity to remain current as regards primary investigations, save for the diminutive studies in which they retain specific interest. In addition, descriptive research reviewing allows clinicians to appreciate the dynamics of natural events which are often observable in therapeutic processes. Dane (2010) defined a natural event as those occurrences which are not manipulated exclusively for research investigations. Natural events, such as population-specific perspectives as suggested in the current study, contributed significantly to the content of this investigation. The previous statement, as may be experienced, was not hassle-free.

In categorising the research method for this thesis, it became apparent that particular stumbling blocks would inevitably be encountered. The most pronounced drawback in employing descriptive literature reviewing was congruent with the threats-to-validity method. Cooper (1998) explored this drawback in depth and placed substantial focus on the manner in which diverse reviewers may elect to catalogue dissimilar procedural features. Nevertheless, the descriptive style to reviewing does not require a great deal of literature assimilation, nor does it require a significant quantity of conjectural assessment. Formulating a decision concerning the danger to validity, commonly termed poor statistical power, was a good case in point. To obviate this obstacle, the reviewer generated a list of possible threats to validity in order to maintain awareness of these threats, and also continuously describe, where possible, the methods used for primary investigations (see Cooper, 2009). In the current investigation, these included generating specific operational definitions, for example. This is elaborated on further.

The current investigation fell within the field of qualitative evidence synthesis. Here, evidence from individual qualitative, and sometimes quantitative, studies were integrated in order to facilitate further insights into a phenomenon. This was achieved by relating perceptions and results from various resources which converged on the same area of interest. This methodological aspect can therefore be appreciated as an inclusive investigatory process in itself but is often considered to be part of either

meta-analyses or systematic literature reviews. Often this type of investigation is interpretive in nature and requires transparency in process by way of proper methodological description, as well as appropriate referencing techniques. Of great significance was not merely to construct a description of specific perspectives, but also of the reasons people possess these perspectives and the consequences of holding these perspectives (Popay, 2005). To therefore differentiate this seeming essay-like process from stringent methodological process implied deliberating on the structural aspects of research reviewing.

Employing structure to expound the rationale for the composition to be articulate, one ought to make certain that the method of recording is constant and remains dedicated to the topic. The discrete fragments of the thesis may be viewed as separate elements of an argument. Thus, each element possesses adequate and essential data which, when merged in the correct structure, forms an argument (Hart, 1998).

Structure configures and conducts a review. The following structure was applied and allowed the reviewer to evaluate the competence of its appliance. Primarily, the reviewer ascertained the expense of the claim. Here, he reflected on the claim's credibility, feasibility, coherence, intelligibility, and effect. Thereafter, the primary research was reviewed in terms of its evidence. The reviewer accordingly considered aspects of reliability, quantity, reproducibility, significance, and dependability. Third, the reviewer concerned himself with data relating to the information. These included contacts, time intervals, particulars, and resources. Subsequently, the merits of information were essential. The reviewer needed to take into account the suppositions of the research, vigour, language, and level of association. This allowed the reviewer to focus on the penultimate structural process, the supporting structures. At this stage, he weighed up the problem perception, its acceptability, resilience, and validity. The conclusive structural element entailed an examination of the reasoning in the literature, corroboration, outcomes, and plausibility (Toumlin, 1958). These were essential elements of the present systematic literature review.

3.3.2 Aims and principles of the systematic literature review

The following goals were regarded as points of origin. The first goal was to demonstrate the structural analysis of research. Thereafter, flaws were uncovered within various arguments in the reviewed literature. Finally, the opportunities made available as regards the current review's position were exhibited (Hart, 1998; Ridley, 2008; Schmidt & Smyth, 2008). Subsequent to processing the claims posited, consideration was afforded in view of the support employed to validate those claims. The objective at this time was to illustrate deficient substantiation by either unearthing prejudiced, extraneous, and/or unsatisfactory evidence. The categories that were employed in argument analysis included reflecting on whether the data was based on hypothetical examples, hypothetical scenarios, statistics, testimony, personal experience, and/or examples. The purpose, of course, was to recapitulate the advantages of the current critique. This allowed the reviewer to construct his own outlook during the investigation. He thereafter illustrated the dilemmas as had transpired in the research, including disparities in analysis, incorrect use or basis of evidence, or erroneous consequences and findings (Hart, 1998).

To consolidate the methodological approach, it ought to be observed that a consistent and clear structure was utilised. Relevant terminology was defined, using lucid illustrations. Where appropriate, adequate justification was provided and assumptions were authenticated by formulating implicit arguments explicitly. Only dependable assumptions without explicit value judgments were presented, and anchored, in an analytic approach. The review also averted fallacies such as oversimplification, vagueness, and disoriented accuracy. This was achieved by using trustworthy, recognisable data from freely available spheres that were authentic and appropriate, not inconsequential (Hart, 1998; Ridley, 2008). This further supported the primary use of published literature. In effect the reviewer considered the process of composing the review to be an opportunity for exhibiting academic execution and erudition.

3.4 Criteria for eligibility of literature

This sections details the criteria for inclusion of literature in the study. As such, research parameters are defined. These are accounted for in the eligibility criteria,

which comprises the inclusion and exclusion criteria. Higgins and Green (2008) provide specific guidelines for considering eligibility criteria with regards to including or excluding literature in systematic literature reviews. These guidelines allow the investigation to be repeated and/or updated (Green et al., 2008). Based on their recommendations, the eligibility criteria for this study included research relating to psychological distress in African culture, clinical psychology, and the South African context.

3.4.1 Inclusion criteria:

- Published studies from 1980 onwards – in order to account for the researcher's observation of the increase in published literature since 1985 during the preliminary review (see Figure 6.2.), thereby increasing the potential for a larger data pool with regards to African perspectives. Published studies, here, refer to formal avenues such as books, articles, and theses from libraries and academic journals for example;
- Studies that were justifiably, if not overtly, relevant. This implied including literature that may predate 1980 if it enriched the review, or if literature exploring specific ideas could not be located post-1980. This practice is acceptable according to Higgins and Green (2008);
- Studies which explored subjectivity, including both the identification and exploration of psychiatric diagnostic criteria (i.e. symptomatology). This implies *exploration* of the disorder;
- Studies which focused on African perspectives of psychological distress;
- South African literature on culture and psychological distress;
- Literature with regards to culture-bound syndromes in Africa and South Africa;
- Literature focused on integrative theory;
- Literature which promoted new understanding with regards to the clinical context; and
- Studies relating to psychopathology in terms of: culture; diversity; subjectivity; and a bio-psycho-social-spiritual appreciation.

3.4.2 Exclusion criteria:

- Informal (that is, unpublished) literature;
- Studies which were older than 30 years (1980) unless they were justifiably relevant – as indicated by the inclusion criteria;
- Studies which focused primarily on identifying psychiatric diagnostic criteria. This implies diagnosing disorders, *without exploring* their dynamics; and
- Literature which evidenced maleficence (e.g. negative stereotyping of participants, or data which contraindicates the philosophy of the South African constitution).

It should be noted that the majority of all studies located were retrospective in nature in that past experiences were addressed. However, this did not preclude including prospective studies particularly as eligible criteria included meta-analyses (Light & Pillemer, 1984).

Higgins and Green (2008) indicate that perceived outcomes of the prospective study should not establish eligibility criteria. However, a well-formulated research question will suggest specific outcomes. It was therefore urbane, at the outset, to list probable outcomes for the current study that appear to be meaningful to the audience and/or interested parties. According to Gough (2004), probable outcomes are merely ideas which the researcher may have based on a preliminary review of some of the literature which, according to the EPPI-Centre (2007), may not actually transpire during the research process. An analysis of this possible outcome may be extremely constructive to various disciplines (EPPI-Centre, 2007).

Initial notions of possible outcomes for this investigation therefore included a more integrated understanding of psychopathology from a South African perspective and the role of African culture in understanding psychological distress. Higgins and Green (2008) indicate that non-accomplishment to achieve these outcomes during the study should be explored in order to inform the audience, as well as to recommend directions for further research. This will be explored in detail in Chapter 6. Should future research be considered, Gøtzsche, Hróbjartsson, Maric, and Tendal (2007)

suggest that short-term, medium-term, and long-term outcomes be developed. This was generated during the study itself and also related to primary and secondary outcomes which were generated as a result of the study. This is also discussed in Chapter 6. The aim, consistent to the guidelines of the EPPI-Centre (2007), was to promote diversity in ideas by allowing for variability in the literature so as to procure a comprehensive data pool.

In addition, Furlong and Oancea (2007) indicate that one should focus on literature that relates to the research design of the study being conducted. This improves the dependability of the outcomes. This was in keeping with the methodological application in order to ensure that the design remained appropriate. Furthermore, the foci of the literature consistently related to responding to the research question and these foci were considered as outcomes as the overall general influence of substantiation was based on all of these factors.

Higgins and Green (2008) recommend that review readers be aware of the temporal indicators suggested in any systematic literature review. The literature search date began on 15 June 2009 and was completed on 31 January 2011. As such, the current literature review is considered to be up to date as of 31 January 2011. The current literature review search therefore spanned approximately 18 months, and each literature source (e.g., Google Scholar) was accessed at least once a month.

3.5 Doing the systematic literature review

In this section, the researcher describes the systematic process of reviewing. The section describes the way in which the review process began. The pre-writing phase of the systematic literature review included a synopsis of current effort as regards the subject matter. This was followed by a critical appraisal of earlier research and selected findings relating to research already conducted on the topic. This allowed for the selection of a suitable structure for the review (Hart, 1998; Ridley, 2008; Schmidt & Smyth, 2008).

Furthermore, in order to preserve the systematic process, a taxonomy regarding the literature sourcing and reviewing was applied; this took place during the data

collection stage of conducting the review. Here, the researcher considered the reviewed literature, which included various literatures pertaining to African perspectives on psychopathology. While the focus was on literature regarding clinical psychology in relation to African culture, associated literature was reviewed based on the process of the systematic literature review.

As the current study served as a literature review, and utilised post-postmodern integrative theory as its framework, the research process remained fluid (Bryman, 2001; Terre Blanche & Durrheim, 2004). This taxonomy therefore proposed a foundational structure of the research. Hence, the current systematic taxonomy referred to the central fields of literature, while related literature augmented the central fields and served as peripheral sources of information. The implication here was the warranted exclusion of literature which did not stimulate the understanding of the central fields of literature.

3.5.1 The stages of the systematic review

While methodologists may diverge in understated aspects of the research process, the core stages of a research review are agreed upon with sufficient accord (Cooper, 1998; Swales & Feak, 2009; Schmidt & Smyth, 2008). There are five stages in systematic literature reviewing. The first stage of systematic literature reviewing is the problem formulation stage. The second stage is the data collection stage, followed by the data evaluation stage. The fourth stage is the analysis and interpretation stage, and the fifth stage is the presentation stage.

3.5.1.1 *The problem formulation stage*

In many ways, primary research possibilities appear to be almost boundless. However, secondary researchers may only investigate data which are present in the literature. While novel topics and themes may be explored during primary research, unresearched notions are most likely unsuitable to be incorporated into a review except under the circumstances where the unresearched ideas have generated significant awareness in a field, or because the idea has been comprehensively explored in theory (Cooper, 2009; Ridley, 2008).

Straightforwardly, the research problem comprised the characterisation of variables, as well as the justification for associating the variables to each other. The *raison d'être* was that various feasible or perceptive reflection(s) unearthed during the study were potentially of significant consequence (Cooper, 2009; Swales & Feak, 2009). The consequence of the present investigation, therefore, was its probable aptitude to develop hypotheses. Furthermore, according to Hart (1998), literature reviewing illustrates incorrect notions and describes the problem; recommends a solution to the problem; explores the advantages that would transpire if the proposed solution were implemented; and recognises and rebuts potential protestations to the proposed solution.

3.5.1.1.1 *Various functions in literature reviewing*

A significant latent disparity may manifest whilst performing the problem formulation. To begin with, one should foresee the manifold processes which may commence in utilising an extensive problem definition. Here, the reviewer might discover that the operations employed in preceding pertinent literature have been either fairly restrictive or have been conceptualised in a distinct manner. Both of these prospects may pose challenges in determining their applicability for inclusion in the review (Cooper, 2009; Ridley, 2008; Schmidt & Smyth, 2008). This was significant to an investigation such as the present study in that definitional agreement appears complex. Consider, for example, that some research suggests that multiculturalism and African culture are equivalent terms, while others do not agree with this view; or in empirical studies, mixed cohort groups are implied as specific cultural groups. According to Cooper (2009), in such cases, it is necessary to limit the conceptual foundations of the review so as to ensure that the scope of the review matches the operations as closely as possible. In a sense, this suggested finding a complementary balance between the two, the outcome of which, as Cooper (1998) indicated, facilitated wide-ranging deductions that the data affirms. Translating this view to the context of the current investigation, applying broader definitions of primary terminology (e.g. African) broadened the data pool of literature retrieved during the search.

Of acute value was the reviewer's re-appraisal of the connection between the degree of definitional abstractness of an idea and the characteristics of the functions that primary researchers have employed to identify it. Although re-classifying the scope of a problem is sometimes scowled upon in primary research, this litheness in definition reconsideration was crucial, and is often extremely constructive in secondary research (Hedges & Cooper, 1994).

As literature reviews habitually unearth information which have been moulded in conceptual frames that vary from the reviewer's frame, these reviews should also take account of constructions germane to conceptions of interest to the reviewer. Where appropriate operations relating to diverse theoretical constructs were recognised and considered for incorporation in the literature review. Indeed, diverse hypotheses and models which concerned comparable operations were frequently utilised to exhibit the constitution of phenomena (Cooper, 1998). It therefore transpired that issues such as the tension of opposites, for example *what is African*, became central to particular arguments in the review. Furthermore, the inclusion of long-standing literature relating to concepts that augment knowledge was necessary to consider as they justifiably enhanced the robustness of the findings.

According to Hart (1998), all aspects of the systematic process should endeavour to formulate suggestions and execute specific operations. These operations included compiling an account of prior literature, including the unearthing of chief ideas, descriptions, and theories. Moreover, reflecting on the manner in which concepts were cultivated and operationlised, and recognition and illustration of issues which other scientists deemed significant. The latter position suggested including a personal account of what is considered to be incorrect in previous literature, and recommendations regarding ways in which difficulties may be addressed. Here, the research being conducted was one of the proposed solutions to existing problems. The reviewer explicated the advantages from consideration of the proposed recommendations and provided a rebuttal of potential protestation of the proposed recommendations. This indicated suggesting appropriate terminology, including substitute descriptions and ideas, as well as reviewing the methodological dilemmas in essential references. During the systematic process, it was also important to provide a review of the manner in which methodological suppositions and central definitions

were operationalised in the literature. As one proceeds in the investigation, the review must be endowed with summational markers indicating the direction of the discussion. Accordingly, the accumulated deductions connected the researcher's conceptualisations with his discussion in a systematic process (Hart, 1998). In this vein, a comprehensive, inclusive data exploration permitted the researcher to carry out the review with extended operational commission (Hedges & Cooper, 1994).

Hence, the aforesaid entailed composing a persuasive justification of the review, and in so doing lent itself to the appreciation of some occurrence. The core position here was to recognise that all reference work had historical substance, and it was this substance that set the model for contemporary research (Hart, 1998). This was particularly relevant to the current research project. In terms of literature reviewing, the point of origin and destination can be poles apart. The reviewer therefore anticipated the unanticipated (Hart, 1998; Ridley, 2008).

As maintained by Hart (1998), the central features that typify effectual critique include acceding or supporting a view, or challenging its utility by means of appraisal of its fortes and flaws. One may then justifiably forfeit present notions, or validate why certain aspects of a view ought to be maintained or abandoned. The idea is to challenge opinions, as opposed to researchers, in an attempt to afford prudent, respectful, and substantiated appraisal. In so doing, the researcher recognised the value of a personal analytical perspective and distinguished possible motives for electing specific works for critiquing, and identified the limitations, in his own assessments. It was valuable to also choose constituents from current discussions and reconceptualise them into an integrated gestalt, thereby indicating an innovative approach to research. Suggested herein was discovering errors in research by detecting misleading notions, shortfall of substance, deficient proof, and/or inadequate tenability. This was coupled with the identification of inaccurate critique proposed by other researchers (Hart, 1998). In effect, the reviewer presented a considered critique and in so doing promoted the value of the original reference and rationale for excluding the critiques imposed on it.

3.5.1.1.2 *Moderating conceptual relevance*

As discussed previously, two stimuli on investigations considered appropriate include the conceptual definition and degree of abstraction thereof. However, a concourse of other aspects exerts influence on one's consideration with reference to the vetting of data. The wide-ranging proposal relates to embarking on the literature exploration with a wide-ranging definition. In resolving the adequacy of operations regarding inclusion contained by the wide-ranging model, it was imperative that the researcher continue to be undogmatic in his approach as far as possible. For the duration of the data evaluation, the researcher was permitted to reject particular operations attributable to deficiency in relevance and/or probable contamination in abstractness (Cooper, 1998; Swales & Feak, 2009).

Nevertheless, during the problem formulation and exploration stages the researcher was especially inclusive albeit some information could potentially not be applied in the investigation. This was done to inhibit the grievous process of salvaging lost portions of a semi-comprehensive data search which would then have to be regenerated (Cooper, 1998; Machi & McEvoy, 2008). To allow the audience access to the excluded data (see section 5.18), a general view of the literature was included, explicating the reasons for exclusion (Cooper, 2009).

3.5.1.2 *The data collection stage*

The intended population in this study (traditional Africans), comprised those groups, persons, and/or constituents that the researcher anticipated to characterise in his investigation. Often, reviewers will be unable to retrieve data relating to an intended populace as it is often an unreasonably expensive process, and/or accessing the data is extremely problematical (Cooper, 1998). Open literature sources were therefore used for the current investigation.

3.5.1.2.1 *Locating literature*

Primary avenues included making use of academic journals and libraries. Furthermore, cross-referenced data were consulted if relevant information happened

to be restricted. This is often termed the ancestry method and straightforwardly indicates consulting sources from the primary research reference list. As such, the ancestry method refers to reference tracking. Primary avenues were therefore not an exclusive data resource devoid of persuasive validation. Information from personal libraries, such as the researcher's personal collection of books and journals, institute bias by disproportionately representing the theories and outcomes that are contained in the researcher's preferred data reference nexus. In addition, absolute use of the ancestry method (i.e., reference tracking) will introduce bias as well. Either of these techniques was not used exclusively, as this would have introduced biases into the research without underscoring new-fangled insights into the literature (Cooper, 2009; Machi & McEvoy, 2008). It was therefore advantageous to use electronic journals and important to follow the extensive areas they implied. This allowed for heterogeneity in data collection.

For this investigation, the available electronic databases (Wiley Online Library; Springer; Elsevier; Ingentaconnect; PubMed; Sagepub; and Questia), Google Scholar, hand-searching for key resources, and asking personal contacts and experts in the field for relevant authors, was employed to resource the literature. Literature was sourced using the following keywords: African perspectives; indigenous views; cultural psychopathology; South African perspectives; African mental illness; idioms of distress; culture-bound syndrome; cultural psychiatry; Africa; clinical psychology; and cosmology. These terms were used consistently, but were also used simultaneously (e.g., Africa + clinical psychology).

3.5.1.2.2 *Abstracting and indexing services*

Secondary resources ought to construct the vertebrae of a systematic literature review. This is due to the need for secondary resources to include and express data from the closest sector to all applicable research available in the public domain. These references indicated very slight restrictions with regards to the requirements for an investigation to achieve access into the academic sphere (Cooper, 1998; Swales & Feak, 2009).

Abstracting and indexing facilities relating to the social sciences have demonstrated to be of particular assistance to the literature reviewer. These facilities converge on specific areas of knowledge, and all references in the primary channels are indicated in the system. This process proves to be extremely rigorous and the time consumption implied herein is often a noticeable limitation of employing these facilities. Often, primary studies take approximately four years to complete and reviewers will only have access to these investigations once they are in the public domain. It is therefore useful to mention upcoming studies which could not have been included in the review (Cooper, 2009; Machi & McEvoy, 2008). An example of such a resource is the DSM-5, which is currently being researched and compiled.

3.5.1.2.3 *Determining the competence of literature searches*

There are no universal guidelines as to the number of, or which, resources to include in a literature review. The apposite sources were utilitarian based on the reviewer's access to resources. A useful directive included utilising diverse channels of information in order to facilitate including a lesser amount of unidentified bias in the literature search. If the various investigations, from diverse channels, share dissimilar biases then other reviewers conducting similar studies will be able to replicate the review. The statute implied here exemplifies the scientific condition of replicability (Cooper, 1998; Cooper, 2009; Swales & Feak, 2009).

It may be argued that focusing on formal research probably constructed a collection of research that overstated noteworthy findings. Alternatively, one may counteract this view by considering that formal research endured meticulous methodological evaluation by reputable investigators and is most likely of premier quality (Hedges & Cooper, 1994; Ridley, 2008). It was for this reason that this study mostly included research published in the academic avenues available to students at the University of Pretoria.

3.5.1.2.4 *Legitimacy issues*

As literature exploration aims to investigate prior research and personage or constituents appropriate to the subject being investigated, the researched

populations(s) must be attended to during the research process in terms of competence exhibited in the associated investigations. Thus, the researcher needed to question how the selected study varies from other studies, as well as how the constituents in the selected investigation were at variance with constituents in other investigations (Cooper, 1998; Machi & McEvoy, 2008; Swales & Feak, 2009).

A threat, relating to the soundness of the data, occurred during the data collection period where the researcher was unlikely to include all of the applicable studies relating to the subject of interest. Once more, the researcher gained access to as many channels as possible to restrict bias. This was considered within the context of the restrictions imposed by logistical and functional operations, such as financial implications (Cooper, 1998; Ridley, 2008).

In considering legitimacy issues, a subsequent threat existed. During data retrieval, the populace or constituents represented in the investigations may not be representative of the populace or constituents intended in the reviewer's target population. Certainly, the choice of units investigated in the primary researcher's study was outside of the reviewer's control; however the reviewer was compelled to illustrate the variance circumspectly and validate the findings based on the variant samples (Cooper, 2009).

3.5.1.2.5 *Protecting legitimacy*

The central defence in opposition to compromised legitimacy, as regards data collection, stemmed from an extensive literature search. Although the rule of diminishing returns certainly applied in this regard, an inclusive data investigation must incorporate a bare minimum of one major abstracting facility, and the bibliographies of prior investigations. A meticulous search justified a proportionately assured review. Accordingly, comprehensive studies which reference similar data fostered comparable findings due to the accuracy in reporting the data (Cooper, 2009; Swales & Feak, 2009).

Consider that a reviewer's manuscript ought to be unequivocal with regards to the process of retrieving studies. S/he must therefore take account of the source, year(s)

of study and/or publication, and fundamental phrases included in the search. Excluding this data offers the audience nought opportunity in certifying the review's findings with the findings acquired in other reviews (Hedges & Cooper, 1994). Researchers should also put forward any indicators of possible biases in retrieving specific sources which are accessible to them (Cooper, 1998; Ridley, 2008). The ancestry method was one such potential bias available to this study.

3.5.1.2.6 *Judging the quality of research*

With the current state of affairs in literature reviewing, numerous dilemmas concerning value decisions are present. In fact, these vast ranging difficulties are probably closely associated with the reviewer's particular biases. Perhaps it is to be expected that impartiality remains a subjective property whereby the (dis)interest in a topic defines what is, or is not, a valuable investigation (Cooper, 2009; Swales & Feak, 2009).

Critically reviewing the global value of an investigation necessitated the assessor's consideration of numerous aspects. As a result, the most viable opportunity existed in detecting two sources of dissent in the assessor's decisions. The first was to be deliberate on the value he assigned to various design features, and secondly, the resultant point of view regarding the competence level between the design standard and the specific investigation (Cooper, 1998). Thus, a concerted effort to appreciate the methodological framework and ontological nature of the literature presents the review audience with a view of the way in which the reviewer assigned weight to specific investigations.

Moreover, the dependability of decisions in literature reviewing may perhaps be additionally augmented by including extra reviewers (Hedges & Cooper, 1994; Ridley, 2008). Within the scope of this investigation, and outside the scrutiny of the study's supervisor, the best reviewers appear to be the wider academic community, as well as potential reviewers aiming to update the review. Furthermore, clinicians may comment on the results and the way in which the review themes correspond with, or counteract, practical experiences. This was a position propagated by Dane (2010). It was therefore anticipated that some of the most valuable feedback regarding this

investigation will transpire once the academic article is published, thereby allowing the wider clinical audience the opportunity to respond to the review.

A priori exclusion investigation in opposition to *a posteriori assessment of research* is every so often at variance. The research of conformity as regards research value and the function of preference during the assessment process reveals occasions in which subjectivity infringes on efforts to achieve agreement. In the context of the current investigation, this potentially includes disagreement with regards to worldview. Thus, the subjective nature of defining *African* was often a subjective interpretation. This position is significant as there are substantial disputes concerning whether or not a priori views of data value should, or should not, have be drawn on in order to reject literature (Cooper, 1998). There is merely one condition in which a priori omission of research is probably proper. This is when the norms for including/excluding literature are delimited prior to the literature investigation where the rules are invariable irrespective of the reviewer's inclination. In addition, within this process, the data pool was adequate to allow the reviewer to sufficiently support all general findings. In the majority of situations, allowing the data to inform the study proxied an exploratory process for the inclination of the researcher (Cooper, 2009).

3.5.1.3 *The data evaluation stage*

Data evaluation in this systematic review entailed qualifying, or disqualifying, characteristic data aims for inclusion in the inquisition. It was required that this pursuit be carried out notwithstanding whether data points represented the result of the sample population or the findings of the investigations. Data appraisal necessitated the formation of norms for arbitrating the technical competence of the way in which the data were collected. The investigator was required to explore all of the prospective effects on the data points which may have facilitated recognising some of these intricacies as extraneous to the study at hand (Cooper, 1998; Swales & Feak, 2009).

3.5.1.3.1 *Appraisal assessment in scientific inquiry*

In a literature review, a renowned rationale for dispensing with data pertains to the soundness of the investigation's methodology. Hence, the reviewer concluded if

primary studies were accomplished assiduously to the extent that the outcomes were regarded with sufficient dependability. Accordingly, the research reviewer was permitted to make a distinct judgment to include or exclude specific investigations, and to make continuous judgments to illustrate the degree of credence in the reliability of various investigations (Cooper, 1998; Schmidt & Smyth, 2008).

When the reviewer deemed certain research as unconstructive, it was inadequate to generate equally unconstructive discussion in opposition to that research. Thus, one deficient line of reasoning did not counter another equitably erroneous line of reasoning (Hart, 1998). With an inductive writing structure, as was applied within this study, the reviewer collected research, enquired about the occurrence, and then categorised the data. Thereafter, he reviewed the searches for configurations in the literature and proposed prospective theories. Subsequently, theories were developed and researched until they were compared with other configurations and theories (Hart, 1998; Machi & McEvoy, 2008).

It is also valuable to reflect on the requirements of the audience. Here, the reviewer must question the capacity of information regarding the topic which one can assume the audience possesses; the components of data the audience may be looking for; their probable response(s) to the investigation; and which responses will best suit potential enquiries, as well as what the best line of reasoning will be (Hart, 1998). Certainly, this is variable based on the reader's interest; the context; and the sociocultural environment s/he is in. However, these constituents lay the foundation for preparing a review suited to meet the wider audience's needs. Certainly, amongst others, considerations regarding the present review included the academic nature of the thesis, the clinical value attached to the content by the researcher, and the sociocultural applicability of the interpretive material regarding culture in a rapidly transforming South Africa.

3.5.1.4 *The analysis and interpretation stage*

In an attempt to provide a central point of reference regarding the literature included in the literature review, pertinent information regarding the literature was consolidated and tabularised. The tables are listed as Appendix A (coding sheet –

literature details) and Appendix B (coding sheet – themes), but additional observations regarding trends in the literature will be discussed in Chapter 6.

The primary decree in composing a literature review coding sheet was to consider any data that may have held the slightest prospect of being applicable to the study. On instigating the literature search, the researcher was careful to record specific detail of the literature as it is exceptionally complex to recover original data from research studies which have not been previously recorded on the coding sheet. It was relatively uncomplicated to initially take account of research that would probably be excluded from the study (Cooper, 1998; Ridley, 2008). To record and code the data referred to the process whereby a durable duplication of the observation was recorded. Coding thus necessitated assigning meaning to the examination (Dane, 2010).

In literature reviews, research must take particular care to incorporate certain data from the primary research investigation, where possible. At the outset, data regarding the credentials of the primary research was recorded. This included recording the details of the authors, the source of the literature, the date of publication, and the information relating to the channel of detecting the data (Cooper, 1998; Ridley, 2008; Swales & Feak, 2009). The current investigation, incorporating descriptive reviewing, did not necessitate the exclusive use of strict empirical design; however a polished version of the original coding sheet which summarises the reviewed literature is available (Appendix A and Appendix B). Appendix A details the key characteristics of the reviewed literature, while Appendix B lists the prominent themes in the literature. The key words were used to identify literature to be included. Each literature source was read through at least twice. During each reading, central ideas were listed on the coding sheet under the heading ‘emerging themes’. Ideas that related to these themes, but could not be listed under the emerging themes, were listed under sub-themes. As suggested by Braun and Clarke (2006), the researcher placed emphasis on those areas which appeared to be highlighted across the literature. Phase one, according to the method described by Higgins and Green (2008), included coding the literature as they were searched. The scrutiny-based compare and contrast technique was applied. According to Strauss and Corbin (1999), this method indicates that the researcher employ constant comparison by conducting meticulous text analyses. During this process, the researcher questions the significance of the

information, as well as the ways in which in differs to other texts. In this way, the researcher is able to maintain the relevance of the actual data, without becoming engrossed in interpretations that do not directly apply to the text. The researcher records the data and assigns key words to each theme. The recorded keywords typically followed the word repetition method, which indicates that the researcher keep track of the number of times keywords appear within the data (D'Andrade, 1995). Thereafter, a number was assigned to each emerging theme and sub-theme: 0 indicated 'not significant', 1 indicated 'somewhat significant', and 2 indicated 'very significant'. Phase 2 followed the recommendations by Higgins and Green, as well as Braun and Clarke. Thus, the data was recorded on a spreadsheet and sorted, in ascending order, according to those themes that evidence the highest-to-lowest number of 2s, that is 'very significant', thereafter the number of 1s, and the number of 0s. This was the way in which the researcher progressed from coding the literature to extracting the themes.

It is of critical value to unequivocally affirm the particular conditions in which the utilisation of quantitative methodology is inapt. First, the central principle for employing statistical methods suggests that a sequence of investigations are detected, and investigated, which attend to a corresponding conceptual premise. Should the suppositions of a literature review not attest to this contention, then there is little motivation to consider cumulative statistics. Quantitative methods pertain expressly to statistical integrative reviews, not to literature reviews which centre on other objectives. Researchers should shy away from quantitatively coalescing research at a wide-ranging theoretical level than the audience would find informative and/or beneficial (Cooper, 2009; Swales & Feak, 2009). These views were consonant with the goals of this investigation (see Chapter 1) and could not therefore accommodate statistical analyses.

A major requisite was to encapsulate views in a manner that was impartial and just. Therefore, the reviewer did not presuppose that the audience was acquainted with the literature being presented. This process necessitated recognising, where fitting, the positions he (dis)agreed with. The reviewer was also congruent in his view, as feigning a view often distorts the reviewer's standing; so too does projecting an academic persona (Hart, 1998; Ridley, 2008).

While one needs to assert deficiencies in a discussion, the reviewer must also provide a structured justification as to the reasons s/he disagrees with a specific view. The reviewer must focus on the most important reasons, not merely lesser details. In so doing, s/he averts underestimating the investigation by including uncorroborated analyses and/or employing hypothetical illustrations. Hence, contesting arguments were performed responsibly by the use of well thought-out systematic appraisal (Hart, 1998). The literature review, as well as the discussion in Chapter 6, was divided into themes and sub-themes to further aid the systematic process (Higgins & Green, 2008).

The analysis of themes and sub-themes is relatively flexible, but is based on the guidelines by Higgins and Green (2008). In addition, one will certainly become aware that the analysis is rooted in the post-postmodern integrative theoretical framework. From this perspective, the analysis may be regarded as contextualist in nature (see Braun & Clarke, 2006). Certainly, the ideas presented in the thesis, and in fact throughout the research process, were reflected on (Higgins & Green, 2008). For this reason, a reflexivity section was explored in Chapter 6 (see section 6.6).

3.5.1.5 *The presentation stage*

In presenting the review, the researcher was obliged to consider the following aspects in each segment of the review: the introduction, the methodology, literature sourcing and retrieval, presenting the results, the discussion section, and directions for future research.

The introduction of the literature review calibrated the platform for the observations that were discovered in the research process. This section included a conceptual colloquium of the research problem, as well as an account of the magnitude of the problem. A number of disparities are evident in literature reviews when contrasted against primary research. Most evidently, referenced works in primary research are concise and are limited to a restricted volume of resources which directly address the central topic. Conversely, in literature reviews, research must endeavour to communicate an extensive chronological, or thematic, synopsis of academic and procedural efforts aimed at appreciating the research question. The present investigation focused on a thematic synopsis so as to appreciate the research question.

At this point, the researcher needed to enquire the origin(s) of the views associated with the problem, the philosophical and applied consequences thereof, the academic disputes regarding the significance and functions thereof, and the way in which existing theories envisage how concepts relate to, and associate with, one another (Cooper, 2009; Machi & McEvoy, 2008; Ridley, 2008; Savin-Baden & Major, 2009).

The methodology section of a literature review is noticeably dissimilar to the methods segment in primary research reports. Although the rationale in both are identical, that is to operationally illustrate the way in which the examination is performed, literature reviews are obliged to address a collective of features. To begin with, the reviewer was required to expand on the particulars of the literature investigation. Moreover, the reviewer detailed the years covered in searches employing the services of abstract, indexing, and bibliography facilities (Cooper, 1998; Savin-Baden & Major, 2009).

Recording keywords and references regarding the literature investigation was fundamental to the research methodology. It provides the audience with an unsurpassed indication a propos the coverage of the search and consequently the degree of credibility which may be consigned in the findings of the review. Sketching the literature exploration process informs the audience of the diversity of the search for data. One should also be aware that a comprehensive depiction of the literature exploration affords academia the opportunity to scrutinise the manner in which the reviewer approached the data, as well as the opportunity to attempt to understand the review alongside similar reviews, even though the findings may be at variance with each other. This dimension, therefore, aids in improving the review's proficiency to be replicated (Cooper, 1998; Swales & Feak, 2009).

The next subject that was engaged in regarded the conditions of relevance that were put into operation during the data investigation. Here, the researcher explored the criteria applied in determining the relevance of studies, whether titles and/or abstracts and/or full reports were necessary to investigate specific studies, and brief details regarding excluded studies. Based on this process, the audience is permitted to analytically appraise the reviewer's perception of the way in which concepts and operations correspond with each other. A great deal of academic discussion may concern the findings of reviews and the manner in which the reviewer resolved these

dilemmas. Certain members of academia will invariably unearth some of the inclusion criteria as especially wide-ranging, for example including operational definitions which they regard as extraneous to the study (Cooper, 1998; Ridley, 2008).

This disputation may be attended to by applying these peculiarities in considering prospective arbitrators or research findings. Yet other audience members may find that the reviewer employed, in their opinions, extremely limited operational definitions. This may direct their appraisal of the study towards further examination of excluded studies in order to ascertain whether the findings in the excluded studies may have affected the outcome of the current investigation. By and large, the inclusion/exclusion criteria illustrated the manner in which the reviewer elected to ascend from conceptions to operations. A thorough account of this method is pivotal to constructive academic and conceptual discussion as regards the reviewer's findings (Cooper, 2009; Swales & Feak, 2009). In the review section of the study, the researcher offered a précis account of the literature. This section therefore exhibited a combination of descriptions of separate studies and ties in several ideas regarding the gestalt of literature.

The discussion section of the literature review functions in the same way as is expected in primary research. First, the researcher offered a synopsis of the key findings of the review. An examination of how and why this review differs to other studies was essential. In addition, the researcher was required to explore the findings relative to the hypothetical and conceptual arguments outlined in the introduction. Where any of the aforesaid did not apply, a discussion concerning this process and context was incorporated into this section (Cooper, 2009; Ridley, 2008).

As a final point, a discussion considering the possible courses of primary research, as a product of the review, will be prolific to academia. Thus, the discussion section was applied to propose the substantive analyses of interactions, the foundations and/or outcomes of previous arguments, and creative directions for potential investigations (Hedges & Cooper, 1994).

3.6 Ensuring research quality

Owing to the extensive sources of social science data, the legitimacy and dependability of review conclusions cannot be presupposed. Reviewers undertake a myriad of verdicts during the research process, all of which has some influence upon the conclusions and/or the trustworthiness thereupon (Cooper, 1998; Ridley, 2008; Schmidt & Smyth, 2008). This holds true for most research. Hedges and Cooper (1994) therefore recommended that the research reviewer consequently be as rigorous in the methodological slant as is expected of primary researchers. One such area includes data appraisal. It should be noted that the appraisal process is ordinarily be conducted by more than one person and/or subjected to the inspection of a supervisor (EPPI-Centre, 2007). This enhances the dimension of quality assurance, increases the credibility of the research, improves reliability, and ensures that the research question is answered. Furthermore, coding and appraising should also be subjected to a team member (in this study, the supervisor) in order to facilitate comprehension, as well as to ensure applied consistency (Oliver & Peersman, 2001). In attempting to produce a reliable literature review, Dane (1990) suggested that the reviewer continuously remain faithful to the objective of the research.

According to Dane (2010), the foremost objective of a review is to contextualise present literature within the scientific outlook. The existing literature permitted one to establish the way in which the review augmented the present information status. This was often likened to progressive education in that the degrees of knowledge are expanded if additional knowledge is added to the current body of knowledge. Thus, the research did not aim to reinvent the wheel, but to add new dimensions to the function of the wheel, as well as to explore if the wheel itself remains functional. This process was facilitated when the reviewer placed the study into perspective and contextualised it in a way that depicts the current state of research as regards the topic (Dane, 2010; Machi & McEvoy, 2008; Ridley, 2008). Thus, the thesis considered the function(s) of the African perspective as regards psychopathology, as well as the applicability of current theories in relation to the accrued functions.

The next objective in ensuring research review quality was to steer clear of duplicating previous research efforts. This implies re-conducting research without

improving the current body of knowledge (Dane, 1990). As such, the literature review accounted for similar investigations which were conducted and the manner in which they differ to the current investigation. Finally, the researcher aimed to forestall or explain difficulties which other researchers have met. Thus, prior research served as a stepping-stone to avoiding potential drawbacks (Dane, 1990). An example of this is often present in the manner in which previous researchers operationalise abstract terms. By drawing on current literature to recognise problem areas, the researcher was better equipped to avoid similar problems (Dane, 2010). The secret to supplying quality to a review is to present a lucid and equilibrated portrayal of principal ideas, theories, and research germane to the subject matter of the investigation (Hart, 1998). This process is often complex, but may appear to be even more so should limited reliable data be available.

It is therefore also valuable to inform the audience when limited reliable data are available, especially if these data may be valuable to policy planners. The researcher should also indicate if selected studies carry a high risk of bias, and/or the rationale for population-specific investigation (Higgins & Green, 2008). The motive for focussing this study on a segment of the traditional African population was due to the apparently limited body of research focused on this population, and particularly their perspectives of psychopathology.

Another important aspect to include in research appears to be reflexivity. Reflexivity refers to a cyclical interaction between cause and consequence. In the domain of human science research, reflexivity is often employed in order to illustrate the bidirectional influences between the research and the researcher. Often, the researcher engages in self-reference narratives so as to challenge his/her influence on the data analysis and vice versa (Archer, 2007). As a result, the audience is able to assess the dynamic way in which the researcher interacted with the data. To contextualise reflexivity during the course of this investigation, one ought to note that the researcher continuously made notes of aspects of the literature which appealed, or influenced, him. This was done throughout the research process, and notes were made on the original coding sheet, as well as on the printouts of the indexed abstracts. The results of this reflexive process are comprehensively explored in Chapter 6.

3.7 Ethical considerations

Habitual in literature reviewing is the deferential handling of data. Abiding to this directive engenders exceptional academic standards (Hart, 1998). In addition, data analyses promote relative equipoise within the process of the research and should not be deliberated on as simply a medium of sagacity conceptualisation. Quality research involves more than the contribution of data, it also demands that resources be dealt with ethically (Dane, 2010).

In portraying research findings, illustrating research correctly was crucial. The accrual nature of moral conscientiousness remained during the entire research process (Dane, 2010). Furthermore, the researcher aims to prevent his study from possibly prejudicing the field of psychology (Dane, 1990).

In addition, the researcher is obliged to forestall others in misusing literature, and to inhibit possible literature abuse. Certainly, it is unrealistic to assume that one may regulate the manner in which the data are utilised. However, one should make every attempt to correct apparent inaccuracies. The ultimate objective of ethical research is to progress knowledge, regardless of the source (Dane, 2010).

It should be noted that meticulous care was undertaken to ensure that the study remained ethical. Although no human subjects participated in this study, ethical considerations were observed. Thus, the rights of the authors and publishers of the literature were protected. Three principles were stringently subscribed to, namely (1) the principle of respect for intellectual rights and privileges. Accordingly, accurate referencing techniques were employed to ensure that the owners of the original literature receive credit for their work. To ensure this, the sixth edition of the American Psychological Association referencing style (American Psychological Association, 2010) was used. This will also be extended to possible publications which may be cultivated as a result of this research; (2) the principle of nonmaleficence, in that great care was taken not to undervalue and/or misrepresent the work of authors; and (3) the principle of beneficence which functioned as the principal aspiration of the study in that clinical psychology, psychiatry, other clinical disciplines, and society at large (albeit vicariously or in the future) benefit from the

research with possible developments in the clinical field (Terre Blanche & Durrheim, 2004). Furthermore, ethical approval was obtained from the University of Pretoria's Postgraduate Committee and was given on 01 November 2010.

3.8 Dissemination of research results

The research results are presented in the format of the current thesis and may also be made available in electronic format on the University of Pretoria's library website. A number of academic articles may stem from the research and will be published in academic journals. While the journal articles are better attuned to reach the academic fraternity, the author aims to disseminate the outcomes of this review at workshops and seminars. Dissemination in this way is aimed at reaching practitioners.

3.9 Conclusion

This chapter sketched the research methodology applied within the present investigation. The research design was explored, including applicable information relating to the structured, systematic process of literature reviewing as applied in this study. The current chapter also highlighted specific methodological requirements, including the aims and principles of the methodology, the problem formulation, the way in which the data was collected, aspects relating to evaluating the data, and the methods for analysing and interpreting the data. The technical section of this chapter was concluded with a description of the way in which the data is presented. The chapter concluded with ethical considerations, as well as information relating to the dissemination of the research results. Chapter 4 is the first part of the literature review and allows the academic fraternity the opportunity to survey the literature regarding the foundations for questioning an African perspective on psychopathology. The review includes the literature which met the inclusion criteria and augmented the study, and was accrued during the course of the investigation.

CHAPTER 4

LITERATURE REVIEW: FOUNDATIONS FOR QUESTIONING AN AFRICAN PERSPECTIVE ON PSYCHOPATHOLOGY

4.1 Introduction

Chapters 4 and 5 form the literature review. The literature review forms the nucleus of the present investigation. This chapter commences with aspects of the literature that explored the foundations for questioning an African perspective on psychopathology, and may be appreciated as the platform for a more comprehensive understanding of the literature in Chapter 5. The current section of the thesis includes literature that provides a context for specific ideas relating to African perspectives on psychopathology. The chapter is designed to follow a developmental path, beginning with the historical context of psychopathology. The researcher then introduces the cultural context and relates these to issues such as race and ethnicity. However, as was anticipated and discussed in the introductory chapter, the literature review included pertinent questions such as the definition of African, as well as aspects of African identity. However, these issues are also addressed in topics such as cosmology and legend.

4.2 The cultural context

People ardently defend their cultural worldviews (Eagle, 2005). This is understandable as worldview defines the nature of reality and all epistemological notions thereof. Indeed, culture and religion define the acceptability of affect, cognition, and connation. One such behaviour includes suicidal behaviours (Dein & Dickens, 1997). As an example, a common Muslim view is that suicide is forbidden in Islam, but in certain Japanese communities it may be seen as honourable.

Draguns' (2000) review of literature indicates that clinician empathy is vulnerable to decay if continuously applied beyond his/her own cultural realm. This decay is due to the clinician having to actively engage clinical material with little understanding of

the cultural dynamics influencing that material. It is unsurprising, therefore, that current views reflect a need for cultural self-knowledge, as well as interventions which are culturally-sensitive (Tomlinson-Clarke, 2000).

If erudition in culture logically suggests cultural competency, then it may be hypothesised that potential benefits exist as a result. The present body of academic literature, cantered on culture and counselling, suggest that counsellors ought to be competent in addressing cultural dynamics. Being knowledgeable in cultural dynamics suggests that the counsellor be equipped with the information and skills needed to work with diverse populations. Results may include the supplication of culturally-sensitive treatment, and may also foster the establishment of rapport in clinical interactions (Pope-Davis et al., 2002).

There appears to be an increase in the body of literature regarding ethnic, racial, and cultural perceptions (Draguns, 2000; Patterson, 1996; Tomlinson et al., 2007). These appear to focus on increasing awareness into various perspectives on psychological distress (Patterson, 1996). As a result, recent research has attempted to explore what *culture* means in clinical psychology (Eagle, 2005).

Eagle (2005) is of the view that the term *culture* possesses significant rhetorical energy. As such, culture creates a context whereby psychopathology has meaning and assists in developing theories about psychopathology. Furthermore, culture provides a foundation which allows patients and families to know what to expect. Likewise, understanding culture allows professionals to appreciate the human condition in such a way that the professional may provide services that are culturally competent (Beiser, 2003). Unfortunately, the terms culture, race, and ethnicity have been applied with confused utility, and have consequently represented a noteworthy hurdle in the development of cultural psychology (Trujillo, 2008).

It is true that culture is associated with ethnicity. As such, one may contend that culture and ethnicity intermingle, but are not the same (Sen & Chowdhury, 2006). Eshun and Gurung (2009) point out that many individuals, including professionals and untrained individuals, misuse and variously imply culture to represent ethnicity,

race, and/or culture. It appears that these terms are often, and incorrectly, used interchangeably. The obvious question here is: what is culture?

4.2.1 The evolving definitions of culture

In line with White's (1959) reasoning, some have defined culture as conditioned behaviours, while others appear to define culture as an abstraction of behaviour. While material objects may be perceived as culture, culture is not dependent on material objects. Often, culture appears to relate to objects and behaviours which are perceptible, but it is equally fair to state that culture exists in the mind. The vast possibilities in defining culture are so intricate and complex in its diverse conceptions of energy, that physics would probably become convoluted if it were able to encompass culture's verve (White, 1959).

These ideas fascinated White (1959), but did not account for the technical aspects of a definition for culture. White's rigorous exploration of these technical aspects yielded the following result. The scientific definition of culture entails that a belief, operation, or article is associated with culture if (a) it relies on symboling, and (b) relates to the extrasomatic context, including nonhuman characteristics which may not rely on symboling. These nonhuman characteristics may include personal grooming, suckling, and fornication practices which subsist in the social milieu. However, duality, plurality, and sociality do not differentiate cultural and/or human occurrences from noncultural and/or nonhuman occurrences. Symboling is the differentiating feature. In addition, the extrasomatic context includes any and all elements of culture, irrespective of the quantity in its class (White, 1959).

There is little doubt that defining culture is difficult. The body is a cultural and physical object. Attempting to define the end of physical matter and the beginning of cultural perception is complex (Scheper-Hughes & Lock, 1987). The difficulties herein are compounded by the observation that many definitions appear to suggest that culture exists within a person (López & Guarnaccia, 2000). The social world represents an important cultural setting because social events have the propensity to influence the way people behave. However, to assume that behaviour exclusively represents culture suggests that behaviour represents beliefs. This reinforces the

notion that behaviour is based on psychological constructs which reside within the person. To consider psychological processes in culture does not imply disregarding the social world. The most apt view would be to consider social and psychological worlds as equally producing human behaviour (López & Guarnaccia, 2000).

Culture is dynamic in that it may be simultaneously unadorned and multifaceted. As such, culture may involve predefined functions for cultural members, social positioning, systems of power, and the dynamics involved in experiencing collective forms of distress (Wilson, 2007). When culture is exclusively characterised in this way, culture is a composite and multifaceted conception (Eshun & Gurung, 2009). The definition of culture is not static, and has changed over time (López & Guarnaccia, 2000).

Culture certainly is an authority that supplies rules and social norms in order to train the individual body to comply with the needs of the political and societal bodies (Scheper-Hughes & Lock, 1987). As a collection of edicts, passed from community to individual, it defines the community's worldview, the nature of interpersonal relationships, and the nature of being. These edicts are diffused through language, customs, art, and symbols (Helman, 1990).

Culture is also a network of dynamic attributes that direct and train perception, reasoning, interaction, and behaviour (Mazrui, 1986). It is resourceful and dynamic in the sense that large groups may share specific histories and contexts, and that some cultural features may be common to these groups. Society experiences shifts, and people must adapt to these shifts continuously. Accordingly, culture cannot remain static and is reconstructed according to these shifts. Culture, therefore, evolves (López & Guarnaccia, 2000).

As a unit of interrelated attitudes, beliefs, ethics, and behavioural perceptions shared by a community and carried down from one generation to the next, it is a construct that operates at the collective level and does not relate to biological or individual performance. It does, however, reside in the individual's knowledge schema and is developed during childhood, but is fortified during the life-cycle (Triandis, 1995). Greenfield, Keller, Fuligni, and Maynard (2003) consider culture to be socially

interactional and consist of collective practices and joint interpretations of phenomena. The process of cultural intercourse is therefore one which is communicated and structured within developing contexts.

As a result, culture forms collective meaning, and structures communities via folklore and history. Culture therefore creates a foundation for organising ethnicity, but is not ethnicity. Because culture relates to meaning, it influences aspects such as belief systems, traditions and lifeways that represent *real* ethnicity. While ethnic boundaries signify the structural aspects that influence ethnic opinions, culture signifies human agency and in-group operations of cultural protection, renovation, and advancement (Nagel, 1994). A superior definition of culture must appreciate the person's agency in creating his/her social world. This suggests that people do not inherit culture from generalised society. While society helps shape cultural perception, so does the individual's life experiences. It is reasonable to appreciate that a person may transform, augment, or discard aspects of culture based on personal perception (López & Guarnaccia, 2000).

4.2.2 The locus of culture

The views of culture as directly, or indirectly, perceptible elicit the burning issue regarding the locus of culture. Culture is positioned in time and space and can be appreciated as existing within people. Thus, culture is evident in beliefs, views, concepts, and feelings. Furthermore, culture operates in objects which are external to the person, but relate to social interactions between people. Therefore, culture is evident in material elements such as art and technology. Finally, culture functions in interpersonal relationships. These considerations suggest that culture is extraorganismal, interorganismal, and intraorganismal (White, 1959).

With regards to culture being rooted in time and place, it has the capacity to transform, and is affected by contemporary views as well as environmental pressures (Sen & Chowdhury, 2006). Culture in Africa is frequently linked to early practices, particularly those which operated prior to colonisation, modernisation, and Westernisation. Along these lines, culture may denote something inborn to a group of people. In a sense, this refers to the quixotic perception of culture as authentic and

unpolluted. This view of culture communicates a longing for the pre-modern (Eagle, 2005). However, culture as a construct must not be oversimplified to suggest that it does not transcend individual, material, and temporal dimensions. Culture is an elemental facet in the memoirs of each society (Cabral, 1974). Shared history cultivates a shared culture (Ritchie, 1997). Ritchie indicates that even though European cultures have nuances which appear to render them unique, various European societies facilitate a common culture anchored largely in shared historical experiences.

Consequently, the construct *culture* has multiple meanings, particularly when discussed in African, and South African, contexts. This is due to the political association of the term (Eagle, 2005). In the context of modern-day South Africa, for example, the term culture is applied with various rhetorical aims. These include authority, affirmation, opposition, and sedition (Eagle, 2005), which may suggest systemic patterns relating to discord with the present socipolitical system and/or may reflect historical tensions fostered by the previous socipolitical system. The researcher was unable to locate supporting evidence in this regard.

4.3.3 Culture as a multidirectional construct

Confronting allegations that biologically-complete hominids spontaneously contrived culture is a view opposed by Shore (1996). Shore suggests that culture may be attributable to evolution, but is independently a selective feature of evolution.

Many traditional African communities discuss past and present experiences in rhetoric, using expressive and symbolic language devices to communicate personal experiences. The simultaneous use of verbal and nonverbal communicative devices is employed to unite and divide, magnetise and resist, underpin and transform. With these processes at play, it becomes extremely complex to distinguish between history and representation. Here, it must be appreciated that history exists within the representation. While this suggests rhetoric, it does not suggest stark contrast to realism. Thus truth, and the perception of truth, form consciousness. Within consciousness, history fashions culture, and culture fashions history (Comaroff & Comaroff, 1987).

In addition, much research regarding culture and aspects of the self have been conducted. These have included numerous topics which have transcended disciplinary peripheries. Areas which have exhibited much interest in this field include social psychology, sociolinguistics, and psychological anthropology (Miller, 1999). Anthropological research in the first half of the 20th century illustrated the way in which culture influenced personality. More recent trends appear to aim at exhibiting the way in which personality and culture interrelate and influence people's lives (McCrae, 2001).

Longitudinal research has found that personality traits remain constant, notwithstanding major shifts in life experiences (McCrae, 2001). In terms of culture-related data, cross-cultural research indicates that personality traits in adulthood are universal. Furthermore, behaviour-genetic research reveals that genetic disposition is a major determinant of personality traits in adulthood. Consequently, while one may notice some cultural influence on personality, personality traits appear to transcend culture (McCrae, 2001). As an additional observation, Dzokoto and Okazaki (2006) indicate that it is also likely that emotions are experienced differently, depending on the culture. However, culture and behaviour interrelate and influence people's lives. White (1959) is of the view that behaviour is a reaction to, and function of, culture. As such, behaviour is the dependent variable, and culture is the independent variable. If the culture transforms, the behaviour will also be transformed (White, 1959).

While these considerations certainly relate the person and culture, they do not account for the constitution of national culture. National culture affects the cultural contours of individuals. However, personal experiences and personality will foster variation. This invariably influences value orientations and generate diversity within socio-cultural factions (Thomas, Au, & Ravlin, 2003).

Hofstede (2001) distinguished four dimensions relating to national cultures. These dimensions were based on global multivariate research of work-related principles. The first dimension is individualism-collectivism and concerns the extent to which a person experiences himself or herself as either naturally integrated into a community or family, rather than as a self-contained, self-governing individual. Draguns and Tanaka-Matsumi (2003) are of the view that people generally define themselves as

either collectivistic or individualistic. On the one hand, the individualistic self is differentiated from other people and more focused on independent actions. On the other hand, the collectivistic self lacks a distinct boundary between the individual and one's community. While the individualistic self is prone to separation and self-blame, the collectivistic self is prone to interpersonal rejection and guilt (Draguns & Tanaka-Matsumi, 2003). Of significance to the current review are Watkins et al.'s (2003) view that many African populations embrace collective cultures, and a collectivistic self. Another dimension refers to power distance and relates to the acknowledgment of inequity in social positions and financial revenue. The third dimension relates to femininity-masculinity and indicates the extent of gender-role differentiation and the value of compassion and relationship versus triumph and accomplishment. Lastly, uncertainty avoidance concerns the degree of distress encountered in amorphous, vague conditions. These notions are discussed in sections 4.8 and 5.11.

4.3.4 The framework of culture

Culture encompasses creed, mores, family ideals, race, geographical location, physical attributes such as degrees of aggression, frequent outward traits such as attire, explicit and implicit attitudes, and subjective positions such as perceptions relating to gender and nationality (Eshun & Gurung, 2009). It has symbolic utility as a meaning system and includes collective appreciation of the facets of experience, in addition to regulatory functions such as norms for behaviour. Moreover, culture also provides constitutive functions by circumscribing and generating particular realities. Culture's role in generating these realities is wide-ranging and includes elemental epistemological wisdom, artefacts, roles, and acknowledged social institutions (Miller, 1999). Perhaps examples in this regard would be beneficial. A birthday card is an artefact, a teacher fulfils a role, and marriage may be seen as an example of a social institution.

It is also appropriate for psychotherapists to consider phenotype, as interpersonal relationships influence the lived experience of the person, including perceptions of one's position in his/her world (McDowell et al., 2005). Phenotype refers to the way in which physical and biochemical features are influenced by environmental and

genetic influences. Phenotype, therefore, influences worldview (see McDowell et al., 2005).

Adjustment, or cultural adjustment to be more precise, ought to be seen as dynamic positioning on a continuum. The one end of the continuum indicates complete adjustment, while the other end indicates no adjustment. Adjustment, here, refers to psychological adjustment and a person may shift and change positions depending on his/her context (Van der Vijer & Phalet, 2004). The result of such adjustment has the potential to facilitate cultural empathy.

Being skilled in cultural empathy indicates that a therapist is able to appreciate the patient's cultural worldview. Cultural empathy is absolutely essential in therapeutic processes involving people of diverse backgrounds. In addition, the therapist must demonstrate sensitivity and maturity in communicating similarities and differences in such a way that the patient feels comfort in sharing his/her lived experience. Within this process, the patient is able to experience a deep sense of connection with the therapist. However, success in this area implies that the therapist must be willing to engage in deep reflection of, and confront, his/her own cultural experiences (McDowell et al., 2005). Certainly these facets percolate psychological experiences and, by implication, the manifestation and experience of psychological distress.

In addition, recognising culture-specific indicators of psychopathology is a diagnostic necessity that takes advanced education and prodigious respect for cultural dynamics (Toldson & Toldson, 2001). Understanding the role of culture in the development of psychopathology has the potential for clinicians to be proactive and to facilitate preventative measures before the pathology develops (Miller & Pumariega, 2001).

4.3.5 'Culture' misunderstood

Regrettably, the term culture is often employed to suggest perspectives which are not Western, and not Eurocentric. As such, culture may imply a focus on those populations which are marginalised. Perhaps this definition of culture demonstrates complexity by being reliant on a contradicting construct. References to culture, in this regard, suggest *other than* and may be interpreted as a challenging view, as well as a

type of co-option compared with those hegemonic characteristics (Eagle, 2005). *Culture* should not erroneously be equated with any culture apart from Western culture. Western medicine, for example, is also entrenched in a specific culture, the Western culture (Anderson, 1996).

Influential considerations that arise at this stage, and which must be confronted within this review, include areas relating to pure forms of specific cultures, acculturation, and enculturation. Consider the *kulturkreis*, for example. The kulturkreis is regarded as the vicinity where every cultural facet originates in its most authentic form (Herskovits, 1926). However, the kulturkreis has been criticised for being a concrete process of arranging cultural material into specific, linear patterns (Herskovits, 1926). The view does not appear to lend itself to dynamic understandings of cultural phenomena, specifically in terms of the multifactorial processes at play. The prominent question of *who is African?* attests to this observation. Further literature in this regard will be addressed further in the review.

As a point of note, it has been suggested that the outcome of schizophrenia in developing countries is often more positive than the outcome in first-world countries (Bhugra & Bhui, 2001). Bhugra and Bhui hypothesise that this occurrence might be due to developing countries exercising healthier coping strategies, mind-sets, family communication, and operate within a more accommodating culture. Further deliberation in this regard will be explored within the review.

4.3.6 Culture and psychopathology

In terms of culture in relation to mental illness, an overarching definition of culture may be extremely useful in appreciating patterns of psychopathology (Eshun & Gurung, 2009). For this reason, culture must also be appreciated as a quality which is environmentally acquired which contains beliefs, principles, standards, activities, and symbols. It therefore reflects mutual societal experiences, is conveyed cross-generationally, and transforms in due course. Culture is also self-sufficient, and consists of concrete and abstract components. Furthermore survival and acclimatisation of a population are dependent on culture. Many aspects of culture, such as cultural principles, impact the manner in which people perceive and react

(Eshun & Gurung, 2009). Amplifying the definition of culture assists in unearthing the opulence of cultural analysis as regards the investigation of psychopathology. Furthermore, an extensive definition allows further appreciation of intracultural variation (López & Guarnaccia, 2000).

Briefly, culture exerts pathogenic, psychoselective, psychoplastic, pathoelaborating, psychofacilitating, and psychoreactive influences. According to Tseng (2001), the pathogenic effect refers to culture's propensity to affect the course of the disorder. In essence, and upon reflection, I propose that the pathogenic effect be appreciated as the way in which culture *habituates* psychopathology. The psychoselective effect refers to the way in which cultural variables enable the person to tolerate stressors. Of equal importance is the psychoplastic effect, which elaborates the manner in which culture modulates the expression of psychopathology. Structured manifestation of this modulation, as implied in mainstream categories as well as culture-specific illnesses, suggest culture's pathoelaborating effect. However, as psychopathological experiences often relate to the personalised experience of psychological disturbances, the psychoreactive effect explores the subjective reaction to the disturbance (Tseng, 2001).

4.4 Ethnicity

Unlike culture, ethnicity refers to a group that shares social and cultural norms, which are preserved within the group, and across time. Individuals within the ethnic group share origin and history, and are therefore easily able to identify with one another (Last, 1995). Nagel (1994) indicates that ethnicity is an interactive and progressive aspect of identity formation, for both individuals and groups. Culture and identity are central to ethnicity. In constructing identity, individuals address issues relating to ethnic restrictions and meaning. Ethnic groups structure culture and self-definition, thus constructing ethnicity.

Belonging to an ethnic group does not mean that one ascribes to all values and norms of that ethnic group (López & Guarnaccia, 2000). Community processes arrange alliances, adversaries, authorities, and boundaries. This creates specific divides and unions, and is characteristic of ethnic group processes. These processes fall under the

umbrella of ethnicity, specifically the subdivisions constructed by culture, language, religion, ancestry, appearance, and geographical location. Ethnicity, in terms of boundaries, is subject to revision, negotiation, and revitalisation. This may be facilitated by ethnic members, as well as external observers (Nagel, 1994).

The current state of psychopathology suggests that the comprehension of collective definitions of ethnic groups, and the heterogeneity thereof, necessitate deliberate consideration so as to assure depth in understanding and facilitate evocative analyses (Bhugra & Bhui, 2001).

4.5 Race

The term *race* is commonly used to signify society's constructions of physical attributes (Cashmore, 1988). The biological conception of race denotes genetic and physical attributes such as pigmentation of skin, the colour of eyes, and the texture of hair. These attributes produced historical taxonomies such as Negroid (Black), Caucasoid (White), and Mongoloid (Asian). In contrast, the sociocultural conception of race suggests the geographic exodus and process of identity construction. Thus, the concept of race is employed to assist in describing people, albeit representative of constructions created by people (Eshun & Gurung, 2009).

Racism is restrictive and often creates a divide between Black and White. In truth, the social fabric is more complex than racial categorisation (Mabie, 2000). Recognising skin colour does not imply racism, nor does it instinctively initiate racism (Swartz, 2007). The reality of African consciousness, race, faith, education, racial discrimination, and the socioeconomic and political position of African people must be acknowledged (Toldson & Toldson, 2001). If one employs the concept of race as a social construct, race is associated with ethnicity. This is accounted for by the process whereby culture organises individuals into racial clusters as maintained by a collection of socially important features (Sen & Chowdhury, 2006).

In terms of racism, some traditional Africans appear to be of the view that they are victims of adversity due to racial discrimination (Sharpley et al., 2001). Racism is of great consequence in the areas of psychopathology and politics. Racism, in this

regard, is defined as systems that malign persons in the grounds of phenotypic traits or ethnic association. All works focused on culture must encourage discussions regarding racial discrimination and, in so doing, challenge racism (Sen & Chowdhury, 2006).

A lasting ethnocentric view, on the margin of racial discrimination, is the implied view that the perceptions and experiences of African people are primitive or disordered (Mezzich, Kleinman, Fabrega, & Parron, 1996). Subtle, daily forms of passive-aggression and racism towards Africans may be termed *micro-aggressions*. Many African people believe that micro-aggressions have a negative impact on their health (Sharpley et al., 2001).

Especially in South Africa, the term *Black* often implied *non-White*. In South African society, Black comprised indigenous African, Indian, Coloured, and Chinese people. According to Modood and Ahmad (2007), the concept of Black was first divided into different race groups, and later fragmented into identity categories, including religious identities, such as Christian, Muslim, Hindu, traditional, and so forth. This suggested the development of a pluralistic condition. South Africans are fixated with race (Swartz, 2007). Historical racial tension has reinforced this process. Often, dialogue regarding race is met with anxiety. Similar to the experience at a grass-roots level, clinicians and academics should question whether these anxieties immobilise professional deliberations and practices (Swartz, 2007).

Reality, including the reality for those who have been subjected to trauma such as racial prejudice, is forbidding and iniquitous. The neurotic tensions that overwhelm all people are, to a large extent, a product of lived experience. Some of the psychosocial mêlée, those internalised tensions, are not resolved by environmental change. The focus in therapy ought to include reinforcing and developing the patient's capacity to successfully cope with the demands of the external world (Wohl, 2000).

4.6 Who is African?

It is feasible to conceive Europe in terms of physical regions. It is equally feasible to conceive Europeans as those people who live in Europe (Ritchie, 1997). The

analogous question, then, is whether this is the case with regards to Africa and Africans. Ritchie is of the opinion that discernment of shared culture and history may initiate Eurocentricism. Within the African context, this suggests possibly initiating Afrocentricism. This is a fine line to tread, specifically within an investigation aligned to the scope of the current literature review. It is my opinion, however, that these subjects, contentious as they may appear for some, be explored in order to allow the literature to inform the review.

Makgoba (1998) is of the view that for many scholars, Africans are diverse and include negroids, caucasoids, and orientals. This view is as much a question as it is a statement as it is an argument. Multiple consciousness is widespread in Africa. Even when race is removed from the equation, Africans see themselves as possessing many identities including, but not limited to, ethnicity, subculture, kinship, and language (Airhihenbuwa & DeWitt Webster, 2004). Africa has also been influenced by Western and Eastern traditions. As such, Africa has traditions which are multiple, intricate, interlinked, and interacting. These traditions help Africa to preserve its uniqueness, as well as to adjust to modernisation. African thought is born out of, and grows, from intrinsic and extrinsic features (Makgoba, 1998).

Bhui and Bhugra (2001) have observed that many studies claim to be African but are essentially American studies of Black Africans and African Americans. They, therefore, urge researchers in Africa to produce more research in order to facilitate further appreciation of African culture, from contexts within Africa. For Toldson and Toldson (2001), the African versus African American debate has little value since all Black people are imbued with a traditionally African identity. Kwate (2005) is of the view that African models of personality suggest that the fundamental place of origin defines the primary features of personality. As such, African people across the world, with differing values, share equivalent subterranean cultural and personality structures. Assessment may therefore be homogenous, irrespective of seemingly variable environmental influences (Kwate, 2005).

Jones (1995) and Kwate (2005) are in agreement in this regard. Jones suggests that African consciousness inheres in the innermost self of Africans and African descendents. Aeons have not altered that the African psyche is imbued with

traditional African beliefs and attitudes, irrespective of whether the African person resides in Africa or not (Jones, 1995). Urbanisation, acculturation, and modernisation influence, but do not eradicate, these deeply-entrenched cultural perspectives (Nsamenang, 1992).

But is African more closely linked to Africa? Watkins, Akande, and Mpofu (1996) assessed self-esteem from an African perspective. Participants in their study were approximately 13-years-old and resided in Kenya, Nigeria, and Zimbabwe. Their results indicated that self-esteem was more similar between African children, than when compared to African and Australian children. The study, therefore, suggests the possibility that African consciousness as a construct deserves some merit. However, it could not be ascertained if the instruments used in the study were culture-fair.

Most erroneously, it appears that many authors refer to tribalism when converging on the subject of Africa (Mafeje, 1971). African culture is all together pre-modern, modern, and postmodern. It is also traditional, thus pre-scientific; Western, thus scientific; and integrative, thus post-scientific (Du Toit, 1998). Literature regarding African epistemology is often loaded with emphasis on non-biblical views of the supernatural. These are often based on traditional African legends (section 4.8.7) and correspond with theme 15 in Chapter 6. Some would refer to this as stereotyping as African culture has many other belief systems, such as nutritional techniques and medical care. However, scholars in African literature are reviving, as well as proliferating, traditional perspectives. This must be embraced without trepidation that deep-rooted, traditional perspectives hamper growth and/or progressive views (Du Toit, 1998). Supernatural influence is not unique to African perspectives, nor does it suggest the level of development in a community (Du Toit, 1998). To therefore exclude comprehensive exploration into supernatural phenomena would imply that the African cosmological stance is somewhat aberrant.

According to Makgoba (1998), debates regarding Africa appear to stem from non-Africans. In searching for *Africa*, challenges in exploring African science, language, and democracy are rampant. The difficulty in pursuing the quest for *unique Africa* is a moral and political dilemma. *Unique Africa* gives the impression that one attaints the authority to explore the self. In this way, the person develops mastery into identity, a

supposed constitutive of subjectivity. Essentially, the African begins to assert his/her differences, instead of wavering the position of alter ego for being African (Mbembe, 2002).

With regards to the history of defining Africa, race relates to the moral arena, as well as to the inherent fact of consciousness. Irrespective of the perceptions of diverse forms of Pan-Africanism or negritude, the insurrection has little to do with a discrete race, but much to do with perceptions of race as inferior (Mbembe, 2002). As an appeal to proponents of the multicultural perspective, at least temporarily, bear in mind the historical influences suggested in the development of the Afrocentric perspective (see Asante, 1980). The Afrocentric view appears to relate strongly to Africanity.

Constructing ethnicity and negotiating ethnic boundaries involves self-identification, as well as perceptions of external views. In this way, the view of the self is contrasted against what others assume your ethnicity to be (Nagel, 1994). Being African, therefore, comprises the way in which the self and others negotiate one's identity. Hence, the view that a non-Black person is African is entirely plausible. The current review, however, will initially pivot on traditional African cosmology, and thereafter introduce modern African views.

For 200 years, the perceptible, material, and emblematic borders within Africa have increased and decreased. The flux has transformed the area. Novel territorial structures and unanticipated forms of locality have emerged. These boundaries differ from official boundaries. Inconsistently, discourses which have the capacity to illuminate the transformations have obfuscated them. One long-standing view is that colonialism defined boundaries, detaching African states based on capricious boundaries which ultimately divided societies, ethnic groups, and cultural communities which naturally fashioned a homogenous gestalt before colonialism. This view may be perceived as simplistic due to the historical connotations associated with boundarying in Africa. Most notably, the reductionistic view that boundaries serve international law as opposed to the law of the people, suggests that territory is an object of appropriation used to influence populations (Mbembe, 2000).

These opinions are based on little consideration for whether the law of the people differs from international law. Furthermore it affords weight to arbitrary boundaries, thereby fleecing the potential of Africa's people to supersede synthetic peripheries. In addition, according to Mbembe (2000), many of the boundaries are formed in harmony with natural limitations such as mountain ranges, for example. While the colonial boundaries were not fashioned by Africans, negotiation among the colonial powers was often employed, as was consideration for the old kingdom. In addition, religious, military, and political boundaries were established, redefining the terrain. Boundaries in Africa, as a result, are complex in that some were created out of necessity, others for convenience, and yet others were imposed. Subsequently, the structure of the African experience is influenced by a long-standing social and cultural process (Mbembe, 2000).

The idea that subcultural variation within Africa deserves more exploration in that the unified African unity has been severely contested. Nsamenang (1992) suggests that no other continent has experienced as much internal movement as Africa. Traditional African populations have historically travelled the continent, leaving traces of ethnicity throughout Africa. Africanity, the African cultural inheritance, was steadily constructed. Subcultural distinction, therefore, deprives the African of his/her true African heritage (Maquet, 1972; Nsamenang, 1992).

Surely, contestation in this regard may be easily contrived. Yet, to contest this view suggests a fracas of epistemological views – one which African-focused theorists refuse to accommodate (see Kwate, 2005; Nsamenang, 1992). The intention within this review, will be to initially focus on perspectives aligned to the philosophy of Africanity (Nsamenang, 1992), but to introduce differing views at a later stage.

African-centred psychology focuses on culture-specific models and in so doing unites subcultural groups in Africa. This view is heretical in the general social sciences, but necessary in the Pan-Africanist worldview (Kwate, 2005). African-centred psychological models are dependent on indigenous African perspectives, irrespective of whether the theory is developed by, or relate to, Africans in the Western world. These models focus uniquely on the experience of people of African ancestry and do not relate to the APA's DSM psychiatric classification system (Kwate, 2005).

The African continent presents a significant framework for studying the association between culture and well-being. In particular, the African context has highlighted that theory and practice suggest particular interpretations of reality (Adams & Salter, 2007). Africa is diverse in every possible way. However, in general, Africans have a holistic perspective and find significance and symbolism in phenomena. Additionally, group identity features greatly in Africa (Makgoba, 1998). For Africans, disease is both spiritual and physical (Mbiti, 1970).

African descendants enjoy an opulent culture and are more suited to psychotherapeutic interventions attuned to traditional African culture. Innate to every African descendent is a focus on collectivity, spirituality, oral tradition, and interpersonal significance (Asante, 1980; Nsamenang, 1992). Occasionally, these foci are inconsistent with what Asante considers to be European culture. African cultural processes support specific styles of cognition and information processing. Holism, as opposed to European-focused analytical thinking, is valued in African culture. Owing to the weight afforded to holism, African descendents are perspicacious in perceiving ostensibly disparate variables and phenomena. Indeed, these persons set great store by inventiveness as is evidenced by their cultural transformations. The Afrocentric view has deeply influenced African American psychotherapists, even those who do not support the perspective (Asante, 1980).

Mafeje (1971) suggested that if African history was written by Africans, atypical concepts may have been utilised to explore experience, thereby altering history. In Mafeje's opinion, this would have allowed for African-aligned concepts to be used, thus precluding the application of Western-aligned concepts to explore African experiences. For purposes of contextualising the current discussion, it seems apt to define *Africa* as referred to at this stage.

Africa comprises many cultures, subcultures, and ethnic groupings. Yet, these divisions are not substantially alien in each others' beliefs that general assertions cannot be made (Kudadjie & Osei, 1998). The outward diversity exhibited in African countries deceives the inveterated cohesion across subcultures in Africa (Nsamenang, 1992).

Africanity is made up of Africa's subcultural unanimity. There are three processes which facilitate Africanity. First, African cultures are exposed to similar environmental circumstances and must employ comparable acclimatisation devices. Secondly, Africans share indelible experiences of distress related to slavery, colonisation, racism, and poverty, for example. Finally, cultural traits are diffused and reintegrated into all African cultures through acculturation and enculturation between African societies (Nsamenang, 1992). Gibson (2004) indicates that collective memory is an additional feature which appears to reinforce the notion of Africanity. Collective memory refers to conventional truths within a community. The manner in which a community perceives historical events, and agrees to the validity of those perceptions, suggests a collective memory. An embedded collective memory makes it extremely difficult to deny its existence (Gibson, 2004). Certainly there are many arguments, relating to European theory, which may be considered in this regard. The collective unconscious, as proposed by Jung may be one such example (see Jung, 1969).

It appears important to consider that *community* does not simply refer to a group of people living in close proximity to each other. The term suggests the inclusion of the entire bios. Thus, the elements, people, animals, and plants all form part of the community. Maintaining harmony with the entire bios signifies success in life (Setiloane, 1998b). Throughout ontogeny, the environment influences the biogenetic constitution and implements developmental change (Nsamenang, 1992).

Do these views suggest that African people differ to people in general? Some have vocalised that African cognitive processes differ. Makgoba (1998) suggests that academia reconsider patterns of African thought. According to this author, *patterns* suggest that particular thought processes operate amongst Africans, and that atypical thought processes are genetically inherent to African people. Furthermore, a pattern points toward the idea that consistent components create coherence. Makgoba prefers the latter approach. The uniqueness or lack thereof regarding African thought processes remain contentious and debatable. This argument will certainly not augment the scope of this review, nor is it one which merits defence or opposition. Reflexive views in this regard will be explored further on in the thesis. It appears logical that a discussion on Africanity ought to be followed by a discussion on African identity.

4.7 African identity

Cultural identity includes perceptions of the person's reference group, as well as his/her degree of involvement with additional cultures (APA, 1994). With regards to African identity, the view that there may be multiple identities, or a single identity, both have value (Makgoba, 1998).

Identity is a social construct because it does not refer to a reality, as such. It refers to a discourse aimed at fostering organisation and classification (Gervais-Lambony, 2006). Researchers often imply that discourse allows access into social reality. This assertion points toward the epistemological, not ontological, stance. Therefore, discourse represents reality while bringing cultural constructions into play. Two interconnected levels may be considered in endeavouring to explore determining discourses such as culture, and constructing discourses such as agency. The socio-cultural level configures daily discourse, while the interactional level negotiates significance in daily communication (Puttergill & Leildé, 2006).

Who one *is*, is not identity. Identity refers to what we *do* (Puttergill & Leildé, 2006). Every person belongs to communities defined by various identities. Based on the context, the person may therefore choose which identity s/he prefers. Identifying with an identity says much about whom one is, and in so doing, says much about whom one is not. In this way, shared identity creates a sense of mutuality among some, and simultaneously differentiates one from others. Identity is complex in that it refers to the individual, as well as to the collective (Gervais-Lambony, 2006). Cultural identity forms a great part of self-definition and its dimensions include race, language, gender, ethnicity, sexuality, and spiritual convictions (Trujillo, 2008).

Draguns and Tanaka-Matsumi (2003) are of the view that the evolution of the self has become a prominent theme in cultural psychology. Of particular interest has been the contrasting perception of defining oneself within collectivistic and individualistic cultures. A collectivistic self is conceptualised as flexible to varying circumstances and lacks an explicit margin between the individual and other people. Psychopathology in collectivistic cultures would be expected to be characterised by the experience of humiliation, unfulfilling interpersonal relationships, and social

rejection. An individualistic self, on the other hand, may be described as greatly differentiated and invariable across time. The experience of psychopathology in individualistic cultures may be expected to be characterised by isolation, and self-reproach. This certainly suggests correspondence with uncertainty avoidance. On the high end of uncertainty avoidance, reliability and articulation are valued. On the low end, however, intuition and sensing is accepted (Draguns & Tanaka-Matsumi, 2003).

Watkins et al. (2003) suggest that the interpretation of self as individual is inaccurate for the majority of people in non-Western cultures. These populations, therefore, exemplify subdued power distance. Elevated power distance encourages the progression of an encapsulated self and is focused on personal status. Subdued power distance cultivates a more preambled self and is focused on rewarding interpersonal relationships. Power distance may be coupled with feelings of hopelessness and lack of success in not being able to meet typical standards of achievement (Draguns & Tanaka-Matsumi, 2003).

Identity is dynamic, and can represent an independent perception, or a group perception. Sidestepping the idea that independent identity is a fallacy since all people belong to a group, is unfortunately, a fallacy in itself (Gervais-Lambony, 2006). Identity is a personal feature, although the group may influence it. Furthermore, it is multifaceted, and can be transformed (Gervais-Lambony, 2006).

In many cultures, genders portray themselves on an individualistic-collectivistic continuum. Basically, a specific gender in one culture may view itself as group orientated, while the other gender may view itself as self orientated (Watkins et al., 2003). Collectivism and individualism also affect the individual's perceptions of, and responses to, psychopathology (Eshun & Gurung, 2009).

An interesting view of the self, which is sometimes confused with collective identity, is evident in the idea of the multiplicity of selves. Some societies, such as the Cuna Indians (Colombia and Panama) and the Bororo people (Brazil), perceive themselves as consisting of more than one person. The Bororo, for example, believe that each self exists in relationship. S/he is therefore perceived as a particular self by a parent and a different self by kinspeople, for example. The Cuna Indians believe that they

comprise eight selves. Each self corresponds to a specific part of the body, and his/her character relates to which part of the body dominates him/her. For example, the hand dominates a thief (Scheper-Hughes & Lock, 1987).

Identity is made up of self-identification, social-identification, and the context within which the person operates (Kim, 2003). Multiple selves in Western perceptions of psychopathology may easily be classified as a dissociative state, often diagnosed as schizophrenia. Non-Western perceptions often view these states as typical, and may suggest an altered state of consciousness, or possession by a spiritual force. The Western idea of a single self disallows cultural institutions predicated on ethnopsychology's view of multiple selves as normal. In Haiti and Brazil, for example, female saints are encouraged to learn to summon dead saints at will. This is appreciated as both religious and therapeutic (Scheper-Hughes & Lock, 1987). While Scheper-Hughes and Lock do not clearly examine the dynamics of identity in their example, they intimate that the religious view would regard the saint as a separate entity, while the modern view would probably appreciate the saint as an aspect of the self. James (1907) would probably have suggested that these experiences were both functional and real for the person in terms of epistemological perceptions, but that persons with other epistemological views would probably be unable to appreciate the experience as real. Perry (1996), however, would later suggest that James would acknowledge the different epistemology as one rooted in spiritualist views focused on mental events as a function of the soul.

Later expansions on James's works, by Hermans, Kempen, and Van Loon (1992), suggest that the multiplicity of selves may be appreciated as an operation of the dialogical self. The dialogical self refers to an internal, extended topography within the self in which the person may accommodate more than one spatial position. In a sense, the separate selves may dialogue with each other and thereby construct the narrative self (Hermans et al., 1992).

Ethnic identity is compulsory as much as it is voluntary. An individual, therefore, may select from an array of ethnic identities, and is also liable to operate within the confines of those categories (Nagel, 1994). Choosing an identity is informed by experience, and may include past, present, future, and dream experiences. These

aspects influence experience and shape identity in the process (Gervais-Lambony, 2006). Appreciating this view of identity may be extremely valuable within the psychotherapeutic process, and certainly suggests the acknowledgment of diversity.

Respect for diversity includes realising that the process of developing an African identity has immense therapeutic significance for Africans (Toldson & Toldson, 2001). African history is essential to the African identity, as well as to optimal well-being (King, 1990). History has influenced the African psyche and shaped social identity (Nsamenang, 1992). The oneness of being operates within the psyche of each African person and symbolises an authentic African identity (Mbiti, 1970). Sub-Saharan Africans give emphasis to unity in interpersonal relationships. Children revere parents and elders who, in turn, provide much support for children. Being a parent is consonant with traditional African cultural identity, and is vital to achieving personhood and provides the person with a sense of well-being (Watkins et al., 1996).

Cultural identity is flexible. Each person may incorporate those cultural influences which resonate with him/her. As such, categorising cultural identities is generic in that it refers to those people who ascribe to the conventional worldview of the culture (Trujillo, 2008). For many migrant workers in South Africa, for example, the notion of a masculine identity serves as a coping mechanism, and buffers daily stressors (Campbell, 1997). *Masculinity* is exemplified in subjective perceptions of being a man. Campbell found that migrant workers experienced themselves as masculine because they occupied high-risk jobs and were able to concurrently support their families financially.

4.7.1 Developing an African identity

In Africa, a person is expected to internalise the role of community member and enact the duties defined by this role. This is part of a developmental process in Africa, and the person systematically achieves personhood if s/he adheres to these norms. Existence does not equal personhood. In this way, an older person is more of a person than a child. During ontogeny, people endure progressive humanisation. Personality, therefore, continues to develop throughout life (Nsamenang, 1992). The child is seen as a person-in-progress. The vital source is contained within the body. Self-hood

embarks its ontogenetic development when a child receives his/her name. Naming a child is of great importance as it signifies the potential for development (Nsamenang, 1992).

During ontogeny, different behaviours are expected at various stages in life. In early childhood, the child is expected to meet biological standards such as teething, sitting, and so forth. However, when a child learns to walk, s/he is expected to begin to meet social standards, such as munificence, 'good' conduct, and so on. Africans anticipate that social maturity will overcome the limitations of biological maturity (Nsamenang, 1992).

Social ontogeny consists of seven stages. The first stage is at birth. Soon after birth, the child is given a name. The name projects a socialisation process, denoting the family's expectations of the child. The second stage of social ontogeny is infancy. During this stage, the child is expected to meet biological milestones. The third stage runs from childhood to early adulthood, and is characterised as a time when a child must be systematically and regularly coached into an assortment of social roles. The fourth and fifth stages occur simultaneously and are referred to as an intermediary process. During this process, the individual moves from social novice (stage three) to socialised neophyte. In addition, the individual may participate in puberty rites and begin his/her social internship. During the sixth stage, adulthood, the person is expected to marry. S/he is also expected to want to have children and become a conscientious parent. Old age is the final stage of social ontogeny. While many of the aged are regarded to be physically weak, they are revered as the embodiment of social expertise (Nsamenang, 1992). Social ontogeny falls within the ambit of self-hood.

There are three dimensions of self-hood. The first dimension is the spiritual self-hood and begins at conception and ends at the point when a child receives his/her name. The second dimension is the social self-hood and occurs from the point when a child receives his/her name, until the time s/he dies. Third, the ancestral self-hood extends from the natural death through the ritual initiation until s/he enters the higher spiritual realm (Nsamenang, 1992).

Because societies institute different learning conditions for its constituents, developmental fortes vary from culture to culture. The environmental and cultural influences revolutionise the developmental process in terms of cognitive learning, socio-affective wisdom, and performance dexterity (Nsamenang, 1992). In terms of gendered identity, the feminine self tends toward affect, altruism, and relationships, while the masculine self focuses on effectiveness and productivity. While masculinity may produce subjective experiences of self-denigration and guilt, femininity may produce experiences relating to anxiety and dependent symptoms (Draguns & Tanaka-Matsumi, 2003).

Language affects identity, and for non-English speakers, knowledge of the English language introduces new perspectives (Kim, 2003). One may contend that the converse is equally valid. In the context of this investigation, knowledge of African languages may illuminate areas of knowledge which were previously inaccessible and/or difficult to conceptualise. Language transmits meaning and fosters acceptance within a culture. It also implies that the person probably ascribes to those cultural norms and values (Gervais-Lambony, 2006). There is a desperate need for further research into English-as-second-language and its influence on identity (Kim, 2003).

Interestingly, African populations prefer healing processes focused on identity and the self. Traditional healing focuses on aspects of the *self*. It considers people and the universe as a whole. Many African people refuse to compare traditional healing with science and often indicate that science is unable to encapsulate facets of the self (Ashforth, 2005).

4.7.2 Acculturation

Acculturation can be unidimensional. This implies that migrants ultimately adapt to the majority culture. This view has received much criticism, particularly with the observation that people maintain much of their original culture and thereby retain a bicultural identity. Bidirectional views of acculturation have supplanted unidirectional views in academia (Van der Vijer & Phalet, 2004). Biculturalism is also referred to as integration. This implies that the person attempts to combine aspects of the original culture with the new culture (Van der Vijer & Phalet, 2004).

If the person maintains his/her original culture, and chooses not to accept any of the new culture's perspectives, s/he is said to engage in a process of separation (Van der Vijer & Phalet, 2004). Assimilation is the reverse of separation. With assimilation, the person incorporates the new culture and forfeits the original culture (Kottak, 2005; Van der Vijer & Phalet, 2004). Marginalisation refers to a process whereby the person fails to incorporate aspects of the new culture, but concurrently forfeits the original culture. It is not uncommon for second or third generation youth to experience marginalisation (Van der Vijer & Phalet, 2004). In a diverse country such as South Africa, one wonders about the ways in which acculturation processes have shaped African identity (see section 5.1.4).

Wolf, Kahn, Roseberry, and Wallerstein (1994) suggest that many studies illustrate the way in which communities employ *agency* for self-construction, relative to interest and power. Agency, therefore, rises above power-irrelevant relativism. Furthermore, essentialist views of culture are forestalled, while compositional, constructionist perspectives are embraced. In this way, culture is compiled and recreated from various facets, in preference to opaque, cyclical, and static regiments. Therapists and researchers must be aware that issues of identity and history have shaped the patients they work with (Moodley, 1999). Qualitative methods, such as those methods aimed at exploring phenomenological issues, are adept at communicating identity as constant, multifarious, and emotional in nature (Nesbitt, 1998).

4.7.3 Influences on identity

According to Watkins et al. (1996), physical appearance does not define self-esteem. Self-esteem and self-definition relate to the perceived quality of interpersonal relationships, and are reflected in value orientations of togetherness. The terms used to describe this sense of togetherness include *ubuntu* among the Nguni, *unhu* among the Shona, and *tabia* in Swahili. However, self-concept is affected by physical attributes and many African people refer to one's body parts as an insult (e.g. your head!). Apart from self-esteem, culture and personality shape one's views, thereby perturbing identity formation. Recent research has reconceptualised personality traits as endogenous tendencies which interact with culture and produce habits, views, and

aptitude for example (McCrae, 2001). In addition, psychopathology influences identity. For example, Caribbean women affected with Anorexia Nervosa evidenced that the disorder posed a significant threat to identity formation (Katzman, Hermans, Van Hoeken, & Hoek, 2004).

According to Nsamenang (1992), Africa's struggle has been to foster an environment that could meet the political and economic needs of the African population, but also to sustain an African identity. This process would be compounded in multicultural Africa. According to Kim (2003), this is because defining identity in a multicultural society is multifaceted and challenging due to the identity transformations experienced by people so as to obtain acknowledgement and belonging.

4.8 The influence of colonisation in Africa

In 1482, identity was defined by the collective experience of sharing language and culture. It is probable that colonisation and segregation fostered racial categorisation (Mabie, 2000). Colonisers were able to sustain political power by repressing the natural cultural lives of indigenous people. In order to rule, a substantial component of the dominated people had to be subdued (Cabral, 1974).

When more than one population falls within the governance of one order, each population attempts to preserve those conditions which are compatible with the order existing prior to the contact. Maintaining this position differs from the various populations and is often at odds with the various shifts (Lieberson, 1961). Often, the contradicting shifts breed conditions fostering a hierarchical structure, and renders one group superordinate and the other subordinate. At this juncture, societies fail to conform to a foreseeable social development cycle (Lieberson, 1961).

In previous times, North African citizens assumed 'abnormal' experiences to be a spiritual interface. However, with French colonisation came the reframing of 'sacrosanct' to 'psychosis' (Bullard, 2001). Earlier, Fanon (1968) observed a phenomenon whereby colonised Africans began to integrate colonial dictates, language, and culture into their psyches and came to believe that they could become 'White.' This observation does not reside exclusively in bygone literature, and is

evident in the putative African disorders suggested by Kwate (2005), and will be discussed further on in the thesis.

Similarly, Hickling and Hutchinson (1999) emphasise that psychopathology in Africa is closely linked to oppression and colonisation. African people continue to experience pathology related to issues of identity, particularly with regards to the ambivalence present in personal and collective histories. Hickling and Hutchinson further propose that many psychotic symptoms evident in Western countries develop due to the same process suggested in the evolution of disorders such as roast breadfruit syndrome. That is to say, the double-bind experienced by Africans in Western society has an adverse influence on racial identity.

4.9 Cosmology

Rene Descartes was most influential in articulating direct antecedents of modern biomedical perspectives regarding the human being. He resolved to only hold true that which evidenced verifiable proofs; Descartes argued the existence of only the body and mind, his view being that the body was palpable, while the mind was intangible. Faith, however, stage-managed his perception and was expressed in his widely-renowned maxim, *I think, therefore I am*. As a devout Catholic, Descartes sought to resolve the dilemma of religious beliefs and attempted to reunite religious constructs with verifiable proofs. He therefore spent much time in researching evidence that the soul resided in the pineal gland. Along these lines, he was able to maintain the body as an artefact of science, and the soul as a facet of theology. His unrelenting notions of dualism afforded biology the licence to pursue extremist Cartesian views, especially fortifying dramatic ideas of clinical and natural sciences. Regrettably, this process forced the theory of mind to be neglected, at least in Western science, for no less than three hundred years (Scheper-Hughes & Lock, 1987).

Scheper-Hughes and Lock (1987) provide a prolegomenon regarding the Cartesian approach explored in academic works, most often assumed to be associated with biomedicine. The dualism fostered in this approach splits soul and matter, psyche and body, actual and invisible. This epistemology is not a universal one, and is itself a cultural and historical construction. Appreciating those perceptions which differ from

the main implies the prorogation of usual perceptions related to the tension of supposed opposites, such as rational/magical or mind/body. Essentially, one must integrate the notion that the body is inextricably a physical and symbolic relic, a construction of culture and nature, and attached to a specific epoch (Scheper-Hughes & Lock, 1987). Cosmology, as such, defines selfways.

Selfways are perspectives, worldviews, cultural prototypes, and social interpretations that provide and encourage specific cognitive patterns with regards to the perception of self and collective truth. African selfways are defined by the reciprocality between rational mind and emotional body (Adams & Salter, 2007). However, to assume that all African cultures assume a coalesced mind-body structure would be incorrect (Patel, 1995). Africa continues to teem with traditional perspectives. However, many African people have to incorporate two or more worldviews into their being (Du Toit, 1998). This is explored further on in the thesis.

Where different cultures operate within the same landscape, often, the contradicting shifts breed conditions fostering a hierarchical structure, and renders one group superordinate and the other subordinate. At this juncture, societies fail to conform to a foreseeable social development cycle (Lieberson, 1961). As a result, research into diverse perceptions must be comprehensively explored in order to develop an appreciation thereof.

Culture serves as the nucleus from which reality is structured, characterised, and deciphered (Okello & Musisi, 2006). Culture comprises endogenous and exogenous symbols. Endogenous symbols include beliefs and attitudes, for example. Exogenous symbols include artefacts and institutions, for example (Okello & Musisi, 2006). The nucleus of one's identity comprises fundamental perspectives, and is represented by cosmology (Hammond-Tooke, 1998).

Cosmology endeavours to impose meaning, and thereby make sense of the world (Hammond-Tooke, 1998). Cosmology and worldview may be used interchangeably and refer to perceptions of reality. It defends the authentic nature of reality, standards which define the plausibility of explanations, the legitimacy of reasoning, and perceived racial values (Hammond-Tooke, 1998).

Cosmology refers to the examination of the universe as an organised, congruous gestalt. The two major sections in cosmology are philosophy and astrophysical study. The former deals with the foundation and constitution of the universe, while the latter deals with the arrangement and fundamental dynamics of the universe. In this way, studies of cosmology may be scientific or metaphysical (Kudadjie & Osei, 1998).

This area need not suggest logical consistency. The human mind is competent in acclimatising to contradiction and inconsistency (Hammond-Tooke, 1998). Cosmology may be expanded to include all cognitive approaches employed in organising perceptions of the world. As such, cosmology may include religion, kinship, botanical and zoological taxonomies, perceptions of illness, political views, ecological wisdom, and technical expertise. In this way, composite cosmology includes secular and sacred perceptions (Hammond-Tooke, 1998).

4.9.1 African cosmology

In traditional African cosmology, humans appeared on the earth as a community, not as individuals such as Adam and Eve portrayed in the bible. It is perhaps for this reason that African spirituality suggests that the group supersedes the individual. The idea that individualism is disfavoured in traditional African thought attests to this. People exist in relationship, and everybody *belongs* to a community (Setiloane, 1998a). Life is defined by fulfilling one's basic needs and it is regarded as sinful to disturb homeostasis. Sin, malevolence, and cruelty are always punished by spiritual forces (Setiloane, 1998b).

The African worldview is incomplete if one does not consider the world of invisible beings. These include the ancestors, spirits, deities, and God (Appiah, 1992; Patel, 1995). Spiritual forces are deemed to be real (Toldson & Toldson, 2001). In fact, the dead are presumed to be alive and reside in the spirit world (Patel, 1995). The Ugandan Bagandas, of the Bantu people, ascribe to this belief, but do not consider the spirit world to be a parallel world. Instead, they refer to the spirit dimension (Liddell, Barrett, & Bydawell, 2005). Ancestral spirits are alive in the world of the dead, and influence the physical world. They may be labelled the *living dead* (Mbiti, 1970). Ancestors maintain their positions in the family and therefore allow the family to be

indemnified against possible harm. This may be done if the family members maintain kinship affiliation and reciprocate other kinspeople. Communal virtuosity is recognised by the ancestors who then consider the person as having achieved the status of full personhood (Kudadjie & Osei, 1998).

Certainly, death is mourned in the African world. However, death is believed to be a conduit from the physical world to the supernatural world. In West Africa, for instance, the person transcends the self. The person is believed to be part of the greater universe, not particularly part of the physical world. The recent dead are assumed to have a close relationship to the living and are therefore referred to by personal names (Nsamenang, 1992). Igbo and Tabwa cosmology are two examples that illustrate traditional African cosmology.

4.9.1.1 *Igbo cosmology*

The Igbo, from Nigeria, Sierra Leone, and Ghana, believe that before birth, people negotiate their destiny with Chiukwu (God). This negotiation is fortified by spiritual essence called chi. Being in harmony with one's chi suggests that the person is moral and virtuous. Once s/he has agreed, the child enters the human world at an intersection between the physical and spiritual worlds. At this intersection, a water entry port controlled by Nne-miri (a spirit guard), the child encounters deities who aim to test the determination of the person. To conduct this test, the deity attempts to sway the person from following the conditions stipulated by Chiukwu and thereby influence the person to become devoted to the deity. The moral and virtuous will not succumb to the deities, and will enter the physical world with their destiny unchanged (Achebe, 1986).

However, the immoral person submits to the deity and alters his/her destiny. People who submit to the deities are often physically attractive, become successful, and are talented. They are often referred to as ogbanje. However, these persons are viewed negatively in the Igbo culture, especially as any association with Nne-miri is assumed to imply that the person will not marry as s/he is in a relationship with mammy water. Furthermore, this relationship signifies that the person will have a short natural life. Ogbanje (spirit children) are thought to be capable of communicating supernaturally

with other ogbanje through dreams and hallucinations. Dreams and hallucinations are seen as a medium to indulge in sexual behaviours, socialise, or impose group discipline on other ogbanje, which manifest as peculiar diseases (Achebe, 1986).

4.9.1.2 *Tabwa cosmology*

The Tabwa are from Tanzania and Zambia and are a traditionally African people, meaning that they ascribe to traditional cultural mores. Tabwa perspectives of pathology appear to overlie many other African perspectives in the way that psychological distress is constructed from a traditional point of view. This is a result of Tabwa cosmology's clear relation to the majority of other African cosmologies (Drewal, 1988; Roberts, 1988). Tabwa cosmology may be explored by focusing on the central ideas within the culture's perspective. Foremost to Tabwa cosmology is the idea of duality. This relates specifically to seemingly opposing factors such as light and dark, and negative and positive. Hierarchical structures are interwoven in order to accommodate duality. Within these structures are chiefs; benevolent and malevolent spirits; and twins that possess both light and dark qualities. The eternal lines of symmetry serve as the structural pattern of Tabwa cosmology, and are referred to as Mulalambo. Within this worldview, every person is imbued with power, but the way in which power is perceived determines the way in which it is experienced (Lubell-Doughtie, 2009).

4.9.2 <u>The creation of the universe</u>

Similar to the biblical view, many traditional Africans believe that God sustains the world. They also believe that the visible and invisible universe is undivided, with representational power and relationships (Kudadjie & Osei, 1998). The leading view with regards to the creation of the universe is that God, the Supreme Being, created it (Kudadjie & Osei, 1998). The two primary views regarding the order of creation is that (a) the heavenly universe was created, followed by the physical world, people, vegetation, animals, and other creatures; or (b) the sky was created, followed by the physical world, water, vegetation, people, and animals (Kudadjie & Osei, 1998).

Cosmology in West Africa is based on multiple worlds. A three-tier *next* world respectively includes the Supreme Being, higher deities and remote ancestral spirits; and lesser deities and recently dead ancestral spirits (Nsamenang, 1992). Although God controls the universe, the deities, ancestors, and spirits govern and oversee the natural order, including human concerns (Kudadjie & Osei, 1998).

Predestination is a common belief in Africa. Many traditional Africans are of the view that the courses of their lives were decided upon before they entered the world in human form. However, the preordained destinies relate only to major events in one's life, but may be altered if specific customs and rituals are observed. These customs and rituals regulate people's roles, but also maintain equilibrium in the universe (Kudadjie & Osei, 1998). Similar to the ancient Greeks and Romans, African cosmology consists of many ancestors, gods, witches, and spirits. In addition, the person is regarded to be a physical, as well as psychosomatic, entity. Various events in a person's life are decided on by spiritual beings (Kudadjie & Osei, 1998). The social representations regarding the supernatural constitute consensual realities and are prominent in traditional, as well as Western, settings in Africa (Dzokoto & Adams, 2005).

An important dimension of the African experience includes a bidirectional relationship between group identity and communal accountability (Toldson & Toldson, 2001). The African cognitive process is primarily influenced by an appreciation of the collective, not the individualistic. In this regard, the maxim *I am since we are, and because we are hence I am* is embedded in all African descendents (Boykin, Jagers, Ellison, & Albury, 1997). African identity is intrinsic to collective cultures, but also includes reverence for elders and the acknowledgment of spiritual influences (Toldson & Toldson, 2001).

African spirituality refers to the full spectrum of life. It regards all energies that are essential to human life. Life, and the world, are rejoiced but is nothing more than spiritual. Ubuntu, the reverential relationship between people, gives depth and dimension to life, as does the unseen supra-empirical spheres. Furthermore, maintaining harmony and equilibrium is vital to holistic engagement with all fields of reality (Edwards, 1998). Daily life is marked with spiritual pragmatism in order to

integrate nature from a holistic perspective. The interconnectedness of cosmological organic units defines the pursuit of each African to search for meaning. This quest has certainly been equally evident in Arab and European cosmologies (Chandler, 1998).

African perception is also influenced by spiritual forces and affects common facets of everyday living. Consider, for example, that the concept of time cannot be separated from life force and is therefore not perceived as being measurable and invariable. For the African population, time resides in the spirit of experience (Kwate, 2005).

Many cultures, in general, refer to the person possessing a soul. Some, after translating the many African words, come to believe that Africans also refer to the soul (Nsamenang, 1992). However, accurate interpretations of the words indicate that Africans refer to a *vital source* (sometimes referred to as vital force) which is similar to the general understanding of *soul*. Respect between people is expected in recognition of the vital source contained within the body. The vital source, not the body, is linked to God. When the body dies, the immortal vital source rejoins the spirit world. The vital force belongs to nature and permeates human existence entirely (Nsamenang, 1992).

According to Nsamenang (1992), African people are greatly offended if one does not offer a greeting. Greeting another person reflects respect for the presence of the *vital force*. It is therefore habitual for Africans to expend much time on greeting others. This is a symbol of the deep veneration of the vital source within (Nsamenang, 1992). Non-Western cultures exemplify the embodied world. The human body therefore symbolises the physical environment (Scheper-Hughes & Lock, 1987), but is simply a container for the vital source within (Nsamenang, 1992). Traditional African people appear to focus on the spiritual dimension more than the material and physical dimensions (Kwate, 2005).

Similarly, kinship is significant in African society and defines the individual and collective self. Furthermore, kinship extends beyond people, and in the essence of oneness, envelops plants, animals, and inanimate objects (Kwate, 2005). Kinship systems are usually suggested in ethnobiological views as regards procreation. Communities with unilineal descent have certain beliefs and accentuate the role of

gender in patrilineal and matrilineal societies. In Ghana, the Ashanti follow matrilineal lineage and believe that spirit is inherited from the paternal line, while flesh and blood are inherited from the maternal line (Scheper-Hughes & Lock, 1987).

Africans do not shy away from specific gender roles, and males and females are expected to fulfil specific duties. Child-rearing is an example of a female-specific duty (Watkins et al., 1996). It is also not unusual in African populations to hear people refer to the neonate as 'it.' It follows, then, that the course of people's lives move from it-ness to person-ness (Nsamenang, 1992). Personhood is a process. The African perception that genital-shrinking (discussed later) 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).

Infancy and late adulthood are transitional phases in which the vital source prepares to experience significant domains. The infant is about to embark on a journey towards attaining self-hood, while the elderly person is about to embark on a journey of ancestorship (Nsamenang, 1992).

4.9.3 Worldview and psychopathology

Worldview has a direct influence on conception of illness, the manifestation of symptoms, and pathways to healthcare. That is to say, values, beliefs, emotions, perceptions, and behaviour influence the psychological functioning of people (Aponte & Johnson, 2000). Being connected to the community is significant to the Xhosa person, as disconnectedness often implies the induction of distress (Berg, 2003). Speight (1935) suggests that many African descendants perceive psychopathology as a symbol of dysfunction within the broader social framework and therefore requires therapeutic intervention at both the individual and collective levels. Consider that Hehe patients in Tanzania, irrespective of the nature of psychopathology, receive community support once they are engaged in traditional healing. This allows the patient to conclude the process of catharsis and re-enter the community (Edgerton, 1971). Catharsis is perceived as an efficacious treatment for biological and psychopathological illnesses. Here, catharsis is defined as the expulsion of the adverse

in order to accomplish homeostasis. This is a process coveted in Western and African cultures (Littlewood, 2007). It should be noted that while Edgerton's and Speight's works are relatively old references, they stem from the context of the themes under discussion, and are relevant to the current review.

In African models of psychopathology, health is defined as that which promotes collective health, while dysfunction refers to the dissonance from African moral codes and a focus on individualism (Kwate, 2005). African people believe that misfortune stems from many sources. Four of these sources, however, appear to carry the most weight. First, personal or collective iniquity may invoke negative spiritual operations. Second, however, misfortune may simply be part of one's destiny. Third, it is possible that other people impose misfortune on so-called *innocents*. Lastly, exposure to adversity may be thought to be an act of God. Causality, as implied in the four sources of misfortune, supplies African people with an acceptable justification for misfortune and disorder (Nsamenang, 1992).

Environmental conditions also have the potential to significantly influence interpersonal relationships (Pronyk et al., 2006). Individual indicators of psychological distress are thought to be representative of social difficulties (Okello & Musisi, 2006). Furthermore, failing to conform to cultural codes may displease the ancestors and thereby result in harmful consequences. Consequently, many psychopathological conditions are perceived to signify a challenging relationship between the physical and spiritual entities (Okello & Musisi, 2006).

4.9.4 The African epistemology and psychopathology

Culture determines the definition, course, and treatment of illness. Clinicians ought to ensure that they understand the context of the patient's perception of the illness (Saldaña, 2001). Moral indiscretions are regarded as spiritual transgressions and result in psychopathology. The transgressions foster imbalance in the group and the individual, thereby encouraging illness (Toldson & Toldson, 2001). In African cosmology, the ancestors have the authority to influence health (Okello & Musisi, 2006). Having lived in the physical world; ancestors are expected to have knowledge about worldly affairs. Rituals are performed by people of the earth so that the

ancestors may negotiate with the African concept of God, in support for people's causes and thereby expel the illness (Nsamenang, 1992).

Taboos are suggestive of social control and refer to the moral codes of society. Taboos are believed to be codes prescribed by supernatural forces and cover most areas of life. Contraventions of these prescriptions warrant punishment from the spirit forces. However, punishment may affect the individual, the family, and/or the entire community. Rituals serve to pacify affronted spirits (Kudadjie & Osei, 1998). Furthermore, many of the forbidden sexual behaviours represent the African view that health may be negatively influenced by death, a process imbued with supernatural *pollution* (Green, Zokwe, & Dupree, 1995). In terms of pollution, women are often 'polluted' during times such as menstruation, for example. Pollution has become associated with 'dirt' related to witchcraft and immorality (Jewkes, Levin, & Penn-Kekana, 2003). Specific sexual behaviours are considered as taboo in traditional African societies. These include intercourse with a widow who has not undergone cleansing rituals subsequent to her husband's death, homosexuality, having intercourse while the female menstruates, having intercourse after a miscarriage or abortion, having intercourse immediately after birth, engaging in commercial sex, engaging in fellatio and cunnilingus, and having premarital sex (Green et al., 1995).

Worldview influences the way in which psychopathology is experienced, as well as the way in which patients and their families respond to the pathology. Those patients who hail from communities that regard psychopathology as possessing a mystical foundation, appear to prefer the services of traditional healers (Mateus, dos Santos, & de Jesus Mari, 2005).

Due to the dynamic nature of culture, cultural perspectives have transformed and acclimatised to adapting epistemological views (Liddell et al., 2005). In some parts of Africa, physical and social states of ill-health may coexist. Somatic complaints, including stroke-like symptoms, are believed to emanate from a physical illness, as well as a social illness. While xistroku refers to the English equivalent for stroke, xifulana is an illness caused by human beings which inhibits blood circulation in various parts of the body (Hundt, Stuttaford, & Ngoma, 2004). For this reason, the Western diagnosis of the stroke-like symptoms would, from a traditional African

perspective, be a partial diagnosis as it only accounts for a fractional view of the disorder. In a similar way, while the traditional African groups investigated in Jilek-Aall, Jilek, Kaaya, Mkombachepa, and Hillary's (1997) study were aware of modern dietary behaviours to maintain the afflicted person's positive health, they attached traditional views to the negative associations of eating these foods. Thus, when clinicians taught them that specific foods were inadvisable to consume, the local people reinterpreted these messages and indicated that these foods were imbued with evil influences, for example.

In contrast to modern biomedicine, many non-Western ethnomedical systems do not differentiate between self, mind, and body. As a result, psychopathology cannot reside exclusively in the body and/or mind. Pathology, in these cultures, suggests that the person is vulnerable to feelings, desires, nature, the behaviour of others, and supernatural influences. In effect, the body is perceived as a microcosm in the macrocosm (Scheper-Hughes & Lock, 1987).

Comaroff and Comaroff's (1987) study on perceptual disturbances in African patients suggested that the content of the disturbances often contained communicative devices. Psychotic persons often communicated their distress through visual imagery, while non-psychotic persons explored psychological states of distress through verbal metaphor. Therefore, they concluded that clinicians become privy to the dynamics of these experiences by regarding the symptoms as poetic expression of the patient's experiences (Comaroff & Comaroff, 1987).

From a traditional African perspective, treatment devoid of spiritual influence is implausible, or at the least, somewhat ineffective (Iwu, 1986; Yoder, 1982). Performing rituals allow for spiritual influence. Ritual is often used as a coping strategy. In this way, ritual coping is the active expression of spiritual coping (Utsey, Bolden, Lanier, & Williams, 2007).

Some South African Zulus, for example, believe that psychological and spiritual realities are interwoven (Wilson, 2007). Because supernatural influences dictate human experience, the negative implications associated with violating spiritual codes of conduct are perceived to be judicious (Okello & Musisi, 2006).

4.9.5 Witchcraft

Ashforth (2001) states that witches and witchcraft are endemic to the lives and experiences of African people, and particularly to the influence and understanding of hardship. Witchcraft refers to the aptitude of a person to initiate socially-prohibited power and/or prosperity via supernatural agency and is a predominant feature of African life in South Africa (Ashforth, 1998). Witches are equated with criminals in many African societies, and are often perceived to be a danger to society as a whole (Ashforth, 1998). Witchcraft forms part of the daily dialogue in Soweto (Johannesburg, South Africa). Although the daily discussions of witchcraft in Soweto appear to reflect frivolous concerns, witchcraft is perceived as extremely grave (Ashforth, 1998). Deeming witchcraft as a cause provides an explanation regarding the reason for the misfortune, as opposed to the way in which it occurs (Pritchard, 1937). From an African perspective, all people are susceptible to malevolent influences (Nsamenang, 1992). Many Africans believe that it is sacrilegious to alter God's creations. That is to say, engaging in witchcraft is perceived negatively as manoeuvring positive and negative influences are meant to remain within the prowess of God (Toldson & Toldson, 2001).

Christianity typifies witches as malevolent. The introduction of Christianity in South Africa elicited much contestation in terms of deep-seated traditional beliefs in supernatural influences (Hundt et al., 2004). Witchcraft permeates many facets of life in African communities, and many resources are invested into preventing potentially negative effects (Ashforth, 1998). Many Africans are of the view that witchcraft is real. Many Africans also link wide-ranging difficulties, such as unemployment, to witchcraft (Ashforth, 1998). Social anthropology's exercise in assessing the schismatic and synthesising dynamics of witchcraft as a social process, deduced that witchcraft permits communities to engage in social action, thereby alleviating and transforming social pressures (Dzokoto & Adams, 2005; Pritchard, 1937).

Cosmological information suggests that witchcraft is conceptualised as real, not as a social function (Ashforth, 1998). Local perspectives suggest that witchcraft is mostly the result of jealousy. Jealousy dwells in the sinister alcoves of the heart and thrives on acrimony. The witch is prompted into action by jealousy, and may be jealous of

almost everything. There is a spherical process in the nature of the witch's jealousy. S/he becomes jealous, the jealousy generates abhorrence, and the abhorrence impels witchcraft (Ashforth, 1998). It is valuable at this stage to consider Ashforth's (1998) study. Even though some of the participants in Ashforth's study were disappointed with traditional healers in that they did not achieve their desired outcomes, they continued to believe that they possessed supernatural powers and highlighted the battle between good and evil in everyday experiences. Their hope was that inyanga's (traditional healers) actively work towards maintaining the common good. It appeared that the participants in Ashforth's study desired to experience the victory of good.

The researcher is cognisant of the fact that this section relies heavily on Ashforth (1998). However, attempts to accrue supporting sources from reliable avenues proved unsuccessful. This does not indicate that the literature was absent, but was inaccessible to the researcher during the research process.

4.9.6 Symbolism

In Africa, symbolism prevails over the restraints of brain-centred rationalisation. Over and above the five senses, symbolism fosters an association between inner knowledge and external investigation (Makgoba, 1998).

In diverse kinship groupings, concealed technologies as regards nature can be discovered. Human, plant, and animal bodies, as well as the environment, exhibits fruition, innovation, and involution. The Dogon from Mali and Burkina Faso, for example, live in circular homes, believing that power travels in circles. A square represents the finite and logical. Africans appreciate that metaphysical constructs facilitate discernment, consciousness, and engagement with the creative dimension that exposes the relativity of truth and interprets the mysteries of the physical world. The African perception of the circle, therefore, represents the *spirit-space* and framework within which power moves (Chandler, 1998).

The collective assessment of symbols which transcend all African communities reveals philosophical archetypes. Consider the primeval egg as a coffer for impartiality which pulsates and traverses an entryway; the blacksmith as a spiritual

intermediary between the active (hunter) and the passive (farmer); the phases of nature and agriculture as sequential enumerators; and the elderly as imbued with God (Chandler, 1998).

4.9.7 Legend and mythology

African mythology refers to the collection of legends which Africans have narrated as part of their oral traditions. African legends of genesis shape African theology (Setiloane, 1998a). Exploring these legends appear to be useful in appreciating African cosmology, and may further aid acknowledging what may be perceived as reality, perceptual disturbances, psychopathology, and the like.

4.9.7.1 *The Zulu creation story*

uMvelinqangi was the first being and marks the origin of everything. After some time, the princess uNomkuhbulwane appeared and gave birth to a man. The story does not suggest that uMvelinqagi and uNomkuhbulwane related to each other. The birth of the man was followed by other births and so the people began to multiply. uMvelinqangi decided to send a chameleon to notify the people that they were immortal. uMvelinqangi, however, soon thereafter decided to send a lizard to inform them that they were liable to die. During the journey, the chameleon sojourned to enjoy a feast of wild berries. This allowed the lizard to take the lead in uMvelinqagi's quest. By the time the chameleon had reached the people, its message that they were immortal was duly unaccepted, as the lizard's message was appreciated to be the first, and therefore authentic, message. Throughout this time, uNomkuhbulwane encouraged fecundity of vegetation, people, and animals. uNomkhubulwane's proposal that women perform specific rituals during spring served to ensure fruitful harvests, an abundance of cattle, and healthy children (Ngubane, 1977).

4.9.7.2 *The Boshongo creation story*

The Central African Boshongo believe that Bumba (God) vomited the sun, which dried up the water that consumed the earth. Bumba then vomited the moon, stars, animals and humans (Crystal, 2010).

4.9.7.3 *The Abaluyia creation story*

The Kenyan Abaluyia are of the view that God made people entirely for the sun to have someone to shed its light upon (Crystal, 2010).

4.9.7.4 *The Bushman creation story*

The Bushmen believe that Kaang (God), people, and animals existed beneath the world. However, Kaang decided to allow the people and animals to live above this world. Once Kaang moved the people and animals to the new world, he warned them not to produce fire lest they be inflicted by great evil – a warning which the people assured Kaang that they would abide by. However, when the sun set for the first time, fear enveloped the people. Unlike the animals, the humans did not possess the prowess to adapt to the darkness. Distressed and forlorn, the people decided to create fire, and thereby defied Kaang. While the fire comforted the humans, the animals feared the fire. The fire, therefore, separated the humans from the animals, species that previously were able to live harmoniously. Fear had come to define the former friendship. To this day, however, traditional Bushmen believe that the human spirit may travel and reside temporarily in an animal's body. This suggests the ancient link between people and animal (Crystal, 2010).

4.9.7.5 *The legend of the bed of reeds*

The south-eastern Bantu people, the Nguni, share a prevalent legend called *the myth of the bed of reeds*, which straightforwardly relays that the first people tore their way out of a patch of reeds (Setiloane, 1998a). It is uncertain as to why the word myth is attached to this legend, and further investigation in this regard proved unsuccessful. In addition, investigation into whether the Nguni people also referred to this legend as a myth proved similarly unsuccessful. The same was true for the hole in the ground myth.

4.9.7.6 *The hole in the ground myth*

The hole in the ground myth is a Bantu story relating to the way in which people entered earth. According to this legend, families and their animals entered earth from a hole in the ground. These people and animals lived with Modimo, the Supreme Being, in the *big abyss*. Modimo asked his representative, Loowe, to guide these people through the hole and into earth. Loowe, a person of mammoth proportions and single-sided, thus appearing to be someone who had been cut through the middle, guided the people to earth and returned to the big abyss to reside with Modimo and the other denizens. People who live on earth are thought to return to the land of Modimo. Bantu people celebrate this myth at funerals by sending fond messages and greetings to the other inhabitants of the big abyss (Setiloane, 1998a).

4.9.7.7 *The miraculous child of Sankatane*

The miraculous child of Sankatane is widely-known to the Tswana-Sotho people. Kgodumodumo was a person-eating monster and could be heard from afar. He used his sense of smell to locate people who feared him. Kgodumodumo attacked Sankatane, a village where non-violent people lived, and devoured the villagers and their animals. But unbeknown to Sankatane, one pregnant villager was hiding in fear and went into labour. A child prodigy was born. He could walk and talk and appreciate his surroundings. The child asked his mother what had happened to the village. She sadly explained to him what Kgodumodumo had done. After enquiring further, the child armed himself with a spear and his dead father's shield and sought to find the monster. As advised by his mother, the boy found Kgodumodumo by the mountainside, asleep. His snore was fear-provoking, but the child found the courage to furtively approach the beast and sever its major blood vessel with the spear. Because the blood vessel was located in the neck, blood could not be transported to Kgodumodumo's brain, thus immobilising the monster. The powerless monster had no choice but to watch as the child extracted the villagers from Kgodumodumo's stomach. The people were then restored to Sankatane (Setiloane, 1998a).

4.10 The historical context of psychopathology

It is pertinent to include this section as part of the literature review in that it creates the context of the present conditions and constructions of psychopathology. Stated differently, it forms the foundation of the present climate in psychopathological nosology. It is, therefore, advantageous that fairly contemporary literature (e.g. Pilgrim, 2007) is cited in order to construct the historical context of psychopathology. This appears to suggest the ongoing and present-day interest in history's influence on current clinical practice. In addition, exploring the historical context of psychopathology allows one the opportunity to examine whether specific cultural perspectives (e.g. Western) have shaped psychiatric nosology, or if culture-relative perceptions (e.g. Western) have come to be constructed as culture-free perspectives. As a result, the historical foundation inherently addresses the research question.

Early philosophers initially placed less emphasis on the value of psychopathological symptoms and instead questioned the locus of pathology. Socrates believed that psychopathology resided in the diaphragm or heart (Hergenhahn, 2005; Pilgrim, 2007). Hippocrates revised this view by questioning the manifestation of psychopathology. However, he remained dubious as to whether symptoms or syndromes were meant to be explored (Green & Groff, 2003; Pilgrim, 2007). Using the observations of former observers, Galen embraced a solitary symptom method and explored conditions such as uncertainty and exhilaration (Pilgrim, 2007).

Time saw many evolutions of the conceptualisations of psychopathology and its manifestations. In Scotland, the 18th century saw Cullen's proposal for a diagnostic system of then so-called *neuroses*. It was only in the late 18th century that de Sauvages, of France, presented a disease classification system. Soon thereafter, the classification of psychological disease began to grow rapidly, particularly in Germany (Pilgrim, 2007).

The early observations, while not entirely representative of the modern conception of mental illness, suggested depth in contextualising symptoms in relation to the gestalt of experiences of the person. Ancient Greek philosophers and doctors promoted holism. In fact, Socrates was of the view that if the person-as-a-whole was unwell, no

part of the person was well (Mezzich, 2007). While Patel (1995), for example, was of the view that all cultures distinguish between body and mind, the current review will attest to influential literature that refutes this observation (see Adams & Salter, 2007).

4.10.1 Misunderstanding psychopathology

As it appears, historical views aligned themselves to the belief systems of the observers of the time. In many ways, the cultures relative to the epochs and geographical contexts determined the development of present-day psychopathology formulation. As such, the understanding of psychopathological symptoms varied from place to place, time to time, and community to community. None of the formulations, however, appear to have received as much academic interest as the Western view of mental illness. Bhugra and Bhui (2001) hold that the misdiagnosis of what they describe as Western-specific psychopathology may occur due to limited cultural awareness. This is particularly evident if one considers the body of knowledge signifying, for example, that auditory hallucinations are dependent on the pathoplastic influences of culture. Pathoplastic influences of culture refer to the ways in which psychological distress manifests (Bhugra & Bhui, 2001). This is discussed later on in the review.

Language, as a basic medium of interpersonal intercourse, has come to suggest that differences thereof adapt the connotations attached to the experience of affective and perceptual disturbances. Trujillo (2008) is of the view that differences in language and culture have the potential to severely compromise the clinical encounter between clinician and patient. As a result, rapport may not be established, the patient may not feel understood, and the diagnosis may be inaccurate.

With this potential limitation in mind, Draguns and Tanaka-Matsumi (2003) suggest that flawed diagnoses may give rise to clinicians' falsely equating deviance with psychopathology, and may in turn facilitate the escalation of apathy on the clinician's part, due to lack of insight into the patient's condition. This, according to Draguns and Tanaka-Matsumi, stems from a lack of appreciation with regards to the patient's cultural milieu and subjective experiences. Moreover, overemphasis in considering diminutive cultural features often facilitate the development of stereotypes and

impede the appreciation of individual traits, as well as grasping the dynamics of the patient's affective range and perspective (Draguns & Tanaka-Matsumi, 2003).

To illustrate this observation, consider the literature regarding comparative studies focused on the resemblance and dissimilarities of schizophrenia or schizophrenia-like disorders across various cultures (see Habel et al., 2000). On the subject of schizophrenia, it is not uncommon for pathological symptom phenomena to fall within the categorical structure of the schizophrenia spectrum. This ought to be construed as misdiagnosed schizophrenia, as the diagnostic formulation lacks perspicacity of the distress state which may be culturally sanctioned (Bhugra & Bhui, 2001).

Thus, the lack of correspondence with regards to the clinician's frame of reference and the patient's frame of reference falls short of allowing reciprocal discernment. Bhugra and Bhui (2001) consider the adoption of this cognitive process to be restricted and offer meticulous discussion in this regard. Of note, they explore how this closed system of cognition contaminates methodological processes in research, and interpretative processes in psychotherapy.

Within the domain of research, Cheetham and Griffiths (1981) observed many diagnostic inaccuracies with regard to the interviewing phase of Indian and African patients in South Africa. It was evident that these errors were accountable to the misinterpretation of presenting symptoms. At times, it appeared that the apparent somatic complaints were suggestive of malingering. Malingering suggests false reports with regards to psychopathological experiences. Thus, illness is feigned with the intention to achieve some secondary purpose (Reber & Reber, 2001). To attest to Cheetham and Griffith's view, consider the study which assesses whether patients actually exhibit symptoms of specific syndromes or may be malingering (see Rogers, Salekin, Sewell, Goldstein, & Leonard, 1998).

4.10.2 Progressive philosophical conceptualisations on mental health

Tomlinson et al. (2007) indicate that comprehensive investigation into the patient's complaints will initiate, and accrue, opulent description, and not focus specifically on

classificatory symptomatology. This enriches clinician understanding of the phenomena, as well as meeting the patient's need to further appreciate the dynamics of his/her experiences. In this regard, psychiatry's interpretations are debatable as they rely on a clinician's perception of the distress. It may be argued that underlying philosophical systems justify psychosis in a more comprehensive way than psychiatric conceptualisations, particularly as philosophical systems include moral and political concerns (Thomas & Bracken, 2004).

4.11 Conclusion

This chapter reviewed aspects of the literature that explored the foundations for questioning an African perspective on psychopathology. The chapter served as the dais for literature in Chapter 5. This chapter included literature that highlighted a framework for particular ideas relating to African perspectives on psychopathology. The chapter followed a developmental path, beginning with the historical context of psychopathology and then introduced the cultural context. These were related to issues such as race and ethnicity. However, the literature review considered important areas such as the definition of African, aspects of African identity, cosmology, and African legends.

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.

CHAPTER 6

DISCUSSION

6.1 Introduction

The purpose of this chapter is to process the findings obtained during the literature investigations by further analysing the ways in which the findings interact with academic material. In discussing emergent themes from the review, literature is consulted so as to respond to the research question, as well as to make recommendations for future research. As such, the ideas contained in this chapter stem from the data in Chapters 4 and 5. Bear in mind that themes are constructions of ideas that will undoubtedly vary depending on the person that writes the review. The themes were identified by analysing its importance across the literature (Braun & Clarke, 2006). In the present case, eighteen conceptual themes were identified from the literature. These included: redefining psychopathology, the supernatural in the psychoanalytic frame, the locus of pathology, exploring somatisation, metaphysical vitalism, culturology, culture-bound syndromes, the representational world, psychopathology embedded in interpersonal relationships, legends, transformation, ecumenical psychopathology, the psychosocial and socio-political aetiological sphere, the social functions of psychopathology, configurationism, traditional healing, schism/immix, and sectionalisation. The discussion aims to assimilate the themes from the literature review in such a way that the sub-themes in the review (see Appendix B) may be incorporated into conceptual themes in this chapter. However, in certain cases, sub-themes had to be included as they formed distinctly separate facets of the conceptual themes. Moreover, integrative theory is applied to the themes in order to provide the academic and applied fraternity with concentrated insight into the emerging psychological and sociological dynamics at play. The discussion then centres on the researcher's reflexive view throughout the research process. The chapter is concluded with a discussion relating to the strengths and limitations of the investigation, as well as recommendations for future research. However, this section will probably benefit with a brief account of the trends in the reviewed literature.

6.2 Trends in the literature

This section provides a record of the literature consulted during the literature review process. Figures 6.1 and 6.2 graphically illustrate the trends in the literature. The number of included literature that was reviewed was 239, and there were a total of 35 excluded studies from the collected literature (see Figure 6.1). It ought to be noted that 19 sources published before 1980 were used within the review to augment important ideas in the present investigation.

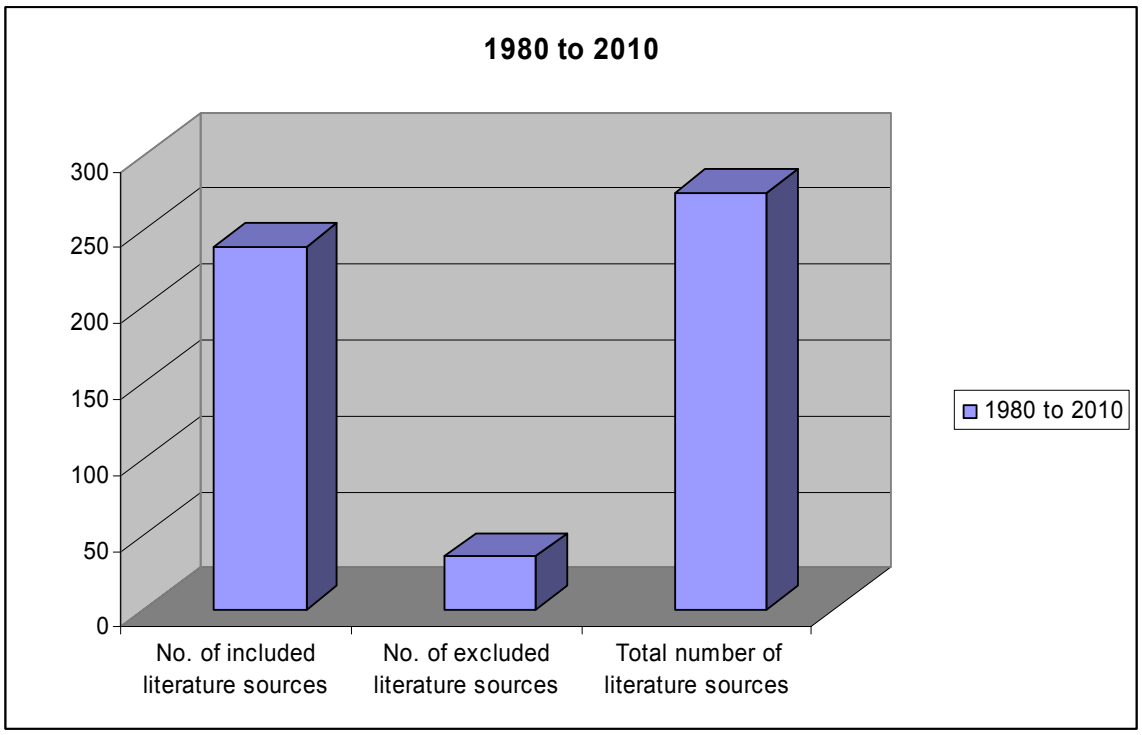

Figure 6.1. Number of sources

Figure 6.2 considers the statistics of the published literature between 1980 and 2010. The blue line includes all abstracts that were retrieved in the study, and the pink line indicates the studies that met the criteria to be included in the literature review. The scatter pattern on the graph indicates the temporal trends of the available literature sources and clearly indicates an increase in literature sources from 1985 to 2008. From 2009 onwards there appears to be a decrease in the number of published literature sources available. This may be due to the databases available to the researcher and literature having not yet been made available in the public domain. Certainly, the researcher is aware that some literature was available in these domains,

but could not access these for a number of reasons (e.g. cost involved) at the time of the literature review.

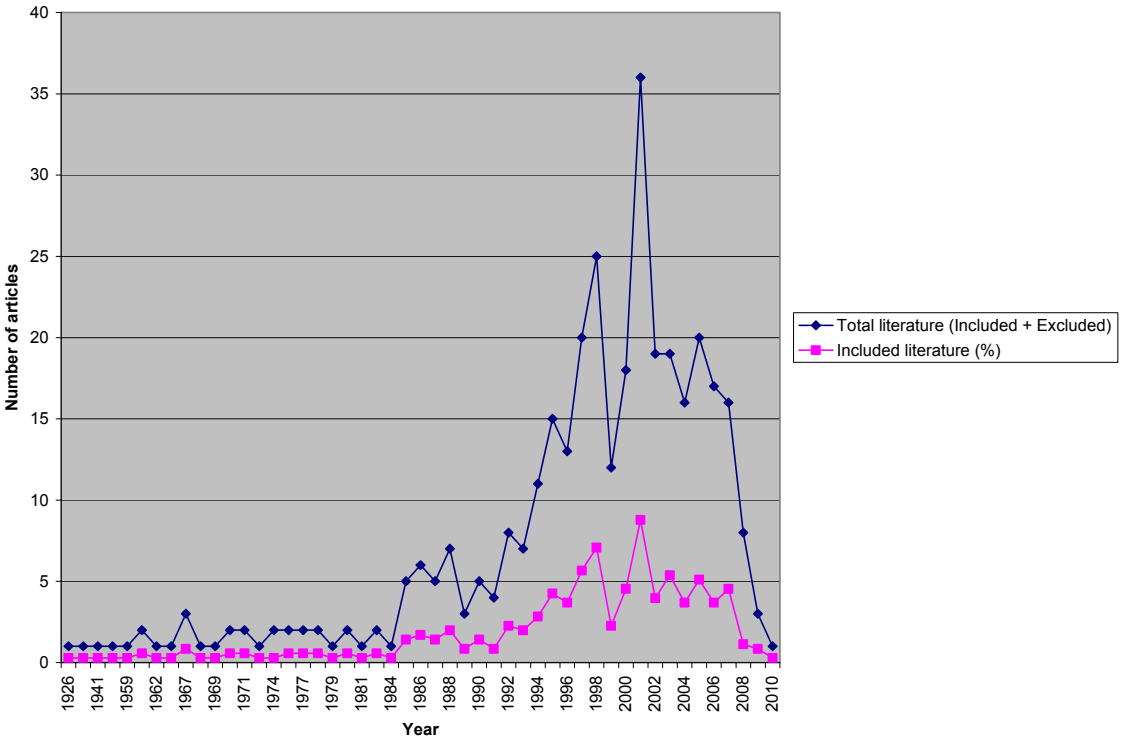

Figure 6.2. Number of studies retrieved (per year)

Much of the seminal literature appears to have been conducted before the year 2000 (e.g. Ashforth, 1998; Edgerton, 1966; Nsamenang, 1992). It is due to these observations that the researcher chose to cover thirty years of research, from 1980 to 2010. Other influential works have become available in recent times (e.g. APA, 2000; Ashforth 2005; Draguns & Tanaka-Matsumi, 2003; Mpofu, 2006; Tseng, 2001), all of which are discussed widely in Chapters 4 and 5.

The pre-1980 sources were included in the review as they provided a foundation for specific topics and/or corroborative evidence for specific ideas (see Appendix A). These were necessary for important ideas in the literature and, while it would have been preferred to include more recent references to these ideas, none could be located by the researcher. One will also notice in Appendix A that the researcher did not include *sample size* as one of the categories in the systematic review. This was due to the observation that only nine reviewed literature sources specified the sample size.

This also attests to the observation that 177 (almost 70%) of the sources were conceptual investigations, and all but the nine empirical investigations were classified as *not specified*. This appears to allude to the idea that literature regarding the scope of the present review has not enjoyed sufficient empirical, quantifiable, and diversified research practice.

Similarly, approximately 130 sources (51%) included research relating to the African population, but were often conceptual articles. This speaks of a great need within the research fraternity to tap this apparent gap in the literature and/or to focus more attention on explication of the context and sample included in the research.

It is also interesting to note that much of the African literature (e.g. Eshun & Gurung, 2009; Janse van Rensburg, 2009; Swartz, 1998; Trujillo, 2008) has been authored by researchers who would not be classified by the current population classification system in South Africa as Black. Consider that 79,5% of the South African population is classified as African (Black), while only 20,5% make up the White, Indian/Asian, and Coloured population (Statistics South Africa, 2011). This is a crude generalisation as despite consulting websites and reviewing the biographies of some of the authors, the researcher could not locate biographical information regarding the majority of authors mentioned in the literature review. Yet another interesting observation is the idea that quite a number of non-Black and non-African (*African*, here, is used to specify any person born in Africa) researchers conducted what appears to be some of the most in-depth and comprehensive African studies in the review – particularly as they focused on exploring cultural psychopathology (e.g. Tanaka-Matsumi & Marsella, 1976; Sow, 1980; Tseng et al., 1992). This suggests that Africa has much to offer in terms of influencing worldwide research in cultural psychology and psychiatry.

However, the observation on whether researchers are African may not be particularly profound should one consider Deely's (2001) implication that knowledge is constructed symbolically and relationally. As such, there would be little significance attached to a seemingly non-African researcher conducting research on *African* topics. Arguably, Deely would possibly suggest that the appreciation and investigation into African dynamics would sufficiently construct knowledge within that area. In fact, he

indicates that 'being' and the experience thereof defines a higher level of appreciation. This level of synthesis defines the substance with which knowledge is created (Deely, 2001). Similarly, Schofield (1998) indicates that scientific knowledge is constructed by scientists and does not represent truth. In addition, Schofield further debates the interpretation of sensory experiences as mental constructs. Therefore, the construction of knowledge is dependent on the architect(s) of these constructions.

6.3 Presentation of findings

With regards to the research question, the current investigation aimed to collate and analyse academic literature that possibly suggests an African perspective on psychopathology. As a result, literature relating to cultural constructions of psychological distress, worldviews, and psychosocial dynamics was consulted. Utilising an integrative framework, a comprehensive review of phenomenological, dynamic, and existential material transpired. While these were clustered into content-focused superordinate themes within the literature review chapters, a concerted effort to unify these themes according to conceptual investigation is employed so as to synthesise and distil the data (Foley, 1999). Discussions relating to the 18 superordinate themes are, therefore, rearranged according to conceptual sections in the current chapter.

6.3.1 Theme 1: Redefining psychopathology

Although early reports suggested lower prevalence rates of psychological distress among the African population (see Bhugra & Bhui, 2001), later reports rectified this inaccurate perception (see Swartz, 1998), and suggested that psychopathology is as old as the human species (Pilgrim, 2007). Thus, psychopathology is a human, not non-African, experience. While universalistic vegetative disturbances, such as sleep disorders, appear to be equally prevalent among all distressed persons, the reviewed literature suggested that personalised experiences mediate the experiences of the person (see Draguns, 1997). An observation worthy of note, and prevalent in Africa, includes the relatively recent remarks regarding the experience of guilt in patients experiencing psychopathological disturbances (Swartz, 1998; Tomlinson et al., 2007). Implied within the study, but not explicitly stated, is the idea that many African

patients come to experience shame due to negative perceptions of the self associated with experiencing psychopathology. While this is not an all-inclusive account (e.g. Hall, 2006), one ought to question the foundation of cultural constructions regarding the negative associations assigned to psychopathology.

In terms of cultural constructions, there is little doubt regarding the pivotal role of culture's influence in constructing medicine and healing (Lupton, 1994). Critics of this view have, understandably, been ill-equipped to account for the complex and multifarious dynamics relating to psychotic processes (Sharpley et al., 2001). While biological theory has afforded the clinical domain many insights into healing, proponents have thus far offered disappointing views in comprehensively accounting for psychotic processes (Lupton, 1994; Szasz, 1961).

As a minimum, in Airhihenbuwa and DeWitt Webster's (2004) view, clinicians ought to acknowledge that health, or lack thereof, is partly dependent on culture. Culture may have a positive, as well as a negative, effect on health. This is especially evident in terms of the ways in which culture influences on behaviour (Airhihenbuwa & DeWitt Webster, 2004). The review suggests culture's influence on behaviour, but also that the dynamics of culture influence the ways in which people behave when they are ill, thereby influencing interpersonal interaction during illness (Brody, 1987; Pakaslahti, 2001). This operation then perturbs the psychopathological experience (Adams & Salter, 2007). It is unsurprising, then, that culture influences psychopathology, regardless of the aetiology (Tseng, 2006). This appears to be especially significant with regards to the present psychiatric classificatory systems in mainstream clinical practice.

As it appears, diagnostic classes fail to consider operational definitions with regards to culture. For this reason, many clinicians have to depend solely on clinical impressions (Bird, 1996). Often, culture-focused researchers have found that this process has lent itself to frequent misdiagnoses (Bhugra & Bhui, 2001). This is particularly evident if one considers the body of knowledge signifying, for example, that auditory hallucinations are dependent on the pathoplastic influences of culture (Bhugra & Bhui, 2001). In addition, the current investigation suggests that psychological formulation regarding psychopathology continues to experience an

eruption of data suggesting alternative perspectives regarding pathology. Consider that contemporary views of psychopathology, such as the archetypal oedipal complex, suggest that the pathology mirrors external and familial chaos (Bullard, 2001).

Draguns and Tanaka-Matsumi (2003) indicated that the manifestation of pathology across cultures is diverse. The cultural interpretation of the symptom, therefore, ought to be largely interpreted within the cultural context. Discounting the correlation between culture and pathology (Draguns, 2000) often leads to inaccurate clinical impressions and diagnoses (Trujillo, 2008). Perhaps, the culture-pathology association has been overstated at present, with insufficient information relating to the way in which pathology is affected by culture.

In response to the overwhelming influences of culture on pathology, Mio et al. (2006) suggested that multiple frameworks were established. Initially, the ecocultural framework was developed, and was shortly followed by the sociobiological approach. However, neither of the two approaches received as much attention as the trimodal biopsychosocial approach, an approach which appeared to appeal, at least to some degree, to proponents of multiculturalism. This was explored in section 5.5 - Psychopathology from a cultural perspective.

The influences of culture, therefore, suggest that perceptions of normal and abnormal experiences are regulated by culture, modulating intrapsychic conflict and psychological distress (Trujillo, 2008). If it is accepted that culture exerts an influence on psychopathology, then the social function of pathology is insinuated. Perhaps further elucidation in this regard may be valuable. Summerfield (2001) is of the view that diagnosticians assume the subsistence of mental illness, irrespective of whether it is diagnosed or not. Summerfield counters this assumption by indicating that psychopathology is a social construct, buttressed by cultural conceptions of personhood. In this regard, cultural influences shape that which people deem as normal or abnormal, as well as acceptable or unacceptable. In recent times, the psychological formulations of the wounded psyche and the effects thereof, suggest that the conception of personhood has undergone a transformative process. This transformative process is a process facilitated by socioeconomic and cultural revolution. Modernisation has fostered a continuum of expressive individualism,

proposing individuation at the one end, and a deficiency of cultural unity at the other end. The individualistic stance has promoted a sense of personal damage. In the course of this dynamic, individuals are afforded the opportunity to disavow the status of survivor and assimilate the persona of medicalised victim (Summerfield, 2001). The social functions, here, may be a process devised to siphon guilt (see Swartz, 1998; Tomlinson et al., 2007), or to align attributions according to cultural norms (see Sharpley et al., 2001).

At this juncture, the discussion of the current theme appears to be gaining momentum towards the direction of the social functions of cultural conceptualisations. However, I contend that to mindlessly and exclusively consolidate cultural conceptions with social processes lacks depth in terms of the dynamics relating to issues of the self. Yet, the way in which the self is defined bears great significance on the present contention.

Self-identification forms part of identity, as does social identification (Kim, 2003). The literature review highlighted that African perceptions of multiple selves are not necessarily pathological. While ethnopsychology suggested that the view of multiple selves is dependent on the specific community (Scheper-Hughes & Lock, 1987), Draguns and Tanaka-Matsumi (2003) suggest that the largest differentiation of identity is based on defining oneself as either individualistic or collectivistic, and occurs worldwide. This was discussed in various sections of the literature review, but was particularly prominent in sections 2.8 (integrative therapies), 4.3.3 (culture as multidirectional construct), and 6.23.2 (limitations of the current state of affairs with regards to research on cultural psychopathology). Within these sections, the view that many African populations embrace collectivism was explored (Draguns & Tanaka-Matsumi, 2003; Watkins et al., 2003).

Research has suggested that collective cultures often relate psychopathological experiences to social disturbances (e.g., Summerfield, 2001). This process is not alien to individualistic cultures. For the clinical field, Summerfield identified significant ethical dilemmas in this regard. Of late, Western society sees increasingly more compensatory fees being awarded to persons experiencing psychological disorders. However, the idea of being compensated for psychic discomfort is based entirely on

the distress being classified as a psychiatric condition. The ethical question practitioners ought to ask themselves is obvious: If the social construct of mental illness as psychiatric condition (e.g., Post-traumatic Stress Disorder) warrants compensation, should other constructs of psychic discomfort (e.g. poverty, or imprisonment) not warrant compensation too? Consider that many disorders are shaped by society (e.g. Antisocial Personality Disorder). Psychopathology is not consistently a disorder with a life of its own. One ought to, therefore, consider the entire system of psychopathology as descriptive and phenomenological data (Summerfield, 2001).

Summerfield's view certainly highlights societal influences on psychopathology. However, the literature review underscored that limited attention was afforded to the interpretation and definition of psychopathology in non-Western cultures. According to Littlewood (2007), cumulative anxieties and difficulties can be understood as an increase in stress, or pressure. In Trinidad, if one does not release this pressure by verbalising and ventilating negative feelings, the person ruminates about these feelings. This rumination causes extremely elevated internal pressure and induces psychopathology, particularly psychosis. Intense feelings, especially sexual drives, must be discharged or else they generate pressure. A socially acceptable and constructive way to release pressure is through relaxation practices (Littlewood, 2007). Similarly, Black African females in South Africa were of the view that stress was the greatest factor that negatively influenced their mental health (Spangenberg & Pieterse, 1995). These sources highlighted the similarities in the way that some populations appeared to transform external influences into personalised states of psychological distress.

In an extreme illustration of stress and mental health, Sharpley et al. (2001) utilised attribution theory to provide a clear explanation of stress in schizophrenia. Their view tessellates with long-standing principles in attribution theory (see Fritz, 1958). According to these researchers, some posit that a negative attributional, or perceptual, style may be a predisposing factor. Activation occurs when the person is exposed to heightened stress, effecting incongruities between the ideal and actual self. The ideal self refers to the person's aspiration for a superlative way of being, while the actual self refers to a realistic view of the self (Seligman, 2006; Sharpley et al., 2001).

Delusional sets serve to limit the incongruity by modifying the self-concept in such a way that positive perception of the self is maintained. This process is carried out to the detriment of others as carriers of negativity. As part of the delusional set, the person demonstrates external attribution (Lefcourt, 1996; Sharpley et al., 2001). Similarly, persecutory delusions develop from incessant use, and are an extreme form, of external attributions. In this dynamic, beliefs about others and self-perceptions lead to incongruities which become manifest by activating a negative perceptual style and thereby emphasising a delusional set (Kamen & Seligman, 1987; Kinderman & Bentall, 1996). Non-Western perceptions of stress as a cause of psychopathology were described in detail in the literature review (e.g., Hickling & Hutchinson, 1999). This view appears to be similar to the diathesis-stress model (Sadock & Sadock, 2007), which suggests the combined influence of biological and external factors (Zubin & Spring, 1977).

It is probable that having suggested a review of the definition of psychopathology, as well as psychosocial forerunners as causes of pathology, will inevitably draw criticism. However, the critical frame underlining the current investigation necessitates such devices so as to contrast contextual views with typical views. With regards to the discussion thus far, the common thread connecting the discourses has been implied, but remains unaddressed. Many may take issue with regard to the intimation that psychosocial, not biological, influences ought to take precedence in the formulation of psychopathology. To address this issue, and to limit the opportunity for the discussion to be riddled by covert constructions, it ought to be noted that the critical frame, at least from a sociological perspective, will inevitably question mainstream interpretations so as to heighten hermeneutic perceptivity of various dynamics (Outhwaite, 2009). To initiate this process, it may be beneficial at this stage to consider views that question the biological fraternity, as this was often implied in the reviewed literature (e.g., Edgerton, 1971; Hall, 2006; Nsamenang, 1992; Trujillo; 2008).

Some critical theorists are of the view that medical naturalism is applied to mental illness so as to affirm that the disturbance is actually an *illness*. Medical naturalism suggests that when medical vocabulary is applied to psychological distress, it becomes legitimate (Pilgrim, 2007). Other critical theorists have been more activistic

in their approach and suggest that mental illness was established by the psychiatric discipline. Proponents of radical constructivism suggest that psychiatry created psychopathology, and as these seemingly appropriate classifications resonated with people, they were soon adopted as valid constructions of distress (Pilgrim, 2007; Szasz, 1995). Critical theorists are, however, not exempt from critique by other critical theorists. In exploring evaluations regarding medical naturalism and radical constructivism, it was observed that the critical narratives afforded the professional disciplines most of the responsibility regarding the interpretation of mental illness. Advocates of critical realism noted the roles and responsibilities of the recipients of psychiatric services. Critical realism mediates medical naturalism and radical constructivism. This position assumes that although peripheral influences determine psychopathological constructions, the patient may accept or reject this position based on altering subjective and intersubjective experiences (Pilgrim, 2007). The same arguments could be applied to psychology.

6.3.2 Theme 2: The supernatural in the psychoanalytic-oriented frame

Irrespective of one's view regarding conventional perspectives of mental illness, the idea that the disturbance or experience is regarded as an atypical experience suggests evident psychological dynamics. If the atypical manifestations are perceived as negative, chaos and stigma often accompany the manifestation. Chaos, whether perceived or real, is met with unconscious anxiety (Joffe, 1999). Fear of the *other* and the *unknown* represent chaos. By projecting one's fear of chaos onto another, one siphons the fear and anxiety by *othering*, or stigmatising (Cambell, Foulis, Maimane, & Sibiya, 2005). It appears to be important to also consider ideas relating to othering and multiple selves by James (1907), Perry (1996), and Hermans et al. (1992), as was discussed in Chapter 4. Consider also that psychopathology is perceived as the *other* because it does not meet the *norm*, that is to say, people perceive *normal* to mean a lack of psychopathology. Where this perception operates, the system justification perspective would suggest that a wider social interest is being fulfilled. This may imply that the *abnormal* are excluded, or that the *normal* differentiate themselves in order to be perceived as *not abnormal* (Jost & Banaji, 1994). It appears that the negative connotations attached to psychopathology are such that many would prefer to steer clear of the stigma.

The rationale for employing this psychoanalytically-aligned view is intentional. While the view appears to hold universal applicability, Cambell et al. (2005) applied this formulation to culturally contextual material. While inclusion of this formulation may potentially add depth to the universalistic-relativistic debate (discussed later), it also highlights the way in which personalised, contextual, and traditional perspectives are critical to psychoanalytic psychotherapy (Reichbart, 2007). These perspectives afford the therapist the opportunity to gain access to the experiential world of the patient (Harman, 1990; Reichbart, 2007). Psychoanalytic approaches are, therefore, not technically universalistic in nature. In contrast to a purely universalistic approach, one ought to be cognisant of the notion that the clinical encounter becomes eclipsed if data relating to cultural and spiritual beliefs are discounted (Reichbart, 2007).

It is also a misconception that psychoanalytic-oriented approaches are fixated on individual-focused, intrapsychic conflicts. Some psychoanalytic-oriented theorists are of the view that anxiety regarding enemies, for example, suggests a societal disorder (see Mullings, 1984). Since the literature review drew attention to enemyship in African cultures as a source of pathology, further discussion concerning enemyship appears to be in order.

In many African cultures, enemyship is natural. The experience of enemyship in Africa, therefore, does not suggest perceptual disturbance, but rather indicates an alternative perception of embedded experience (Adams & Salter, 2007). To perceive enemyship as automatically negative is, therefore, in itself a misconception. Enemyship has allowed the order of being to be in balanced harmony. Reality, therefore, is made up of positive and negative dimensions. In this line of reasoning, enemyship is also constructed of positive and negative dimensions (Adams & Salter, 2007; Geschiere, 1997).

Adams and Salter (2007) are of the view that the African experience of emancipation from enemies is reflected in the selfways that support the sense of being in relationships (cf. Sullivan, 1953). As such, these selfways are freely chosen facets of an intrinsically protected self. In this regard, the positive-negative dimension suggests either the ability to deflect enemies, or the aptitude for social separation (Adams &

Salter, 2007). In addition to highlighting the positive and negative dimensions of enemyship, the review also underscored the African belief in malevolent spectres.

Beliefs in the supernatural enter the psychoanalytic stage more often than literature suggests (Reichbart, 2007). For example, Reichbart's study focused on an African American boy's therapy, the content of which centred on demonic influences. Reichbart suggested that the therapy indicated the demon introject. It appeared that one of the pressures of the demon introject may have been the persistent inattendance of a paternal figure. In addition, the internalised woundedness that resulted from cognitive and/or bodily limitations suggested an added pressure of the demon introject. The third pressure related to complex oedipal anxieties that were rooted in a conflictual and eroticised bond between mother and child (Reichbart, 2007). The Freudian view of devil reverence suggested the adulation of a phallicised father (Berzoff & Flanagan, 2008). Here, the father-son relationship was underscored as one in which the young boy desires his father and simultaneously experiences the internal insurgence against experiencing a seemingly feminine feeling about his father. From this perspective, the idealised devil may be appreciated as the surrogate father, particularly if the patient experiences paternal rejection. Additionally, the demonic introject may suggest a parental figure who similarly experienced a consistent paternal object, as well as experiencing severe castration anxiety (Reichbart, 2007).

Unresolved oedipal anxieties suggest a parent-opposite-sex-child relationship riddled with feelings of shame and sexual tension (Childers & Hentzi, 1995). Freud suggested that the experience of relating to a paternal object was critical to the child's development, and a lack thereof may give rise to the devil entity. In addition, a parent's continuous reference to the devil entity, within the experiential world of the child, serves to reinforce the lived truth of experiencing the devil entity. In this way, the parental figure allows 'the devil' to become the object that is able to manipulate the person's behaviour by inculcating the guilt complex and angst in the child in such a way that this process models that parental figure's own antagonistic and libidinal phantasies and behaviours (Reichbart, 2007). Consequently, the devil signifies the anthropomorphised superego, and represents a feature of the parental object. If the cultural conceptualisation of the devil is regarded to be negative, then the devil may become experienced as an ambivalent icon. In one way, the devil exerts influence by

threatening to become overly punitive if the person fails to conform to specific rules, but the devil also symbolises those repressed aspects the person is conditioned to defend against. During individuation/separation, integration of the devil object binds the child to the parent. The child, therefore, assimilates the parent's split-off and projected illicit desires. As such, the devil becomes the bad, but split-off, part of the parent and compels the child to fulfil the parents' needs. Cultural perspectives often engender the demonic introject (Reichbart, 2007).

Certainly this formulation cannot be generalised to a cultural population. Yet, it highlights the link between the internal world and external world, one marked by heightened difficulties and therefore suggesting psychological disturbance. While the content may differ contextually for each patient, the abstract process may be useful in generating hypotheses with regards to patients affected by malevolent spectres. It would be naïve to assume that psychodynamic formulation would not escape criticism, nor should one be obliged to conceptualise malevolent and demonic spectres in this manner. However, it is equally essentialist to exclude psychodynamic theory as it has been successfully utilised in various cultural settings (Reichbart, 2007). The naïve use of ethnic groupings may reinforce essentialism. Yet, research specific to phenomena closely related to race may be completely appropriate, particularly where race, culture, and ethnicity are overtly intertwined (Bhui & Bhugra, 2001).

6.3.3 Theme 3: The locus of pathology

While many people assume that psychopathology resides in the brain (Marsella, 1998), some traditional African populations assume that psychopathology is supernatural (Nsamenang, 1992; Pakaslahti, 2001). Only when traditional healers find no explanation for the experience, the assumption that the disturbance is natural or biological in nature is accepted (Edgerton, 1971). Edgerton found the supernatural-psychotic relationship to be incorrect (see section 5.8.4). Nsamenang, however, is of the view that African cultures are comfortable with accepting unknown aetiologies and accepting the unknown.

While the Kenyan Akamba, for example, maintained that psychopathology was the result of a tired brain (Edgerton, 1966), the preceding discussion suggests that other

African populations assume otherwise. The researcher could find no current literature that indicates if Edgerton's aged statement remains relevant. However, that the locus of pathology does not reside in the brain is not exclusive to African cultures. According to Draguns (2000), this perception is shared with a few Latin American populations. Additionally, the interpretation of psychopathological conditions is also mediated by culture. Consider that pibloktoq is not considered to be hypomania or epilepsy; and dhat, shen-k'uei, sukra prameha, and jiryan symptoms are not considered to be hypochondriasis or an anxiety disorder (see Trujillo, 2008). However, locura does appear to correspond to the biopsychosocial model (Hall, 2006). Assessing these observations as a whole may leave one with a mixed picture relating to the way in which cultures compare with conventional classificatory systems. However, the basis for placing these observations side-by-side is not to compare these perceptions with the conventional models, but rather to give emphasis to the variations in term of the definition of psychopathology.

As a matter of interest, one may question the way in which redefining psychopathology will influence current affairs. Consider Harris' (2002) view that xenophobia is a new pathology in South Africa and that the foreigner has become the new container and victim of racism and aggression. While one may raise concerns regarding the psychiatric classification of such pathology (Harris, 2002), less restraint is required in terms of psychology. Certainly, the psychological distress associated with the dynamics of xenophobia leaves much room for conceptualisation. Harris, for one, has given the idea some thought.

According to Harris (2002), the isolation hypothesis views xenophobia as reflecting the segregation experienced by South Africans during the apartheid era. This sense of segregation indicates the experience of societal divide within the country, as well as the isolation experienced due to the supposed ennui exerted upon the state by the international community. The scapegoating hypothesis, however, posits that the foreigner acts as a scapegoat for societal crises, often being the recipient of displaced culpability. Regrettably, this hypothesis does not elaborate on why the foreigner becomes the scapegoat, and not any other group (Harris, 2002; Katz, Glass, & Cohen, 1992). Finally, the biological-cultural hypothesis proposes that physical appearance draws attention to trait differences, implicitly and essentially pointing out possible

targets of aggression (Harris, 2002). The three hypotheses do not account for why there appears to be a particular emphasis on xenophobic violence towards Black African foreigners. Thus, the hypotheses have much to account for (Harris, 2002).

6.3.4 Theme 4: Exploring somatisation

The way in which people in Africa discuss psychopathology is imbued with the capacity to communicate psychological distress via somatic symbolism (Dzokoto & Okazaki, 2006). On a more concrete level, somatic complaints afford the patient the opportunity to communicate the urgency and severity of his/her difficulties (Draguns, 2000; Lipowski, 1988). The advantage in relating psychological distress via somatic symbolism is that somatic complaints are potentially less emotionally threatening because of the focus on the outer self (Draguns, 2000).

The literature review reinforced Mai's (2004) view that the analysis of somatisation is tricky, even in areas with levels of increased incidence. This is often due to socioeconomic and community constructional variations. Often, somatisation may be a sign of particular modes of healthcare within a culture (Kirmayer & Young, 1998). However, various cultures employ illness narratives as communicative schemata which fulfil sociological and psychological functions. Somatisation can be appreciated as a sign of psychopathology, a manifestation of disease, a cultural form of articulating anguish, a representational indicator of intrapsychic conflict, a means of positioning oneself in his/her local context, and/or a channel for communicating social dissatisfaction (Kirmayer & Young, 1998).

Somatic symptoms have been viewed from various interpretative perspectives. Prospective meanings of somatisation may include the notion that somatic symptoms are a result of disturbed physiology. Thus, somatic symptoms may be regarded to be a sign of subjacent disease (Kirmayer & Young, 1998; cf. Trujillo, 2008). In addition, social or intrapsychic disturbances give rise to somatic symptoms (Kirmayer & Young, 1998). According to Somer and Saadon (2000), communicating intrapsychic conflict via somatic complaints often serves as a coping strategy. The symptoms may also serve to verify particular modes of psychopathology, or may be viewed as an idiom of distress (Kirmayer & Young, 1998). The latter view suggests ciphering

cultural representations of illness. Cultural representations of illness equip individuals with a lexis of disorder indicators and endow the patient with possible rationalisations for the distress. Somatisation, then, befits a culturally-pertinent idiom of distress which is lucid within the patient's cultural context but may allude to a dissimilar problem when deliberated on by an outsider. What may manifest as somatisation may, in point of fact, translate an ethnomedical concept. The dominant complaint may possibly veil noteworthy undertones which designate constrained emotions, social dilemmas, and moral sentiments.

An alternative interpretation of somatisation includes a construct commonly referred to as secondary gain. Thus, the presentation of somatic complaints may be perceived as a reaction to inadequate social positioning and familial relationships. This often facilitates the process and experience of immobilisation, acclimatisation, and help-seeking. In this regard, the degree of conscious and/or unconscious perceptivity available to the patient is often dependent on the cultural restraints imposed upon the person as regards the acceptable and/or unacceptable. Hence, somatic symptoms are laden with meaning and circumnavigate local structures of influence (Kirmayer & Young, 1998). Correspondingly, symptoms may be viewed as a form of dissent, particularly if they are in response to repressive circumstances (Gaw, 1993; Kirmayer & Young, 1998). It is worth mentioning that the acknowledgment of these attributions does not entail factitious pathology (Kirmayer & Young, 1998; Mai, 2004).

In terms of psychological conceptualisation, Shedler, Mayman, and Manis (1993) propose that the psychogenic induction of bodily distress transpires as a result of mediational procedures devoid of the patient's consciousness with regards to the underlying conflict or its influences. Similarly, Kirmayer and Young (1998) refer to the Manichean process of suppressed emotional distress emerging as somatic symptoms. To address this process, they propose that the therapeutic space reflect a shift from somatic representation to emotion-focused therapy. Enhanced prognostic factors may be accredited to cognitive-psychodynamic processes, interpersonal consequences, and psychophysiological mechanisms. Kirmayer and Young suggest that a practitioner who is unacquainted with the societal significance attached to culture-related syndromes may enable the patient's corporal fixation. The practitioner, as opposed to the patient, may therefore be seen as somatising.

6.3.5 Theme 5: Metaphysical vitalism

The literature review suggested that spiritual offences are returned with psychopathological symptoms. Ritual and purification serve to neutralise the cosmic disturbance (Kudadjie & Osei, 1998; Nsamenang, 1992). In general, persons from collective cultures employ both physical and spiritual resources to cope with these disturbances (Utsey et al., 2007). These counteractive behaviours, along with collectivistic-attuned support, serve as protective factors. They therefore appear to reduce the prevalence rates of psychopathology in non-Western communities when compared to Western communities (Dein & Dickens, 1997).

However, the spiritual dimensions from an African perspective extend beyond faith in the unseen, often defining the African worldview and incorporating spiritual kinship (Kwate, 2005). To appreciate the interactive dynamics within the African worldview, one ought to appreciate the oneness of being, a term frequently referred to in the literature review by Kwate (2005) and Nsamenang (1992). Thus, animals, plants, spirits, and inanimate objects are unified with the African worldview, none being more, or less, significant (Kwate, 2005). It appears that no area of existence is divorced from the African view of oneness. Beliefs regarding conception, the pre-birth existence, birth, and ancestor-hood all fall within the intertwined dynamics between primary and supra systemic processes (Kwate, 2005; Nsamenang, 1992; Scheper-Hughes & Lock, 1987). In Reichbart's (2007) view, spiritual, systemic, intrapsychic, and historical processes commingle within the cultural context and in so doing, shape the person's experience. Here, too, cosmology and history in Africa appear to play a pivotal role in shaping an African perspective on psychopathology.

The reviewed literature appeared to highlight the parallel between trauma and psychological distress in patients in Africa (e.g., Draguns, 2000; Gibson, 2004; Wohl, 2000). According to Reichbart (2007), traumatic history may produce a relentless onslaught on superego prowess, object constancy, defensive capacity, and/or one's aptitude to sublimate. By discounting the cultural context within which these realities are entrenched, one jeopardises the possibility of translating the experience as animated or psychologically lucid. Culture, including myths, traditions, and cosmology provides the fabric of the dynamics of life (Fiske, Kitayama, Markus, &

Nisbett, 1998; Markus & Kitayama, 2003; Reichbart, 2007; Schweder, 1991). From an ego perspective, they denote the cognitive structures to which the person is drawn to. In addition, from the point of view of assimilated superego restraint, they denote that which the person has categorised as parental reassurance (Reichbart, 2007). Still, socio-historical events ought not to represent the single focus of illness causation, and must be viewed as concurrently influential as spiritual influences (Nsamenang, 1992).

Often, African cultures appear to be relatively specific in terms of harmful behaviours. Consider that menstruation, forbidden sexual practices, and death encompass supernatural 'pollution' (Green et al., 1995; Jewkes, Levin, & Penn-Kekana, 2003). In order to decontaminate the affected person(s), rituals must be performed (Kudadjie & Osei, 1998; Nsamenang, 1992). Performing the rituals probably serves a cathartic function (see Dzokoto & Adams, 2005). Not performing the rituals may enforce supernatural disturbances. In fact, not fulfilling cultural duties such as burying the dead according to traditional processes may banish the vital source (likened to a soul) into supernatural exile, compelling the vital source to persecute those who defied the traditional processes (Nsamenang, 1992; Swartz, 1998). It may therefore be concluded that, according to the African worldview, non-compliance with regards to cultural practices is often the cause of spiritual, psychological, and physical distress.

Many culture-related experiences, as a result, are ascribed to unseen realities and may be misrepresented as psychiatric conditions (Trujillo, 2008). This is not an African-specific process and does not reinforce an African-as-different dynamic if appreciated within context. At least in terms of spiritual influences, similar dynamics operate in Korean cultures that experience shin-byung (Hall, 2006), in Middle Eastern cultures that experience zar (Hall, 2006), in Taiwanese cultures that experience hsieh-ping (Hall, 2006), and in Haitian and West African cultures that experience boufée deliriante (Trujillo, 2008). These comparative views are made available as to limit potentially essentialist views, however, the scope of the investigation relates to possible African perspectives on psychopathology and must therefore attend to research relating to the African perspective.

The research relating to the African perspective of illness categorisation is elegantly recapitulated by Toldson and Toldson (2001). In essence, moral indiscretions are regarded as spiritual transgressions and result in psychopathology. The transgressions foster imbalance in the group and the individual, thereby encouraging illness.

6.3.6 Theme 6: Culturology

Culturology studies the structure of cultural dynamics, including social, historical, and political influences, and is prominent in the field of anthropology (Bunge, 1998; White, 1975). The review exhibited that anthropology's loyalty appears to rest with the emic perspective (e.g., Patel, 1995). The relative approach in social anthropology converges on beliefs regarding malevolence, benevolence, prediction, causation, and healing (Pritchard, 1937). The unification of culturology and social anthropology, therefore, appears to meet the scope of the current investigation. As such, Dein and Dickens (1997) contend that understanding anthropology's investigations into systemic patterns is important in appreciating culture's influence on psychopathology. However, while anthropological data has been incorporated into the literature review so as to develop the review, psychological data will be applied in this section so as to bridge psychology, anthropology, and culturology. A concept which appears to foster this bridge is 'idiom of distress.'

The view that wellbeing is defined by physical and emotional symmetry is foundational in appreciating the functions of an idiom of distress. This view suggests that negative experiences may perturb equilibrium and generate syndromal outcomes. Consequently, particular individuals appear to be more susceptible to these disturbances due to their lived experiences within their social contexts (Kirmayer & Young, 1998). Certainly this interpretation relates to Becvar and Becvar's (1996) view of morphostasis within systemic processes. However, the representational view of culture may characterise the most important distinction between perspectives in cultural psychology and ecological perspectives (Miller, 1999). Cultural psychology also pays particular attention to that which is perceived to be typical, but is in fact grounded in cultural influences masked as universalistic perceptions.

Consider Scheper-Hughes and Lock's (1987) view that many popularised psychology theories suggest that the process of individuation is essential to the maturation process. Individuation is defined as the steady separation from family. This is in stark contrast to the aforementioned African-centred, collectivistic process of interpersonal relations. Individuation, therefore, appears to be a culture-bound view of human development and relates very much with Western perceptions of societal structure (Scheper-Hughes & Lock, 1987). However, some contend that traditional African practices encourage a form of individuation. Initiation rites and customs in African cultures, which symbolise the coming of age, serve to represent an individuation process (see Reichbart, 2007). From this discussion, one is obliged to accentuate the overt epistemological variances between African and traditionally Western socio-ontological processes. While the Western expectation that individuation is both essential and typical (Scheper-Hughes & Lock, 1987), the African view is that life processes are transitional. Thus, the infant enters a process of attempting to attain self-hood, while the elder enters a process towards attaining ancestor-hood (Nsamenang, 1992). Perhaps further refinement regarding the internal process of individuation, as opposed to the external process of independence, may clarify this discrepancy. Information relating to this potential process, with regards to traditional practices, could not be located during the course of this investigation.

6.3.7 Theme 7: Culture-bound syndromes

As one continues to reflect on the dynamics influencing culture-related pathologies, it becomes more apparent that symptom-classified systems would probably be inept in elaborating on the phenomenological functions of culture-related experiences, as well as the social functions of symptomatology (Kirmayer & Young, 1998). Consider that litego, as a culture-related illness, often yields Western-aligned depressive symptoms such as guilt and a depressed mood. Yet, local constructions of the illness suggest that these symptoms are a result of moral transgressions. It appears that traditional healers, as well as psychiatrists and psychologists, are perceived as being ill-equipped in treating people affected by litego. According to Edgerton (1971), the affected person(s) would have to endure atonement, in the form of confession, apology, and material compensation, to treat the disturbance, lest s/he experience fatal consequences.

Similarly, Korean, Chinese, and Taiwanese cultures also perceive mental illness causation as a result of historical, individual, and collective processes (Hall, 2006; Kirmayer & Young, 1998). Maintaining the unseen dimension as the source of mental illness causation, the Latin American and Greek populations view historical precipitating factors as a significant factor influencing mental health. However, high levels of expressed emotion appear to be prominent in terms of their illness narratives (Hall, 2006). It is interesting that the Native American population often share similar symptomatology with the African population. However, for Native Americans, a prominent symptom resulting from witchcraft includes the experience of asphyxiation (Hall, 2006; Saldaña, 2001; Trujillo, 2008). The literature review did not evidence this similarity in African-related symptoms of mental illness, and further research in this regard would potentially aid the clinical discipline, particularly with communicative and phenomenological material attached to somatic symbolism (cf. Dzokoto & Okazaki, 2006).

In considering the similarities between Eastern and African perspectives, a common view regarding psychological disturbances included the notion of *evil eye*. This phenomenon is common in African (Trujillo, 2008), Islamic (Lykiardopoulos, 1981), Western (Story, 2003), and Spanish (Trujillo, 2008) cultures. While this suggests the potential fusion of worldviews, it does not automatically suggest evil eye as universalistic. It appears that each culture attaches culture-specific nuances to the construction of evil-eye as a cause of distress (Lykiardopoulos, 1981). It may be argued, therefore, that psychopathology is not universalistic.

Concerning the analysis of culture-related syndromes, Kirmayer and Young (1998) are of the opinion that a preference for specific interpretations ought to be based predominantly on that which is valuable to the patient, and not that which is perceived to be verifiable or moderately verifiable. While this view appears to accentuate a more relativistic stance, it also brings to the fore the postmodern philosophy that no ultimate truth exists (Vitz, 2005).

Regardless of the relativistic attitude attached to interpretations of culture-bound syndromes, some have attempted to cluster and classify the syndromes (Tseng, 2001). However, the proposed classification systems appear to be organised in a way so that symptoms do not become particularised, and leeway is allowed in order to explore

spiritual and phenomenological process. According to Tseng, particular syndromes have been clustered into a number of groups: dhat and koro fall within the 'culture-related beliefs as causes' group; brain fag and taijin kyofusho are part of the 'culture-shaped adaptations of psychological distress' group; latah is an example of a 'culturally elaborated unique behaviour reaction;' mass hysteria and substance abuse are part of the 'culture-provoked recurrent occurrences of pathological conditions' group; and hwa-byung and susto fall within the 'cultural construal and response to specific psychopathology' group. These groups reflect the various ways in which culture affects psychological distress and has generally been regarded as an expressive approach in appreciating cultural psychopathology (Tseng, 2001).

While these clusters appear to be attuned to cultural perspectives on psychopathology, they do not appear to provide a context for healing processes. As a result, Marsella (2005) provides an interesting framework regarding healing subcultures. Healing subcultures are made up of five factors. The first relates to a collection of automatic thoughts regarding the aetiology and source of pathology that tessellates with the patient's cosmology and perception of reality. The second relates to the cluster of perspectives regarding the circumstance, framework, and conditions necessary for healing to take place. Third, the suppositions and practices required to bring forth specific cognitions, feelings, and actions come into play. The fourth regards the set of obligations and functions set out for patient, psychotherapist, and family. Finally, the particular conditions that determine the definition of therapy play a vital role in conceptualising that which constitutes healing (Marsella, 2005).

Implied herein is the view that universalistic interpretations do not necessarily resolve psychological distress. An accurate interpretation is one that finds agreement between the patient and clinician. The patient's cultural construction of infirmity dictates the precision of the clinician's analysis (Kirmayer & Young, 1998). Dodson (2005) also indicates that the distress ought to be formulated at the collective level if the cultures, as African cultures often appear, call for this need. In this regard, Dodson suggests that family patterning be appreciated as possessing its own cultural components, culturally personalised social reasons, and its own inborn societal strong points. Family patterns should, therefore, be traced with a cultural stencil instead of being moderated by a Western perspective. Within the African context, culturally

sanctioned child rearing procedures and extended family functioning ought to be included in family patterning (Dodson, 1995).

6.3.8 Theme 8: The representational world

The literature evidenced the way in which cultural perspectives are embedded in the psyches of people (see Hundt et al., 2004; Okello & Musisi, 2006). As a result, culture-related healing is preferred (Okello & Musisi, 2006). As a culture-related healer, the traditional healer is, or possesses material objects, imbued with supernatural curative properties (Edgerton, 1971). Although this implies qualities that are not readily available to psychologists and psychiatrists, there appears to be some opportunity for clinical intervention. According to Comaroff and Comaroff (1987), the imagery manifested by persons affected with seemingly psychological disturbances, offers the clinician the opportunity to explore these states in such a way so as to discharge stress associated with the experience. Furthermore, Pritchard (1937) suggested that exploration into social pressures may assist African patients in working through social difficulties and thereby siphon internal conflict.

As locus of control is often assigned externally in some African cultures, it appears that the clinician has little opportunity to intervene according to popularised clinical interventions. Ashforth (1998) expressed the entrenched belief in the reality of witchcraft and the way in which the witch is able to generate both individual and collective disquiet. Even in circumstances where local populations had little evidence confirming the influences of witches and traditional healers, Ashforth's participants maintained their cultural constructions. This appeared to suggest fixed cultural perceptions, as well as an unrelenting desire of the cultural norm of anticipating positive outcomes. Psychotherapeutic focus on providing the patient with a means to reduce stress, while not aiming to disrepute cultural beliefs, may be beneficial to African patients. In some situations, the clinician is often consulted to assist the patient with immediate, personal relief, while the patient awaits cosmic retribution (Littlewood, 2007).

This does not necessarily suggest the futility in clinical intervention. While it may be valid that unseen entities possess the greatest measure of curative influence (Santino,

1985), some African cultures believe that all entities are imbued with power (Lubell-Doughtie, 2009). Makgoba (1998) intimates that the power to tap into the cultural influences within African worldviews, is located in working with the symbolic value of belief systems. Thus, external knowledge ought to primarily focus on internal experience (Makgoba, 1998). In harmony with Chandler's (1998) observation, interpreting the metaphysical and creative dimensions of African perceptions allows the patient the opportunity to interpret the physical world. Knowledge in symbolism, therefore, allows the clinician the opportunity to access the representational world. The converse is also valid. Knowledge in this regard places the psychotherapist at an advantage due to the oratory nature of psychotherapy, correlating with African oral tradition (Chandler, 1998). In this regard, the literature review notes Chandler's observation of significant symbolic and archetypal images. These included the primeval egg, the blacksmith, and the elder. These were explored in section 4.8.6.

A significant theme available in the literature review suggests, from an African perspective, that the person is, by nature, prone to error and may have been predestined to exhibit negative behaviours (Achebe, 1986). If these belief systems are evident within the clinical encounter, it may be fruitless to attempt to alter these perceptions. This is evidenced in the process whereby culture mediates consciousness and the articulation thereof (Comaroff & Comaroff, 1987). It may be beneficial, therefore, to encourage phenomenological explorations so as to engage the dimensions of rhetoric and realism available within the clinical encounter. From a phenomenological perspective, personal explanations during the process of illness diagnosis and treatment are logical (Kudadjie & Osei, 1998). In terms of representation, consider the two primary modes. Realism symbolises accurate indications of the world, while rhetoric suggests that the world is depicted based on the way it is experienced (Mitchell, 1986).

In addition, the literature review suggested that acknowledging the African belief in a multiplicity of selves is important. It is also important to consider the psychological dynamics suggested in the role of each self (Scheper-Hughes & Lock, 1987). Certainly, the developmental expectations associated with the cultural perspective must also be acknowledged. Acknowledgement, here, refers to understanding that the person is a person-in-progress, the body is a container for the vital source, the vital

source is linked to God, a person's name reflects familial expectation, the child belongs to the community when s/he is born, and social maturity precedes biological maturity (Nsamenang, 1992). It is also important to consider that time resides in the spirit of experience (Kwate, 2005).

6.3.9 Theme 9: Psychopathology embedded in interpersonal relationships

The evolution of Homo Sapiens has exhibited many alterations over time. Darwin was of the view that ensuring continued existence would depend on the ability of the species to preserve mutually beneficial, loving relationships with everyone else. The need for this type of relating defined the survival of the species and became instinctual. This social instinct cultivated a humanitarian need within all people, and developed the core of *conscience* (Makgoba, 1998). For the Tswana people, the African view of genesis resembles Darwinian patois. The Tswana believe that people emerged from the caves, the home of the baboon (Setiloane, 1998a). While the literature only suggested the Tswana story of genesis as relating to evolution in the Darwinian sense, the literature review mainly evidenced that African beliefs regarding human genesis and interpersonal relationships are consistent with Mokgaba's observations (see Crystal, 2010; Setiloane, 1998a). Interestingly, the interpersonal processes suggested by these authors, including others in the literature review (e.g. Nsamenang, 1992), are similar to Harry Stack Sullivan's views regarding the interpersonal theory of psychiatry. In his work, Sullivan (1953) details psychoanalytic influences of interpersonal relationships, limiting unconscious dynamics that are typically associated with psychoanalytic theory. According to Rioch (1985), Sullivan's view that interpersonal relationships influence mental health reinforces the notion that culture influences psychopathology. The interpersonal theory of psychiatry, therefore, focuses on observable and interactional patterns rather than intrapsychic conflicts.

While collectivity suggests an affiliation to social relating, it must be stressed that positive interpersonal relationships are fundamental to African perceptions of mental wellbeing (Nsamenang, 1992). In this regard, Le Roux et al. (2007) underscore how Xhosa males undergo the psychologically strenuous process of initiation in order to symbolise the person's inherent connection to the community. However, individual-

focused psychological rewards are also apparent in the initiation process. According to Carstens (1982), initiation represents the end of immaturity and the beginning of manhood. Thus, while collective processes operate within collectivistic cultures, so do individual processes. Consider the way in which genital shrinking may elicit instant justices, but more specifically has an influence on the individual (Dzokoto & Adams, 2005). Some of the affected individuals in Dzokoto and Adams's study believed that witches had consumed or concealed the genitalia in order to bring about infertility or impotence. Similarly, witches are perceived as being capable of devouring the spiritual body and organs so as to cause death. In this way, genital-shrinking may be formulated as a spiritual process symbolising the demise of one's procreative capacity and existence (Dzokoto & Adams, 2005).

The discussion's focus on interpersonal relations and procreation appears to bring forward the Nigerian Igbo and Yoruba understanding of ogbanje/abiku. Ilechukwu (2007) describes the transpersonal, interpersonal, and spiritual processes of being a spirit child. It is often assumed that the affected person fashions his/her fate before birth and is able to be born and die repeatedly. This is referred to as malignant re-embodiment. However, once born, the person displays behaviours that are deemed to be atypical in their cultures. Often, behaviours which set the individual apart from functioning according to typical cultural norms, such as perceptual disturbances or exceptional talent, are perceived to be disordered and indicative of ogbanje/abiku. While the symbolic function of ogbanje/abiku represents the celebration of life and the fear of death (Ilechukwu, 2007), the influence of the affected child and his/her mother appear to be profound.

For the affected child, the symptomatology of ogbanje suggests that there is a lack of awareness with regards to emotional and cognitive processes. As a result, the person's behaviours are separated from psychological processes. It is therefore logical to regard this process as suggestive of a disembodied psyche (Ilechukwu, 2007). While individual dynamics were often deficient in the literature, much attention was paid to the mother figure. In fact, the mother figure is frequently discussed in terms of everyday experiences (Ilechukwu, 2007), stories regarding genesis (Ngubane, 1977), and as healers of psychological disturbances (Littlewood, 2007). While the role of 'mother' is seen as significant in psychodynamic theory (e.g. Sullivan 1953), other

approaches also highlight the significance of the mother figure, such as Jungian approaches, particularly with reference to the Great Mother archetype. This archetype refers to the positive and superior qualities attached to the mother figure (Hayman, 2001). Regardless of the abstract connotations associated with mother-child interaction, the mother–child interaction has the propensity to significantly influence relational resonance in interpersonal relationships. This certainly implies a concrete and biological process in each person (Seltzer, 2005).

Here, the term *resonance* appears to feature. Resonance refers to the concurrent neuronal firing and mirroring that occurs in the brain when two or more people relate to each other. The innate relational resonance between mother and child, when they first meet, triggers neuronal activity. This becomes the template for neuronal activity in future interpersonal relationships and continues all through life (Seltzer, 2005). Resonance appears to refer to intersubjective experience, that is, the space where subjectivity meets subjectivity (Hassim, 2009).

Perhaps the implication of introducing *resonance* into the discussion is to draw attention to the interplay between individual, society, culture, and politics. Scheper-Hughes and Lock (1987) indicate that perceptions of body may be analysed in terms of the phenomenological experience of the individual body-self; the collective body as symbolic of thoughts relating to the interplay between community, culture, and nature; and as body politic, that is an object d'art of political and societal domination.

Much attention has been afforded to the symbolic functions of African beliefs. However, it ought to be noted that Western symbolism can relate to African symbolism. Western metaphorical views are not so different from African symbolic views that the two cannot locate common ground (Scheper-Hughes & Lock, 1987). Hook (2004b) suggests theories relating to the collective unconscious would suggest that all human beings share universal archetypes that allow symbolism to be understood by other human beings. An archetype is a symbol of a universal image shaped in the collective unconscious (Hook, 2004b).

However, some have argued against the theory of the collective unconscious. Fanon is one such example (Hook, 2004b). According to Fanon, historically racist systems

were suggestive of a European collective unconscious, reinforcing the so-called Negro myth. The myth suggested that Black people served as the container for negative racist perceptions. Fanon indicated that the European collective unconscious was not a genetic product, but rather, a product of culture (Hook, 2004b).

6.3.10 Theme 10: Legends

The literature review clearly illustrated the way in which legend influences psychological distress, as well as the way in which the distressed can be resolved (e.g., Dow, 1986). Operating at the level of collective memory (Toldson & Toldson, 2001), legend also appears to have the potential to modulate the way in which culture influences psychopathology (Arlow, 1961).

African consciousness personifies the collective memory of ancestral sapience (Toldson & Toldson, 2001). The extraordinary way in which the collective imagination induces a person into cultural clusters is often a process suggestive of meeting fundamental group needs. Legend, as a result, facilitates psychic integration, often dispelling experiences of self-reproach and anxiety. It fashions the adjustment to reality and the way in which interpersonal relationships unfold. Accordingly, it characterises the lived experience of the individual, within a cultural context, and thereby illustrates how legend stimulates the crystallisation of personal identity, as well as the utility of the superego (Arlow, 1961).

The African story of the hero Kgodumodumo is representative of many heroic stories in Africa. The Western name for Kgodumodumo is *dinosaur*. Science confirms that dinosaurs existed, and that they inhabited the same territory populated by the Tswana-Sotho people (Setiloane, 1998). Setiloane is of the opinion that academic literature rarely explored the interaction between humans and dinosaurs. Accordingly, this legend fills the gap. Kgodumodumo's story certainly suggests affiliation to the hero image, as well as the dynamics suggested in heroism.

Campbell (1992) conceptualised the universality of the hero archetype by focusing on various cultural myths. He suggests that the hero's journey, often called monomyth, is characterised by being plunged into the depths of distress and after many

transformations becomes renovated in body, mind, and spirit. The factors which facilitate the hero's journey, and survivor of distress, comprise multiple processes. First, the person is faced with an emotional journey that s/he must undertake at any, even many, stages of one's life. As a result, the person is exposed to distress, defeat, bereavement, and catastrophe. The adventures contained in the access to, and exodus from, the distress are influenced by powerful unseen dimensions. These adventures try the human spirit. During these trials, the person experiences the rotation of re-birthing, of encountering the successions of living and dying. Within these cycles, the hero emerges and confronts the challenge of transforming within the process (Campbell, 1992; Jewett & Lawrence, 1977). The hero's journey represents the process whereby regular people endure remarkable experiences (Campbell, 1949). The myths allow for the person to translate his/her expedition in life, with origins in neonatal purity toward the ultimate experience of meeting and overcoming apparently insuperable trials (Campbell, 1992).

A hero, that is to say any person who confronts distress, encounters six effects in locating the pathways to reparation. First, the hero aims to recondition the balance with regards to body, mind, and spirit. Second, the hero aims to rejuvenate fundamental bodily and psychological vigour. Thereafter, s/he fosters healing via psychic assimilation and mindfulness. Fourth, the person sanctions those facets which provide energy to his/her journey in life. Then, s/he employs the restorative and remedial facilities supplied within his/her cultural framework. Finally, the hero embraces those restorative actions that foster resilience (Campbell, 1992).

Acknowledging myth, legend, and imagination in psychotherapy is greatly beneficial to the patient (Leeming, 1981; Mansell, 2005). Imagery, particularly imagination, occurs at the lower levels of the hierarchy. The lower the level, the more accurate the simulation becomes. As the simulation becomes more vivid, it is disposed to prompting behaviours that manipulate the environment. As is apparent, the imagination mode is clinically appealing as, based on fantasy, it is disengaged from the higher and lower levels. Input is therefore a process of feedback based on what appears to be perception, but lacks environmental stimuli. The simulation allows the person to experience events without actually risking environmental engagement (Mansell, 2005). Embracing the imaginal mode in therapy therefore allows access to

lived experience with less threatening stimuli in the foreground. An effective way of introducing this dimension in psychotherapy is via sub-verbal memories and resonance (Seltzer, 2005).

Sub-verbal memories are those memories which are inaccessible to the conscious mind. These memories tend to communicate their existence through physical and psychological symptoms (Seltzer, 2005). The subjective and intersubjective experience of *connection*, that the therapist and patient have established rapport, is an indication of the dynamics of the resonant brain and mind (Seltzer, 2005). Bear in mind that worldview stems from culture, but is experienced and managed at interpersonal and individual body and mind levels. As a result, cognition, affect, socialisation, and behaviour are annulated via cultural influences, and acknowledged as such by cerebro-neural activity. Consequently, establishing a trusting relationship with the patient will allow the patient the space to communicate psychological disturbances via resonant dynamics – a process which is evident interpersonally and biologically (Seltzer, 2005).

Confronting that which rouses life, allows patients to become aware of the significance of their lived peregrination. The embodied self becomes defined by one's transformations and the possibilities of what one will become. Herein lays undiscovered riches such as awe and ecstasy (Schneider, 2007). Along these lines, the patient experiences psychological emancipation. Schneider further asserts that the transformative journey allows the patient to access greater meaning and in so doing, respond rather than react to the changes in life.

According to Dow (1986), the mythic world is the intersubjective arena of the healer and patient. The healing process in this world is symbolic. As such, healing depends on the way in which the healer reorganises the illness, compelling the curative process to be based on experiential reality. Myth becomes the platform upon which the patient's experience is appended to transactional symbols. In this way, the healer is able to influence the transactional symbols in such a way that the patient becomes competent in coping with his/her feelings (Dow, 1986).

6.3.11 Theme 11: Transformation

Berry (1998) is of the opinion that the individual's self-concept and the level of acculturation s/he experiences are fundamental to the diagnostic and treatment process. To assume that acculturation automatically implies psychological distress would be fallacious. In fact, individuals may be able to adopt new cultural perspectives which they experience as beneficial, and may abandon those perspectives which they experience as unconstructive. During this process, it is possible that the individual may experience mild or moderate psychological distress. However, if the individual attempts to incorporate new perspectives but struggles to abandon deep-seated, conflicting perspectives, s/he may experience acculturative tension and experience moderate to substantial psychological distress. Individuals are vulnerable to experiencing severe psychological distress if the transformations they experience during the acculturation process are so stressful that they subjugate his/her capacity to cope (Berry, 1998). With regards to acculturation in South Africa, and as explored in Chapter 1, acculturation in South Africa is surrounded by transformation. In line with Nagel's (1994) view that self-definition as an individual process may apply, one ought to question the way in which the African patient defines him/herself as traditional, as an African in the process of acculturation, or otherwise. Arguments in the thesis (e.g. Appiah, 1992) acknowledged these contentions.

6.3.12 Theme 12: Ecumenical psychopathology

Interactional approaches to schizophrenia suggest that diathesis, a biological susceptibility, and stressful life events precipitate the manifestation of psychopathological conditions. As such, the interface between the diathesis and stress foster the development of mental disorders (Sadock & Sadock, 2007; Walker & Diforio, 1997). Dynamics that serve as stressors and thereby increase one's susceptibility to developing psychosis include traumatic experiences in youth such as lack of secure maternal attachment, birth and obstetrical difficulties such as anoxia, and gestational hazards such as malnutrition and exposure to certain viruses (Le Roux et al., 2007). The Afro-Caribbean population is one such population where African descendents appear to ascribe to an ecumenical model of psychopathology (see

Hickling & Hutchinson, 1999). This suggests that a universalistic approach to psychopathology is embraced.

6.3.13 Theme 13: The psychosocial and socio-political aetiological sphere

Negotiated covenants of what we think is beneficial to our cultures, determine truth. Furthermore, that objectivity is impartial is a canard, as the only objectivity is intersubjectivity. Under the conditions of a logical argument, the most plausible conclusion based on the preceding premises is that science, even psychosocial science, is cohesion defined by the limits imposed upon it by culture (Louw, 1998).

In this regard, consider the literature relating to the way in which local cultural understandings of genital theft imply a major shift in cosmic functioning (e.g., Adams & Dzokoto, 2007; Dzokoto & Adams, 2005). That local people employ instant justice to restore the *stolen* organ appears to be a systemic operation aimed at attaining homeostasis. While some have noted the media sensationalism attached to genital theft epidemics (Adams & Dzokoto, 2007), local communities affected by the disturbance exhibited severe psychological trauma (Adams & Dzokoto, 2007). Affected persons were confronted with the prospect of concurrently losing their abilities to feel like a whole person, as well as unwillingly fuelling malevolent trade. The same may be said for persons affected by koro (Dzokoto & Adams, 2005). Indubitably, what is real from a cultural perspective, is real nonetheless.

Genital-shrinking epidemics may be understood in terms of the MPI explanation. Mass psychogenic illness (MPI) refers to the group experience of symptoms without an identifiable pathogen (Dzokoto & Adams, 2005; Sadock & Sadock, 2007). MPI differs from folie à deux, a shared psychotic disorder (Reber & Reber, 2001) which occurs on a much smaller scale than MPI (Sadock & Sadock, 2007). Classically, MPI originates in settings where psychological and psychical arousal is increased by social tension. The tension accumulates to the extent that members of the group experience feelings of diffuse arousal. At the point where the tension reaches its crescendo, cultural perceptions of the tension are employed in order to supply the group with a plausible justification for their experiences. Mediated by cultural perception, the justification receives extensive attention by those who share these perceptions. MPI

may apply to various cultures as this explanation validates that reality is locally constructed (Dzokoto & Adams, 2005).

Well-being cannot be split off from the discourse of social alterity. The diverse socioeconomic and political influences in Africa's history launched the basis for current perceptions of diagnosis, treatment, well-being, and illness (Feierman, 1985). Similar views regarding ataque de nervios have been cited in the literature review. Much of the current body of literature regards ataque de nervios as a common illness that symbolises the lived experience of people affected by social disturbances (López & Guarnaccia, 2000). Reality, including the reality of those who have been subjected to trauma such as racial prejudice, is forbidding and iniquitous. The neurotic tensions that overwhelm all people are, to a large extent, a product of lived experience. Some of the psychosocial mêlée, those internalised tensions, are not resolved by environmental change. The focus in therapy ought to include reinforcing and developing the patient's capacity to successfully cope with the demands of the external world (Wohl, 2000).

Due to the substantial influences of political and socioeconomic dynamics, professionalist forms of treatment appear to have played a much smaller role in shaping perceptions of health and healing (Feierman, 1985). Feierman's view appears to have endured, and this was particularly evident in the South African context (Tomlinson et al., 2007). Furthermore, as environmental conditions influence psychopathological experiences, it ought to be acknowledged that social conditions influence psychopathology (Okello & Musisi, 2006; Pronyk et al., 2006), although social conditions should not be interpreted as being tantamount to clinical conditions (Tseng, 2006). It is clear that this juncture necessitates further clarification with regard to the idea of social process.

There is much to be learnt from traditional social processes. Reunification of political discord, for example, may benefit from employing the way in which impandes resolve ethnic difference. Reconciliation, from this perspective, highlights the similarities among people and applies these to larger systems (Green, Zokwe, et al., 1995). However, disregarding cultural diversity may imply fears related to discussions on race. From a psychodynamic perspective, the oedipal stage is regarded as the phase

when awareness of racial identity has an effect on the person's entrance into the social. Oedipal anxieties are intensified by experiences with forms of social disparities. Resolving oedipal anxiety should include the confrontation of perceptions of race, particularly where these perceptions reflect fear, idealisation, or withdrawal (Swartz, 2007).

The body as a representation of the social influences will undoubtedly be reflected in African conceptualisations, and psychological formulation may appreciate these dynamics as representative of the embodied world (Kwate, 2005; Scheper-Hughes & Lock, 1987). Nevertheless, the interpretation of somatic and social disturbances will probably suggest disconnectedness as the source of the distress. This disconnectedness may relate to the physical, social, and/or spiritual (Berg, 2003). These considerations often play a pivotal role in traditional healing, and clinicians will benefit their patients by not discounting these dynamics (Edgerton, 1971). Acknowledging these influences often allows African patients the opportunity to engage in cathartic experiences (Littlewood, 2007), but also allows the patient to explore supportive resources within his/her community (Edgerton, 1971).

The African endeavour to explore meaning in one's life is defined as cosmological interconnectedness (Chandler, 1998), as well as interpersonal unity (Boykin et al., 1997). These dimensions appear to display reverence for a combined view relating to those aspects often perceived to be subdued power distance (Draguns & Tanaka-Matsumi, 2003), as well as individual identity processes (Gervais-Lambony, 2006). Personal, or non-scientific, explanations are socially and spiritually constructive. They serve to comfort people, particularly if they are delivered with acumen and tact (Kudadjie & Osei, 1998).

6.3.14 Theme 14: The social functions of psychopathology in Africa

It appears that psychopathology has specific social functions in Africa. These topics seem to fall under three sub-themes, namely stigma; secondary gain; and social healing.

6.3.14.1 *Sub-theme 1: Stigma*

The literature review abounded with ideas relating to the negative stigma often attached to psychopathology (e.g., Bhugra & Bhui, 2001; Rogers et al., 1998; Sieff, 2003). Stigma functions as an efficient type of psychosocial monitoring by penalising persons who contravene inequitable power relationships such as age, race, ethnicity, and gender (Cambell et al., 2005). Fear of physical and symbolic contamination leads to stigmatisation. Continued fear threatens the well-being of wounded persons, but also allows the stigma to evolve (Cambell et al., 2005).

6.3.14.2 *Sub-theme 2: Secondary gain*

In Nigeria, children perceived as ogbanje are sent off to live with non-relatives, do chores, and baby-sit the children of these non-relatives. In this way, they earn money to send to their families. The non-families pay the ogbanje in advance. However, the children are often physically and sexually abused. In response, the child labourer begins to exhibit ogbanje symptoms (that is, they display symptoms which are congruent to local understandings of disordered behaviours), and is duly returned to his/her family. The ogbanje symptoms often abate upon return to the natural family. Repeated patterns of this behaviour are assumed to be the actions of scam-artists and are becoming frequent. While genuine cases have been reported, the scam-artists are regarded to be exploiting the cultural phenomenon for secondary gain, such as receiving material income without having to fulfil the duties expected by the non-relatives (Ilechukwu, 2007).

6.3.14.3 *Sub-theme 3: Social healing*

The theme of social healing was prominent within the literature. Healing is a universal process. If one aims to heal a person, it is automatically assumed that one is aiming to heal the society, as well as the natural world. As inseparable constructs, one cannot heal one aspect without influencing another (Edwards, 1998).

6.3.15 Theme 15: Configurationism

Scheper-Hughes and Lock (1987) provide a prolegomenon regarding the Cartesian approach explored in academic works, most often assumed to be associated with biomedicine. The dualism fostered in this approach splits soul and matter, psyche and body, actual and invisible. This epistemology is not a universal one, and is itself a cultural and historical construction. Appreciating those perceptions which differ from the main implies the prorogation of usual perceptions related to the tension of supposed opposites such as rational/magical or mind/body. Essentially, one must integrate the notion that the body is inextricably a physical and symbolic relic, a construction of culture and nature, and attached to a specific epoch (Scheper-Hughes & Lock, 1987).

Even in its attempt to reintegrate body and mind, psychoanalytic psychiatry and psychosomatic medicine continue to regard psychopathology as either organic, or psychological in nature (Scheper-Hughes & Lock, 1987). Devoid of a vocabulary to describe the interactions between mind-body-society, we employ hyphens to link these terms. These hyphenated phrases symbolise the disorganised nature of our thoughts. Although some may articulate theories of unified configuration, literature abounds with conceptual terms that demonstrate the disconnectedness. These include conceptualisations relating to somato-social, psycho-somatic, and bio-social. These terms are ineffectual in communicating the integrated mind-body-society process, and merely imply some of the ways in which the body communicates messages from the mind (Scheper-Hughes & Lock, 1987). In this regard, considering theories aligned to yin/yang cosmology (Porkert, 1974) and gestalt-aligned approaches (Sternberg, 2003) may be beneficial. These views are regarded under the umbrella term *holism*, in that an integrated and undivided view of experience is appreciated (Porkert, 1974; Sternberg, 2003).

6.3.16 Theme 16: Traditional healing

The literature review demonstrated the symbolic value of traditional healing (e.g., Koss-Chioino, 2000). This value is not unique to African cultures, and is also shared by a diversity of other cultures (see Hall, 2006). A significant theme which transpired

during the review was that, unlike modernistic conceptualisation, non-Western conceptualisations share a positive belief in supernatural forces (see Saldaña, 2001) and maintain their beliefs in the ability of traditional healing to address psychological disturbances (Trujillo, 2008). This also applied to Western populations that maintained, at least some, traditional perspectives (Hall, 2006).

An interesting observation during the current investigation included that African patients often experienced traditional healing as cathartic. In addition, performing traditional rituals appears to allow the person to develop closeness to God (Nsamenang, 1992). However, traditional rituals also serve as an effective coping mechanism, both physically and spiritually (Utsey et al., 2007). In a process similar to modern views of sublimation, the person is offered the opportunity to spiritually destroy malevolence (see Ashforth, 2005).

However, traditional healers are often mistrusted by modern practitioners. Because the work of a traditional healer primarily includes counteracting witchcraft, the healer is bound to, and dependent on, the witch (Wreford, 2005). Furthermore, modern practitioners question the reliability of traditional diagnoses. Although there are many con artists, genuine traditional healing practices may be discrepant due to the possible divergence in meaning (Wreford, 2005). At this juncture, it may be valid to suggest that modern clinicians also diverge in diagnoses as the diagnostic process is not an objective process. Diagnoses also become adjusted as more information transpires. I draw on this opinion from personal experience in the clinical field. As a point of note, consider also that the reliability of modern diagnoses has also been fervently questioned by Western theorists (e.g., Szasz, 1995).

6.3.17 Theme 17: Schism / immix

Schism/immix refers to a duality of ideas, specifically with regards to the similarities and differences in cultures. In this way, multiculturalism, as well as cultural diversity, may be appreciated in that comparative views are offered as a gesture of learning about various cultures.

An erroneous assumption that modern and traditional views are in disharmony must be dispelled. Certain views regarding the similarities with the process of constructing psychopathology may apply to traditional and modern conceptions of psychological distress. This was comprehensively explored in Chapter 1 by Appiah (1992), Chick (2000), Eshun and Gurung (2009), and Nagel (1994). It appears that internal conflict, over and above the influences of phenomenological cultural experiences, may be understood to apply to both modern and traditional conceptions of psychopathology. There are a variety of symptoms which suggest conflict. Emotional disturbances such as grief and anxiety are common symptoms. Furthermore, perceptual disturbances such as hallucinations and imagery may suggest conflict, as does cognitive disturbances such as delusions and intrusive thoughts. Behavioural disturbances such as arbitrary control and displacement activity are also symptoms of conflict. Other symptoms include physical effects, loss of self-control, and loss of control over one's environment (Mansell, 2005).

Reducing psychopathology to a biological disorder which can be medicalised alters the social into the organic (Scheper-Hughes & Lock, 1987). The environment is perceived via the sensory organs. During the sensory (input) stage, disturbances may become apparent. An internal comparator assesses incongruities between environmental stimuli and internal reference points. Internal reference points are defined by instinctive predilection and/or previous perceptual experience. Behaviour (output) occurs as a response to these incongruities and aims to moderate the impact thereof. From a biomedical perspective, this process may be compared to the body's tendency to manage and regulate temperature by perspiring, for example. In the same vein, a person is prompted to obtain food when s/he becomes hungry (Mansell, 2005).

The uppermost goal of every person is related to the self-ideal system concept. As such, a person strives to be perceived as, and experience oneself as being, competent, reliable, and likable. People behave in ways which aim to fulfil this goal. The system concept stipulates rules which specify behavioural programmes. For example, a system concept rule may suggest that the person conceal signs of anxiety, the responsive behavioural programme may be that the person obscures bodily quivers. The system concept then limits this programme to simplistic forms, to the extent that the body regulates low levels of sensation, as well as the degree of discrepant stimuli.

As follows, minor modification, such as adjusting muscle tension, may be employed to reduce the quiver (Mansell, 2005).

Worldviews are not simply derived from logical inference (Gettier, 1963), but are rooted in system concepts which manipulate the environment in such a way so as to influence the perceptual experience of the person (Checkland, 1997). The uppermost goals establish the reference points for lower goals so as to guide behaviour. This allows for perceptions which are congruent with the internal rules. Uppermost goals do not require to be consciously accessed, as the predefined reference points are competent in influencing the environment. Therefore, a person may perform specific behaviours devoid of awareness into uppermost goals, or overarching motivation (Mansell, 2005). Positive feedback cycles are prone to volatility. These cycles thrust the individual clear of perception, with no goal to achieve. The volatility of such an anti-goal may precipitate psychopathology, according to the conventional definition (Sadock & Sadock, 2007). An example that often emerges in psychopathological conditions is the fear system (Mansell, 2005).

Internal bases of conflict include arbitrary control, intolerance of ambiguity, inflexibility, irregular feedback cycles, behavioural difficulties, and inadequate adaptation approaches to achieve goals (Mansell, 2005). External bases of conflict include interpersonal control, significant life experiences, and transformations in environment and/or self (Mansell, 2005). These appear to relate strongly to African perceptions of external influences on psychopathology.

6.3.18 Theme 18: Sectionalisation

By forming impression through the senses, Western psychology is dependent on that which is material. From an African perspective, oneness is a reality. The material and spiritual are inseverable. Intuition, the sixth sense, and the unseen dimension are valued more than that which is material (Toldson & Toldson, 2001). Perceptions of historical consciousness in this way differ from typical Western perceptions of ‘real’ accounts of events (Comaroff & Comaroff, 1987). Western-centred classes of psychopathology are rooted in Eurocentric models of rationality, individualism, and anti-spiritualism. This biomedical view of psychological distress automatically

contradicts African cosmology and is, according to Kwate (2005), therefore not suitable in detecting psychopathology amongst Africans. Differences in interpretations of reality reinforce the notion of otherness. Yet, polarised differences in construction of reality have led to Western perceptions of the African experience as pathological. Those subtle critics sometimes imply that supernatural constructions of reality are a product of superstition or lack of knowledge (Adams & Salter, 2007). The debates relating to the *other* are often most evident in Afro-radical and nativist views.

In exploring African perspectives regarding the realisation of selfhood, the development of self-consciousness, and becoming independent, intersects with two types of historicist thinking, both of which suggest blind alleys. On the one hand, Afro-radicalism is laden with political expedience and instrumentalism. Described as democratic and progressive, this type of historicist thinking employs separatist views to illustrate African culture as emancipatory in nature, with the hope that a discourse of the authentic African experience may be cultivated. Nativism, on the other hand, is laden with the metaphysics of radical diversity. This perspective endorses that the African identity is unique as a result of race (Mbembe, 2002). While these views are indicative of difference, it appears that a focus on similarity may reduce separatist discourses. In this regard, the similarity-attraction hypothesis appears to apply. The similarity-attraction hypothesis suggests that perceived similarity brings about attraction. Thus, individuals who perceive others as similar will probably regard others more positively (Osbeck, Moghaddam, & Perreault, 1997). Notwithstanding the benefits of this hypothesis, human beings are often aware of differences (Lieberson, 1961). Giles and St. Clair (1979) are of the opinion that the human process of recognising differences is due to the human need to maintain one's group identity.

Certainly, and almost automatically, the title of this investigation, like many sources consulted in the literature review (e.g. Ashforth, 1998), suggests an us-them dynamic. Considering the influences of culture on psychological experiences necessitates deliberating on conceptions of the unintentional or fundamental. Unintentionally, people differ due to ethnic and racial differences, but are fundamentally human (Patterson, 2004). Patterson is of the view that humanity precedes any unintentional

differences. Because shared culture represents the intersection of more than one culture, it embodies the dynamism of multiculturalism and disallows the exclusion of related cultures (Ritchie, 1997).

The pre-eminent statute in considering population-specific experiences is to bear in mind that all people are constituents of a common genus and follow parallel developmental processes, such as biological development (Achenbach et al., 2008). Culture-specific groups are becoming a rarity. The permutation of cultures within every society suggests that people, especially counsellors, are automatically developing the capacity to work with people from various cultures. Furthermore, attempting to generate theories and techniques to work with every culture and/or subculture would be impossible (Patterson, 1996).

From a philosophical point of view, the Hegelian thematics regarding the self lacks phenomenological insight. In this regard, pseudo-historical traits such as race are thought to characterise people based on geographical location, as well as racial collectivity (Mbembe, 2002). It appears that personal experiences relating to unsaid dynamics, during the course of this investigation, ought to be reflected on. It appears that evidence of *otherness* is closely monitored so as to avoid the replication of historical separatist dynamics. Yet, the awareness of *otherness* has the potential to allow for the appreciation of the *other*. Appreciation, in this sense, appears to entail exploring the way in which the *other* sees oneself. It appears, however, that the underlying anxieties related to *otherness* often overpower the opportunity to appreciate *otherness* that lacks separatism.

Anxieties regarding *otherness* operate within dissociated unconscious material. The *other* remains a part of who we are, the self that we repress. Race appears to be a contentious issue in this regard. From a psychoanalytic perspective, there is no standardised way of considering issues of race. Irrespective of what or who is perceived to be *other*, these are embodied in unconscious anxieties and reside permanently within us. The *other* becomes the expelled part of the self that cannot be retained in conscious awareness (Swartz, 2007). During the oedipal period, from approximately age three to age five, racial identity is formed. This is the same period in which gender identity is formed. In racially prejudiced societies, the growing awareness of race during the oedipal stage is not naïve. In the same way that a female

comes to know that she will have to endure unfairness in a male-dominated society (cf. Foster, 1999), so does the child come to realise that race will influence his/her life as inevitably as gender will (Swartz, 2007).

The oedipal period also includes personality development marked by rivalry, primal love, autophobia, and primitive hate. The volatile experiences of idealisation, defamation, attack, and defense all operate simultaneously, as does the amplification of similarities and differences. Those unacceptable experiences are repressed, and include positive and negative perceptions of the *other*. Resolving these oedipal anxieties includes developing the propensity to endure exclusion devoid of experiencing abandonment, and to appreciate diversity as harmonious. This resolution applies to individual as well as social dynamics (Swartz, 2007).

Racism does not include the awareness of race (Foster, 1999), but could potentially include considering the cultural *other* as wholly different (Banton, 1987). Furthermore, attempts to counter attempts at reducing racism, such as employing multiculturalism and anti-racism, have the potential to elicit multiple racisms (Wieviorka, 1995). Discounting cultural perspectives, even in its slightest form, may also suggest racism. This if often referred to as symbolic racism (Hopkins, Reicher, & Levine, 1997). To deny the African perspective on psychopathology may therefore imply symbolic racism.

The multiplicious, seemingly non-essentialist, multicultural perspective underpins the opinion that culture is unstable, hybridist, and transitory. The prospective difficulty, here, is that this perspective may overlook the opportunity to exercise proactive measures in constraining racism (Gilroy, 1993; Goldberg, 1993; Wetherell & Potter, 1992). With these ideas in mind, Hook (2004b) is explicit in his view that universalising conceptualisations in the South African context may be inappropriate at present. How, then, does one fulfil the task of exploring cultural perspectives? Perhaps the first task would be to monitor ethnocentric views.

Ethnocentrism often suggests applying capricious perceptions of one's own culture as a benchmark for gauging other cultures. This dynamic absolutises one's own culture to the detriment of the self-understanding of other cultures (Louw, 1998). The

Afrocentric perspective, as suggested by Mabie (2000), is also essentially an ethnocentric perspective and caution should be exercised with regards to the essentialist conclusions drawn from this perspective (Foster, 1999).

6.4 Conceptual conclusions

In attempting to respond to the research question, that is questioning an African perspective on psychopathology, the current investigation found that many clinicians appreciated non-Western conceptualisations of mental illness as universalistic psychiatric disorders with atypical features (e.g. Yen & Wilbraham, 2003). The literature review, however, also evidenced an existence of traditional African psychiatric nosology and treatment (e.g. Edgerton, 1971). A similar induction may be made on the basis that the DSM-IV has included culture-bound syndromes in its classificatory system. Certainly, the evidence presented in the literature review of the many culture-related disorders may suggest the authenticity of an African perspective on psychopathology. Cross-cultural psychopathology and contemporary transcultural psychiatry appear to assent to this view (see Tseng, 2006). Furthermore, that cultural misinterpretation has led to diagnostic flaws and ineffective treatment (Kirmayer et al., 2003) certainly highlights the idea that universalistic diagnoses misrepresent culture-attuned diagnoses. Levers and Maki (1995) were therefore unsurprised to find that patients experienced superior outcomes after receiving culture-specific treatments. While formulations regarding the cause of illness differed between Western and African healers (Kudadjie & Osei, 1998), traditional Africans evidence better prognostic outcomes from traditional healing processes (Levers & Maki, 1995). However, the possibility that language differences create a barrier between Western practitioners and traditionally African patients may be a confounding factor with regards to treatment outcomes (Janse van Rensburg, 2009). Therefore, further investigation in this regard is necessary.

With regards to non-Western approaches to healing, spiritual, holistic, and collective approaches have been shown to successfully treat psychopathology (see Bojuwoye, 2005; Levers & Maki, 1995; Mbiti, 1969; Toldson & Toldson, 2001). Furthermore, aetiological views relating to the cause and course of psychopathology in Africa has been formulated and treated from traditionally African frameworks (Kudadjie & Osei,

1998; Liddell et al., 2005; Odejide et al., 1978; Okello & Musisi, 2006), the literature being unable to reach consensus regarding the origins of this treatment. The implication is that, possibly, treating mental illness from a traditional perspective occurred with the inception of traditional healing. This begs the question: did culture-related psychopathology ever *not* exist? Additionally, if culture influences the developmental process, including cognition (Nsamenang, 1992), as well as the experiential process (Draguns & Tanaka-Matsumi, 2003), then those experiences regarded as symptomatic of psychopathology certainly suggest a cultural perspective on psychopathology (cf. Draguns & Tanaka-Matsumi, 2003).

Obvious concerns regarding the foundational aspects of traditional healing may include some apprehension towards the supernatural grounding of illness causation and healing. Professionals may go so far as to elaborate on the seemingly non sequitur process of culture-related psychopathology. Certainly, it is possible that beliefs regarding the supernatural may suggest some illogical foundation, yet it is equally illogical to assume that the supernatural does not exist. Proof, in this regard, constitutes subjective reality (Adams & Salter, 2007). African subjective realities are not separated from biomedical perspectives. For instance, the Tanzanian Hehe people attribute illnesses to natural phenomena, witchcraft, and/or the transgression of cultural norms. Depending on how the illness is perceived, this community seeks the assistance of Western and/or African doctors (Edgerton, 1966; Edgerton, 1971; Nsamenang, 1992). As a consequence, equal value must be assigned to the importance of both traditional and modern constructions of illness and healing practices (Patel, 1995).

Modern medicine providers may experience some trepidation with regards to the concurrent use of modern and traditional treatments. These concerns may be valid as traditional healers may compel the patient to discard his/her Western medicines, as has been done. Western practitioners, in their aversion from being perceived as insolent, may fail to communicate these concerns with the patient. This promotes failing communication between the two central healthcare providers and erroneously places the patient in an ambiguous situation, thus having to choose one of the two services (Mpofu, 2006).

It also appears that certain cultural factions would probably prefer to receive culture-specific treatment from traditional healers so as to address culture-related psychopathology. Arguably, it is possible that persons experiencing culture-related disturbances may feel that their distress will not be appreciated by persons who do not understand their cultures. In this regard, Eshun and Gurung (2009) indicate that the concept of trust ought to be reflected on. An individual, or group, that trusts a professional practitioner's ability to appreciate cultural perceptions, is more likely to seek help from those clinicians (Eshun & Gurung, 2009).

Based on the findings of this review, it is impossible to conclude that an African perspective on psychopathology does not exist. In fact, it appears that African conceptualisations of mental illness have always existed. At the conceptual level, then, one is able to provide the central tenets of an African perspective on psychopathology.

6.5 A conceptual view on an African perspective on psychopathology

In a transformational continent such as Africa, as in other acculturating populations, a clinician must not disregard the psychological adjustment process which may colour the clinical picture (Van der Vijer & Phalet, 2004). The potential threat here, if one attends primarily to modern nosology, would be the repudiation of contextual material which may influence the diagnostic and treatment process (Toldson & Toldson, 2001). This may be a function of the psychoselective effect, but will yield astute insight into psychoreactive influences (Tseng, 2001), thereby benefiting the clinician and the patient.

From a conceptual perspective, an African perspective of psychopathology would include a focus on holism (Asante, 1980). Following this view, the expression of symptoms may invariably consider physical and psychological symptoms as indiscrete. In the same vein, biological and spiritual processes may be treated as inseparable. As discussed in section 4.6, the entire bios is perceived as interconnected and inseparable (Setiloane, 1998b).

The literature review suggests that psychopathology in the African context would probably be perceived as psychopathology by those persons that have a shared African culture (Ritchie, 1997), and identify with the African worldview (see section 4.7 and 4.9). As such, the description, experience, and treatment modalities for such pathology would be based on shared epistemological views (Perry, 1996). Bear in mind that the influence of the shared epistemological stance would suggest that similar expressive and behavioural reactions to the psychopathology will be accepted as such by other persons in the same culture (Dzokoto & Okazaki, 2006). Thus, the African perspective on psychopathology will indicate pathoplastic coherence (Tseng, 2001). In addition, the symptomatology is more likely to possess symbolic utility relating to historical experiences in Africa, spirituality, and collectivism in society (Asante, 1980; Miller, 1999; Nsamenang, 1992; Perry, 1996). The clinician ought to become particularly familiar with patterns of pathology according to culturally acceptable norms (Eshun & Gurung, 2009).

At this juncture, consider Tseng's (2001) view on the psychoselective effect as discussed in section 4.3.6. The collectivistic societal patterning of some African communities may allow the person to experience interpersonal support. In addition, the spiritual connotations attached to the psychological experience may further provide the person with an adequate appreciation for the symptoms s/he experiences. As a result, treatment options may become diversified in the sense that the person may elect to engage in plural healing such as modern and traditional intervention. The psychoselective effect, therefore, assists the patient in tolerating the stressor(s), but also assists clinicians in considering the effects of concomitant treatments.

According to the literature review (see section 4.9.4), moral transgressions transform into psychopathology (Toldson & Toldson, 2001). Examples of other precipitants of symptoms include taboos, supernatural pollution, and witchcraft (Ashforth, 2001; Green et al., 1995; Jewkes et al., 2003; Kudadjie & Osei, 1998; Patel et al., 2001). Some of the symptoms may be described as somatic complaints (Draguns, 2000; Hundt et al., 2004), imagery, and metaphors (Comaroff & Comaroff, 1987). The preferred method for intervention would be via ritual processes in order to attenuate spiritual influences so as to assuage psychopathological symptoms (Nsamenang,

1992; Okello & Musisi, 2006; Utsey et al., 2007). Thus, the overt acknowledgement of modern psychological symptoms may not necessarily be the patient's chief complaint (Perkins & Moodley, 1993). Indeed, a particular focus on environmental and socio-political influences may also be apparent (Sharpley et al., 2001; Toldson & Toldson, 2001), with reference to both individual and collective disharmony (Kwate, 2005). As a result, treatment ought to include plural healing, thus allowing both Western and traditional healers the opportunity to collaborate and thereby benefit the patient (see section 6.5.5).

Certainly, the diagnosis may fully meet the criteria of Western diagnostic systems. However, to appreciate the dynamics of the psychopathological experience, clinicians ought to continue to acknowledge and attend to cultural perspectives on psychopathology (Jilek-Aall et al., 1997). This area was considered in section 5.2.2.1. Reflect, however, on the potential limitations of providing a conceptualisation of African psychopathology such as the present formulation. Some of these were explored in section 5.9, implying that such a formulation may foster an *us-them* dynamic, thereby separating Africa from the rest of the world. In addition, those treatments which have yielded positive results worldwide may be disregarded. In this way, the relativistic position is applied in an extreme fashion, invariably prejudicing the patient from useful treatments (see section 5.10). This process may also promote the idea that the African population does not correspond with the *human* population. In some ways, the relativistic stance has the potential to encourage an unethical attitude towards the African population. On the one hand, one is able to embrace cultural diversity (Tomlinson-Clarke, 2000). On the other hand, a disregard for multiculturalism may largely isolate the African view from similar Western perspectives (see Swartz, 1998). The ideal, then, is to guard against an extreme position and to allow the patient the opportunity to delimit the diagnostic and treatment process (see Smit et al., 2006).

6.6 Recommendations for clinicians and future researchers

This section identifies and discusses certain gaps in the literature review, these include research in somatisation, self-development and awareness, collaboration, and

culture-aligned reformulation and intervention. The section begins with recommendations to update the review, as prescribed by Higgins and Green (2008).

6.6.1 Updating the review

Trends and rules should not be confused. Almost all traits which exhibit social consequences are dispersed in multiple modes in all societies and do not amount to statistically significant outcomes with unequivocal and unconditional characteristics (Draguns, 2000). For this reason, future researchers may significantly expand the academic body of knowledge by updating and progressively reassigning the current investigation. As suggested by Higgins and Green (2008), systematic literature reviews should be updated every year or two if possible. Therefore, it is suggested that future research be conducted in this regard. Potential research endeavours may include updating the current review, exploring sub-cultural perspectives of psychological distress, and identifying similarities in psychopathological conceptualisations among various cultures. However, awareness of the disparities in the available literature is particularly important to those who consult a review, as well as to those who aim to update a review. For this reason, the researcher has included a section of the limitations of the current state of affairs as regards the research. These disparities were identified during the two phases in coding the literature and were integrated during the presentation stage. The outcomes are presented hereafter.

6.6.2 Limitations of the current state of affairs with regards to research on cultural psychopathology

Much attention has been paid to the empirical investigation of psychological dynamics in non-Western cultures (Miller, 1999). A systematic literature review was conducted in 2004 and focused on psychopathology in a collective, non-Western culture (Mirza & Jenkins, 2004). The results of this investigation indicated that depressive and anxiety disorders are closely associated with being female, a house-wife, middle aged, experiencing financial strain, possessing low formal education, and having poor interpersonal relationships. Furthermore, approximately 25% of the reviewed literature in Mirza and Jenkins' study suggested that marital discord and

conflictual relationships with in-laws were positively associated to psychopathology. While the population investigated in Mirza and Jenkins' study indicated that depressive and anxiety disorders accounted for an overall prevalence rate of 34%, mostly precipitated by social obstacles, informal and trusting interpersonal relationships served as a buffer to developing severe psychopathology.

Prevalence rates of psychiatric conditions, however, have offered further insights into the psychosocial dynamics on non-Western populations. Early research indicated the pervasiveness of mental illness in Colombia as approximately 11%, Sudan as approximately 11%, Philippines as approximately 16%, and India as approximately 18% (Harding et al., 1980). Rin and Lin (1962) explored psychopathology among the Chinese and Taiwanese populations. They found that differences in the prevalence rates of psychopathology among these populations appeared to be closely related to impoverished economic circumstances, rather than fundamental cultural variations. To illustrate, although beliefs such as genital-shrinking may appear strange in the Western context, they are acceptable in a few non-Western cultures and societies (Dzokoto & Adams, 2005). One ought to reflect, therefore on the view that many psychologists and psychiatrists conceptualise psychological distress in the non-West population as a psychiatric illness with atypical features (Yen & Wilbraham, 2003).

People from collective cultures use others, both physical and spiritual, to cope with adversity (Utsey et al., 2007). One of the reasons that the prevalence rates of psychopathology in non-Western cultures is lower than the prevalence rates in the West, may be as a result of protective factors within non-Western cultures (Dein & Dickens, 1997). Bear in mind that collectivism is not an African-specific orientation. However, although many other collective cultures propose models for non-Western systems of psychopathology, they ignore the socio-political concerns relevant to African people, and can therefore not be suitably applied to the African population (Kwate, 2005).

The Native Americans, African Zulu, Indian Ayuverda, and Chinese TCM are all collective cultures and share common perspectives with regards to healing. Each believes in the balance of relations between earth, humans, and communities. They also believe in the vulnerabilities within the individual. All four cultures aspire

towards facilitating balance in biological and psychological processes. Furthermore, they regard illness to be suggestive of disharmony and imbalance. For these cultures, health is defined as the maintenance or restoration of balance. Finally, people of these cultures believe that healing fosters vital energy (Wilson, 2007). Comprehensive research in this regard is needed, as the present literature base does not appear to offer much empirical research on the topics at hand.

Appendix A, and Figures 6.1 and 6.2 suggest that very little empirical research has been conducted with regards to this investigation's body of research. Furthermore, more than half the research could not be overtly identified as being exclusively focused on traditional African populations, although the research included traditional African perspectives with non-traditional views. This reasserts the need for research such as the present study, but also indicated a great need for future research to accommodate these limitations.

6.6.3 Research in somatisation

The central issue of the present investigation's subject matter, that is the role of culture in psychopathology, requires further attention (Miller, 1999). Based on Kirmayer and Young's (1998) observation that ethnophysiological influences on bodily distress yield somatic symptoms, further research in this regard would assist in clarifying the ways in which ethnophysiology and somatisation interact. It is also recommended that these influences, and the associated syndromes, undergo sufficient epidemiological research and be included in standard psychiatric nosology. However, psychological intervention also has much to offer. This applies to both patients and therapists.

Psychologists will undoubtedly assist patients that experience somatic-related psychopathology, by facilitating self-focus interventions. The failure to focus on the self and thereby confront hidden dimensions can have significant consequences. A lack of self-focus facilitates unresolved intrapsychic conflict and produces somatoform and psychoform dissociations. An example of the latter would be dissociative possession, a trance-like state in which the person experiences one's own body as being inhabited by a supernatural body (Somer & Saadon, 2000).

6.6.4 Self-development and awareness

Notwithstanding the implications of an incorrect diagnosis, clinicians may also fall victim to misplacing the subjective and affective dynamics associated with misinterpreting perceptions based on local contexts. The suggestion here is a convoluted intersubjective experience as the interpretation of data is based on the observer's belief system (Bhugra & Bhui, 2001). Clinicians ought to become more actively aware of this process. Practitioners should be conscious of their personal cultural perceptions and prejudices. They should also cultivate a standard of continually reflecting on the influence that culture imposes on perception. This includes reflecting on the perceptions of self and other. These reflections ought to inspire the clinician to aim to promote the aptitude to work with particular cultural populations (Eshun & Gurung, 2009). In order to work with diverse populations, clinicians are encouraged to reflect on their personal epistemologies, and take note of those epistemologies in relation to psychiatric categorisation (Pilgrim, 2007). Certainly, many clinicians encourage and foster this process. However, further engagement in this regard ought to augment clinical skills.

In clinical practice, the mental status examination relies on the surveillance and interpretation of behavioural, linguistic, and mental processes. Mental status examination, however, is susceptible to misrepresentation if influenced by cultural barriers. The examination, therefore, must be conducted with appreciation for culturally-appropriate processes. This allows the clinician to limit the opportunity for enacting the category fallacy. To do so would imply attempting using Western norms for non-Western standards. The resulting diagnosis will be invalid and/or unreliable (Trujillo, 2008). However, to shy away from some modernistic processes and techniques merely on the basis of the idea that Westernised processes are inept for non-Western populations is imprudent. Some tools from industrialised populations have proven to be fitting for non-Western populations (Bass, Bolton, & Murray, 2007).

Some Western professionals often imply that culture-related illnesses are less severe than 'real' illnesses (Yen & Wilbraham, 2003). A cultural view of psychopathology appears to exhibit more utility than a purely biomedical perspective in Africa. As

such, clinicians are expected to provide patients with causes that surpass biological explanations. Explanations which combine psychological, cultural, socioeconomic, and geopolitical dynamics have the capacity to fulfil the needs of African patients (Adams & Salter, 2007). It ought to be encouraged that clinicians aim to steer clear of broad generalisations and stereotyping when formulating cultural concerns. Furthermore, clinicians ought to conceptualise cultural issues which show a strong association to the patient's pathology (Kirmayer et al., 2003). The disciplines of medicine and public health may benefit from anthropology's in-depth investigations into cultural influences on health (Bass et al., 2007).

Appreciating culture in psychotherapy amplifies the therapist's consciousness and hones therapeutic efforts. Psychotherapists discover their patients' personal perceptions from conscious and unconscious communications (Wohl, 2000). When the patient's culture differs to the clinician's culture, therapists are encouraged to clarify that their interpretations are accurate, and that the communication between patient and therapist is clear (Sadock & Sadock, 2007; Wohl, 2000). The process often allows the clinician to deal with the countertransference, that is to clarify if the interpretations are based on the therapist's frame of reference, instead of the patient's frame of reference (Wohl, 2000). From personal observations, it is encouraging that this area is being exercised by some clinicians.

It is essential that clinicians be conscious of their personal views regarding cultural differences. Insights into personal perceptions allow clinicians to steer clear of potentially stereotypical attitudes when working with diverse cultures. Furthermore, awareness of one's personal perceptions aids the aversion of pseudo-insight. Thus, over-reliance on specific techniques may suggest the clinician's discomfort in working with particular cultural groups (Wohl, 2000). In considering diverse populations, Wohl suggests that one continually observe and evaluate that stereotyping is circumvented. Wohl indicates that a basic means of avoiding stereotyping is to ensure that, as researcher, one obtains as much information about the topic as possible. Increased knowledge coupled with researcher self-awareness has the potential to trounce prejudice. While some ordinarily practice these skills, the current investigation may assist in further developing these areas of clinical practice.

In psychotherapy, assessment cannot divulge as much about the patient as *presence* can. Presence makes room for spontaneity, self-correction, and the gradual unfurling of experience. It also makes available an abundant and extensive understanding of the therapeutic process. As such, the therapist is able, and may continue, to use 'impression' and 'sense' to define the texture of the encounter (Schneider, 2007).

Invoking the actual refers to those experiences which surpass the content of the patient's narratives. This refers to the experiential liberation discussed in section 2.8 (integrative therapies) and acknowledges areas such as the cosmic dimension (Schneider, 2007). The therapist ought to acclimatise to these dynamics and, where suitable, bring these to the fore. This allows patients to come into contact with the vast range of polarisations they experience. Invoking the actual, while being a fairly adaptable process, is often extremely intense. Therapist empathy allows the patient to experience the process as both beneficial and liberating (Schneider, 2007).

In terms of developing techniques, there is little empirical evidence supporting the idea that therapy techniques improve patient outcomes (Patterson, 1996). The best therapeutic tool appears to be the relationship between the therapist and patient. Technique has the potential to overshadow this process and may take away potentially beneficial aspects from the patient-therapist relationship (Patterson, 1996). One of the principal responsibilities of every psychotherapist is to use expert knowledge and perspicacity in human functioning to afford patients the opportunity to come to know their personal truths. Irrefutably, this stimulates psychological emancipation (Wohl, 2000). By implication, it appears that Wohl attempts to propose that clinicians come to advocate psychological libertarianism, and aim to fulfil the task of fostering psychic eleutheromania, that is the desire to cultivate the patient's psychological freedom. Put differently, it appears that the psychotherapist internalises the role of emancipator. By modulating lived experiences which amount to emotional liberticide, the therapist assists patients in embracing their personal truths. In so doing, the patient may come to experience a sense of psychological unshackling.

6.6.5 Collaboration

The Tswana-speaking Tshidi are from South Africa, and live primarily in the North West region of Mafikeng. The Tshidi perspective of their current context is structured by their perception of a consciousness of history. Here, *consciousness of history* refers to the social construction of current and historical events. However, history is not linear, nor is it stripped of the Tshidi's subjective reality. History encompasses the dynamics between different aeons, and is channelled into various modern perceptions. In this way, perceptions of the world become meaningful to the Tshidi (Comaroff & Comaroff, 1987). What is meaningful to some, is not necessary meaningful to others. Psychotherapy, for example, is not necessarily meaningful to all people (Beiser, 2003).

In fact, Beiser (2003) found that many people in Ethiopia were doubtful that psychotherapy could be beneficial to them. This may relate to the idea that the heart of the African approach to expression is naturalistic (Toldson & Toldson, 2001). In therapeutic practices, the clinician will have to counteract this obstacle with empathy. Empathy is of extreme significance in patient-clinician relations. As such, it is valuable for clinicians to further educate themselves with regards to culture-specific adaptations of empathy in order to continue to culture a stance of empathy (Draguns, 2000). This is not to suggest a lack of empathy, but rather to allow clinicians opportunity to further develop empathy skills. Odejide, Olatawura, Sanda, and Oyeneye (1978) coveted the idea that traditional and modernised practitioners would collaborate to serve the health care requirements of African people. Integrating traditional and modern approaches may fulfil this ideal.

In Africa, diverse healers coexist in close proximity. Healers include psychologists, Muslim healers, traditional African doctors, spirit mediums, psychiatrists, diviners, herbalists, biomedical doctors, and faith healers (Feierman, 1985). However, little correspondence exists between the disciplines. It is recommended that these disciplines interact, at micro, meso-, and academic levels so as to develop the utility of mental illness services to local populations. Perhaps learning a few well-chosen African proverbs may assist in establishing rapport, as well as to communicate to patients that their perspectives are respected. More importantly, many African

proverbs communicate care and support (Alao, 2004). Furthermore, clinicians must be trained to work with interpreters and cultural advisors (Kirmayer et al., 2003). The collaboration suggested here has not been available in the literature search by the researcher, however, Giarelli and Jacobs (2003) have indicated that some medical and traditional practitioners in South Africa have attempted to collaborate at least at the micro (practical) level.

The preferred therapeutic intervention entails the patient engaging in plural healing. Plural healing typically includes multiple treatment modalities such as Western medicine and African medicine. Typically, the patient will visit a traditional healer to treat the spiritual and/or social cause, and s/he will concurrently receive medical treatment from a clinic or hospital (Hundt et al., 2004). Mutual respect between modern and traditional disciplines ought to be exercised.

However, plural healing must not end with correspondence between the disciplines. Researchers must further embrace the median of universalistic and relativistic perspectives. According to Rutter and Nikapota (2002), a combined approach, that is an approach incorporating both universalistic and relativistic perspectives, suggests that certain pathologies (such as schizophrenia) are probably universal as they suggest neural deficits. Nevertheless, the combined view suggests that many psychiatric disorders are shaped by culture, development and social circumstances, irrespective of the biological foundation. The combined approach does not suggest intolerance or discrimination of culture and race, for example, but more that each culture deserves to be appreciated within the context of its worldview (Rutter & Nikapota, 2002).

6.6.6 Culture-aligned reformulation and intervention

In terms of psychosis, the literature review demonstrated the way in which cultural perspectives influence psychotic content (e.g. Hall, 2006). It is therefore recommended that the clinical and academic fraternity deliberate on constructing a descriptive identifier for this process. In the interim, I propose that *culture-aligned thematic psychosis* be considered as a potential operational identifier. This term is meant to indicate that the content within the perceptual disturbance is aligned to the cultural identity of the patient. The significance of incorporating such an identifier

into psychopathological conceptualisation may allow for depth in appreciating the influences of culture on developing and maintaining the psychosis, as well as the phenomenological value of culture in formulating the content of the psychosis, and the effects thereof. This may allow for rich qualitative material within the therapeutic process, and therefore may be appreciated as a shift away from the narrowed definition of culture-bound syndrome.

Many African patients have a positive view of including the extended family in the psychotherapy process (Alao, 2004). If group or systemic interventions would improve the therapeutic process, then clinicians must conduct such an intervention (Speight, 1935). This is especially important in communities where psychopathology represents broader social influences. Clinicians who aim to learn all the control system hierarchies of their patients are on a journey of impossibility. The result of such arbitrary control is the disruption of the system itself (Mansell, 2005).

If the differential diagnosis suggests a culture-bound syndrome, this diagnosis ought to be applied after cultural constructions of the symptoms have been considered. Continuous education into the meanings of the symptoms ought to be encouraged, or the clinician should consult a person who is familiar with the cultural manifestation of culture-bound syndromes (Trujillo, 2008).

Working with diverse cultures does not translate into developing culture-specific techniques. Technique does not address culture, for to acknowledge this would be to reinforce stereotyping. Furthermore, the focus on technique in psychotherapy would be tantamount to watering-down the therapeutic process and denying the patient the opportunity to develop effective coping skills. In fact, what is needed appears to include reinforcing that understanding the patient and allowing him/her the opportunity to explore subjective perception ought to facilitate so-called effective interventions (Patterson, 1996).

All patients will exhibit perceptions influenced by multiple factors. It is of the utmost importance that the therapist be aware of the multiplicity of influences imposed on the patient's perceptions. This is due to the fact that people, in general, belong to numerous groups. Perception, therefore, is influenced by the infusion of diverse

cultural views (Patterson, 1996). As explored in the literature review, traditional African culture contends with holding more than one cosmological stance, and is often comfortable with the apparent paradoxes (Du Toit, 1998).

With limited literature available, investigating culture and personality disorders will make significant contributions to clinical psychology and psychiatry (López & Guarnaccia, 2000). In addition, appreciating local conceptualisations of psychopathology is of inestimable value, particularly if the aim is to provide the local populace with instruments and services aimed to assess local psychological dynamics (Bass et al., 2007).

Overemphasising diversity and culture-specific therapies brings about a focus on technique, transforming the therapist into mechanised facilitator of presumably culture-related methods. This deviates from the therapist as an intuitive, insightful, real person. Furthermore, it detracts from the fact that views are not so contrasting that they may be understood by others. The world is rapidly integrating different views, and a focus on difference ignores this process. Ultimately, the human being ought to precede the notion of the cultural being (Patterson, 1996).

Tuition in the appreciation of culture is essential in allowing clinicians to grasp the multicultural dynamics in operation in all contexts (Sen & Chowdhury, 2006). Due to the dynamic nature of culture, cultural perspectives are transforming. With the trust that cultural research continues to expand the dynamics of multiculturalism, clinicians ought to steadily acclimatise to transformative epistemological views (Liddell et al., 2005).

6.7 Reflexivity

The reflexivity section aims to explore the researcher's perception of the way in which the research process interacted with his personal perceptions, and vice versa. Here, richness in detail regarding those aspects of literature which the researcher experienced a profound influence is discussed. This offers the audience the opportunity to further preview the personal experiences of the researcher during the research process. Prominent areas for the researcher during this study included the

emic and etic approaches, kinship and oneness, culture, critical theory, and the researcher's personal process.

6.7.1 On emic and etic

Koss-Chioino (2000) certainly made an impression on me with regards to the etic-emic debate. One may make a case that all healing, whether traditional or modern, is influenced by the cultures within which they operate. In this sense, all healing is ethnomedical in nature. Based on these two logical premises, the logical conclusion is that healing, by nature, ought to be emic-focused, incapable of applying generalised, universal standards of healing (Koss-Chioino, 2000). Perhaps further reflection may be necessary in this regard. While it is possible to debate all areas of this view with various literature sources, I contend that a number of philosophical and ratiocinative difficulties arise with this argument. First the biomedical approach has been able to treat many illnesses across the world, thereby limiting the influence of specific pathogens across all cultures. Second, the possibility that some illnesses may be universal appears to suggest that a search for middle ground between the two approaches is more viable than either approach. Third, the blatant support for the emic approach gives the impression that many context-focused clinicians strive to defend against the etic approach, thereby endeavouring to preserve differences in human experience. Fourth, that human-ness unites the human species, a focus on similarities may preclude ethnocentrism. In this way, the etic approach may forebear stereotypical views. Finally, the emic approach reveres human experiences as kinetic. Underscoring the etic approach, in preference to the emic approach, may provide one with a sense that human experience is reduced to torpidity.

6.7.2 On kinship and oneness

While Nsamenang (1992) exhibited intensive opinions, I was mostly struck by the discussions relating to kinship. Kinship allows each person to discover his/her own position in society. Kinship in Africa is a moral obligation, and defines the way in which each person is expected to act, based on his/her cultural script (Nsamenang, 1992). As I reflect on this view, I seem to be drawn to the idea that psychopathology

can become the 'norm' in which illness is characterised, and appears to manifest within the cultural systems reinforced by kinship and tradition.

Furthermore, I am also interested in exploring the ways in which universal balance is affected by spiritual kinship. Here, I wonder whether there is any suggestion that the collective unconscious cathects with the individual psyche and comes to represent an *imbalance* in the harmony of the universe?

Oneness, as an archetypal form of completeness, had a great influence on my view of interconnectedness. In this regard, Nsamenang's (1992) description of oneness, and Crystal's (2010) review on the Bushman creation story highlighted the necessary link between humans, animals, the unseen dimension, and the universe.

6.7.3 On culture

It is peculiar that attempts to limit the restrictions associated with biomedicine unintentionally reconstruct oppositions in a different way (Scheper-Hughes & Lock, 1987). Certainly, various aspects included in this study evidence this point. As it is expected in academic research, it is a process that, at least to some measure, must be endured I wish to reassert that none of the dynamics discussed within the thesis are actually delineated in the way that I have structured them during the research. Culture is interactive and complex. The themes and sections I created are merely a feeble attempt at communicating multifaceted, and often fused, dynamics. However, I would also like to reflect on my view of the way in which this thesis may possibly influence psychotherapy process.

To allow for appreciation of culture to develop, clinicians should be trained in multicultural and intercultural models. Immersion in culture should only be recognised as a windfall, not zenith, of one's ability to be able to appreciate culture (Eagle, 2005). As a therapist, I am confronted (as I have been and probably will be) with the reality that no amount of preparation and education will prepare me for the uncertainties that arise in the therapeutic encounter. This confrontation is often accompanied by the ambivalent experience of anxiety and exhilaration. It leaves me with a constant yearning to want to know more about various dynamics, and I am

appreciative of, as much as I am nervous about, what this means to me as a therapist. In addition, it is also unfortunate that I may have perpetuated the idea that Western clinicians are not sensitive to cultural encounters and/or do not have sufficient empathy to appreciate non-Western populations. It is unfortunate because I am of the opinion that therapists are (generally) particularly sensitive to their patient populations. Although I have had to transpose views from the literature which suggest diminished sensitivity, I disagree with these views and would like to reassert that insight into these perspectives may assist in developing *further* empathy into acknowledging various cultural phenomena.

6.7.4 On critical theory

Before I embark on more personalised reflexive material, I feel that it is essential to discuss one more aspect of the research material. Perhaps the greatest influence of all during this research process was literature focused on critical theory. Foster (1999), for example, compelled me to think about the ways in which seemingly innocent views have the capacity to denigrate others. In fact, even now, I grapple with the way in which modernistic, European, and biological perspectives have been, to some degree, victimised during the research process. With no intention to disrespect any discipline or culture, I hope to have made it clear that I have found immense value in all of the perspectives. I therefore hope that the critical stance employed during this research process conveyed the message that each cultural perspective deserves equal esteem.

6.7.5 Warnings

Foraging the terrain of culture-specific perspectives in research may, at times, appear to be something of a landmine. Counter-arguments suggesting ethnocentrism and essentialism often compel researchers into a frenzy of tentativeness. In this regard, one ought to consider the socio-political discourses which engender these fears in academia (Hook, 2004a). On the one hand, it appears that a focus on specific cultural perspectives often appears to segregate other cultural perspectives. In the context of this investigation, the Africa/West divide certainly became apparent. The researcher

hopes that he sincerely conveyed respect for all cultural views, even when the literature evidenced differing opinions.

Of noteworthy mention, was the idea of defining African with regards to race. In contemporary South Africa, the term African is all-encompassing with regards to race. However, the term was previously regarded to indicate all non-Caucasian people in South Africa (e.g. Coloureds, Indians, etc.). As mentioned in Chapter 1, other views regarding the definition of African suggest that the African consciousness is limited to the original inhabitants of Africa and/or specifically to the Black population. Undoubtedly, race and culture as definitional constructs were challenging, but I hope that I have academically problematised these constructs to a fair extent – particularly as my aim was to regard traditional African culture as explored in Chapter 1.

While concerted efforts were exercised to guard against essentialism, the researcher struggled to accommodate the diverse views in the literature. Specifically, the researcher grappled with managing the views that culture-specific research may be essentialist versus the views that universalistic research is essentialist (discussed in Chapters 1, 2, and 4). Certainly, steering away from research focused on genotype accommodated limiting an essentialist perspective (American Psychological Association, 2010). The researcher is, therefore, of the opinion that the thesis is not essentialist in nature, and respectful to diverse cultures.

However, the review certainly evidenced the fusion and overlapping amongst various cultures. As such, one has the opportunity to reconsider and review the need for an African perspective on psychopathology. The suggestion here, as was discussed in Chapter 1, is that the focus on culture-specific data certainly appears to reside in the domain of one's personalised perspective. Bear in mind that the people-are-human debate will often confront the people-in-culture debate. This view stems from my experience of the research process. However, this view is also addressed in various ways by others in research (e.g. Mpofu, 2006).

6.7.6 Personal process

Many definitions of culture allude to the notion that the authenticity of opinions regarding culture depends on the licence of the researcher, as well as the perceived substance suggested in the opinion of the researcher (Eagle, 2005). This view confronted me, both overtly and in subtle implication, with questioning how being, or not being, African and Black either tinted my perceptions, as well as the way in which the wider audience may perceive this body of research with regards to my culture and race. Studies relating to African identity establish particular challenges. In communities, such as South Africa, where issues relating to race, ethnicity, and culture have profound historical influence, the researcher will probably be tagged as belonging to, and thereby representing, a specific population. In fact, the process of obtaining the authority to conduct this investigation left me with concerns regarding the way in which others constructed my ethnicity. In many ways, the process of acquiring approval to conduct this investigation appeared to centre on whether I was African-enough to work with African-focused perceptions. Often, left with a swooping sensation that I might not be *qualified* to conduct the research fostered an intensive process of self-reflection. Certainly, for all intended purposes, I am academically and practically qualified to research the subject area. However, the impression impressed upon me by committees within the academic fraternity deeply entrenched the possibility that I am not an African. I feel that the time is ripe for me to, at long last, express my personal view regarding my *qualifications* to have conducted this investigation.

In short, yes, I am African. I was born in Africa and have lived amongst other African people throughout my life. I have blood lineages that are traditionally Black African, Indian, and European. My cultural milieu is strongly influenced by Indian and Muslim cultures, but has been significantly influenced by local South African cultural dynamics. This may also account for part of the reasons why the comparative views evidenced in the literature review resonated with me. As was my experience before reviewing the literature, and was progressively fortified, my personal cultural and spiritual views often seem to parallel with traditional African spiritual and cultural views. In effect, it is my personal conviction that while I am multicultural in the broadest sense of the word, I am certainly African. Indeed, I have come to experience

that those who have questioned my African-ness during the course of this research process appear to possess immoderate views of personal definitions regarding *being* African.

Debates regarding the integrity of opinions as regards culture appear to be dependent upon the researcher's interest in a culture, and some experience with a culture before s/he is endowed with any authority to discuss that culture (Eagle, 2005). Eagle suggests that some are of the opinion that lived experience imbues the researcher with the agency and authority to discuss culture. I certainly can account for having lived both cultural and African cultural experiences, yet my lived experience as a traditional Black African is severely deficient. Yet, I have come to observe that many 'authorities' appear to take this tough stand when race and culture come into play. I would therefore like to propose a question as a counter-argument in my favour. I am a clinical psychologist and therefore work with patients affected by severe psychopathology, such as schizophrenia. Does my inexperience in experiencing symptoms of schizophrenia deny me the ability to research or work with affected persons?

The view that lived experience fosters an understanding of culture is not based on logical premises. If this were true, the training context would be incapable of including the various cultures operating in society. By implication, this specious view would further suggest that therapists with children are the only people who can work with children, for example. Unfortunately, the severely indigent would suffer the consequences of a scarcity of therapists that stem from impoverished communities. Although anthropology may have been able to immerse itself within cultures for extended periods of time, clinical psychology does not necessarily ascribe to this standard. Clinical psychology rests on the assumption that psychotherapy should be broadly based to the extent that the individual may be understood holistically and within context. From this vantage point, the idea of lived experience as the determining factor for cultural appreciation is flawed (Eagle, 2005).

The nature of reality is dependent upon culture (Okello & Musisi, 2006). Thus, it is logical to conclude that the interpretation of reality will probably differ, even in degree, from one culture to another. If this is a reasonable conclusion, then employing

one's own perception of reality in order to interpret another's reality may be an extremely convoluted process. As the researcher of this study, it appears necessary, in fact essential, that certain biases be disclosed. A bicultural worldview, imposed upon by both collectivistic and individualist cultural traits may have fostered a transitional opinion, coloured by both personal and cultural epistemological perceptions. The implication that non-Western perceptions have been victim to scapegoating has been made apparent in the literature (Hook, 2004b), but also in the process of assessing personal views regarding the content of this thesis. It is perhaps unfortunate, and entirely plausible, that the non-Western aspect of my self has allowed me to focus more on differences than on similarities – often emphasising a larger burden on Western processes than others would. In the same way, it may appear that various projections operated within the discourses of this investigation. These *symptoms*, as Hook would call them, have operated in many references consulted during the investigation. The deduction here is that one cannot exclude oneself within the research process. Most unfortunately, not acknowledging that one's history and culture inevitably tints one's perceptions is a symptom in itself and reflects the repressive and repressing dynamics reminiscent of historical subjugation (Hook 2004). With no attempt to expunge these observations, awareness into these dynamics certainly appear to be more morally ethical than the proclamation of encompassing an unrealistic ideal.

Over the previous two decades, culture has been at the centre of concern within the discipline of psychology (Draguns & Tanaka-Matsumi, 2003). According to Achenbach et al. (2008), the unification and disputes experienced within, and amongst, cultures has become a universal experience. Understanding these dynamics will lead to improved assessment and insight into psychopathology. To offset the negative implications of the restrictions discussed by Bhugra and Bhui (2001), increasing awareness of cultural perspectives appears to be beneficial. This appears to suggest an overarching strength of the current investigation and therefore contributed to the body of knowledge as is expected of a PhD thesis.

6.8 Limitations of the research

Having applied comparative views (e.g. Hall, 2006) may have created the false impression that collectivistic dynamics account for African perspectives. An attempt was made to highlight the obvious similarities between African cultures and other cultures. However, even where clear cultural dynamics are apparent (e.g. Wilson, 2007), cultural experiences do not mirror each other equally (Kwate, 2005). This is a potential limitation of the current investigation.

Having unified the sub-cultural perspective in Africa in this thesis, and incorporating research relating to *African culture* suggests that African people form a single cultural unit (see Schönpflug, 2001). Certainly this is not the case. Various sources (e.g., Anise, 1974; Chick, 2000; Mbiti, 1970; Nagel, 1994; Ndletyana, 2006) evidenced this in the introductory chapter of this thesis. In addition literature regarding the process of individuation in traditional African societies could not be located. This area of interest would certainly have aided the discussion on collectivism and independence.

The current review procured data focusing on *African* in what may be considered as an idiographic term, thereby potentially constricting the way in which some African cultures parallel non-African cultures. For Owomoyela (1994), this poses potential incongruities concerning researcher objectivity versus pro-African championing. Furthermore, that Africanity creates a diffuse picture of sub-cultural factions as a single unit, may deprive sub-cultural nuances, context-specific lustre, and phenomenology. In a sincere endeavour to guard against the potentially superficial position that the current investigation aims to develop Africa (as suggested by Owomoyelo), the researcher reasserts the proposition that the aim of the thesis is to provide a central point of reference for perspectives on African perspectives on psychopathology, and thereby stimulate prospective primary investigations.

Appiah (1992) provides a valuable argument promoting race and ethnicity as social constructions of identifying and othering. He certainly sets the stage for disbanding the notions of these variables as scientifically-legitimate institutions. One may, therefore, viably make a case against both the definition of African, as well as the way in which the term African is applied. Here, Owomoyelo (1994) and Appiah form a

cohesive alliance, providing a convincing rationale to reintegrating fragmented social constructions. With these views in mind, the academic fraternity may make a concerted effort to continually interrogate definitional constraints with reference to population studies.

Due to the scope of the review, much attention was paid to differences and diversity. A limitation, therefore, may be the diminutive focus on cultural integration and acculturation (see Swartz, 1998). Due to the dynamic nature of culture, cultural perspectives are transforming. With the trust that cultural research continues to expand the dynamics of multiculturalism, clinicians ought to steadily acclimatise to transformative epistemological views (Liddell et al., 2005). Chapter 1 addressed these areas by exploring multicultural national identity (Chick, 2000), individual identity formation (Nagel, 1994), and the multidimensional influences of cultural identity (Ndletyana, 2006).

Finally, as a literature review, the current investigation was not a primary study and did not elaborate on personalised experiences. From this supposed limitation, it is recommended the primary research be conducted to fulfil this need. In this regard, Cooper (1998) draws attention to the idea that a literature review does not ordinarily allow for participant-based experiences to be explored. This limitation is reinforced by the method's focus on published works.

According to Dane (1990), the researcher's aptitude to rationalise his/her application of science is referred to as the dilemma of academic integrity. If it is impossible to demonstrate that theoretical concepts are accurate, if paradigms are transient, and if evidence and methodology may alter, then how does one acknowledge the scientific method as a legitimate means to conduct research? There is only one available justification that may assist us in addressing the dilemma of academic integrity. In basic terms, it is the most developed means of research which we have available. Researchers approve of the scientific method for the reason that we can logically and analytically deduce that it succeeds in its functions. We therefore imbue the scientific approach with trust. It is important to observe, though, that we instil trust in the method, not unreservedly in a specific theory which stems from the method (Dane,

1990). The employment of integrative theory, then, afforded the thesis further application.

While an investigation is capable of complying with various academic communities, it cannot fully convince scientific curiosity in a subject. Thus, the idea of a definitive investigation does not exist and no research can fully respond to a problem. Human activity is multifarious in a way that will always leave some questioning certain ideas and/or further addressing those questions which have been answered, albeit to a different degree. This line of inquiry often signifies the prospect for further investigation (Dane, 2010). An anticipated outcome of this investigation included the generation of suggestions for further enquiry. This did not preclude reporting the findings of the reviewed literature, but appended the findings with information which may stimulate primary research in the field of clinical psychology. Did the process suggest the formation of a definitive study? To respond to this, Dane (1990) indicates that definitive investigations are fictional, but are important to consider as they activate the complete research agenda. Definitive investigations possess a substantial proportion of heuristic value. Consequently, they incite further research endeavours. Thus, in addition to generating hypotheses for further research, the current investigation engendered heuristic specifiers as conduits for future investigations. These, in effect, reflected the code and purpose of utilising literature reviewing as the preferred method.

6.9 Directions for future research

Future research ought to further explore the sub-cultural nuances of categorising psychopathology according to contextual standards (Bhugra & Bhui, 2001). Furthermore, aged research ought to be re-investigated so as determine their validity at present. An example would be Edgerton's (1971) finding that psychoses in African cultures differ vastly to psychoses in Western cultures. Assessing similar findings would address a relatively overlooked area of research.

An important consideration for further investigation into psychopathology in Africans in Africa would be to consider the current state of census data. In the U.K., for example, the under-enumeration of census data with regard to the African population

warranted a large body of problematic empirical investigations by underestimating the influence of psychopathology on the African population (Bhui & Bhugra, 2001). Furthermore, data regarding specific syndromes is needed in Africa. Research regarding the influence of culture on eating pathology, for example, is necessary. Research focused on the interplay between culture, biology, and psychology would pervade inadequate research fissures in the current body of literature (Miller & Pumariega, 2001).

The definitions of individualism and collectivism are subject to revision and remain dependent upon the cultural meanings attached to them. Hence, providing a comprehensive definition of these terms, may elaborate the complexity of these terms. According to Eshun and Gurung (2009), vertical individualism may be conceived as a preference for hierarchical structures whereby one endeavours to distinguish oneself from others and employs competitive attitudes and behaviours. Horizontal individualism differs from vertical individualism in that one may aspire to distinguish oneself from the group, but s/he does not employ competitive attitudes and behaviours and deems others as equal to him/her (Eshun & Gurung, 2009). Vertical collectivism refers to a preference for hierarchical structure in that the individual sacrifices personal objectives in order to fulfil group objectives. Horizontal collectivism refers to the accentuation of interdependence, equality and an enthusiasm for collective goals (Eshun & Gurung, 2009). The literature reviewed during the current investigation gives the impression that cultures predominantly tend towards individualism or collectivism. This appears to be simplistic in nature. It would probably be equally simplistic to imply that African cultures generally tend towards either vertical or horizontal collectivism. These features appear to be ignored in the literature and therefore require further investigation.

The use of psychotropic medications has enjoyed success in the 20th century. However, these medications were developed and tried in Western and westernised settings. As the field of cross-cultural psychopharmacology requires further development, specific issues arise as regards the usage of psychotropic agents with non-Western populations. For instance, culture influences beliefs, perception of time, and the acceptability of interventions. These considerations would determine the parameters for compliance or adherence to medical treatment regimens. In addition,

sustained environmental factors influence metabolic processes, thereby encouraging discrepant treatment interactions (Trujillo, 2008). Moreover, culturally-mediated substances, such as traditional medications and food additives, influence the efficacy and safety of psychoactive medicines. For instance, alcohol reduces medicinal efficacy by supporting the stimulation of important hepatic enzymes. Furthermore, biological factors related to ethnicity, have an effect on the bioavailability, and therefore the success, of medications. Research into cultural influences on the interplay between pharmacodynamics, pharmacokinetics, and pharmacogenetics will aid in providing appropriate medications to non-Western populations, as well as populations that receive concurrent traditional remedies (Trujillo, 2008). Culture-related research into the metabolisation, clinical effects, and response patterns of chemical compounds in ethnic populations have been demonstrated (Cross, Bazron, Dennis, & Isaacs, 1989; Trujillo, 2008). However, comprehensive investigation is required in this regard.

In line with the study by Skilling, Quinsey, and Craig (2001), the reviewer of the present investigation suggests that future research aims to explore taxonicity in terms of cultural perceptions of illness and culture-bound syndromes. This will probably augment current psychiatric nosology, particularly with regards to improved insights into culture-related psychopathology.

Culture-related research should not be avoided. The international community has enjoyed research data relating to individual and cultural identity (e.g. Nesbitt, 1998). Exploratory research regarding cultural identity in South African populations is therefore encouraged.

6.10 Conclusion

This chapter processed the literature reviewed in Chapters 4 and 5 and comprehensively discussed the overarching themes available within the review. Here, a process of conceptual investigation was applied, yielding 18 prominent themes. These included: redefining psychopathology, the supernatural in the psychoanalytic frame, the locus of pathology, exploring somatisation, metaphysical vitalism,

culturology, culture-bound syndromes, the representational world, psychopathology embedded in interpersonal relationships, legends, transformation, ecumenical psychopathology, the psychosocial and socio-political aetiological sphere, the social functions of psychopathology, configurationism, traditional healing, schism/immix, and sectionalisation. The themes were discussed in concert with academic literature. A conscious and deliberate effort was made to consult academic literature so as to respond to the research question. The researcher then presented the findings and conclusions of the investigation, with specific interest in providing recommendations for clinicians and future researchers. Thereafter, the strengths and limitations of the investigation were discussed, as well as directions for future research. The chapter was concluded with a reflexive section focusing on the researcher's personalised insights as they transpired during the research process.

These insights included the ways in which an absolutist stance on psychopathological nosology poses significant risks to clinical development, as well as to treatment protocols. In addition, it appears that cultural influence on illness, as well as identity, requires concerted focus and would probably differ from person to person. However, the present review certainly suggests that researchers have tiptoed around these constructs for far too long, resulting in a poor volume of data relating to the current topic. Chapter 7 of the thesis is the report, typical of systematic literature reviews.

CHAPTER 7

REPORT

7.1 Introduction

This chapter reports on the process of the literature review. It details the data used throughout the review, particularly in terms of the predefined methodological and interpretative perspectives employed in the review. The chapter includes a literature review protocol that is typical of the systematic literature review methodology. This chapter includes pertinent information such as the approved title and review information; the research abstract; the objectives of the review; the search methods; a brief description of the data collection and analysis; the results of the review; the author's conclusions; and any specific declarations of interest.

7.2 Literature review protocol

Title:

Critically questioning an African perspective on psychopathology: a systematic literature review

Review information:

Author:

Junaid Hassim

Contact person:

Junaid Hassim

(junaidh@telkomsa.net)

Dates:

Assessed as up to date on 01 February 2011

Date of search from 15 June 2009 to 31 January 2011

Abstract:

This study aimed to collate and analyse academic literature with regards to possible African perspectives on psychological distress. The purpose of conducting the literature review was to explore thirty years of critical arguments supporting and refuting an African perspective on psychopathology. Literature (e.g. Bhugra & Bhui, 1997) appeared to suggest that some of the contemporary views regarding psychopathology fail to adequately address psychological distress as it presents in Africa. The scope of this study is based in the broad sphere of clinical psychology. Thus, the focus of the investigation was on theory and practice relating to psychology and the assessment and treatment of abnormal behaviour (Reber & Reber, 2001). A systematic literature review was selected as the methodology for this study, and the specific method of the review was research synthesis (Gough, 2004; Popay, 2005). Reviewed literature was sourced between the years 1980 and 2010. The theoretical point of departure was integrative theory, thus falling within the post-postmodern framework. As such, literature regarding psychological theory formed a substantial part of the research, including literature relating to psychodynamic theory, cognitive-behavioural theory, postmodernism, phenomenology, existentialism, critical theory, and systemic patterning (Becvar & Becvar, 1996). These theories formed part of the analysis, thereby allowing contextual analysis as the interpretive method. The review's themes highlighted the following outcomes: current psychiatric nosology employed a universalistic approach to diagnosis an intervention, thus limiting cultural conceptions of mental illness; holistic intervention requires the inclusion of traditional epistemological tenets; collaboration between modern practitioners and traditional healers would probably meet the patient's needs; and that culture-fit assessment and treatment often indicated improved prognosis. The outcomes therefore evidenced the operation of an African perspective on psychopathology. In fact, much of the reviewed literature also suggested culture-contextual perspectives on psychopathology. Furthermore, the way in which lack of cultural coherence exists between patients and clinicians suggested that diagnostic flaws may be a frequent occurrence. Potential benefits of the investigation include awareness that culture-related conceptualisation be explored in the clinical field; that future researchers use the current review as a foundational reference for primary investigations; that contemporary clinical classificatory systems be reviewed in terms of cultural

applicability; and that clinicians reconsider the diagnostic process in terms of culture-fit manifestations of psychopathology.

Objectives

The focus area of the research is to identify literature which suggests the existence, or lack thereof, of an African view with regards to psychopathology. This may allow for theory, research and practice to more overtly inform one another. The aim was therefore not to develop a psychometric instrument to assess perspectives, as this would have implied the quantisation, or imagined quantisation, of subjective experience (Michell, 1997).

In addition, the study aimed to allow research to be placed into a unified system where the dispersed, discrete segments of research were brought together to benefit the discipline of psychology. The outcome of such an investigation may allow comprehensive primary research to be conducted, as well as afford practitioners a single place of reference with which to inform current practice.

Search methods

For this investigation, the electronic databases available to students of the University of Pretoria (Wiley Online Library; Springer; Elsevier; Ingentaconnect; PubMed; Sagepub; and Questia), Google Scholar, hand-searching for key resources, and asking personal contacts and experts in the field for relevant authors, was employed to resource literature.

Data collection and analysis

To summarise, the type of study was defined (i.e. the literature review). After relevant searches were conducted, the researched material was screened based on the taxonomy of the review. At this stage, these studies were described, by summarising key points and themes, in order to map and refine the literature review. Once the process of gathering and describing the research was conducted, the following approach was employed: assessing the quality and relevance of the data; synthesising

the findings of the studies; drawing conclusions and making recommendations; and developing the final report (EPPI-Centre, 2007).

Results

The literature evidenced an existence of traditional African psychiatric nosology and treatment (e.g. Ashforth, 2001; Edgerton, 1971; Nsamenang, 1992). The results of the investigation suggested that cultural misinterpretations have led to diagnostic flaws and ineffective treatment (Kirmayer et al., 2003). With regards to non-Western approaches to healing, spiritual, holistic, and collective approaches have been shown to successfully treat psychopathology (see Bojuwoye, 2005; Levers & Maki, 1995; Mbiti, 1969; Toldson & Toldson, 2001).

Arguably, it is possible that persons experiencing culture-related disturbances may feel that their distress will not be appreciated by persons who do not understand their cultures and, as such, they would probably prefer to receive culture-specific treatment from traditional healers so as to address culture-related psychopathology. In this regard, Eshun and Gurung (2009) indicate that the concept of trust ought to be reflected on. An individual, or group, that trusts a professional practitioner's ability to appreciate cultural perceptions, is more likely to seek help from those clinicians. Trust, here, suggests a concerted effort on the clinician's part to use the patient's frame of reference as a source for treatment (Eshun & Gurung, 2009).

Additionally, culture influences the developmental process, cognition (Nsamenang 1992), as well as the experiential process (Draguns & Tanaka-Matsumi, 2003). As such, those experiences regarded as symptomatic of psychopathology certainly suggest a cultural perspective on psychopathology (cf. Draguns & Tanaka-Matsumi, 2003).

The author reviews the aforementioned ideas in order to provide an analysis of the current body of literature. The findings include an array of ideas relating to the research question. These ideas include the vast array of influences on African identity and cultural construction. From this vantage point, one may appreciate context-related dynamics such as epistemology, consciousness, oneness, witchcraft, traditional

healing, systemic patterning, and psychopathology. These ideas created the foundation for contrasting a conceptual view on African psychopathology with current views on culture-bound syndromes and idioms of distress. To conclude, recommendations for diagnostic and treatment process are formulated in harmony with the reviewed literature.

Author's conclusions

Based on the prominent themes available in the literature review, it is concluded that an African perspective on psychopathology, as a construction of the African worldview, is certainly viable. Indeed, an African perspective on psychopathology appears to be as equally valid as a modern or medical perspective on psychopathology. In fact, African conceptualisations of mental illness appear to have always existed (Nsamenang, 1992). This conclusion is further supported by a critical frame, which proposes that Western nosology progressively overshadowed other perspectives (Foster, 1999).

About the thesis:

Declarations of interest

None known.

7.3 Closing remarks

In harmony with Boote and Baile's (2005) recommendation, the literature review entailed focused attention in excavating as many sources as possible. The references were time-lined (see Appendix A) and arranged into themes (see Appendix B) in order to facilitate fresh insights. Furthermore, a descriptive process of reviewing the literature was employed, and was explored further within the discussion chapter. The result is a literature review that is systematic and unambiguous in structure.

7.4 Conclusion

This chapter concluded the current investigation by providing the literature review protocol as prescribed by the methodology. Accordingly, the chapter reported on the process of the literature review by detailing the data used throughout the review, particularly in terms of the predefined methodological and interpretative perspectives employed. The chapter included a literature review protocol that is typical of the systematic literature review methodology. This chapter included pertinent information such as the approved title and review information; the research abstract; the objectives of the review; the search methods; a brief description of the data collection and analysis; the results of the review; the author's conclusions; and any specific declarations of interest. The chapter was concluded with the researcher's closing remarks.

REFERENCES

Abas, M., & Broadhead, J. (1997). Depression and anxiety among women in an urban setting in Zimbabwe. *Psychological Medicine*, *27*(1), 59–71.

Abolafia, M. (2010). Narrative construction as sensemaking. *Organisation Studies*, *31*(3), 349–367.

Achebe, C. (1986). *The world of ogbanje*. Enugu: Fourth Dimension.

Achenbach, T. M., Becker, A., Döpfner, M., Heiervang, E., Roesner, V., Steinhausen, H., & Rothenberger, A. (2008). Multicultural assessment of child and adolescent psychopathology with ASEBA and SDQ instruments: Research findings, applications, and future directions. *The Journal of Child Psychology and Psychiatry*, *49*(3), 251–275.

Ackermann, L., & De Klerk, G. W. (2002). Social factors that make South African women vulnerable to HIV infection. *Health Care for Women International*, *23*(1), 163–172.

Adams, G. (2005). The cultural grounding of personal relationship: Enemyship in North American and West African worlds. *Journal of Personality and Social Psychology*, *88*(1), 948–968.

Adams, G., & Dzokoto, V. A. (2007). Genital-shrinking panic in Ghana: A cultural-psychological analysis. *Culture and Psychology*, *13*(1), 83–104.

Adams, G., & Salter, P. S. (2007). Health psychology in African settings: A cultural-psychological analysis. *Journal of Health Psychology*, *12*(3), 539–551.

Airhihenbuwa, C. O., & DeWitt Webster, J. (2004). Culture and African contexts of HIV/AIDS prevention, care and support. *Journal of Social Aspects of HIV/AIDS Research Alliance*, *1*(1), 4–13.

Ake, C. (1993). What is the problem of ethnicity in Africa? *Transformation*, *22*(1), 1–14.

Akinnawo, E. O. (1995). Mental health implications of the commercial sex industry in Nigeria. *Health Transition Review*, *5*(1), 173–177.

Al-Issa, I. (1995). The illusion of reality or the reality of illusion: Hallucinations and culture. *British Journal of Psychiatry*, *166*(1), 368–373.

Alao, K. (2004). Silver and gold we have none but what we have, we give unto thee: Indigenous African counselling and the rest of the world. *International Journal for the Advancement of Counselling*, *26*(3), 250–256.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders – text revision (DSM-IV-TR)*. Washington: American Psychiatric Association.

American Psychological Association. (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington: American Psychological Association.

Anderson, P. (1998). *The origins of postmodernity*. London: Vers.

Anderson, R. (1996). *Magic, science and health: The aims and achievements of medical anthropology*. New York: Harcourt Brace College Publishers.

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: A review of population studies. *Acta Psychiatry of Scandinavia*, *113*(1), 163–179.

Anise, L. (1974). The African redefined: The problems of collective Black identity. *A Journal of Opinion*, *4*(4), 26–382.

Aponte, J. F., & Johnson, L. R. (2000). The impact of culture on the intervention and treatment of ethnic populations. In: J. F. Aponte & J. Wohl (Eds), *Psychological intervention and cultural diversity* (2nd ed.) (pp. 18-39). Massachusetts: Allyn and Bacon.

Appiah, K.A. (1992). *In my father's house: Africa in the philosophy of culture.* London: Methuen.

Archer, M. S. (2007). *Making our way through the world: Human reflexivity and social mobility*. Cambridge: Cambridge University Press.

Arlow, J. (1961). Ego psychology and the study of mythology. *Journal of the American Psychoanalytic Association*, *9*(1), 371–393.

Asante, M. K. (1980). *Afrocentricity, the theory of social change*. New York: Amulefi Publishing.

Ashforth, A. (1998). Witchcraft, violence, and democracy in the new South Africa. *Cahiers d'Études Africaines*, *38*(1), 505–532.

Ashforth, A. (2001). On living in a world with witches: Everyday epistemology and spiritual insecurity in a modern African society (Soweto). In H. L. Moore & T. Sanders (Eds.). *Magical interpretations, material realities: Modernity, witchcraft and the occult in post-colonial Africa* (pp. 206-225). London: Routledge.

Ashforth, A. (2005). Muthi, medicine and witchcraft: Regulating 'African science' in post-apartheid South Africa. *Social Dynamics*, *31*(2), 211–242.

Bass, J. K., Bolton, P. A., & Murray, L. K. (2007). Comment: Do not forget culture when studying mental health. *The Lancet*, *370*(1), 918–919.

Becvar, D. S., & Becvar, R. J. (1996). *Family therapy: A systemic integration*. Massachusetts: Allyn & Bacon.

Beiser, M. (2003). Culture and psychiatry, or "The tale of the hole and the cheese." *The Canadian Journal of Psychiatry*, *48*(3), 143–144.

Berg, A. (2003). Ancestor reverence and mental health in South Africa. *Transcultural Psychiatry, 40*(1), 194–207.

Bernal, D. D. (2002). Critical race theory, Latino critical theory, and critical raced-gendered epistemologies: Recognising students of color as holders and creators of knowledge. *Qualitative Inquiry*, *8*(1), 105–126.

Berry, J. W. (1995). Culture and ethnic factors in health. In R. West (Ed.), *Cambridge handbook of psychology, health and medicine* (p. 66). New York: Cambridge University Press.

Berzoff, J., & Flanagan, L. A. (2008) *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts*. New York: Jason Aronson.

Bhaskar, R. (1989). *Reclaiming reality: A critical introduction to contemporary philosophy*. London: Verso.

Bhugra, D., & Bhui, K. (1997). Cross-cultural psychiatric assessment. *Advances in Psychiatric Treatment*, *3*(1), 103–110.

Bhugra, D., & Bhui, K. (2001). African-Caribbeans and schizophrenia: Contributing factors. *Advances in Psychiatric Treatment*, *7*(1), 288–293.

Bhui, H., & Bhugra, D. (2001). Transcultural psychiatry: Some social and epidemiological research issues. *International Journal of Social Psychiatry*, *47*(3), 1–9.

Bird, H.R. (1996). Epidemiology of childhood disorders in a cross-cultural context. *Journal of Child Psychology and Psychiatry*, *37*(1), 35–49.

Black, S. R., Spence, S. A., & Omari, S. R. (2004). Contributions of African Americans to the field of psychology. *Journal of Black Studies*, *35*(1), 40–64.

Blatner, A. (1997). The implications of postmodernism for psychotherapy. *Individual Psychology*, *53*(4), 476–482.

Blatner, A. (2002). *Creative mythmaking: Personal meaning in the new millennium*. Retrieved from http://www.blatner.com/adam/level2/pmodfaq.htm

Bojuwoye, O. (2005). Traditional healing practices in South Africa: Ancestral spirits, ritual ceremonies and holistic healing. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy* (pp. 61-72). California: Sage Publications.

Bolton, P. (2001). Local perceptions of the mental health effects of the Rwandan genocide. *Journal of Nervous Mental Disorders*, *189*(1), 243–248.

Bond, G. C. (2001). Ancestors and witches: Explanations and the ideology of individual power in northern Zambia. In G. C. Bond and D. Ciekawy (Eds.), *Witchcraft dialogues: Anthropological and philosophical exchanges* (pp. 131-157). Ohio: Centre for International Studies.

Boote, D. N., & Beile, P. (2005). Scholars before researchers: On the centrality of the dissertation literature review in research preparation. *Educational Researcher, 34*(6), 3-15.

Boykin, A. W., Jagers, R. J., Ellison, C. M., & Albury, A. (1997). Communalism: Conceptualization and measurement of an Afrocultural social orientation. *Journal of Black Studies*, *27*(1), 409–418.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Brayboy, B. M. (2001, April). Racing toward an interviewing methodology for the "other", *Critical race theory and interviewing*. Paper presented at the American Educational Research Programme, Seattle, Washington.

Breisach, E. (1962). *Introduction to modern existentialism*. New York: Grove Press.

Brody, H. (1987). *Stories of sickness*. New Haven: Yale University Press.

Brooks-Harris, J. E. (2008). *Integrative multitheoretical psychotherapy*. Massachusetts: Houghton-Mifflin.

Bullard, A. (2001). The truth in madness. *South Atlantic Review*, *66*(2), 114–132.

Bunge, M. (1998). *Social science under debate*. Toronto: University of Toronto Press.

Burnett, R., Mallett, R., Bhugra, D., Hutchinson, G., Der, G., & Leff, J. (1999). The first contact of patients with schizophrenia with psychiatric services: Social factors and pathways to care in a multi-ethnic population. *Psychological Medicine*, *29*(1), 475–483.

Cabral, A. (1974). National liberation and culture. *Transition*, *1*(45), 12–17.

Cambell, C., Foulis, C. A., Maimane, S., & Sibiya, Z. (2005). I have an evil child at my house: Stigma and HIV/AIDS management in a South African community. *American Journal of Public Health*, *95*(5), 809–815.

Campbell, C. (1997). Migrancy, masculine identities and AIDS: The psychosocial context of HIV transmission on the South African gold mines. *Social Sciences and Medicine*, *45*(2), 273–281.

Campbell, J. (1949). *The hero with a thousand faces*. Princeton: Princeton University Press.

Campbell, J. (1992). *Pathways to bliss*. New York: Harper.

Canino, G., & Algería, M. (2008). Psychiatric diagnosis – is it universal or relative to culture? *Journal of Child Psychology and Psychiatry*, *49*(3), 237–250.

Canino, G., Lewis-Fernandez, R., & Bravo, M. (1997). Methodological challenges in cross-cultural mental health research. *Transcultural Psychiatry Research Review*, *34*(1), 163–184.

Cantor-Graae, E., & Selten, J. (2005). Schizophrenia and migration: A meta-analysis and review. *American Journal of Psychiatry*, *162*(1), 12–24.

Caradas, A. A., Lambert, E. V., & Charlton, K. E. (2001). An ethnic comparison of eating attitudes and associated body image concerns in adolescent South African schoolgirls. *Journal of Human Nutrition and Dietetics*, *14*(1), 111–120.

Carey, P. D., Walker, J. L., Rossouw, W., Seedat, S., & Stein, D. J. (2008). Risk indicators and psychopathology in traumatised children and adolescents with a history of sexual abuse. *European Child and Adolescent Psychiatry*, *17*(1), 93–98.

Carlson, J., Sperry, L., & Lewis, J. A. (2005). *Family therapy techniques: Integrating and tailoring treatment*. New York: Routledge.

Carter, M. R., & May, J. (1999). Poverty, livelihood and class in rural South Africa. *World Development*, *27*(1), 1–20.

Cashmore, E. (1988). *Dictionary of race and ethnic relations*. London: Routledge.

Castillo, R. J. (1997). *Culture and mental illness*. California: ITP.

Chandler, R. (1998). The concept of the harmony of science and religion in African culture. In C.W. du Toit (Ed.), *Faith, science and African culture: African cosmology and Africa's contribution to science* (pp. 10-18). Pretoria: Unisa.

Checkland, P. (1997). *Systems thinking, systems practice*. Chichester: John Wiley & Sons.

Childers, J., & Hentzi, G. (Eds.). (1995). *Columbia dictionary of modern literary and cultural criticism*. New York: Columbia University Press.

Cheetham, R. W. S., & Griffiths, J. A. (1981). Errors in the diagnosis of schizophrenia in Black and Indian patients. *South African Medical Journal*, *59*(1), 71–75.

Chick, K. (2000, November). Constructing a multicultural national identity: South African classrooms as sites of struggle between competing discourses. *Working Papers in Educational Linguistics*. Presented at the 10th Annual Nessa Wolfson Colloquieum.

Chowdhury, A. N., & Wharemate-Dobson, T. (2002). Culture, psychiatry and New Zealand. *Indian Journal of Psychiatry*, *44*(4), 356–361.

Comaroff, J., & Comaroff, J. L. (1987). The madman and the migrant: Work and labour in the historical consciousness of a South African people. *American Ethnologist*, *14*(2), 191–209.

Cooper, H. M. (1989). *Integrating research: A guide for literature reviews*. California: Sage Publications.

Cooper, H. M. (1998). *Synthesising research: A guide for literature reviews*. California: Sage Publications.

Cooper, H. M. (2009). *Research synthesis and meta-analysis: A step-by-step approach* (4th ed.). California: Sage Publications.

Crane, J. (1991). The epidemic theory of ghettos and neighbourhood effects on dropping out and teenage childbearing. *The American Journal of Sociology*, *96*(5), 1226–1259.

Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care*. Washington: Georgetown University Child Development Center.

Crystal, E. (2010). *Mythology*. Retrieved from http://www.crystalinks.com

D'Andrade, R. (1995). *The development of cognitive anthropology*. Cambridge: Cambridge University Press.

Dana, R. H. (2000). *Handbook of cross-cultural and multicultural personality assessment*. New Jersey: Lawrence Erlbaum.

Dane, F. C. (1990). *Research methods*. California: Brooks/Cole Publishing Company.

Dane, F. C. (2010). *Evaluating research: Methodology for people who need to read research*. California: Sage Publications.

Darder, A., & Torres, R. D. (2001). Mapping the problematics of "race": A critique of Chicano education discourse. In C. Tejeda, C. Martinez, & Z. Leonardo (Eds.), *Charting new terrains of Chicana(o)/Latina(o) education* (pp. 161-172). New Jersey: Hampton.

De Jong, J. T. V. M., & Van Ommeren, M. (2002). Toward a culture-informed epidemiology: Combining qualitative and quantitative research in transcultural contexts. *Transcultural Psychiatry*, *39*(4), 422–433.

Dein, S., & Dickens, H. (1997). Cultural aspects of aging and psychopathology. *Aging and Mental Health*, *1*(2), 112–120.

Deely, J. (2001). *Four ages of understanding: The first postmodern survey of philosophy from ancient times to the turn of the twenty-first century*. Toronto: University of Toronto.

Diala, C. C., Muntaner, C., Walrath, C., Nickerson, K., LaVeist, T., & Leaf, P. (2001). Racial/ethnic differences in attitudes towards seeking professional mental health services. *American Journal of Public Health*, *91*(5), 805–807.

Dodson, J. (1995). Conceptualizations of Black families. In N. T. Goldberger & J. B. Veroff (Eds.), *The Culture and Psychology Reader* (pp. 276-291). New York: New York University Press.

Double, D. (1990). What would Adolf Meyer have thought about the neo-Kraepelinian approach? *Psychiatric Bulletin*, *1*(1), 471–474.

Dow, J. (1986). Universal aspects of symbolic healing: A theoretical synthesis. *American Anthropologist, 88*(1), 56–69.

Draguns, J. G. (1997). Abnormal behaviour patterns across culture: Implications for counselling and psychotherapy. *International Journal of Intercultural Relations*, *21*(2), 213–248.

Draguns, J. G. (2000). Psychopathology and ethnicity. In J. F. Aponte & J. Wohl (Eds), *Psychological intervention and cultural diversity* (2nd ed.) (pp. 40-58). Massachusetts: Allyn and Bacon.

Draguns, J. G., & Tanaka-Matsumi, J. (2003). Assessment of psychopathology across and within cultures: Issues and findings. *Behaviour Research and Therapy*, *41*(7), 755–776.

Drewal, M. T. (1988). Ritual performance in Africa today. *The Drama Review*, *32*(2), 25–30.

Du Toit, C. W. (1998). African rationality: Analysis, critique and prospects. In C. W. du Toit (Ed.), *Faith, science and African culture: African cosmology and Africa's contribution to science* (pp. 99-104). Pretoria: Unisa.

Dzama, E. N. N., & Osborne, J. F. (1999). Poor performance in science among African students: An alternative explanation to the African worldview thesis. *Journal of Research in Science Teaching*, *36*(3), 387–405.

Dzokoto, V. A., & Adams, G. (2005). Understanding genital-shrinking epidemics in West Africa: Koro, Juju, or mass psychogenic illness? *Culture, Medicine and Psychiatry*, *29*(1), 53–78.

Dzokoto, V. A., & Okazaki, S. (2006). Happiness in the eye and the heart: Somatic referencing in West African emotion lexica. *Journal of Black Psychology*, *32*(2), 117–140.

Eagle, G. (2005). Cultured clinicians: The rhetoric of cultural and clinical psychology training. *Psychology in Society*, *32*(2), 41–64.

Edgerton, R. B. (1966). Conceptions of psychosis in four East African societies. *American Anthropologist*, *68*(2), 408–425.

Edgerton, R. B. (1971). A traditional African psychiatrist. *Southwestern Journal of Anthropology*, *27*(3), 259–278.

Edwards, F. (1998). African spirituality and the integrity of science In: C. W. du Toit (Ed.), *Faith, science and African culture: African cosmology and Africa's contribution to science* (pp. 85-98). Pretoria: Unisa.

Eshun, S., &. Gurung, A. R. (2009). Introduction to culture and psychopathology. In S. Eshun, & A. R. Gurung, *Culture and mental health: Sociocultural influences, theory, and practice* (pp. 1-17). New Jersey: Wiley and Sons, Incorporated.

Evidence for Policy and Practice Information and Co-ordinating Centre. (2007). *EPPI-Centre methods for conducting systematic reviews*. London: University of London.

Fanon, F. (1963). *The wretched of the earth*. New York: Grove Press.

Fanon, F. (1968). *Black skin, White masks*. New York: Grove Publishers.

Farlex Incorporated. (2008). *The American heritage dictionary of the English language* (4th ed.). Pennsylvania: Houghton Mifflin Company.

Farrell, F. B. (1994). *Subjectivity, realism, and postmodernism: The recovery of the world in recent philosophy*. New York: Cambridge University Press.

Feierman, S. (1985). Struggles for control: The social roots of health and healing in modern Africa. *African Studies Review*, *28*(2), 73–147.

Ferguson, W. J., & Candib, L. M. (2002). Culture, language, and the doctor-patient relationship. *Family Medicine*, *34*(5), 353–361.

Fiske, A., Kitayama, S., Markus, H. R., & Nisbett, R. E. (1998). The cultural matrix of social psychology. In D. Gilbert, S. Fiske & G. Lindzey (Eds.), *The Handbook of Social Psychology* (4th ed.) (pp. 915-981). San Francisco: McGraw-Hill.

Foley, R. (1999). "Analysis". Entry in *The Cambridge Dictionary of Philosophy*, (2nd ed.). New York: Cambridge University Press.

Foster, D. (1999). Racism, Marxism, psychology. *Theory Psychology*, *9*(3), 331-352.

Foucault, M. (1979). *Discipline and punish: The birth of the prison*. New York: Vintage.

Fox, D., & Prilleltensky, I. (1997). *Critical psychology: An introduction*. London: Sage.

Freud, S. (2002). *Civilisation and its discontents*. London: Penguin.

Furlong, J., & Oancea, A. (Eds.). (2007). Applied and practice-based research. *Special Edition of Research Papers in Education*, *22*(2), 213–228.

Gabbard, G. (2005). *Psychodynamic psychiatry in clinical practice* (4th ed.). Washington: American Psychiatric Press.

Gaw, A. C. (1993). *Culture, ethnicity and mental illness*. Washington: American Psychiatric Press.

Gervais-Lambony, P. (2006). Space and identity: Thinking through some South African examples. In: S. Bekker & A. Leildé (Eds.), *Reflections on identity in four African cities* (pp. 53-96). Stellenbosch: African Minds.

Geschiere, P. (1997). *The modernity of witchcraft: Politics and the occult in postcolonial Africa*. Charlottesville: University of Virginia Press.

Gettier, E. (1963). Is justified true belief knowledge? *Analysis*, *23*(6), 121–23.

Giarelli, E., & Jacobs, L. (2003). Traditional healing and HIV-AIDS in KwaZulu Natal, South Africa: To curb the epidemic, South African nurses, physicians, and traditional healers are learning to collaborate. *American Journal of Nursing*, *103*(10), 36–46.

Gibson, J. L. (2004). Overcoming apartheid: Can truth reconcile a divided nation? *Politikon*, *31*(2), 129–155.

Giles, H., & St. Clair, R. N. (1979). *Language and social psychology*. London: Basil Blackwell.

Gillis, L. S., Welman, M., Koch, A., & Joyi, M. (1991). Psychological distress and depression in urbanising elderly black persons. *South African Medical Journal*, *79*(1), 490–495.

Giorgi, A. (1970). *Psychology as human science*. New York: Harper & Row.

Glazer, N. (1997). *We are all multiculturalists now*. New Jersey: Library of Congress.

Goddard, R. D., Hoy, W. K., & Hoy, W. (2004). Collective efficacy beliefs: Theoretical developments, empirical evidence, and future directions. *Educational Researcher*, *33*(3), 3 – 13.

Gorman, L. L., O'Hara, M. W., Figueiredo, B., Hayes, S., Jacquemain, F., Kammerer, M. H., … Sutter-Dallay, A. L. (2004). Adaptation of the Structured Clinical Interview for DSM-

IV Disorders for assessing depression in women during pregnancy and post-partum across countries and culture. *British Journal of Psychiatry*, *184*(46), 17–23.

Gøtzsche, P. C., Hróbjartsson, A., Maric, K., & Tendal, B. (2007). Data extraction errors in meta-analyses that use standardized mean differences. *Journal of the American Medical Association*, *298*(1), 430–437.

Gough, D. A. (2004). Systematic research to inform the development of policy and practice in education. In G. Thomas & R. Pring (Eds.). *Evidence-based practice* (pp. 21-33). Buckingham: Open University Press.

Gough, D., & Elbourne, D. (2002). Systematic research synthesis to inform policy, practice and democratic debate. *Social Policy and Society*, *1*(3), 225–236.

Green, C.D., & Groff, P.R. (2003). *Early psychological thought: Ancient accounts of mind and soul.* Connecticut: Praeger.

Green, E. C., Zokwe, B., & Dupree, J. D. (1995). The experience of an AIDS prevention program focused on South African traditional healers. *Social Science and Medicine*, *40*(4), 503–515.

Green, S., Higgins, J. P. T., Alderson, P., Clarke, M., Mulrow, C. D., & Oxman, A. D. (2008). Introduction. In: J. P. T. Higgins & S. Green (Eds), *Cochrane handbook for systematic reviews of interventions: Version 5.0.1* (pp. 1-11). United Kingdom: The Cochrane Collaboration.

Greenfield, P., Keller, H., Fuligni, A., & Maynard, A. (2003). Cultural pathways through universal development. *Annual Review of Psychology*, *54*(1), 461–490.

Grillo, R. (2007). An excess of alterity? Debating difference in a multicultural society. *Ethnic and Racial Studies*, *30*(6), 979–998.

Gualbert, R.A. (1997). Traditional models of mental health and illness in Benin. In P.J. Hountondji (Ed.), *Endogenous Knowledge: Research Trials* (pp. 217-245). Dakar: Codesria.

Guaranaccia, P. J., Rivera, M., Franco, F., & Neighbors, C. (1996). The experiences of ataques de nervios: Towards an anthropology of emotions in Puerto Rico. *Culture, Medicine, and Psychiatry*, *10*(1), 343–367.

Guarnaccia, P. J., & Rogler, L. H. (1999). Research on culture-bound syndromes: New directions. *American Journal of Psychiatry*, *156*(1), 1322–1327.

Guindon, M. H., Green, A. G., & Hanna, F. J. (2003). Intolerance and psychopathology: Toward a general diagnosis for racism, sexism, and homophobia. *American Journal of Orthopsychiatry*, *73*(2), 167–176.

Guiness, E. A. (1992). Profile and prevalence of the brain fag syndrome: Psychiatric morbidity in school populations in Africa. *British Journal of Psychiatry*, *160* (1), 42–52.

Gureje, O., Obikoya, B., & Ikuesan, A. (1992). Prevalence of specific psychiatric disorders in an urban primary care setting. *East African Medical Journal*, *69*(1), 282–287.

Habel, U., Gur., R. C., Mandal, M. K., Salloum, J. B., Gur, R. E., & Schneider, F. (2000). Emotional processing in schizophrenia across cultures: Standardised measures of discrimination and experience. *Schizophrenia Research*, *42*(1), 57–66.

Hahn, R.A. (1995). *Sickness and healing: an anthropological perspective*. New York: Yale University Press.

Haidet, P., & Paterniti, D. A. (2003). "Building" a history rather than "taking" one: A perspective on information sharing during the medical interview. *Arch International Medicine*, *163*(1), 1134–1140.

Hall, T. M. (2006). *Index of culture-bound syndromes*. Retrieved from http://homepage.mac.com/mccajor/cbs.htmla

Hammond-Tooke, D. (1998). Establishing dialogue: Thoughts on 'cosmology', 'religion' and 'science'. In C. W. du Toit (Ed.), *Faith, science and African culture: African cosmology and Africa's contribution to science* (pp. 1-9). Pretoria: Unisa.

Harman, G. (1990). The intrinsic quality of experience. In J. Tomberlin (Ed.), *Philosophical perspectives 4: Action theory and the philosophy of mind* (pp. 31-52). California: Ridgeview Publishing Company.

Harding, S. (1987). *Feminism and methodology*. Milton Keynes: Open University Press.

Harding, T. W., Arango, M. V., Baltazar, J., Climent, C. E., Ibrahim, H. H. A., Ignacio, L. L., … Wig, N. N. (1980). Mental disorders in primary health care: A study of their frequency and diagnosis in four developing countries. *Psychological medicine*, *10*(1), 231-241.

Harris, B. (2002). Xenophobia: A new pathology for a new South Africa? In D. Hook & G. Eagle (Eds.), *Psychopathology and social prejudice* (pp. 169-184). Cape Town: University of Cape Town Press.

Hart, C. (1998). *Doing a literature review: Releasing the social science research imagination*. London: Sage Publications.

Hassim, J. (2009). *Becoming and being a lay volunteer counsellor: An interpretative phenomenological analysis (IPA) study* (Unpublished master's dissertation). University of Pretoria, Pretoria .

Hayman, R. (2001). *A life of Jung*. New York: W.W. Norton.

Hedges, L. V., & Cooper, H. (Eds.). (1994). *The handbook of research synthesis*. New York: Russell Sage Foundation Publications.

Helman, C. (1990). *Culture, health and illness*. Oxford: Butterworth Haimann.

Hergenhahn, B. R. (2005). *An introduction to the history of psychology*. California: Thomson Wadsworth.

Hermans, H. J. M., & Kempen, H. J. G. (1998). Moving cultures: The perilous problems of cultural dichotomies in a globalising society. *American Psychologist*, *53*(1), 1111–1120.

Hermans, H. J. M., Kempen, H. J. G., & Van Loon, R. J. P. (1992). The dialogical self: Beyond individualism and rationalism. *American Psychologist*, *47*(1), 23–33.

Herskovits, M. J. (1926). The cattle complex in East Africa. *American Anthropologist*, *28*(1), 230–272.

Hickling, F. W., & Hutchinson, G. (1999). Roast breadfruit psychosis: Disturbed racial identification in African-Caribbeans. *Psychiatric Bulletin*, *23*(1), 132–134.

Higgins, J. P. T., & Green, S. (Eds). (2008). *Cochrane handbook for systematic reviews of interventions: Version 5.0.1*. United Kingdom: The Cochrane Collaboration.

Hofstede, G. (1986). Cultural differences in teaching and learning. *International Journal of Intercultural Relations*, *10*(1), 301–320.

Hofstede, G. (2001). *Culture's consequence: Comparing values, institutions and organisations across nations* (2nd ed.). California: Sage.

Hook, D. (2004a). Foucault, disciplinary power and the critical pre-history of psychology. In D. Hook, N. Mkhize, P. Kiguwa, A. Collins, E. Burman, & I.Parker (Eds.), *Critical psychology* (pp. 210-237). Landsdowne: UCT Press.

Hook, D. (2004b). Fanon and the psychoanalysis of racism. In D. Hook, N. Mkhize, P. Kiguwa, A. Collins, E. Burman, & I.Parker (Eds.), *Critical psychology* (pp. 115-138). Landsdowne: UCT Press.

Hook, D. (2004c). Frantz Fanon, Steve Biko, 'psychopolitics' and critical psychology. In D. Hook, N. Mkhize, P. Kiguwa, A. Collins, E. Burman, & I.Parker (Eds.), *Critical psychology* (pp. 84-113). Landsdowne: UCT Press.

Hook, D. (2008). The 'real' of racializing embodiment. *Journal of Community and Applied Social Psychology*, *18*(2), 140–152.

Hook, D., & Howarth, C. (2005). Future directions for a critical social psychology of racism. *Journal of Community and Applied Social Psychology*, *15*(1), 425–431.

Horton, R. (1993). *Patterns of thought in Africa and the West*, Cambridge: Cambridge University Press.

Hughes, C.C., Simons, R.C., & Wintrob, R.M. (1997). The 'culture-bound syndromes' and DSM-IV. In T. Widiger, A.J. Frances, H.A. Pincus, et al. (Eds.), *Sourcebook for DSM-IV* (vol. 33) (pp. 991-1000). Washington: American Psychiatric Press.

Hundt, G. L., Stuttaford, M., & Ngoma, B. (2004). The social diagnostics of stroke-like symptoms: Healers, doctors and prophets in Agincourt, Limpopo province, South Africa. *Journal to Biosocial Science*, *36*(1), 433–443.

Ilechukwu, S. T. C. (2007). Ogbanje/abiku and cultural conceptualisations of psychopathology in Nigeria. *Mental Health, Religion and Culture*, *10*(3), 239–255.

Isaac, M., Janca, A., & Orley, J. (1996). Somatization – A culture-bound or universal syndrome? *Journal of Mental Health*, *5*(1), 219–222.

Iwu, M. (1986). *African ethnomedicine.* Nigeria: UPS.

Jablensky, A. (1987). Multicultural studies and the nature of schizophrenia: A review. *Journal of the Royal Society of Medicine*, *80*(3), 162–167.

James, W. (1907). *Pragmatism: A new name for some old ways of thinking*. New York: Longman Green and Company.

Janse van Rensburg, A. B. R. (2009). A changed climate for mental health care delivery in South Africa. *African Journal of Psychiatry*, *12*(1), 157–165.

Jewett, R., & Lawrence, J. S. (1977). *The American monomyth*. New York: Doubleday.

Jewkes, R., & Abrahams, N. (2002). The epidemiology of rape and sexual coercion in South Africa. *Social Science and Medicine*, *55*(1), 1231–1244.

Jewkes, R. K., Levin, J. B., & Penn-Kekana, L. (2003). Gender inequalities, intimate partner violence and HIV preventive practices: Findings of a South African cross-sectional study. *Social Science and Medicine*, *56*(1), 125–134.

Jilek-Aall, L., Jilek, M., Kaaya, J., Mkombachepa, L., & Hillary, K. (1997). Psychosocial study of epilepsy in Africa. *Social Science and Medicine*, *45*(5), 783–795.

Joffe H. (1999). *Risk and the other.* Cambridge: Cambridge University Press.

Jones, R. (1995). Why Pan-Africanism failed: Blackness and international relations. *The Griot*, *14*(1), 54–61.

Jost, J., & Banaji, M. (1994). The role of stereotyping in system justification and the production of false consciousness. *British Journal of Social Psychology, 33(1)*, 1–27.

Jung, C. G. (1969). *On the nature of the psyche*. New Jersey: Princeton University Press.

Kale, R. (1995). South Africa's health: Traditional healers in South Africa. *British Medical Journal*, *310*(1), 1182–1185.

Kamen, L. P., & Seligman, M. E. P. (1987). Explanatory style and health. *Current psychological research and reviews,* 6(3), 207–218.

Kamwangamalu, N. M. (1999). Ubuntu in South Africa: A sociolinguistic perspective to a pan-African concept. *Critical Arts*, *13*(2), 24–41.

Kaphagawani, D. N., & Malherbe, J. G. (2001). African epistemology. In P. H. Coetzee & A. P. J. Roux (Eds.), *The African philosophy reader* (pp. 205-274). London: Routledge.

Katz, I., Glass, D. C., & Cohen, S. (1992). Ambivalence, guilt, and the scapegoating of minority group victims. *Personality and Social Psychology Bulletin*, *18*(6), 786–797.

Katzman, M. A., Hermans, K. M. E., Van Hoeken, D., & Hoek, H. W. (2004). Not your "typical island woman": Anorexia nervosa is reported only in subcultures in Curaçao. *Culture, Medicine and Psychiatry*, *28*(1), 463–492.

Kaufmann, W. A. (1956). *Existentialism: From Dostoevesky to Sartre*. New York: Penguin.

Kazarian, S. S., & Evans, D. R. (Eds). (1998). *Cultural clinical psychology: Theory, research, and practice*. New York: Oxford University Press.

Kinderman, P., & Bentall, R. P. (1996). Self-discrepancies and persecutory delusions: Evidence for a model of paranoid ideation. *Journal of Abnormal Psychology*, *105*(1), 106–113.

Kim, L. S. (2003). Multiple identities in a multicultural world: A Malaysian perspective. *Journal of Language, Identity, and Education*, *2*(3), 137–158.

King, R. (1990). *African origin of biological psychiatry*. Tennessee: Seymour-Smith.

Kirmayer, L. J. (2001). Cultural variations in the clinical presentation of depression and anxiety: Implications for diagnosis and treatment. *Journal of Clinical Psychiatry*, *62*(13), 22–28.

Kirmayer, L. J., Groleau, D., Guzder, J., Blake, C., & Jarvis, E. (2003). Cultural consultation: A model of mental health service for multicultural societies. *Canadian Journal of Psychiatry*, *48*(3), 145–153.

Kirmayer, L. J., & Young, A. (1998). Culture and somatisation: Clinical, epidemiological, and ethnographic perspectives. *Psychosomatic Medicine*, *60*(1), 420–430.

Kleinman, A. (1988). *Rethinking psychiatry: From cultural category to personal experience*. New York: Free Press

Kleinman, A., & Good, B., (1985). Introduction: Culture and depression. In A. Kleinman & B. Good (Eds.), *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder* (pp. i-vii). Berkeley: University of California Press.

Kleinman, A., & Kleinman, J. (1991). Suffering and its professional transformation: Toward an ethnography of interpersonal experience. *Culture, Medicine and Psychiatry*, *15*(1), 275–301.

Koss-Chioino, J. D. (2000). Traditional and folk approaches among ethnic minorities. In J. F. Aponte & J. Wohl (Eds), *Psychological intervention and cultural diversity* (2nd ed.) (pp. 145-163). Massachusetts: Allyn and Bacon.

Kottak, C. P. (2005). *Windows on humanity*. New York: McGraw Hill.

Kudadjie, J., & Osei, J. (1998). Understanding African cosmology: Its context and contribution to world-view, community and the development of science. In: C. W. Du Toit (Ed.), *Faith, science and African culture: African cosmology and Africa's contribution to science* (pp. 33-64). Pretoria: Unisa.

Kwate, N. O. A. (2005). The heresy of African-centered psychology. *Journal of Medical Humanities*, *26*(4), 215–235.

Ladson-Billings, G. (2000). Radicalized discourses and ethnic epistemologies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.) (pp. 257-277). California: Sage.

Langdridge, D. (2006). *Phenomenological psychology*. Harlow: Pearson.

Last, J. M. (1995). *A dictionary of epidemiology* (3rd ed.). Oxford: Oxford University Press.

Le Grange, D., Louw, J., Breen, A., & Katzman, M. A. (2004). The meaning of 'self-starvation' in impoverished black adolescents in South Africa. *Culture, Medicine and Psychiatry*, *28*(1), 439–461.

Le Grange, D., Telch, C. F., & Tibbs, J. (1998). Eating attitudes and behaviours in 1,435 South African Caucasian and non-Caucasian college students. *American Journal of Psychiatry*, *155*(2), 250–254.

Leclerc-Madlala, S. (2002), *Traditional medical practitioners' AIDS training and support programme: Final evaluation report*. Durban: AIDS Foundation of South Africa.

Leeming, D. A. (1981). *Mythology: The voyage of the hero*. New York: Harper & Row.

Lefcourt, H. M. (1966). Internal versus external control of reinforcement: A review. *Psychological Bulletin*, *65*(4), 206–220.

Levers, L. L., & Maki, D. (1995). African indigenous healing and cosmology: Toward a philosophy of ethnorehabilitation. *Rehabilitation Education*, *9*(1), 127–146.

Lewis-Fernandez, R., & Kleinman, A. (1995). Cultural psychiatry: Theoretical, clinical, and research issues. *Psychiatric Clinics of North America*, *18*(1), 433–448.

Liang, H., Flisher, A. J., & Chalton, D. O. (2002). Mental and physical health of out of school children in a South African township. *European Child and Adolescent Psychiatry*, *11*(1), 257–260.

Lieberson, S. (1961). A societal theory of race and ethnic relations. *American Sociological Review*, *26*(6), 902–910.

Liddell, C., Barrett, L., & Bydawell, M. (2005). Indigenous representations of illness and AIDS in Sub-Saharan Africa. *Social Science and Medicine*, *60*(1), 691–700.

Lieberson, S. (1961). A societal theory of race and ethnic relations. *American Sociological Review*, *26*(6), 902–910.

Light, R. J., & Pillemer, D. B. (1984). *The science of reviewing research*. Cambridge: Harvard University Press.

Lin, K., & Kleinman, A. M. (1988). Psychopathology and clinical course of schizophrenia: A cross-cultural perspective Psychopathology and clinical course of schizophrenia: A cross-cultural perspective. *Schizophrenia Bulletin*, *14*(4), 555-567.

Lindlof, T. R., & Taylor, B. C. (2002). *Qualitative communication research methods* (3rd ed.). California: Sage.

Lipowski, Z. J. (1988). Somatization: The concept and its clinical application. *American Journal of Psychiatry*, *145*(11), 1358–68.

Littlewood, R. (2007). Limits to agency in psychopathology: A comparison of Trinidad and Albania. *Anthropology and Medicine*, *14*(1), 95–114.

López, S. R., & Guarnaccia, P. J. J. (2000). Cultural psychopathology: Uncovering the social world of mental illness. *Annual Review of Psychology*, *51*(1), 571–598.

Louw, D. J. (1998). The influence of postmodernism: Plurality, ethnocentrism and 'African' science. In: C. W. Du Toit (Ed.), *Faith, science and African culture: African cosmology and Africa's contribution to science* (pp. 19-26). Pretoria: Unisa.

Lubell-Doughtie, P. B. (2009). *African cosmologies – Tabwa*. Retrieved from http://peet.ldee.org/2009/11/african-cosmologies-tabwa.html.

Luck, A. J., Morgan, J. F., Reid, F., O'Brien, A., Brunton, J., Price, C., …. Lacey, J. H. (2002). The SCOFF questionnaire and clinical interview for eating disorders in general practice: Comparative study. *British Medical Journal*, *325*(1), 755 – 756.

Lupton, D. (1994). *Medicine as culture: Illness, disease, and the body in Western societies*. London: Sage.

Lutz, C. (1985). Depression and the translation of emotional worlds. In: A. Kleinman, & B. Good (Eds.), *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder* (pp. 63-100). Berkeley: University of California Press.

Lykiardopoulos, A. (1981). The evil eye: Towards an exhaustive study. *Folklore*, *92*(2), 221–230.

Mabie, G. E. (2000). Race, culture, and intelligence: An interview with Asa G. Hilliard III. *The Educational Forum*, *64*(3), 243–251.

Machi, L. A., & McEvoy, B. T. (2008). *The literature review: Six steps to success*. California: Corwin Press.

Macquarrie, J. (1972). *Existentialism*. New York: Pelican.

Mafeje, A. (1971). The ideology of 'tribalism.' *The Journal of Modern African Studies*, *9*(2), 253–361.

Mai, F. (2004). Somatization disorder: A practical review. *Canadian Journal of Psychiatry*, *49*(10), 652–62.

Makgoba, M. W. (1998). Patterns of African thought: A critical analysis. In: C. W. Du Toit (Ed.), *Faith, science and African culture: African cosmology and Africa's contribution to science* (pp. 27-32). Pretoria: Unisa.

Mansell, W. (2005). Control theory and psychopathology: An integrative approach. *Psychology and Psychotherapy*, *78*(1), 141–178.

Maquet, J. (1972). *Africanity*. New York: Oxford University Press.

Markus, H.R., & Kitayama, S. (2003). Culture, self, and the reality of the social. *Psychological Inquiry*, *14*(1), 277–283.

Marsella, A. J. (1980). Depressive experience and disorder across culture. In H. C. Triandis & J. G. Draguns (Eds.), *Handbook of cross-cultural psychology* (pp. 237-290). Boston: Allyn and Bacon.

Marsella, A. J. (1998). Toward a global-community psychology: Meeting the needs of changing world. *American Psychologist*, *53*(1), 1282-1291.

Marsella, A. J. (2005). Rethinking the 'talking cures' in a global era. *Contemporary Psychology, 50(45)*, 2–12.

Masterson, J. F. (1985). *The real self: A developmental self, and object relations approach*. New York: Bruner/Mazel Publishers.

Mateus, M. D., dos Santos, J. Q., & de Jesus Mari, J. (2005). Popular conceptions of schizophrenia in Cape Verde, Africa. *Revista Brasileira de Psiquiatria*, *27*(2), 101–107.

Mather, C. (2005). Accusations of genital theft: A case from Northern Ghana. *Culture, Medicine, and Psychiatry*, *29*(1), 33–52.

Mattes, R. (2002). South Africa: Democracy without people? *Journal of Democracy*, *13*(1), 22–36.

May, P. A., Brooke, L., Gossage, P., Croxford, J., Adnams, C., Jones, K. L., Robinson, L., & Viljoen, D. (2000). Epidemiology of Fetal Alcohol Syndrome in a South African community in the Western Cape province. *American Journal of Public Health*, *90*(12), 1905–1912.

Mazrui, A. A. (1986). *The Africans: A triple heritage*. Boston: Little, Brown.

Mbembe, A. (2000). At the edge of the world: Boundaries, territoriality, and sovereignty in Africa. *Public Culture*, *12*(1), 259–284.

Mbembe, A. (2002). African modes of self-writing. *Public Culture*, *14*(1), 239-273.

Mbiti, J. S. (1970). *African religions and philosophy*. New York: Anchor Books.

McCrae, R. R. (2001). Trait psychology and culture: Exploring intercultural comparisons. *Journal of Personality*, *69*(6), 819–846.

McDowell, J. (2003). Subjective, intersubjective, objective. *Philosophy and Phenomenological research*, *LXVII*, 675–681.

McDowell, T., Ingoglia, L., Serizawa, T., Holland, C., Dashiell, J. W., & Stevens, C. (2005). Raising awareness in family therapy through critical conversations. *Journal of Marital and Family Therapy*, *31*(4), 399–411.

McLay, R. N., Rodenhausser, P., Anderson, D. S., Stanton, M. L., & Markert, R. J. (2002). Simulating a full-length psychiatric interview with a complex patient: An OSCE for medical students. *Academic Psychiatry*, *26*(3), 162–167.

Mezzich, J. E. (2007). Psychiatry for the person: Articulating medicine's science and humanism. *World Psychiatry*, *6*(2), 65-67.

Mezzich, J. E., Kleinman, A., Fabrega, H., Jr, & Parron, D. (Eds.). (1996). *Culture and psychiatric diagnosis: A DSM-IV perspective*. Washington: American Psychiatric Press.

Michell, J. (1997). Quantitative science and the definition of measurement in psychology. *British Journal of Psychology*, *88*(1), 355–383.

Miller, J. G. (1999). Cultural psychology: Implications for basic psychological theory. *Psychological Science*, *10*(2), 85–91.

Miller, M. N., & Pumariega, A. (2001). Culture and eating disorders: A historical and cross-cultural review. *Psychiatry*, *64*(2), 93–110.

Minsky, S., Vega, W., Miskimen, T., Gara, M., & Escobar, J. (2003). Diagnostic patterns in Latino, African American, and European American psychiatric patients. *Archives of General Psychiatry*, *60*(1), 637–644.

Minuchin, S. (1974). *Families and family therapy*. Massachusetts: Harvard University Press.

Mio, J. S., Barker-Hackett, L., & Tumambing, J. (2006). *Multicultural psychology: Understanding our diverse communities*. Boston: McGraw Hill.

Mirza, I., & Jenkins, R. (2004). Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: Systematic review. *British Medical Journal*, *328*(1), 1–5.

Mitchell, W. J. T. (1986). *Iconology: Image, text, ideology*. Chicago: University of Chicago Press.

Mkize, L. (1998). Amafufunyane – is it a culture-bound syndrome. *South African Medical Journal*, *88*(3), 329–331.

Mkhize, N. (2004). Psychology: an African perspective. In D. Hook, N. Mkhize, P. Kiguwa, A. Collins, E. Burman, & I.Parker (Eds.), *Critical psychology* (pp. 24-52). Landsdowne: UCT Press.

Modood, T., & Ahmad, F. (2007). British Muslim perspectives on multiculturalism. *Theory, Culture and Society*, *24*(2), 187–213.

Moodley, R. (1999). Challenges and transformations: Counselling in a multicultural context. *International Journal for the advancement of Counselling*, *21*(1), 139–152.

Mpofu, E. (2001). Conduct disorder in children: Presentation, treatment options and cultural efficacy in an African setting. *International Journal of Disability, Communication and Rehabilitation*, *1*(3), 1–14.

Mpofu, E. (2006). Majority world health care traditions intersect indigenous and complementary alternative medicine. *International Journal of Disability, Development and Education*, *53*(4), 375–379.

Mudimbe, V.Y. (1988). *The invention of Africa: Gnosis, philosophy, and the order of knowledge*. Bloomington: Indiana University Press.

Mullings, L. (1984). *Therapy ideology and social change: Mental healing in urban Ghana*. California: University of California Press.

Mulrow, C. D. (1994). Rationale for systematic reviews. *British Medical Journal*, *309*(1), 597–599.

Mumford, D. B. (1996). The 'dhat syndrome': A culturally determined symptom of depression? *Acta Psychiatrica Scandinavica*, *3*(94), 163–167.

Nagata, J. A. (1974). What is Malay? Situational selection of ethnic identity in a plural society. *American Ethnologist*, *1*(2), 331–350.

Nagel, J. (1994). Constructing ethnicity: Creating and recreating ethnic identity and culture. *Social Problems*, *41*(1), 152–176.

Ndetei, D. M., & Muhangi, J. (1979). The prevalence and clinical presentation of psychiatric illness in a rural setting in Kenya. *British Journal of Psychiatry*, *135*(1), 269–272.

Ndletyana, M. (2006). How black is black enough? *HSRC Review*, *4*(2), 14–15.

Nesbitt, E. (1998). British, Asian and Hindu: Identity, self-narration and the ethnographic interview. *Journal of Beliefs and Values*, *19*(2), 189–200.

Ngara, C. (2007). African ways of knowing and pedagogy revisited. *Journal of Contemporary Issues in Education*, *2*(2), 1–6.

Ngubane, H. (1977). *Body and mind in Zulu medicine: An ethnography of health and disease in Nyuswa-Zulu thought and practice*. London: Academic Press.

Nickerson, K., Helms, J., & Terrell, F. (1994). Cultural mistrust, opinions about mental illness, and Black students' attitudes toward seeking psychological help from White counsellors. *Journal of Consulting Clinical Psychology*, *41*(1), 378–385.

Niehaus, I. (2001). Witchcraft in the new South Africa: From colonial superstition to postcolonial reality? In H. L. Moore & T. Sanders (Eds.). *Magical interpretations, material realities: Modernity, witchcraft and the occult in post-colonial Africa* (pp. 184-205). London: Routledge.

Noel, D.C. (1997). *The soul of Shamanism: Western fantasies, imaginal realities*. New York: Continuum Publishing Company.

Norcross, J. C., & Goldfried, M. R. (Eds.). (2005). *Handbook of psychotherapy integration* (2nd ed.). New York: Oxford.

Nsamenang, A. B. (1992). *Human development in cultural context: A third world perspective.* California: Sage Publications.

Oakley, A., Gough, D., Oliver, S., & Thomas, J. (2005). The politics of evidence and methodology: Lessons from the EPPI-Centre. *Evidence and Policy*, *1*(1), 5–31.

Odejide, A. O., Olatawura, M. O., Sanda, A. O., & Oyeneye, A. O. (1978). Traditional healers and mental illness in the city of Ibadan. *Journal of Black Studies*, *9*(2), 195–205.

Okello, E. S., & Musisi, S. (2006). Depression as a clan illness (eByekika): An indigenous model of psychotic depression among the Baganda of Uganda. *World Cultural Psychiatry Research Review*, *1*(2), 60–73.

Oliver, S., & Peersman, G. (Eds.). (2001). *Using research for effective health promotion*. Buckingham: Open University Press.

Olley, B. O., Gxamza, F., Seedat, S., Theron, H., Taljaard, J., Reid, E., … Stein, D. J. (2004). Psychopathology and coping in recently diagnosed HIV/AIDS patients – the role of gender. *South African Medical Journal*, *10*(1), 21–24.

Olley, B. O., Zeier, M. D., Seedat, S., & Stein, D. J. (2005). Post-traumatic stress disorder among recently diagnosed patients with HIV/AIDS in South Africa. *AIDS Care*, *17*(5), 550 – 557.

Orubuloye, I. O., Caldwell, J. C., & Caldwell, P. (1994). Commercial sex workers in Nigeria in the shadow of AIDS. In J. C. Caldwell (Ed.), *Sexual networking and AIDS in sub-Saharan Africa: Behavioural research and the social context* (pp. 94-112). Canberra: Australian National University.

Osbeck, L. M., Moghaddam, F. M., & Perreault, S. (1997). Similarity and attraction among majority and minority groups in a multicultural context. *International Journal of Intercultural Religion*, *21*(1), 113–123.

Osterkamp, U. (2009). Knowledge and practice in critical psychology. *Theory psychology*, *19*(2). 167–191.

Outhwaite, W. (2009). *Habermas: Key contemporary thinkers* (2nd ed.). California: Stanford University Press.

Owomoyela, O. (1994). With friends like these… A critique of pervasive anti-Africanisms in current African studies epistemology and methodology. *African Studies Review*, *37*(3), 77–101.

Oxman, A. D., & Guyatt, G. H. (1993). The science of reviewing research. *Annals of the New York Academy of Sciences*, *703*(1), 125–133.

Pakaslahti, A. (2001). Dissociative disorder and possession. Cro*ss-cultural comparisons*. Paper presented at Andorra 2001 Transcultural Studies Section, Andorra la Vella.

Palmer, S., & Woolfe, R. (1999). *Integrative and eclectic counselling and psychotherapy*. London: Sage.

Panksepp, J. (1998). *The foundations of human and animal emotions*. New York: Oxford University Press.

Parker, I. (1999). Critical psychology: *Critical links. Annual Review of Critical Psychology*, *1*(1), 3–18.

Parker, I., & Spears, R. (Eds.). (1996). *Psychology and society*. London: Pluto.

Patel, V. (1995). Explanatory models of mental illness in sub-Saharan Africa. *Social Science and Medicine*, *40*(9), 1291–1298.

Patel, V., Abas, M., Broadhead, J., Todd, C., & Reeler, A. (2001). Depression in developing countries: Lessons from Zimbabwe. *British Medical Journal*, *322*(1), 482–484.

Patel, V., Araya, R., de Lima, M., Ledermir, A., & Todd, C. (1999). Women, poverty and common mental disorders in four restructuring societies. *Social Science and Medicine*, *49*(1), 1461–1471.

Patel, V., & Kleinman, A. (2003). Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organisation*, *81*(8), 609–615.

Patel, V., Rodrigues, M., & DeSouza, N. (2002). Gender, poverty, and postnatal depression: A study of mothers in Goa, India. *American Journal of Psychiatry*, *159*(1), 43–47.

Patterson, C. H. (1996). Multicultural counselling: From diversity to universality. *Journal of Counselling and Development*, *74*(1), 227–231.

Patterson, C. H. (2004). Do we need multicultural counselling competencies? *Journal of Mental Health Counseling*, *26*(1), 67–73.

Pavlov, I. P. (1941). *Lectures on conditioned reflexes*. New York: International Universities.

Peltzer, K., Mpofu, E., Baguma, P., & Bolanle, L. (2002). Attitudes towards HIV-antibody testing among university students in four African countries. *International Journal for the Advancement of Counselling*, *24*(1), 193–203.

Penn, D. L., Guynan, K., Daily, T., Spaulding, W. D., Garbin, C. P., & Sullivan, M. (1994). Dispelling the stigma of schizophrenia: What sort of information is best? *Schizophrenia Bulletin*, *20*(1), 567–577.

Perkins, R. E., & Moodley, P. (1993). Perception of problems in psychiatric inpatients: Denial, race and service usage. *Social Psychiatry and Psychiatric Epidemiology*, *28*(1), 189–193.

Perry, R. B. (1996). *The thought and character of William James*. Nashville: Vanderbilt University Press.

Petticrew, M., & Roberts, H. (2006). *Systematic reviews in the social sciences*: A practical guide. United Kingdom: Blackwell.

Pfeiffer, W. (1994). *Transcultural psychiatry: Findings and problems*. (2nd ed.). Stuttgart: Thieme.

Pfeiffer, C., Madray, H., Ardolino, A., & Willms, J. (1998). The rise and fall of students' skill in obtaining a medical history. *Medical Education*, *32*(1), 283–288.

Pilgrim, D. (2007). The survival of psychiatric diagnosis. *Social Science and Medicine*, *65*(1), 536–547.

Pilgrim, D., & Rogers, A. (1997). Mental health, critical realism and lay knowledge. In J. M. Ussher (Ed.), *Body talk: The material and discursive regulation of sexuality, madness and reproduction* (pp. 33-49). London: Routledge.

Popay, J. (2005). Moving beyond floccinaucinihilipilification: Enhancing the utility of systematic reviews. *Journal of Clinical Epidemiology*, *58*(1), 1079–1080.

Pope-Davis, D. B., Toporek, R. L., Ortega-Villalobos, L., Ligiéro, D. P., Brittan-Powell, C. S., Liu, W. M., …. Liang, C. T. H. (2002). Client perspectives of multicultural counselling competence: A qualitative examination. *The Counselling Psychologist*, *30*(1), 355–393.

Porkert, M. (1974). *The theoretical foundations of Chinese medicine*. Cambridge: MIT Press.

Pretorius, E. (1999). Traditional healers. *The South African Health Review, 18*(1), no pagination indicated. Retrieved from http://www.hst.org.za/pp/chap18.htm

Pretorius, E., de Klerk, G., & van Rensburg, H. (1993). *The traditional healer in South African health care*. Pretoria: HSRC.

Prilleltensky, I., & Nelson, G. (2002). *Doing psychology critically: Making a difference in diverse settings*. New York: Palgrave-Macmillan.

Prince, M. (Ed.). (1915). *The Journal of Abnormal Psychology*. Massachusetts: The Psychological Association.

Prince, M., Acosta, D., Chiu, H., Scazufca, M., & Varghese, M. (2003). Dementia diagnosis in developing countries: A cross-cultural validation study. *The Lancet*, *361*(3), 909–917.

Prince, R. (1967). The changing picture of depressive syndromes in Africa: Is it fact or diagnostic fashion? *Canadian Journal of African Studies*, *1*(2), 177–192.

Prince, R. H. (1990). The brain-fag syndrome. In K. Pelzer & P. O. Ebigbo (Eds.), *A textbook of clinical psychiatry in Africa* (pp. 276-287). Enugu: Chuka.

Pritchard, E. E. (1937). *Witchcraft, oracles and magic amongst the Azanda*. Oxford: Clarendon Press.

Pronyk, P. M., Hargreaves, J. R., Kim, J. C., Morison, L. A., Phetla, G., Watts, … Porter, J. D. (2006). Effects of a structural intervention for the prevention of intimate-partner violence and HIV in rural South Africa. *The Lancet*, *368*(2), 1973–1983.

Putnam, H. (1981*). Reason, truth, and history*. Cambridge: Cambridge University Press.

Puttergill, C., & Leildé, A. (2006). Identity studies in Africa: Notes on theory and method. In S. Bekker & A. Leildé (Eds.), *Reflections on identity in four African cities* (pp. 11-23). Stellenbosch: African Minds.

Reber, A. S., & Reber, E. S. (2001). *Dictionary of psychology* (3rd ed.). United Kingdom: Penguin.

Reichbart, R. (2007). On the convergence of folk belief and psychopathology: A demon as introject in a 12 year old African American boy. *Journal of Infant, Child, and Adolescent Psychotherapy*, *5*(4), 459–485.

Ridley, D. (2008). *The literature review: A step-by-step guide for students*. California: Sage publications.

Rin, H., & Lin, T. Y. (1962). Mental illness among Formosan Aborigines as compared with Chinese in Taiwan. *Journal of Mental Science*, *108*(1), 123–146.

Rioch, D. M. (1985). Recollections of Harry Stack Sullivan and of the development of his interpersonal psychiatry. *Psychiatry*, *48*(2), 141–158.

Ritchie, J. (1997). Europe and the European dimension in a multicultural context. *European Journal of Intercultural Studies*, *8*(3), 291–301.

Roberts, A. F. (1988). Through the bamboo thicket: The social process of Tabwa ritual performance. *The Drama Review*, *32*(2), 123–138.

Robertson, M. M. (2008). The prevalence and epidemiology of Gilles de la Tourette syndrome Part 2: Tentative explanations for differing prevalence figures in GTS, including the possible effects of psychopathology, aetiology, cultural differences, and differing phenotypes. *Journal of Psychosomatic Research*, *65*(1), 473–486.

Roelandt, J. L. (2001). International exchanges. *Culture and mental health*. Paper presented at Andora 2001 Transcultural Psychiatry Section Symposium, Andora la Vella.

Rogers, A., Day, J., Williams, B., Randall, F., Wood, P., Healy, D., & Bentall, R. P. (1998). The meaning and management of medication: Perspectives of patients with a diagnosis of schizophrenia. *Social Science & Medicine*, *47*(9), 1313–1323.

Rogers, R., Salekin, R. T., Sewell, K. W., Goldstein, A., & Leonard, K. (1998). A comparison of forensic and nonforensic malingerers: A prototypical analysis of explanatory models. *Law and Human Behaviour*, *22*(4), 353–367.

Rumble, S. (1994). *Prevalence of psychiatric morbidity in the adult population of Mamre: An empirical and methodological investigation* (Unpublished master's dissertation). University of Cape Town, Cape Town.

Rumble, S., Swartz, L., Parry, C., & Zwarenstein, M. (1996). Prevalence of psychiatric morbidity in the adult population of a rural South African village. *Psychological Medicine*, *26*(1), 997–1007.

Rushdie, S. (2008). *Midnight's children*. New York: Vintage Books.

Russel, J. G. (1989). Anxiety disorders in Japan: A review of the Japanese literature on Shinkeishitsu and Taijin Kyofusho. *Culture, Medicine, and Psychiatry*, *13*(1), 391–403.

Rutter, M., & Nikapota, A. (2002). Culture, ethnicity, society and psychopathology. In M. Rutter & E. Taylor (Eds.). *Child and adolescent psychiatry* (4th ed.) (pp. 1148-1157). Oxford: Blackwell Publications.

Sadock, B. J., & Sadock, V. A. (2007). *Kaplan & Sadock's synopsis of psychiatry: Behavioural sciences / clinical psychiatry* (10th ed.). Philadelphia: Lippincott Williams & Wilkins.

Saldaña, D. (2001). *Cultural competency*. Texas: Hogg Foundation for Mental Health.

Sam, D. L., & Moreira, V. (2002). The mutual embeddedness of culture and mental illness. In W. J. Lonner, D. L. Dinnel, S. A. Hayes, & D. N. Sattler (Eds.). *Outline reading in psychology and culture* (pp. 139-175). Washington: Center for Cross-Cultural Research.

Sandahl, C., & Lindgren, A. (2006). Focused group therapy: An integrative approach. *Journal of Contemporary Psychotherapy*, *36*(1), 113–119.

Sandelowski, M., Voils, C. I., & Barroso, J. (2006). Defining and designing mixed research synthesis studies. *Research in the Schools*, *13*(2), 29–40.

Santino, J. (1985). On the nature of healing as a folk event. *Western Folklore*, *44*(3), 153–167.

Savin-Baden, M., & Major, C. H. (2009). *An introduction to qualitative research synthesis: Managing the information explosion in social science research*. Oxford: Routledge.

Schech, S., & Haggis, J. (2001). Migrancy, multiculturalism and whiteness: Re-charting core identities in Australia. *Communal/Plural*, *9*(2), 143–159.

Scheper-Hughes, N., & Lock, M. M. (1987). The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly*, *1*(1), 6–41.

Schmidt, R. K., & Smyth, M. M. (2008). *Lessons for a scientific literature review: Guiding the inquiry*. Connecticut: Libraries Unlimited.

Schneider, K. J. (2007). The experiential liberation strategy of the existential-integrative model of therapy. *Journal of Contemporary Psychotherapy*, *37*(1), 33–39.

Schofield, L. (1998). *Critical theory and constructivism*. London: Sage.

Schönpflug, U. (2001). Perspectives on cultural transmission: Introduction. *Journal of Cross-cultural Psychology*, *32*(1), 131–134.

Shweder, R. (1991). *Thinking through cultures*. Massachusetts: Harvard University Press.

Seixas, P. (1993). Historical understanding among adolescents in a multicultural setting. *Curriculum Inquiry*, *23*(3), 301–327.

Seligman, M. (2006). *Learned optimism: How to change your mind and your life*. New York: Random House.

Seltzer, W. J. (2005). Pre-cognitive therapy: A way to integrate neuroscience and psychotherapy. *Journal of Systemic Therapies*, *24*(3), 32–48.

Sen, P., & Chowdhury, A. N. (2006). Culture, ethnicity, and paranoia. *Current Psychiatry Reports*, *8*(1), 174–178.

Setiloane, G. M. (1998a). How African (Bantu) mythology has anticipated Darin and Prof Philip Tobias In: C. W. Du Toit (Ed.), *Faith, science and African culture: African cosmology and Africa's contribution to science* (pp. 65-72). Pretoria: Unisa.

Setiloane, G. M. (1998b). Towards a biocentric theology and ethic – via Africa. In: C. W. Du Toit (Ed.), *Faith, science and African culture: African cosmology and Africa's contribution to science* (pp. 73-84). Pretoria: Unisa.

Sharpley, M., Hutchinson, G., McKenzie, K., & Murray, R. M. (2001). Understanding the excess of psychosis among the African-Caribbean population in England. *British Journal of Psychiatry*, *178*(40), 60–68.

Shedler, J., Mayman, M., & Manis, M. (1993). The illusion of mental health. *American Psychologist*, *48*(1), 1117–1131.

Shore, B. (1996). *Culture in mind: Cognition, culture and the problem of meaning*. New York: Oxford University Press.

Sieff, E. M. (2003). Media frames of mental illness: The potential impact of negative frames. *Journal of Mental Health*, *12*(3), 259–270.

Sinha, C. (2000). Culture, language and the emergence of subjectivity. *Culture and Psychology*, *6*(2), 197–207.

Skilling, T. A., Quinsey, V. L., & Craig, W. M. (2001). Evidence of a taxon underlying serious antisocial behaviour in boys. *Criminal Justice and Behaviour*, *28*(4), 450–470.

Slone, M., Durrheim, K., Kaminer, D., & Lachman, P. (1999). Issues in the identification of comorbidity of mental retardation and psychopathology in a multicultural context. *Social Psychiatry and Psychiatric Epidemiology*, *34*(1), 190–194.

Smit, J., Myer, L., Middelkoop, K., Seedat, S., Wood, R., Bekker, L. G., & Stein, D. J. (2006). Mental health and sexual risk behaviours in a South African township: A community-based cross-sectional study. *Public Health*, *120*(1), 534–542.

Smit, J., van den Berg, C. E., Bekker, L. G., Seedat, S., & Stein, D. J. (2006) Translation and cross-cultural adaptation of a mental health battery in an African setting. *African Health Sciences*, *6*(4), 251–222.

Smith, J. A. (Ed.). (2008). *Qualitative psychology: A practical guide to research methods* (2nd ed.). London: Sage.

Solomon, R. C. (1974). *Existentialism*. New York: McGraw-Hill.

Solórzano, D. G., & Yosso, T. (2001). Maintaining social justice hopes within academic realities: A Freirean approach to critical race / LatCrit pedagogy. *Denver Law Review*, *78*(1), 595–621.

Somer, E., & Saadon, M. (2000). Stambali: Dissociative possession and trance in a Tunisian healing dance. *Transcultural Psychiatry*, *37*(4), 581–602.

Sow, L. (1980). *Anthropological structures of madness in Black Africa*. New York: International University Press.

Spangenberg, J. J., & Pieterse, C. (1995). Stressful life events and psychological status of Black South African women. *Journal of Social Psychology, 13*(1), 439–445.

Sparrow, L. M. (2000). Beyond multicultural man: Complexities of identity. *International Journal of Intercultural Relations*, *24*(1), 173–201.

Speight, W. L. (1935). Human sacrifice in South Africa. *The Nongqai*, *26*(2), 141–164.

Statistics South Africa (2011). *Statistical release P0302: Mid-year population estimates 2011*. Pretoria: Statssa.

Sternberg, R. (2003). *Cognitive psychology* (3rd ed.). Belmont: Thomson Wadsworth.

Stetsenko, A., & Arievitch, I. M. (2004). Vygotskian collaborative project of social transformation. *Critical Psychology*, 59(1), 58–80.

Stevens, G., & Lockhat, R. (1997). Coca-Cola kids – reflections on black adolescent identity development in postapartheid South Africa. *South African Journal of Psychology*, *27*(1), 250–255.

Stompe, T. (2001). Religious delusions among schizophrenia. *Newsletter Transcultural Psychiatry Section World Psychiatric Association*, *19*(1), 16–19.

Stone, M., Kaminer, D., & Durrheim, K. (2000). The contribution of political life events to psychological distress among South African adolescents. *Political Psychology*, *21*(3), 465–487.

Story, W. W. (2003). *Castle St. Angelo and the evil eye*. Montana: Kessinger Publishing.

Strauss, A. C., & Corbin, J. M. (1999). *Basics of qualitative research*. California: Sage.

Subramaney, U. (2006). Traumatic stress and psychopathology: Experiences of a trauma clinic. *South African Psychiatry Review*, *9*(1), 105–107.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York: W.W. Norton & Company, Inc.

Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *British Medical Journal*, *322* (1), 95–98.

Susser, I. & Stein, Z. (2000). Culture, sexuality, and women's agency in the prevention of HIV/AIDS in southern Africa. *American Journal of Public Health*, *90*(7), 1042–1048.

Swales, J. M., & Feak, C. B. (2009). *Telling a research story: Writing a literature review*. Michigan: University of Michigan Press.

Swartz, L. (1998). *Culture and mental health: A southern African view*. Cape Town: Oxford.

Swartz, S. (2007). Oedipus matters. *Psychodynamic Practice*, *13*(4), 361–373.

Swift, G., Durkin, I., & Beuster, C. (2004). Cognitive therapy training for psychiatrists. *Psychiatry Bulletin*, *28*(1), 117–119.

Szabo, C. P., & Allwood, C. W. (2004). Application of the Eating Attitudes Test (EAT-26) in a rural, Zulu speaking, adolescent population in South Africa. *World Psychiatry*, *3*(3), 169–171.

Szasz, T. (1961). *The myth of mental illness; foundations of a theory of personal conduct*. New York: Hoeber-Harper.

Szasz, T. (1995). Mental illness is still a myth. *The Journal of Biblical Counselling*, *14*(2), 34–49.

Tanaka-Matsumi, J., & Marsella, A. J. (1976). Cross-cultural variations in the phenomenological experience of depression: I. Word association studies. *Journal of Cross-Cultural Psychology*, *7*(1), 379–396.

Terre Blanche, M., & Durrheim, K. (Eds.). (2004). *Research in practice: Applied methods for the social sciences*. Cape Town: University of Cape Town Press.

Thomas, D. C., Au, K., & Ravlin, E. C. (2003). Cultural variation and the psychological contract. *Journal of Organizational Behaviour*, *24*(1), 451–471.

Thomas, P., & Bracken, P. (2004). Critical psychiatry in practice. *Advances in Psychiatric Treatment*, *10*(1), 361–370.

Thomas, J., Harden, A., Oakley, A., Oliver, S., Sutcliffe, K., Rees, R., …. Kavanagh, J. (2004). Integrating qualitative research with trials in systematic reviews: An example from public health. *British Medical Journal*, *328*(1), 1010–1012.

Tiet, Q. Q., Bird, H. R., Hoven, C. W., Moore, R., Wu, P., Wicks, … Cohen, P. (2001). Relationship between specific adverse life events and psychiatric disorders. *Journal of Abnormal Child Psychology*, *29*(2), 153–164.

Toldson, I., & Toldson, I. (1999). Esoteric group therapy: Counseling African American adolescent males with conduct disorder. *Journal of African American Men*, *4*(3), 71-86.

Toldson, I. L., & Toldson, I. A. (2001). Biomedical ethics: An African-centred psychological perspective. *Journal of Black Psychology*, *27*(4), 401–423.

Tomlinson, M., Swartz, L., Kruger, L., & Gureje, O. (2007). Manifestations of affective disturbance in sub-Saharan Africa: Key themes. *Journal of Affective Disorders*, *102*(1), 191–198.

Tomlinson-Clarke, S. (2000). Assessing outcomes in a multicultural training course: A qualitative study. *Counselling Psychology Quarterly*, *13*(2), 221-231.

Toumlin, S. E. (1958). The uses of argument. In C. Hart (1998), *Doing a literature review: Releasing the social science research imagination* (pp. 81-95). London: Sage Publications.

Triandis, H. C. (1995). *Individualism and collectivism*. Colorado: Westview.

Trujillo, M. (2001). Culture and the organization of psychiatric care. In J. E. Mezzich & H. Fabrega Jr (Eds.), *The Psychiatric Clinics of North America: Cultural Psychiatry: International Perspectives* (pp. 539-552). Philadelphia: W.B. Saunders Company.

Trujillo, M. (2008). Multicultural aspects of mental health. *Primary Psychiatry*, *15*(4), 65–84.

Tseng, W. S. (2001). *Handbook of cultural psychiatry*. California: Academic Press.

Tseng, W. (2006). From peculiar psychiatric disorders through culture-bound syndromes to culture-related syndromes. *Transcultural Psychiatry*, *43*(4), 554–576.

Tseng, W. S., Mo, G. M., Hsu, J., Li, L. S., Chen, G. Q., Ou, L. W., et al. (1992). Koro epidemics in Guandong, China: A questionnaire survey. *Journal of Nervous and Mental Disease*, *180*(1), 117–123

Ussher, J. M. (1997). *Body talk: The material and discursive regulation of sexuality, madness and reproduction*. London: Routledge.

Utsey, S. O., Bolden, M. A., Lanier, Y., & Williams, O. (2007). Examining the role of culture-specific coping as a predictor of resilient outcomes in African Americans from high-risk urban communities. *Journal of Black Psychology*, *33*(1), 75–93.

Vale, P., & Maseko, S. (1998). South Africa and the African renaissance. *International Affairs*, *74*(2), 271–287.

Van der Vijer, F. J. R., & Phalet, K. (2004). Assessment in multicultural groups: The role of acculturation. *Applied Psychology and International Review*, *53*(2), 215–236.

Van Dijk, T. A. (1998). Critical discourse analysis. In D. Tannen, D. Schiffrin & H. Hamilton (Eds.), *Handbook of discourse analysis* (pp. 52-71). Boston: Blackwell Publishing.

Vatrapu, R., & Pérez-Quiñones, M. A. (2006). Culture and international usability testing: The effects of culture in structured interviews. *Journal of Usability Studies*, *1*(4), 156–170.

Vermeulen, T., & Van der Akker, R. (2010). Notes on metamodernism. *Journal of Aesthetics and Culture*, *2*(1), pp. 1–14.

Vitz, P. C. (2005). Psychology in recovery. *First Things, 151*(1), 17–21.

Wakefield, J.C., Pottick, K, & Kirk., S.A. (2002). Should the DSM-IV criteria for conduct disorder consider social context? *American Journal of Psychiatry*, *159*(1), 380–386.

Walker, E. F., & Diforio, D. F. (1997). Schizophrenia: A neural diathesis model. *Psychological Review, 104*(1), 667–685.

Walker, S. P., Odendaal, C. L., & Esterhuyse, K. G. F. (2008). Biograpical, pan and psychosocial data for a South African sample of chronic pain patients. *Southern African Journal of Anaesthesia and Analgesia*, *3*(1), 62–66.

Wassenaar, D., le Grange, D, Winship, J., & Lachenicht, L. (2000). The prevalence of eating disorder pathology in a cross-ethnic population of female students in South Africa. *European Eating Disorders Review*, *8*(1), 225–236.

Watkins, D., Akande, A., & Mpofu, E. (1996). Assessing self-esteem: An African perspective. *Personality and Individual Differences*, *20*(2), 163–169.

Watkins, D., Cheng, C., Mpofu, E., Olowu, S., Singh-Sengupta, S., & Regmi, M. (2003). Gender differences in self-construal: How generalisable are Western findings? *The Journal of Social Psychology*, *143*(4), 501–519.

White, L. (1975). *The concept of cultural systems: A key to understanding tribes and nations*. New York: Columbia University.

White, L. A. (1959). The concept of culture. *American Anthropologist*, *61*(2), 227–251.

Wilbraham, L. (2008). Parental communication with children about sex in the South African HIV epidemic: Raced, classed and cultural appropriations of loveliness. *African Journal of AIDS research*, *7*(1), 95-109.

Wilkinson, D. (2005). *The essential guide to postgraduate study*. London: Sage.

Williams, C. L., & Heikes, E. J. (1993). The importance of researcher's gender in the in-depth interview: Evidence from two case studies of male nurses. *Gender and Society*, *7*(2), 280–291.

Wilson, J. P. (2007). The lens of culture: Theoretical and conceptual perspectives in the assessment of psychological trauma and PTSD. In J. P. Wilson & C. So-Kum Tang (Eds.), *Cross-cultural assessment of psychological trauma and PTSD* (pp. 3-30). New York: Springer Science and Business Media.

Wilson, J. P., & Drozdek, B. (2004). *Broken spirits: The treatment of traumatized asylum seekers, refugees and war and torture victims*. New York: Brunner-Routledge.

Wohl, J. (2000). Psychotherapy and cultural diversity. In J. F. Aponte & J. Wohl (Eds), *Psychological intervention and cultural diversity* (2nd ed.) (pp. 75-91). Massachusetts: Allyn and Bacon.

Wolf, E. R., Kahn, J. S., Roseberry, W., & Wallerstein, I. (1994). Perilous ideas: Race, culture, people. *Current Anthropology*, *35*(1), 1–12.

World Health Organisation. (1978). The promotion and development of traditional medicine. *Technical Reports Services*, 666(1), 2 –38.

World Health Organisation. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guideline*. Geneva: World Health Organisation.

Wreford, J. (2005). Missing each other: Problems and potential for collaborative efforts between biomedicine and traditional healers in South Africa in the time of AIDS. *Social Dynamics*, *31*(2), 55–89.

Yalom, I. D. (1980). *Existential psychotherapy*. New York: Basic Books.

Yap, P. M. (1967). Classification of the culture-bound reactive syndromes. *Australia and New Zealand Journal of Psychiatry*, *1*(1), 172–179.

Yen, J., & Wilbraham, L. (2003). Discourses of culture and indigenous healing, part 1: Western psychiatric power. *Transcultural Psychiatry*, *40*(4), 542–561.

Yoder, P. (1982). Commentary on African systems of medicine. *African Health and Healing Systems: Proceedings of a Symposium*. UCLA: African Studies Center, African Studies Assoc., Office of International Health.

Zerega, N. J. C.; Ragone, D., & Motley, T. J. (2004). The complex origins of breadfruit (Artocarpus altilis, Moraceae): Implications for human migrations in Oceania. *American Journal of Botany*, *91*(5), 760–766.

Zubin, J., & Spring, B. (1977). Vulnerability – a new view of schizophrenia. *Journal of Abnormal Psychology*, *86*(2), 103–126.

APPENDIX A: Coding sheet – literature details

The coding sheet was prepared according to the necessary guidelines suggested by Boote and Baile (2005). The coding sheet was coordinated chronologically so as to assist in the systematic process of literature reviewing, but also to allow one to observe the increase/decrease in the literature across time.

Author(s)	**Year**	**Keywords: study's objective**	**Type of study (t) / study aspects incorporated into thesis (i)**	**Methodological description**	**Sample location / Research focus country**	**Type of finding / classification**	**Does literature older than 30 years influence the review? If yes, provide justifications**
Herskovits	1926	Cattle complex; kulturkreis	Conceptual (t)	Qualitative	Not specified	Descriptive	No
Speight	1935	South Africa; human sacrifice	Empirical (t)	Qualitative	South Africa	Interpretive	No

Pritchard	1937	Witchcraft, oracles; magic; Azanda	Conceptual	Qualitative	South Africa	Interpretive	No
White	1959	Defining culture	Conceptual (t)	Not specified	USA	Descriptive	Yes (historical basis)
Lieberson	1961	Race; ethnic relations	Conceptual (t)	Qualitative	Not specified	Descriptive	Yes (historical basis)
Rin & Lin	1962	Mental illness; Formosan Aborigines; Chinese; Taiwan	Empirical (t)	Not specified	South Africa	Descriptive	Yes (corroborative source)
Edgerton	1966	Psychosis; East Africa	Empirical (t)	Qualitative	Not specified	Interpretive	Yes (historical basis) (corroborative source)
Prince	1967	Depression; Africa	Empirical (t)	Not specified	South Africa	Descriptive	Yes (historical basis)
Yap	1967	Culture-bound reactive syndromes; classification system	Conceptual (t)	Not specified	Zimbabwe	Descriptive	Yes (historical basis)

Fanon	1968	Being Black; White persona	Conceptual (t)	Phenomenology	Not specified	Descriptive	Yes (historical basis)
Jung	1969	Psyche	Conceptual (t)	Qualitative	Not specified	Interpretive	No
Mbiti	1970	African religion and philosophy	Conceptual (t)	Qualitative	Not specified	Interpretive	Yes (corroborative source)
Edgerton	1971	Traditional African psychiatry	Empirical (t)	Qualitative	Not specified	Interpretive	Yes (no recent sources could be found that highlight these issues)
Mafeje	1971	Tribalism	Conceptual (i)	Qualitative	Not specified	Interpretive	Yes (historical basis)
Cabral	1974	Culture; national liberation	Conceptual (i)	Qualitative	Caribbean	Descriptive	No
Tanaka-Matsumi & Marsella	1976	Cross-cultural; phenomenology; depression	Empirical (t)	Phenomenology	South Africa	Descriptive	Yes (corroborative source)

Ngubane	1977	Zulu medicine; Nyuswa-Zulu thought	Conceptual (t)	Not specified	Not specified	Interpretive	No
Odejide et al.	1978	Traditional healing; psychopathology	Conceptual (i)	Not specified	Not specified	Descriptive	Yes (historical basis)
WHO	1978	Traditional medicine development	Empirical (t)	Not specified	USA	Descriptive	Yes (historical basis)
Ndetei & Muhangi	1979	Psychopathology; rural setting; Kenya	Empirical (t)	Quantitative	Not specified	Descriptive	Yes (historical basis)
Asante	1980	Africentricity	Conceptual (i)	Not specified	Africa: specific country not specified	Interpretive	N/A
Harding et al.	1980	Psychopathology; primary health care; frequency; diagnosis; developing countries	Empirical (t)	Quantitative	Not specified	Descriptive	N/A

Marsella	1980	Depressive disorders; culture	Empirical (t)	Not specified	Not specified	Descriptive	N/A
Sow	1980	Anthropology; madness; Black; Africa	Conceptual (i)	Qualitative	South Africa	Interpretive	N/A
Cheetham & Griffiths	1981	South Africa; schizophrenia	Empirical (t)	Mixed methods	Ibadan	Descriptive	N/A
Yoder	1982	African systems of medicine; healing	Conceptual (i)	Not specified	Zimbabwe; South Africa	Interpretive	N/A
Feierman	1985	Social health; modern Africa	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Kleinman & Good	1985	Culture; depression; anthropology; psychopathology	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Lutz	1985	Depression; culture; emotional world; cross-cultural psychiatry	Conceptual (i)	Not specified	Not specified	Descriptive	N/A

Santino	1985	Healing; folk event	Conceptual (i)	Not specified	South Africa	Descriptive	N/A
Achebe	1986	Ogbanje	Conceptual (t)	Not specified	Africa: region/country unclear	Interpretive	N/A
Hofstede	1986	Cultural difference; teaching; learning	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Iwu	1986	Ethnomedicine; Africa	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Mazrui	1986	African heritage	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Comaroff & Comaroff	1987	Historical consciousness; South Africa	Conceptual (i)	Not specified	International	Interpretive	N/A
Jablensky	1987	Multiculturalism; schizophrenia	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Scheper-Hughes & Lock	1987	Defining culture	Conceptual (t)	Not specified	South Africa	Interpretive	N/A
Cashmore	1988	Race; ethnicity	Conceptual (t)	Not specified	East African region	Interpretive	N/A

Drewal	1988	Rituals; Africa	Conceptual (i)	Qualitative	Nigeria	Interpretive	N/A
Kleinman	1988	Rethinking psychiatry; cultural categorisation; personal experience	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Lin & Kleinman	1988	Psychopathology; schizophrenia; cross-cultural perspective	Empirical (t)	Mixed methods	Not specified	Descriptive	N/A
Mudimbe	1988	Invention of Africa	Conceptual (t)	Not specified	Not specified	Interpretive	N/A
Roberts	1988	Tabwa ritual	Conceptual (i)	Not specified	South Africa	Interpretive	N/A
Russel	1989	Anxiety; Japan; culture-bound syndromes	Empirical (t)	Qualitative	South Africa	Descriptive	N/A
Double	1990	Neo-Kraepelinian approach	Conceptual (t)	Not specified	Nigeria	Descriptive	N/A
Helman	1990	Culture; health	Conceptual (i)	Not specified	Not specified	Descriptive	N/A

King	1990	Biological psychiatry; Africa	Conceptual (t)	Not specified	Not specified	Descriptive	N/A
Prince	1990	Brain fag; clinical psychiatry	Empirical (t)	Not specified	South Africa	Descriptive	N/A
Gillis et al.	1991	Psychological distress; depression; elderly Black population	Empirical (t)	Not specified	Not specified	Descriptive	N/A
Kleinman & Kleinman	1991	Interpersonal ethnography; professional transformation; suffering	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Appiah	1992	African; philosophy; culture	Conceptual (t)	Not specified	Africa: specific country not specified	Interpretive	N/A
Guiness	1992	Brain fag; school populations; Africa	Empirical (t)	Not specified	Not specified	Descriptive	N/A

Gureje et al.	1992	Psychiatric disorders; urban primary health care	Empirical (t)	Not specified	Not specified	Descriptive	N/A
Nsamenang	1992	Human development; African context	Conceptual (t)	Not specified	Not specified	Interpretive	N/A
Tseng et al.	1992	Koro; China	Conceptual (i)	Not specified	Southern Africa	Descriptive	N/A
WHO	1992	Psychiatry; psychopathology	Empirical (t)	Not specified	USA	Descriptive	N/A
Gaw	1993	Culture; ethnicity; mental illness	Conceptual (t)	Not specified	Not specified	Descriptive	N/A
Horton	1993	Patterns of thought; Africa; West	Conceptual (t)	Not specified	Not specified	Interpretive	N/A
Perkins & Moodley	1993	Psychiatric inpatients; perception; denial; race; use of services	Conceptual (i)	Mixed methods	South Africa	Descriptive	N/A

Pretorius et al.	1993	Traditional healer; health care; South Africa	Conceptual (i)	Not specified	South Africa	Descriptive	N/A
Lupton	1994	Culture; medicine; Western societies	Empirical (t)	Not specified	Not specified	Interpretive	N/A
Nagel	1994	Ethnic identity	Conceptual (t)	Not specified	Not specified	Interpretive	N/A
Orubuloye et al.	1994	Commercial sex; Nigeria	Empirical (t)	Qualitative	Not specified	Descriptive	N/A
Penn et al.	1994	Stigma; schizophrenia	Empirical (t)	Qualitative	South Africa	Interpretive	N/A
Pfeiffer	1994	Transcultural psychiatry	Conceptual (i)	Not specified	South Africa	Interpretive	N/A
Rumble	1994	Psychiatric morbidity; Mamre	Conceptual (i)	Quantitative	South Africa	Descriptive	N/A
Wolf et al.	1994	Race; culture	Conceptual (i)	Not specified	Zambia	Descriptive	N/A

Akinnawo	1995	Psychopathology implications; sex workers	Empirical (t)	Phenomenology	Africa: specific country not specified	Descriptive	N/A
Al-Issa	1995	Illusion of reality; hallucinations and culture	Conceptual (i)	Not specified	Africa: specific country not specified	Interpretive	N/A
Berry	1995	Culture; ethnic factors	Conceptual (i)	Not specified	Africa: specific country not specified	Descriptive	N/A
Green et al.	1995	Traditional healers; South Africa	Empirical (t)	Not specified	Not specified	Interpretive	N/A
Hahn	1995	Sickness; healing; anthropology	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Jones	1995	Pan-Africanism	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Kale	1995	Traditional healers; South Africa	Conceptual (t)		Not specified	Unknown	N/A
Last	1995	Epidemiology	Empirical (t)	Mixed methods	Not specified	Interpretive	N/A
Lewis-Fernandez & Kleinman	1995	Cultural psychiatry	Conceptual (i)	Not specified	Not specified	Interpretive	N/A

Patel	1995	Body-mind link	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Triandis	1995	Individualism; collectivism	Conceptual (i)	Not specified	South Africa	Interpretive	N/A
Anderson	1996	Medical anthropology; magic	Conceptual (i)	Not specified	Africa: specific country not specified	Interpretive	N/A
Guarnaccia at al.	1996	Ataque de nervios	Conceptual (t)	Not specified	Not specified	Descriptive	N/A
Isaac et al.	1996	Somatisation	Conceptual (t)	Not specified	Not specified	Descriptive	N/A
Mezzich et al.	1996	Culture; psychopathology	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Mumford	1996	Culture-bound syndrome; symptoms of depression	Empirical (t)	Not specified	Not specified	Descriptive	N/A
Patterson	1996	Increase in literature; multiculturalism	Empirical (t)	Quantitative: Literature-based	Pakistan	Descriptive	N/A

Rumble et al.	1996	Psychiatric morbidity; rural population; South Africa	Empirical (t)	Quantitative	South Africa	Descriptive	N/A
Shore	1996	Cognition; meaning of culture	Conceptual (i)	Not specified	South Africa	Interpretive	N/A
Watkins et al.	1996	African perspective; self-esteem	Conceptual (i)	Not specified	UK	Interpretive	N/A
Abas & Broadhead	1997	Depression; anxiety; Zimbabwe; females	Empirical (t)	Quantitative	Africa: central and west	Descriptive	N/A
Boykin et al.	1997	Communalism; Afrocultural society	Conceptual (t)	Not specified	Cape Verde	Interpretive	N/A
Campbell	1997	South Africa; migrancy; mining; identity	Empirical (t)	Not specified	Caribbean; UK	Descriptive	N/A
Canino et al.	1997	Cross-cultural mental health research	Empirical (t)	Quantitative	Curaçao	Descriptive	N/A

Castillo	1997	Culture; mental illness	Conceptual (i)	Not specified	East African region	Interpretive	N/A
Dein & Dickens	1997	Culture; affect; cognition; behaviour	Empirical (t)	Not specified	Nigeria	Interpretive	N/A
Draguns	1997	Abnormal behaviour across cultures; therapy	Empirical (i)	Mixed methods	Nigeria	Descriptive	N/A
Gualbert	1997	Traditional models of psychopathology	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Hughes et al.	1997	Culture-bound syndromes; DSM	Empirical (t)	Not specified	Not specified	Descriptive	N/A
Jilek-Aall et al.	1997	Epilepsy; psychosocial; Africa	Empirical (t)	Qualitative	Not specified	Descriptive	N/A
Noel	1997	Shamanism, Western fantasy; imaginal reality	Conceptual (t)	Not specified	Not specified	Interpretive	N/A
Ritchie	1997	Multiculturalism; Europe	Conceptual (i)	Not specified	South Africa	Interpretive	N/A

Stevens & Lockhat	1997	Coca-cola kids; Black adolescent identity; post-apartheid South Africa	Empirical (t)	Qualitative	South Africa	Descriptive	N/A
Ashforth	1998	Witchcraft; violence; democracy; South Africa	Conceptual (i)	Not specified	Africa: specific country not specified	Interpretive	N/A
Chandler	1998	African culture; harmony; faith; science	Conceptual (i)	Not specified	Ghana	Interpretive	N/A
Du Toit	1998	African rationality; faith; science; culture	Conceptual (t)	Not specified	Not specified	Interpretive	N/A
Edwards	1998	African spirituality; faith; science; culture	Conceptual (t)	Not specified	Not specified	Interpretive	N/A
Hammond-Tooke	1998	Cosmology; religion; science	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Hermans & Kempen	1998	Culture; globalising society	Conceptual (i)	Not specified	Not specified	Unknown	N/A

Kirmayer & Young	1998	Culture; somatisation	Empirical (t)	Qualitative	Not specified	Descriptive	N/A
Kudadije & Osei	1998	African cosmology; worldview; faith; science; culture	Conceptual (t)	Not specified	Not specified	Interpretive	N/A
Le Grange et al.	1998	Self-starvation; impoverished Black adolescents; South Africa	Empirical (t)	Mixed methods	Not specified	Descriptive	N/A
Makgoba	1998	African thought; faith; science; culture	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Marsella	1998	Global psychology; multiculturalism; diversity	Conceptual (i)	Not specified	Not specified	Unknown	N/A
Mkize	1998	Amafufunyane; culture-bound syndromes	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Nesbitt	1998	British; Asian; Hindu; identity	Conceptual (i)	Qualitative / Phenomenology	Not specified	Interpretive	N/A

Panskepp	1998	Foundation of human and animal emotions	Conceptual (i)	Not specified	Not specified	Unknown	N/A
Rogers et al.	1998	Schizophrenia; diagnostic issues	Empirical (t)	Not specified	South Africa	Descriptive	N/A
Setiloane	1998a	African mythology; faith; science; culture	Conceptual (t)	Not specified	South Africa	Interpretive	N/A
Setiloane	1998b	Biocentric theology; ethics; Africa	Conceptual (t)	Not specified	South Africa	Interpretive	N/A
Swartz	1998	Culture; mental health; South Africa	Conceptual (i)	Qualitative	South Africa	Unknown	N/A
Vale & Maseko	1998	South Africa; African renaissance	Conceptual (i)	Not specified	Sub-Saharan Africa	Interpretive	N/A
Hickling & Hutchinson	1999	Roast breadfruit psychosis; African-Caribbean	Empirical (t)	Mixed methods	Not specified	Descriptive	N/A
Miller	1999	Cultural psychology	Conceptual (i)	Not specified	Not specified	Interpretive	N/A

Moodley	1999	Multiculturalism; cultural transformation	Conceptual (t)	Not specified	Not specified	Interpretive	N/A
Patel et al.	1999	Women; poverty; psychopathology	Empirical (t)	Not specified	Not specified	Descriptive	N/A
Pretorius	1999	Traditional healers	Conceptual (i)	Not specified	South Africa	Unknown	N/A
APA	2000	DSM; psychiatry; clinical psychology	Empirical (t)	Not specified	Africa: specific country not specified	Interpretive	N/A
Aponte & Johnson	2000	Culture; psychological intervention; ethnic population	Empirical (t)	Not specified	Africa: specific country not specified	Interpretive	N/A
Dana	2000	Personality assessment; cross-cultural; multicultural	Conceptual (i)	Not specified	Kenya	Descriptive	N/A
Draguns	2000	Clinician empathy	Conceptual (t)	Qualitative / Phenomenology	Nigeria	Interpretive	N/A
Habel et al.	2000	Emotional processing; schizophrenia	Empirical (t)	Qualitative	Not specified	Interpretive	N/A

Koss-Chioino	2000	Traditional approaches; ethnic minorities	Empirical (i)	Not specified	Not specified	Descriptive	N/A
López & Guarnaccia	2000	Cultural psychopathology	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Mabie	2000	Race; culture; intelligence	Empirical (t)	Not specified	Not specified	Descriptive	N/A
May et al.	2000	Fetal Alcohol Syndrome; Western Cape; South Africa	Empirical (t)	Quantitative	Not specified	Descriptive	N/A
Mbembe	2000	Boundaries in Africa	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Somer & Saadon	2000	Stambali; healing; dance; Tunisia	Conceptual (i)	Phenomenology	South Africa	Interpretive	N/A
Sparrow	2000	Identity; multiculturalism and beyond	Conceptual (i)	Not specified	South Africa	Interpretive	N/A

Stone et al.	2000	Political life events; psychological distress; South African adolescents	Conceptual (i)	Not specified	South Africa	Descriptive	N/A
Tomlinson-Clarke	2000	Multiculturalism	Conceptual (i)	Not specified	South Africa	Interpretive	N/A
Wohl	2000	Cultural diversity	Conceptual (i)	Not specified	West Africa : specific country not specified	Interpretive	N/A
Ashforth	2001	Epistemology; spirituality; witches; South Africa	Conceptual (i)	Not specified	Africa: specific country not specified	Interpretive	N/A
Bhugra & Bhui	2001	Transcultural; schizophrenia; research issues	Empirical (t)	Not specified	Africa: specific country not specified	Interpretive	N/A
Bhui & Bhugra	2001	Transcultural; epidemiological research	Empirical (t)	Not specified	Africa: specific country not specified	Interpretive	N/A

Bolton	2001	Perceptions of mental health; Rwanda	Empirical (t)	Quantitative	Australia; Taiwan	Descriptive	N/A
Bond	2001	Ancestors; witches; individual power; northern Zambia; anthropology; philosophy	Conceptual (i)	Not specified	Benin	Interpretive	N/A
Bullard	2001	Madness; truth; critical	Conceptual (i)	Not specified	Caribbean	Interpretive	N/A
Caradas et al.	2001	Ethnic comparisons; eating disorders; South African schoolgirls	Empirical (t)	Not specified	East African region	Descriptive	N/A
Hofstede	2001	Culture across nations	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Kirmayer	2001	Cultural variation; depression; anxiety	Conceptual (t)	Not specified	Not specified	Interpretive	N/A

McCrae	2001	Trait psychology; intercultural comparisons	Empirical (t)	Mixed methods	Not specified	Descriptive	N/A
Miller & Pumariega	2001	Culture; eating disorders	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Mpofu	2001	Treatment; cultural efficacy; African setting; conduct disorder	Conceptual (i)	Mixed methods	Not specified	Interpretive	N/A
Niehaus	2001	Witchcraft; postcolonial reality; colonial superstition; magical interpretations; South Africa	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Pakaslahti	2001	Dissociative disorder; possession; transcultural psychiatry	Conceptual (i)	Not specified	Not specified	Interpretive	N/A

Patel et al.	2001	Depression; Zimbabwe; developing countries	Empirical (t)	Quantitative	Not specified	Descriptive	N/A
Roelandt	2001	Culture; mental health; transcultural psychiatry	Conceptual (i)	Not specified	South Africa	Descriptive	N/A
Saldaña	2001	Cultural competency	Conceptual (i)	Not specified	South Africa	Descriptive	N/A
Schönpflug	2001	Cultural transmission; cross-cultural psychology	Conceptual (t)	Not specified	South Africa	Descriptive	N/A
Sharpley et al.	2001	Psychosis; African-Caribbean	Empirical (t)	Qualitative / Phenomenology	South Africa	Descriptive	N/A
Skilling et al.	2001	Taxon; antisocial	Conceptual (i)	Not specified	South Africa	Descriptive	N/A

Stompe	2001	Religious delusions; schizophrenia; transcultural psychiatry	Conceptual (i)	Not specified	South Africa	Interpretive	N/A
Toldson & Toldson	2001	Biomedical ethics; African-centred psychology	Conceptual (i)	Not specified	South Africa	Interpretive	N/A
Tseng	2001	Cultural psychiatry	Conceptual (t)	Not specified	South Africa	Interpretive	N/A
De Jong & Van Ommeren	2002	Culture-informed epidemiology; transcultural psychiatry	Conceptual (i)	Mixed methods	Malaysia	Descriptive	N/A
Harris	2002	Xenophobia; South Africa	Conceptual (i)	Qualitative	Not specified	Interpretive	N/A
Leclerc-Madlala	2002	Traditional medical practitioners; AIDS training; South Africa	Conceptual (i)	Not specified	Not specified	Descriptive	N/A

Mattes	2002	South Africa; Democracy; people	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Mbembe	2002	Defining African	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Muris et al.	2002	DSM; anxiety; children; South Africa	Conceptual (i)	Quantitative	Not specified	Descriptive	N/A
Peltzer et al.	2002	Africa; university students; attitudes; HIV	Empirical (t)	Not specified	Rwanda	Descriptive	N/A
Pope-Davis et al.	2002	Multicultural counselling competence	Conceptual (i)	Not specified	South Africa	Interpretive	N/A
Sam & Moreira	2002	Culture; mental illness	Conceptual (i)	Not specified	South Africa	Interpretive	N/A
Wakefield et al.	2002	DSM; conduct disorder; social context	Conceptual (i)	Not specified	Tunisia	Descriptive	N/A
Beiser	2003	Culture and psychiatry	Conceptual (i)	Not specified	Africa: specific country not specified	Interpretive	N/A

Berg	2003	Ancestor reverence; psychopathology; South Africa	Conceptual (i)	Qualitative	Africa: specific country not specified	Interpretive	N/A
Draguns & Tanaka-Matsumi	2003	Misdiagnosis; clinical impressions	Conceptual (i)	Qualitative	Nigeria	Unknown	N/A
Green & Groff	2003	Symptoms; syndromes; History	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Greenfield et al.	2003	Development	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Kim	2003	Identity; multiculturalism	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Kirmayer et al.	2003	Cultural consultation; multiculturalism; mental health services	Conceptual (i)	Not specified	Not specified	Unknown	N/A
Patel & Kleinman	2003	Mental disorders; poverty; developing countries	Empirical (t)	Mixed methods	Not specified	Descriptive	N/A

Sieff	2003	Mental illness; negative frames	Conceptual (t)	Not specified	South Africa	Unknown	N/A
Thomas et al.	2003	Cultural variation	Conceptual (i)	Not specified	South Africa	Interpretive	N/A
Watkins et al.	2003	Self-construal; (non)Western findings	Conceptual (i)	Not specified	USA	Unknown	N/A
Yen & Wilbraham	2003	Culture; indigenous healing; Western power	Conceptual (i)	Not specified	Zimbabwe	Unknown	N/A
Airhihenbuwa & DeWitt	2004	Culture in Africa; HIV/AIDS	Empirical (t)	Not specified	Africa: specific country not specified	Interpretive	N/A
Black et al.	2004	African Americans; psychology	Conceptual (i)	Not specified	Africa: various settings	Interpretive	N/A
Gibson	2004	South Africa; apartheid; nation building	Conceptual (i)	Not specified	Not specified	Interpretive	N/A

Hundt et al.	2004	Doctors; prophets; stroke-like symptoms; social diagnostics	Conceptual (t)	Qualitative / Phenomenology	Not specified	Interpretive	N/A
Katzman et al.	2004	Psychopathology; identity	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Le Grange et al.	2004	Self-starvation; eating disorder; impoverished Black adolescents; South Africa	Empirical (t)	Quantitative	Not specified	Descriptive	N/A
Mirza & Jenkins	2004	Anxiety; depressive disorders; Pakistan	Empirical (t)	Not specified	Not specified	Descriptive	N/A
Patterson	2004	Multicultural counselling competency	Conceptual (i)	Not specified	Puerto Rico	Interpretive	N/A
Szabo & Allwood	2004	Eating attitudes; Zulu speaking; South African population	Empirical (t)	Quantitative	South Africa	Descriptive	N/A

Thomas & Bracken	2004	Critical psychiatry	Conceptual (i)	Not specified	South Africa	Interpretive	N/A
Van der Vijer & Phalet	2004	Assessment; multiculturalism; acculturation	Conceptual (i)	Not specified	Trinidad; Albania	Interpretive	N/A
Wilson & Drozdek	2004	Trauma; refugees; treatment	Empirical (t)	Not specified	West Africa : specific country not specified	Interpretive	N/A
Zerega et al.	2004	Breadfruit	Conceptual (i)	Phenomenology	Not specified	Unknown	N/A
Adams	2005	Cultural grounding; personal relationships; enemyship; North America; West Africa	Conceptual (i)	Not specified	Africa: specific country not specified	Interpretive	N/A
Ashforth	2005	Muthi; medicine; witchcraft; African science	Conceptual (i)	Not specified	Africa: specific country not specified	Interpretive	N/A
Bojuwoye	2005	Traditional healing; holistic healing; ritual; South Africa	Conceptual (i)	Not specified	Africa: various settings	Interpretive	N/A

Carlson et al.	2005	Family therapy; integrating and tailoring techniques	Conceptual (i)	Not specified	East African region	Interpretive	N/A
Dzokoto & Adams	2005	Genital-shrinking; Koro; juju; psychogenic illness; West Africa	Conceptual (i)	Qualitative / Phenomenology	Not specified	Interpretive	N/A
Eagle	2005	Cultural worldviews	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Hergenhahn	2005	Psychology history; Socrates	Conceptual (i)	Not specified	Not specified	Unknown	N/A
Kwate	2005	African-centred psychology	Conceptual (i)	Not specified	Not specified	Unknown	N/A
Liddell et al.	2005	Sub-Saharan Africa; HIV/AIDS; psychopathology; Africa	Conceptual (i)	Not specified	Not specified	Unknown	N/A
Mateus et al.	2005	Schizophrenia; Cape Verde; Africa	Conceptual (i)	Not specified	Not specified	Unknown	N/A

Mather	2005	Genital theft; Ghana	Conceptual (i)	Qualitative / Phenomenology	Not specified	Descriptive	N/A
McDowell et al.	2005	Family therapy; critical conversations	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Wreford	2005	Biomedicine; traditional healing; South Africa; HIV	Conceptual (t)	Not specified	Zimbabwe	Unknown	N/A
Dzokoto & Okazaki	2006	Somatisation	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Gervais-Lambony	2006	South Africa; identity	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Hall	2006	Culture-bound syndromes	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Mio et al.	2006	Multicultural psychology; diversity	Conceptual (i)	Not specified	Not specified	Unknown	N/A
Mpofu	2006	Traditional healing; complementary medicines	Conceptual (i)	Not specified	Not specified	Descriptive	N/A

Okello & Musisi	2006	Psychopathology; culture-related illnesses; Uganda	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Pronyk et al.	2006	Intimate-partner violence; HIV; South Africa	Conceptual (i)	Not specified	South Africa	Descriptive	N/A
Puttergill & Leildé	2006	Identity; Africa	Conceptual (i)	Not specified	South Africa	Unknown	N/A
Sen & Chowdhury	2006	Culture; ethnicity; paranoia	Conceptual (i)	Not specified	South Africa	Interpretive	N/A
Smit et al.	2006	Mental health; sexual risk behaviour; South African township	Conceptual (i)	Not specified	South Africa	Descriptive	N/A
Tseng	2006	Culture-bound syndromes; culture-related syndromes; psychiatric disorders	Conceptual (i)	Not specified	Southern Africa	Interpretive	N/A

Adams & Salter	2007	Health psychology; African settings	Conceptual (i)	Not specified	Africa: specific country not specified	Unknown	N/A
Ilechukwu	2007	Ogbanje/abiku; Nigeria	Conceptual (i)	Qualitative / Phenomenology	Not specified	Interpretive	N/A
Littlewood	2007	Psychopathology; Trinidad; Albania	Empirical (t)	Not specified	Not specified	Interpretive	N/A
Mezzich	2007	History; Socrates; humanistic medicine	Conceptual (i)	Not specified	Not specified	Unknown	N/A
Modood & Ahmad	2007	South Africa	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Pilgrim	2007	Psychiatric diagnosis evolution; History	Conceptual (i)	Not specified	South Africa	Interpretive	N/A
Swartz	2007	Psychodynamic	Conceptual (i)	Not specified	South Africa	Interpretive	N/A

Tomlinson et al.	2007	Experiential dynamics; African perspective; current state of literature	Conceptual (i)	Review	South Africa	Interpretive	N/A
Utsey et al.	2007	Culture-specific coping; resiliency; African-Americans	Conceptual (i)	Not specified	Sub-Saharan Africa	Interpretive	N/A
Wilson	2007	Trauma; PTSD; culture	Conceptual (i)	Not specified	West Africa : specific country not specified	Interpretive	N/A
Achenbach et al.	2008	Multicultural assessment; psychopathology	Conceptual (i)	Not specified	Africa: specific country not specified	Unknown	N/A
Canino & Algería	2008	Psychiatric diagnosis; universalism; relativism	Conceptual (i)	Not specified	China	Interpretive	N/A
Trujillo	2008	Multiculturalism; cultural psychology	Conceptual (i)	Not specified	South Africa	Unknown	N/A

Walker et al.	2008	Chronic pain patients; psychosocial data; South Africa	Empirical (t)	Mixed methods	Uganda	Interpretive	N/A
Eshun & Gurung	2009	Culture; psychopathology; socio-cultural influences	Conceptual (i)	Not specified	Not specified	Interpretive	N/A
Janse van Rensburg	2009	Mental health care delivery; South Africa	Conceptual (i)	Not specified	Not specified	Descriptive	N/A
Lubell-Doughtie	2009	African cosmology; Tabwa	Conceptual (t)	Qualitative	Not specified	Interpretive	N/A
Crystal	2010	Mythology	Conceptual (t)	Not specified	Japan	Unknown	N/A

APPENDIX B: Coding sheet - themes

Author(s)	Year	Emerging themes	Additional areas of interest / sub-themes
Abas & Broadhead	1997	Psychopathology in Africa	
Achebe	1986	Igbo cosmology	Ogbanje/abiku
Achenbach et al.	2008	Universalism; relativism; absolutism; cultural diversity; multiculturalism	Etic; emic
Adams	2005	Traditional healing	Harmony and balance
Adams & Salter	2007	Culture and psychopathology; Africanity; cosmology; traditional healing; Africa and the West; Western perspectives; African perspective	koro; genital-shrinking; harmony and balance
Airhihenbuwa & DeWitt	2004	African identities; who is African; universalism, relativism, absolutism; multiculturalism	Acculturation and enculturation in Africa

Akinnawo	1995	Psychopathology in Africa	
Al-Issa	1995	Africa and the West	
Anderson	1996	Culture misunderstood	
APA	2000	Universalism, relativism, absolutism	
Aponte & Johnson	2000	Worldview and psychopathology; multiculturalism	Acculturation and enculturation in Africa
Appiah	1992	African cosmology	
Asante	1980	Afrocentric perspective; who is African; Africanity; holism	
Ashforth	1998	African epistemology and psychopathology; traditional healing; psychopathology in South Africa	Becoming a traditional healer; muthi; healing; witchcraft; science of traditional healing
Ashforth	2001	African epistemology and psychopathology	

Ashforth	2005	Developing African identity; defining self; traditional healing; epistemology and science	Becoming a traditional healer; difference between healers and witches; muthi; science of traditional healing
Beiser	2003	Culturally competent services; psychopathology in Africa; cultural psychopathology	
Berg	2003	Worldview and psychopathology	
Berry	1995	Universalism, relativism, absolutism	
Bhugra & Bhui	2001	Research issues in culture; misdiagnosis; pathoplastic influences; frame of reference; culture misunderstood; ethnicity; psychopathology in Africa; psychopathology and being Black; limitations of current treatment	
Bhui & Bhugra	2001	African studies; who is African; psychopathology in Africa	
Black et al.	2004	Ethnocentricity	
Bojuwoye	2005	Traditional healing	Harmony and balance

Bolton	2001	Psychopathology in Africa	
Bond	2001	Traditional healing	Difference between healers and witches
Boykin et al.	1997	Creation of the universe; ubuntu	
Bullard	2001	Cultural psychopathology; Africa and the West; comparative views; colonisation in Africa	
Cabral	1974	Locus of culture; multiculturalism; colonisation in Africa	
Campbell	1997	African identity; psychopathology in Africa	
Canino & Algería	2008	Cultural psychopathology; culture-bound syndromes; universalism, relativism, absolutism	
Canino et al.	1997	Universalism, relativism, absolutism	
Caradas et al.	2001	Multiculturalism	Acculturation and enculturation in Africa
Carlson et al.	2005	Traditional healing	Traditional and modern collaboration

Cashmore	1988	Ethnicity	
Castillo	1997	Cultural psychopathology	
Chandler	1998	Creation of the universe; compare with Arab and European cosmology; symbolism	
Cheetham & Griffiths	1981	Diagnostic inaccuracies; malingering; Black and Indian patients	
Comaroff & Comaroff	1987	History and culture; culture as multidirectional; African epistemology and psychopathology; psychopathology in Africa; psychopathology in South Africa	
Crystal	2010	Boshongo creation story; Abaluyia creation story; bushman creation story	
Dana	2000	Psychopathology in Africa	
De Jong & Van Ommeren	2002	Theory of culture-bound syndromes	
Dein & Dickens	1997	Acceptable features are specific to culture; somatisation; traditional healing; limitations of current treatment	Healing

Double	1990	Psychiatry and clinical psychology	
Draguns	1997	Psychopathology	
Draguns	2000	Ethnicity and psychopathology; decay in clinician empathy; cultural diversity; current state of literature; psychopathology; psychopathology in Africa; cultural psychopathology; culture-bound syndromes; psychiatry and clinical psychology; African perspective	Ataque de nervios
Draguns & Tanaka-Matsumi	2003	Cultural similarities and differences in psychopathology; African identity; cultural psychology; collectivistic cultures; self-hood; masculinity-femininity; psychopathology in Africa; cultural psychopathology; theory of culture-bound syndromes; universalism, relativism, absolutism	
Drewal	1988	Tabwa cosmology	
Du Toit	1998	Who is African; traditional perspectives; supernatural influence; cosmology; epistemology and science	

Dzokoto & Adams	2005	Creation of the universe; supernatural; African epistemology and psychopathology; psychopathology in Africa; limitations of current treatment; Africa and the West; Western perspectives	koro; genital-shrinking
Dzokoto & Okazaki	2006	Somatic complaints; cultural modulation of emotions; culture as multidirectional	
Eagle	2005	Epistemology; culture among academia; meaning of culture; locus of culture; political domain; culture misunderstood; defining culture; ethnocentricity	
Edgerton	1966	Psychopathology in Africa; traditional healing; Africa and the West	Science of traditional healing
Edgerton	1971	Worldview and psychopathology; psychopathology in Africa; traditional healing; Africa and the West; science	Becoming a traditional healer; healing; science of traditional healing
Edwards	1998	Creation of the universe; traditional healing; comparative views; epistemology and science	Science of traditional healing

Eshun & Gurung	2009	Defining culture and ethnicity; culture as environmental feature; facets of culture; framework of culture; ethnicity; African identity; cultural psychopathology; culture-bound syndromes; Africa and the West; universalism, relativism, absolutism; ethnocentricity	
Fanon	1968	Colonisation in Africa	
Feierman	1985	Cultural psychopathology; traditional healing	Science of traditional healing
Gaw	1993	Somatisation; culture-bound syndromes	hwa-byung
Gervais-Lambony	2006	African identity; developing African identity	
Gibson	2004	Africanity; collective memory; psychopathology in South Africa	Reconciled South Africa
Gillis et al.	1991	Psychopathology in Africa	
Green & Groff	2003	Questioning direction of assessment in psychopathology	

Green et al.	1995	African epistemology and psychopathology; traditional healing; Africa and the West; cultural diversity	Science of traditional healing; traditional and modern collaboration
Greenfield et al.	2003	Collective interpretation; framework of culture	
Gualbert	1997	Traditional healing	Science of traditional healing
Guarnaccia at al.	1996	Culture-bound syndromes	
Guiness	1992	Culture-bound syndromes	Brain fag
Gureje et al.	1992	Psychopathology in Africa	
Habel et al.	2000	Universalistic psychopathology	
Hahn	1995	Cultural psychopathology	

Hall	2006	Culture-bound syndromes	Amok; iich'aa; cafard; wool-hwa-byung; brain fag; koro; genital-shrinking; hsieh-ping; shenkui; qi-gong psychotic reaction; shenjian shuairuo; shin-byung; taijin kyofusho; zar; boufée deliriante; sangue dormido; falling out; locura; ataque de nervios; bilis and colera; susto; mal puesto; voodoo death; spell; ghost sickness; pibloktoq
Hammond-Tooke	1998	Cosmology; traditional healing	Difference between healers and witches; types of healers
Harding et al.	1980	Limitations of current treatment	
Harris	2002	Psychopathology in South Africa	South Africa currently
Helman	1990	Cultural edicts	
Hergenhahn	2005	Physical basis of psychological distress	
Hermans & Kempen	1998	Africa and the West; cultural diversity	

Herskovits	1926	Kulturkreis; linear patterning of culture; culture misunderstood	
Hickling & Hutchinson	1999	Roast breadfruit syndrome; multiculturalism; Western Perspectives; colonisation in Africa; psychiatry and clinical psychology	Acculturation and enculturation in Africa
Hofstede	1986	Ethnocentricity	
Hofstede	2001	Culture as multidirectional; individualism-collectivism; social positioning; four dimensions of national cultures	
Horton	1993	Africa and the West	
Hughes et al.	1997	Universalism, relativism, absolutism	
Hundt et al.	2004	African epistemology and psychopathology; psychopathology in Africa; traditional healing	Traditional healing processes; types of healers
Ilechukwu	2007	Cultural psychopathology; Africa and the West; African perspective	Ogbanje; prototypal names
Isaac et al.	1996	Somatisation	

Iwu	1986	African epistemology and psychopathology	
Jablensky	1987	Psychopathology; universalism, relativism, absolutism	
Janse van Rensburg	2009	Traditional healing	Traditional and modern collaboration
Jilek-Aall et al.	1997	African epistemology and psychopathology; traditional healing; African perspective	Science of traditional healing
Jones	1995	Who is African	
Jung	1969	Africanity	
Kale	1995	Traditional healing	Traditional healing processes; science of traditional healing; traditional and modern collaboration
Katzman et al.	2004	Identity influences	
Kim	2003	African identity; self-hood; language and identity; developing African identity; identity influences	
King	1990	African identity	

Kirmayer	2001	Universalism, relativism, absolutism	
Kirmayer & Young	1998	Somatisation; idiom of distress; culture-bound syndromes	Dhat
Kirmayer et al.	2003	Cultural psychopathology	
Kleinman	1988	Universalism, relativism, absolutism	
Kleinman & Good	1985	Universalism, relativism, absolutism	
Kleinman & Kleinman	1991	Universalism, relativism, absolutism	
Koss-Chioino	2000	Traditional healing; universalism, relativism, absolutism	Becoming a traditional healer; science of traditional healing
Kudadije & Osei	1998	Africanity; cosmology; African cosmology; creation of the universe; African epistemology and psychopathology; traditional healing; epistemology and science	Traditional healing processes; science of traditional healing

Kwate	2005	Who is African; Africanity; creation of the universe; worldview and psychopathology; limitations of current treatment; Africa and the West; colonisation in Africa; psychiatry and clinical psychology; African perspective	Prototypal names; alien-self disorder; anti-self disorder; individualism; mammyism; materialistic depression; self-destructive disorder; theological misorientation
Last	1995	Culture misunderstood; ethnicity	
Le Grange et al.	1998	Psychopathology in South Africa	South Africa currently
Le Grange et al.	2004	Psychopathology in Africa	
Leclerc-Madlala	2002	Traditional healing	Healing
Lewis-Fernandez & Kleinman	1995	Universalism, relativism, absolutism	
Liddell et al.	2005	African cosmology; African epistemology and psychopathology; traditional healing; Western perspectives	Traditional healing processes
Lieberson	1961	Cosmology; colonisation in Africa; psychopathology in South Africa	
Lin & Kleinman	1988	Universalism; relativism; absolutism	

Littlewood	2007	Worldview and psychopathology; comparative views; Western perspectives	
López & Guarnaccia	2000	Socio-cultural mental illness; behaviour and culture; defining culture; culture in groups; cultural shifts; evolutionary nature of culture; ethnicity; culture-bound syndromes; cultural diversity; psychiatry and clinical psychology	ataque de nervios
Lubell-Doughtie	2009	Tabwa cosmology	
Lupton	1994	Western perspectives	
Lutz	1985	Universalism, relativism, absolutism	
Mabie	2000	Ethnicity; ethnocentricity; cultural diversity; colonisation in Africa	
Mafeje	1971	Who is African; Africanity; Africa and the West; cultural diversity	
Makgoba	1998	Who is African; African uniqueness; searching for 'Africa'; Africanity; African identity; symbolism; multiculturalism	Acculturation and enculturation in Africa
Marsella	1980	Psychopathology in Africa	

Marsella	1998	Africa and the West	
Mateus et al.	2005	African epistemology and psychopathology	
Mather	2005	Culture-bound syndromes	Koro; genital-shrinking
Mattes	2002	Psychopathology in South Africa	Reconciled South Africa
May et al.	2000	Psychopathology in South Africa	South Africa currently
Mazrui	1986	African history; heritage	
Mbembe	2000	Africanity; politics; social process; cultural process	
Mbembe	2002	Who is African; Africanism	
Mbiti	1970	Africanity; African identity; African cosmology; traditional healing	Harmony and balance
McCrae	2001	Culture and personality influences; culture as multidirectional; identity influences; cultural psychopathology	

McDowell et al.	2005	Phenotype in interpersonal relations; framework of culture; cultural empathy	
Mezzich	2007	(Meta)physical basis of psychological distress; psychiatry and clinical psychology	
Mezzich et al.	1996	Ethnicity; racial discrimination; ethnocentrism; psychiatry and clinical psychology	
Miller	1999	Researched areas in culture and psychology; culture as multidirectional; framework of culture; culture-bound syndromes; limitations of current treatment; universalism, relativism, absolutism	
Miller & Pumariega	2001	Framework of culture; culture and psychopathology; psychopathology in Africa	
Mio et al.	2006	Cultural psychopathology	
Mirza & Jenkins	2004	Limitations of current treatment	
Mkize	1998	Culture-bound syndromes	Amafufunyane
Modood & Ahmad	2007	Ethnicity; SA make-up; cultural diversity	

Moodley	1999	Acculturation; traditional healing; cultural diversity; multiculturalism	
Mpofu	2001	Traditional healers; Africa and the West	Types of healers
Mpofu	2006	Traditional healing; Africa and the West	Harmony and balance
Mudimbe	1988	Africa and the West	
Mumford	1996	Culture-bound syndrome	Dhat
Muris et al.	2002	Psychopathology in South Africa	South Africa currently
Nagel	1994	Culture organises ethnicity; culture and human agency; framework of culture; ethnicity; Africanity; African identity	
Ndetei & Muhangi	1979	Psychopathology in Africa	
Nesbitt	1998	Psychopathology in South Africa; Acculturation	Reconciled South Africa
Ngubane	1977	Zulu creation story	
Niehaus	2001	Epistemology and science	
Noel	1997	Traditional healing	Becoming a traditional healer

Nsamenang	1992	Who is African; Africanity; African identity; developing African identity; ontogeny; self-hood; identity influences; African cosmology; creation of the universe; worldview and psychopathology; African epistemology and psychopathology; psychopathology in Africa; traditional healing; Africa and the West; universalism, relativism, absolutism; cultural diversity; multiculturalism; epistemology and science	Becoming a traditional healer; healing; acculturation and enculturation in Africa
Odejide et al.	1978	Psychopathology in Africa; traditional healing	Traditional healing processes
Okello & Musisi	2006	Cosmology; worldview and psychopathology; African epistemology and psychopathology; psychopathology in Africa; cultural psychopathology; traditional healing; universalism, relativism, absolutism; African perspective	Traditional healing processes; healing
Orubuloye et al.	1994	Psychopathology in Africa	
Pakaslahti	2001	Cultural psychopathology	
Panskepp	1998	Universalism, relativism, absolutism	

Patel	1995	Culture and psychopathology; cosmology; African cosmology; psychopathology in Africa; traditional healing; Africa and the West; universalism, relativism, absolutism	Science of traditional healing
Patel & Kleinman	2003	Psychopathology; psychopathology in Africa	
Patel et al.	1999	Psychopathology in Africa	
Patel et al.	2001	Psychopathology in Africa	
Patterson	1996	Current state of literature; multicultural counselling; awareness into psychopathology in cultures; universalism, relativism, absolutism; cultural diversity; multiculturalism	Acculturation and enculturation in Africa
Patterson	2004	Cultural diversity; multiculturalism	
Peltzer et al.	2002	Psychopathology in Africa	
Penn et al.	1994	Psychopathology in Africa	
Perkins & Moodley	1993	Psychopathology and being Black	
Pfeiffer	1994	Cultural psychopathology	

Pilgrim	2007	Physical basis of psychological distress; questioning direction of assessment in psychopathology; psychopathology; psychiatry; clinical psychology	
Pope-Davis et al.	2002	Competency in culture to counsel; cultural sensitivity; rapport; cultural psychopathology	
Pretorius	1999	Traditional healing	
Pretorius et al.	1993	Africa and the West	
Prince	1967	Psychopathology in Africa	
Prince	1990	Culture-bound syndromes	Brain fag
Pritchard	1937	African epistemology and psychopathology	
Pronyk et al.	2006	Worldview and psychopathology	
Puttergill & Leildé	2006	African identity; psychopathology in South Africa	Reconciled South Africa
Rin & Lin	1962	Limitations of current treatment	
Ritchie	1997	Locus of culture; multiculturalism; shared history; who is African; Afrocentricism	

Roberts	1988	Tabwa cosmology	
Roelandt	2001	Psychopathology in Africa	
Rogers et al.	1998	Malingering; syndromes; psychopathology in Africa	
Rumble	1994	Psychopathology in Africa	
Rumble et al.	1996	Psychopathology in Africa	
Russel	1989	Culture-bound syndromes	Taijin kyofusho
Saldaña	2001	African epistemology and psychopathology; culture-bound syndromes	amok; mal de pelea; hwa-byung; dhat; taijin kyofusho; falling out; ataque de nervios; voodoo death; ghost sickness; pibloktoq
Sam & Moreira	2002	Cultural psychopathology	
Santino	1985	Cultural psychopathology; traditional healing	Becoming a traditional healer; healing

Scheper-Hughes & Lock	1987	Medical anthropology; mindful body; cultural perception is complex; political and social; African identity; cosmology; historical views (West); Cartesian; creation of the universe; African epistemology and psychopathology; psychopathology; idiom of distress; Africa and the West; comparative views; Western perspectives
Schönpflug	2001	Africa and the West
Sen & Chowdhury	2006	Defining culture and ethnicity; locus of culture
Setiloane	1998a	African cosmology; mythology; myth of the bed of reeds; hole in the ground myth; miraculous child of Sankatane
Setiloane	1998b	Africanity; African cosmology
Sharpley et al.	2001	Ethnicity; passive-aggressive racism; psychopathology in Africa; Africa and the West; Western perspectives; African perspective
Shore	1996	Culture and evolution
Sieff	2003	Psychopathology in Africa

Skilling et al.	2001	Culture-bound syndromes	
Smit et al.	2006	Universalism, relativism, absolutism;	
Somer & Saadon	2000	Somatisation; theory of culture-bound syndromes	
Sow	1980	Psychopathology in Africa	
Sparrow	2000	Multiculturalism	Acculturation and enculturation in Africa
Speight	1935	Worldview and psychopathology	
Stevens & Lockhat	1997	Psychopathology in South Africa	South Africa currently
Stompe	2001	Cultural psychopathology	
Stone et al.	2000	Psychopathology in South Africa	Reconciled South Africa
Swartz	1998	Psychopathology in Africa; culture-bound syndromes; cultural diversity; traditional healing	Amafufunyane
Swartz	2007	Ethnicity; Oedipus	
Szabo & Allwood	2004	Psychopathology in South Africa	South Africa currently
Tanaka-Matsumi & Marsella	1976	Psychopathology in Africa	

Thomas & Bracken	2004	Philosophical systems; moral systems; clinician subjectivity; psychiatry and clinical psychology	
Thomas et al.	2003	Culture as multidirectional	
Toldson & Toldson	2001	Framework of culture; ethnicity; who is African; African identity; African cosmology; creation of the universe; African epistemology and psychopathology; psychopathology; psychopathology in Africa; traditional healing; multiculturalism; Western perspectives; African perspective	Healing; harmony and balance; science of traditional healing; acculturation and enculturation in Africa
Tomlinson et al.	2007	Phenomenological versus symptomatology assessment; biomedical ethics; psychopathology; psychopathology in Africa; psychopathology and being Black; idiom of distress	
Tomlinson-Clarke	2000	Universalism, relativism; absolutism; cultural diversity; multiculturalism	Acculturation and enculturation in Africa
Triandis	1995	Transgenerational values; collective attitudes; knowledge schema	

Trujillo	2008	Cultural similarities and differences in psychopathology; development of cultural psychology; framework of culture; African identity; psychopathology in Africa; cultural psychopathology; culture-bound syndromes; psychiatry and clinical psychology	amok; dhat; koro; genital-shrinking; shenkui; qi-gong psychotic reaction; shenjian shuairuo; shin byung; taijin kyofusho; zar; boufée deliriante; sangue dormido; falling out; locura; ataque de nervios; nervios; susto; voodoo death; spell; ghost sickness; pibloktoq; thanatos; latah; mal de ojo; evil eye
Tseng	2001	Cultural psychopathology	
Tseng	2006	Psychopathology; theory of culture-bound syndromes; culture-bound syndromes; amok; hwa-byung; taijin kyofusho; susto; psychiatry and clinical psychology	
Tseng et al.	1992	Culture-bound syndromes	Koro
Utsey et al.	2007	African epistemology and psychopathology; limitations of current treatment	
Vale & Maseko	1998	Psychopathology in South Africa	Reconciled South Africa
Van der Vijer & Phalet	2004	Framework of culture; acculturation; biculturalism; separation; integration; assimilation; marginalisation; multiculturalism	

Wakefield et al.	2002	Universalism, relativism, absolutism	
Walker et al.	2008	Somatisation; psychopathology in South Africa	South Africa currently
Watkins et al.	1996	Who is African; African identity; identity influences; creation of the universe	
Watkins et al.	2003	African identity	
White	1959	Culture and physics; scientific definition; plurality; extrasomatic context; locus of culture; culture as multidirectional; transformation of culture; somatisation; ethnocentricity	
WHO	1978	Traditional healing	
WHO	1992	Psychopathology; universalism, relativism, absolutism	
Wilson	2007	Social positioning; dynamic nature of culture; African epistemology and psychopathology; limitations of current treatment	
Wilson & Drozdek	2004	Cultural psychopathology	

Wohl	2000	Ethnicity; psychotherapy; traditional healing; Africa and the West; universalism, relativism, absolutism; cultural diversity; multiculturalism	Traditional and modern collaboration; acculturation and enculturation in Africa
Wolf et al.	1994	Acculturation	
Wreford	2005	Traditional healing; Africa and the West	Becoming a traditional healer; difference between healers and witches; healing; harmony and balance; science of traditional healing
Yap	1967	Culture-bound syndromes	
Yen & Wilbraham	2003	Limitations of current treatment; universalism, relativism; absolutism; Western perspectives	
Yoder	1982	African epistemology and psychopathology	
Zerega et al.	2004	Roast breadfruit syndrome	