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.

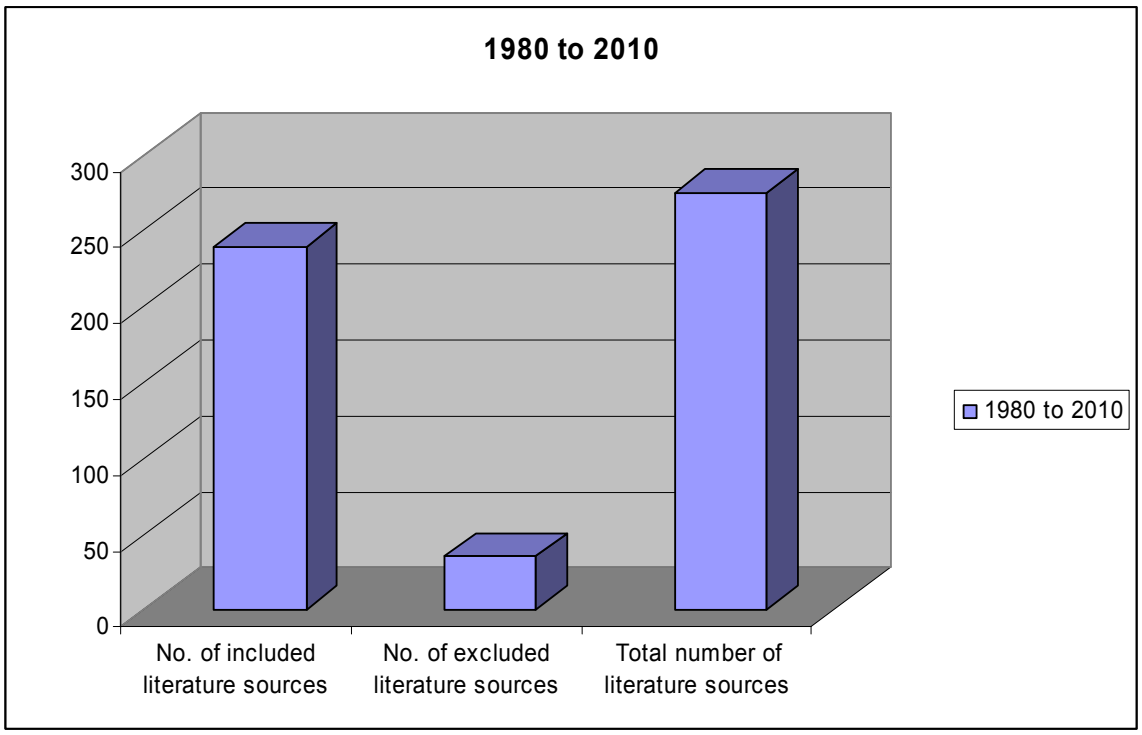

Figure 6.1. Number of sources

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.

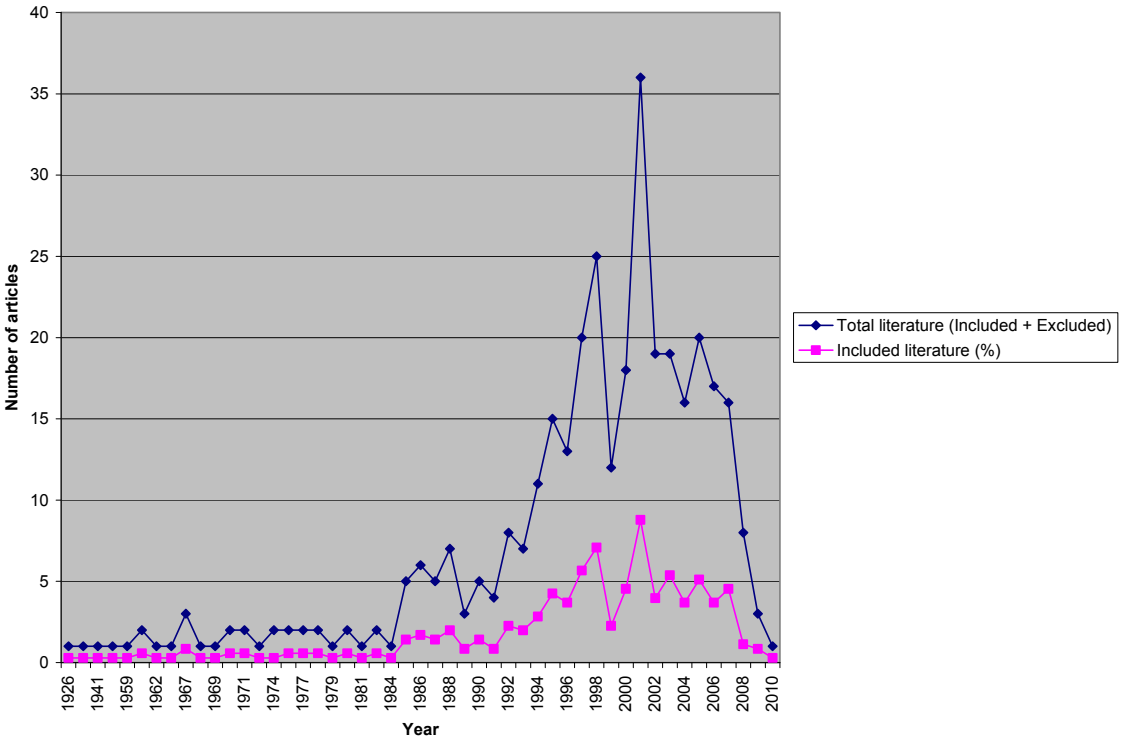

Figure 6.2. Number of studies retrieved (per year)

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:

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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.