Unit 3

Abnormal Psychology

Open Rubric

Learning outcomes

After studying this unit, you should be able to:

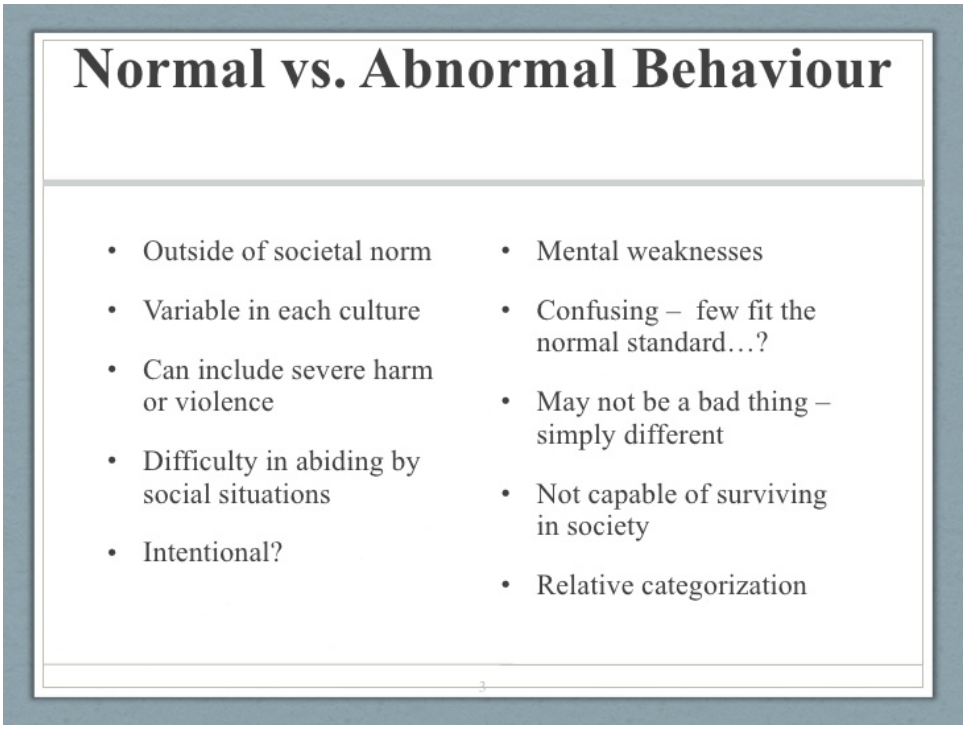
- Differentiate between normal and abnormal behaviour in terms of different worldviews
- Demonstrate a basic understanding of African epistemologies about mental disorders
- Identify the models that explain abnormal behaviour.

3.1 Introduction

There is no consensus on what criteria constitute the necessary and sufficient conditions for defining, and thus properly applying, the term “psychopathology” (Sue et al., 2003). Included are factors such as maladaptiveness (inability to adjust), deviance, functional impairment, suffering, irrationality, incomprehensibility, loss of control, and the presence of underlying psychological or biological deviance (Bergner, 1997). Western conceptualisations of psychopathology seem to rest on normal versus abnormal functioning. The terms “typical” and “atypical” form part of the psychological definition of normal and abnormal behaviour. Any behaviour that is not typical or usual (i.e., uncommon behaviour) is, by definition, abnormal. Table 3.1 outlines the differences between normal and abnormal behaviour.

Table 3.1

Normal versus abnormal behaviour from a Western worldview



Source: www.slideshare.net/innkblotz/defining-abnormality-1997590

The most common method used to clinically diagnose mental health conditions, is the *Diagnostic and Statistical Manual (DSM) of Mental Disorders* (APA, 2000). This classification system, first published in 1952 by the American Psychiatric Association (APA), became the dominant classification scheme for mental disorders around the world, including in South Africa. The classification system has been revised several times, and sequentially included DSM-I (in 1968), DSM-II (in 1980), DSM-III (in 1987), DSM-IV_TR (in 1994), and the latest, fifth edition, DSM-V (in 2013), which is slightly different from DSM-IV_TR. The fourth edition was a multi-axial system which evaluated the individual on five axes or dimensions, and facilitated a comprehensive and systematic evaluation (see Fig. 3.1). The current (fifth) edition discarded the multiaxial system of diagnosis

(formerly Axis I, Axis II, and Axis III), listing them under one section. Axes IV and V have been replaced, and listed as psychosocial and contextual features.

To address the observation that specific populations exhibit discrete syndromes which differ vastly from the clinical picture of typical syndromes, DSM-IV-TR added a new spectrum of disorders called culture-bound syndromes (APA, 2000). DSM-IV-TR, for example, makes references to the ways in which various cultures and identity-related factors influence the manifestation of certain disorders (Canino & Algería, 2008). A few changes become evident with the introduction of DSM-V (APA, 2013): for example, in an effort to improve diagnoses for people of different cultural backgrounds, DSM-V incorporates greater cultural sensitivity in the manual, culture-bound syndromes, cross-cultural variations in the manner in which disorders manifest, as well as cultural concepts of distress (APA, 2013), thus recognising that mental disorders are culture-bound and contextual. This means that, in studying human behaviour we have to be mindful of the different cultures and communities in which mental disorders manifest, since the etiology can be contextual and culture bound. Further, understanding mental disorders from a cultural perspective advances the improved identification and diagnosis of symptoms, in addition to paving the way for effective treatment or manners in which the affected communities can respond to such a diagnosis. Despite attempts by DSM-V to be culture-sensitive, it falls short of delving into culture-specific and varied mental disorders, and largely views culture through western lenses, thereby negating an essential part of conceptualising mental health from an insider's viewpoint.

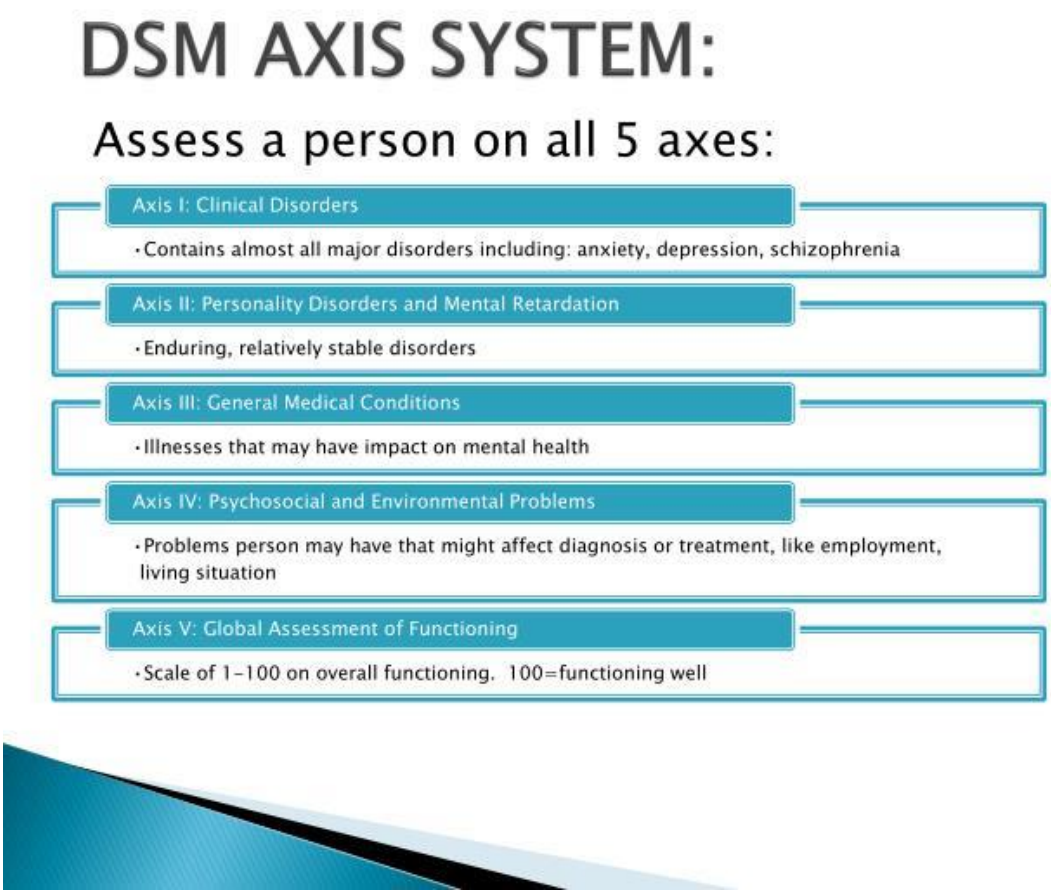


Figure 3.1: DSM-IV multi-axial system

Source: https:// www.slideserve.com/gilead/abnormal-psychology

When we study psychology, our aim is to understand human behaviour and thus to improve our understanding of people. This understanding helps us in our everyday interactions and dealings with others. As we interact with individuals from various cultural backgrounds we make assumptions about them, and for that reason we need to be aware of the ethics (universal truths or principles which appear consistent across different cultures) and emics (findings that appear to be culture specific) in our truths (Jardine, 2004). Put simply, an etic view of a culture is the perspective of an outsider looking in, whereas an emic view is a focus on the intrinsic cultural distinctions that are meaningful to members of a given society – an insider perspective. This means that, when studying

human behaviour (and, by extension, mental illness), some psychologists use a cross-cultural perspective which seeks to understand a phenomenon across various cultures, in order to universalise conclusions about human behaviour (etic approach). By contrast, many psychologists use a culture-specific perspective to understand mental illness (emic approach). The conclusions drawn from employing the emic approach are only applicable and relevant to the context in which the observations were made. Several scholars advocate for a blended approach (combining the etic and emic approaches), to enhance their understanding of human behaviour and mental illness. This is important, because a blended approach helps psychologists to understand and interpret behaviours from an overarching and comprehensive viewpoint.

Research conducted by Draguns and Tanaka-Matsumi (2003) demonstrates a link between culture and psychopathology, and identifies the relationships between psychological distress and cultural features. To better understand how culture influences mental illness, three main theoretical positions from a cross-cultural approach are used: the universalistic, the relativistic, and the absolutist perspectives (Hassim, 2012; Hassim & Wagner, 2013). Universalistic perspectives are etic in nature, in that they offer an explanation of encounters, independent of the attached connotations. That is, the universalistic view acknowledges culture through the supposition that specific behaviours or mental illnesses are common to all people, but that the development and expression of, and response to, the condition are influenced by culture (Eshun & Gurung, 2009). Classification manuals such as the DSM-V and ICD10 (the World Health Organisation's [WHO] *International Classification of Diseases* [ICD]) fall under the universalistic approach, since they assume that the Western understanding of syndromes can be applied to all contexts. The relativistic perspective is based on the notion that mental illness should be understood in the context of a particular behavioural norm within a specific culture. According to the relativistic perspective, classification schemes such as the DSM-V give culture a very restricted position in diagnoses, leading to an incorrect categorisation and unfair homogeneity in pathology across cultures (Kleinman & Kleinman, 1991). According to Wakefield et al. (2002), the idea that pathology lies within a person, is strongly contested by relativists. The absolutist perspective assumes that

culture does not play any role in the expression of behaviour. That is, the presentation, manifestation and implications of psychological distress are the same, regardless of culture (Eshun & Gurung, 2009), thus trivialising the role of culture in shaping human behavioural manifestations.

The African worldview of psychopathology promotes a culture-specific method of understanding mental illness which opposes the universalistic and absolutist approaches. The universalistic approach does not acknowledge the existence of cultural differences and/or other factors that make one culture distinct from another/others, while the absolutist approach does not recognise the role of culture in shaping behaviour. In the sections which follow, we discuss mental illness or psychopathology as understood from the African perspective. We do this by adopting a somewhat relativistic approach, since we regard mental illness as a complex concept that cannot be simplified by adopting the biased lenses of the universalistic and absolutist approaches. Instead, we regard mental illness as a broader concept that can be understood *relatively*, or in relation to a particular frame of reference, such as the cultural context.

3.2 Normal and abnormal behaviour

African people's worldviews are based on societal and cosmological relationships. African people have a strong understanding of respect for self, others, and all of nature, especially the land, trees, and water (Mbiti, 1969). This explains why land remains such a thorny issue in Africa. When one thinks of mental illness in the African context, one must think about the loss of land, which rid people of control over what they produce and consume. This loss of land also meant people lost a sense of their healing systems, which were primarily reliant on nature. People could no longer access the forests for medicinal plants, and the rivers and mountains no longer served the healing purpose they did prior to colonisation. This resulted in disharmony between nature and the people. Before colonisation, indigenous peoples treated illness by relying on their cultural belief systems. Any behaviour that fell outside of the expected cultural norms, was considered abnormal.

In contrast to the Western concept of psychological wellbeing, which focuses on the individual, wellbeing from an African perspective encompasses the individual's physical, spiritual and social dimensions. Traditional African psychopathology defines dysfunction as a state of collective and individual imbalance, especially regarding differences in the community, and physical and social functioning (Kwate, 2005). That includes disharmonious and fractured social and spiritual relationships. Disharmonious relationships with the spiritual world, nature, family and community, are believed to cause people to suffer ill health. Any disturbed relationship with the above critical entities creates an uneasy imbalance, which is expressed in the form of physical problems such as illness, or mental problems (Nwoye, 2015).

Wellbeing, from an African perspective, encompasses the physical, spiritual, and social dimensions of an individual. Many cultures experience psychopathology and disease, but according to the African perspective, the cause is thought to exist outside of a person's control. In African cultures, control belongs to invisible beings such as God, the ancestors, and/or spirits (Santino, 1985). According to Hammond-Tooke (1989), the spirits of the departed are believed to look after the best interests of their descendants but, at the same time, can also send them illness and misfortune when moved to wrath. Abnormal behaviours such as alcoholism, drug abuse and addiction, constant and unresolved conflicts in relationships, and women's barrenness, to name but a few, are attributed to external forces. Since the spiritual dimension foregrounds African existence, the ancestors play a critical role in people's lives. The ancestors, who are known to be people who once lived, are able to provide guidance and healing to those still in the earthly dimension. They are referred to as *baholo* (in Sesotho) or *abantu abadala* in the Nguni languages. The ancestors are thus the ancients with whom life is shared. You may not be familiar with the terms *baholo/abantu abadala* because the commonly used words these days are:

- *Midzimu* (TshiVenda)
- *Badimo* (Sesotho languages)
- *Iminyanya* (isiXhosa)
- *Amadlozi* (isiZulu)

Task 1

In a discussion forum on myUnisa with your e-Tutor, reflect with your peers how these terms are defined in your own language.

NB: Please note that it is compulsory for you to have these discussions.

An important aspect to note, is how the speakers of isiZulu also refer to *amadlozi* as *abaphansi* (those who reside below the surface). That concept draws from the same understanding that life is like a seed – it emerges from the ground. It also means that, in African cosmology, the ancestors are like roots to which those who are still on the earthly plane, are attached. The view is that any detachment from the roots cause will illnesses of a "mental-spiritual" nature – we use this term for lack of an expression of the interconnectedness between the mental and spiritual realms. According to Nwoye (2015), mental illness is not just seen as an illness, but also as a carrier of messages that must first be decoded. This means that when the elders are faced with abnormal behaviour, they look beyond the presenting problem.

3.3 African epistemologies in relation to mental disorders

The concept of *umntu/motho/muthu*

The traditional African perspective takes a holistic view of wellbeing, in that minimal distinction is made between physical and mental functioning. There is a strong belief in the unity of spirit, mind, and matter. This implies that, in terms of this perspective, the physical and psychosocial systems are interconnected, and changes in one system inevitably bring about changes in all others. Traditional African views on illness, mental illness, and health in general are therefore holistic, and cosmological in emphasis. Africans do not distinguish between the individual and the group, and recognise that social factors play a major role in the causation, maintenance, or cure of abnormality.

Traditionally, Africans believe that mental disorders occur with a particular intention, and that the causes can be identified (Beuster, 1997). Within the African perspective, disorders are grouped into two categories, in line with their perceived causal factors. A distinction is made between *umkhuhlane* (diseases/infections caused by natural factors) and *ukufa kwabantu* (disorders caused by supernatural factors or the ancestors).

These disorders are “diseases of the African people” – in other words, the diseases and symptoms are associated with Africans, and their interpretation is bound up with African views on health and disease. Such diseases can best be explained by animistic theories which ascribe disorders to the dissatisfaction or anger of some personalised, supernatural agent such as a spirit, god, or ancestor. This is expressed in the sayings *abaphansi basifulathele* and *badimo ba re furaletse*, which mean that the ancestral spirits have withdrawn their protection. *Ukuthwasa* refers to a “creative illness” following the calling by the ancestral spirits to become a diviner, or to a religious conversion experience (Murdock et al., 1980, p. 19, cited in Vilakazi, 1997).

Badimo (Sesotho) or *amadlozi* (isiZulu) are the living spirits of the deceased. The ancestors are believed to be benevolent creatures that preserve the honour, traditions, and good name of a tribe. They invariably play a significant role in maintaining mental health, as they protect against evil and destructive forces. According to African beliefs, ancestors are “like angels” who serve as intermediaries between the people and their creator (God). The ancestors maintain intimate relationships with their families, and their primary concern is the welfare of their descendants (Ngubane, 1977).

The ancestors punish their kin in situations where they are disappointed or angered. The disorder or misfortune sent by the ancestors serves as a warning to amend one’s behaviour and follow the culturally prescribed code of conduct. The ancestors also cause mental and physical suffering if important rituals and customs concerning critical life events are either neglected or incorrectly carried out.

To avoid punishment, extensive birth, initiation, marriage and death rites must be performed (Beuster, 1997). These rites were prescribed in the distant past by African people who trusted in, and were grateful to, their ancestors. It is still believed that if these rites are not performed, the spirits of the ancestors will show their disapproval in no uncertain terms through visitations on their offspring, which may take the form of ill health, misfortune, a lack of material resources, or even the death of a family member (Gumede, 1990).

The ancestors also make demands on their kin in that they have to be appeased regularly through offerings of animal sacrifices and sorghum beer. They also need to be informed of new developments in the family. If the demands of the ancestors are ignored protection will be withdrawn, and physical or mental disorders can occur. Since the ancestral spirits are believed to play a significant role in the causation of illness, it is also believed that they, and God, have the strength to decide whether or not to cure someone (Gumede, 1990).

Traditional Africans believe that malicious people such as witches and sorcerers can cause mental disorders, via supernatural means. These types of disorder can best be explained by magical theories which attribute mental disorders to the covert actions of malice and jealousy on the part of humans, who magically cause injury through sorcery and witchcraft. *Idliso/sejeso* refers to poisoning which is attributed to sorcery.

The African understanding of illness is based on how Africans conceptualise *umntu/motho* which we earlier defined as being not just a biological denotation, but that which is earthed by spiritual forces and guided through life by the cultural prescripts of *isintu*. Every human being has relatives, living or dead. Every human being encounters and experiences nature in some way, be it as rain, trees, or the like. No one is an island entire of him/herself. As the Basotho say, *motho ke motho ka batho* (I am because we are), or “a person exists because others exist”. A person is viewed in terms of the whole of his/her community; priority is thus given to interpersonal relations. Let us revisit the *ubuntu* concept of *Umntu ngumtu ngabantu* (Nguni) and *Muthu ndi muthu nga vhathu*

(Tshivenda), which mean “I am because we are, and since we are, therefore I am”, to re-emphasise the critical role the community is expected to play in the wellness of its members. Thus, in principle, the community is responsible for the wellbeing of all its members.

From an African perspective, conflicts in interrelationships, killing animals that the community consider sacred, or cutting down sacred trees may cause an individual, family or community some health problems. A psychologically unhealthy person is therefore that individual who lives in disharmony with the forces of nature. From a traditional African perspective, ill health is manifested in physical disease (microbiological infection) or psychological-mental illness, as well as a breakdown in the social and spiritual mechanisms of the individual and the community. The interconnectedness of the natural and unnatural phenomena world and spirituality are two significant aspects of the traditional African worldview which deals with ill health, the causes thereof, and healing. Ill health, from an African perspective, accrues from multiple reasons (mostly external). These external causes identify humans, the supernatural and ancestral spirits as agents of disease of various kinds. According to Sogolo (1993), if an African is involved in an adulterous act with his brother’s wife, whether or not this act is detected, he undergoes stress which disturbs his social harmony. If he cheats his neighbour, is cruel to his family or offends his community, the anxiety that follows may take the form of phobias, as a result of bewitchment or an affliction with some disease. According to the Sotho people, a widow who fails to carry out cultural prescriptions – not wearing mourning clothes for a prescribed period of time, not avoiding contact with men during a prescribed period, and coming home late after sunset before a prescribed mourning period has elapsed (*ho bula thapo*) – is bound to suffer from a physical condition called *mashwa*. *Mashwa* is also a general label used for any disorder with bodily manifestations, which are assumed to have at least a partial cognitive and emotional aetiology, that is, bodily manifestations that are to some extent psychological in Western terminology. For example, the guilt and worries of not adhering to these cultural norms will make the individual sick, either mentally or physically, or both. In a nutshell, the interconnectedness of the phenomenal and spiritual worlds (discussed above) conceptualises psychopathology from the perspective of

psycho-behavioural modalities such as collectiveness, sameness, and commonality. The ethos of this view rests on ensuring survival for the tribe, and the individual being one with nature.

For interest: Covid-19 has put the world at risk of complicated or prolonged grief (Goveas & Shear, 2021; Johns et al., 2020; Tang et al., 2021). For instance, due to the enacted regulations, people could not perform death-related cultural practices on their loved ones, or properly bury a deceased. Many of the traditional ways in which people grieve were denied them, and the bereaved were left without the option of creating new experiences and social connections after a loss. This not only tampered with traditional grieving processes, but also made it difficult for families to find closure.

Task 2

In a discussion forum on myUnisa with your e-Tutor, reflect with your peers on psychopathology and think of other examples of psychopathology that may arise from pandemics or universal stressors.

NB: Please note that it is compulsory for you to have these discussions.

3.4 Models that explain abnormal behaviour

Causes of illness

In lands that have undergone colonial disruptions, it is not uncommon to have a society subjected to energy imbalances that cause illness. As alluded to in the preceding sections, colonisation resulted in cultural misorientation, which affected people's personalities and ways of relating to themselves and others. The societal changes that the colonisers imposed caused a misalignment with which the colonised are still grappling to this day. Their altered ways of life have forced them to exist in dissonance (see earlier reference to the double consciousness affect *isemo/semo sabo* – their psychological state). As such, many have resorted to unhealthy behaviours that numb their feelings of misalignment. Their relationship with materiality, food, and those around them has been

disrupted. Arguably, that is the reason for many of the illnesses prevalent in today's society. Colonialism distorted indigenous people's relationship with their bodies and their communities. Their bodies were suddenly portrayed as sources of labour and symbols of everything bad (their skin colour determined their position in society). Their relations with the community became increasingly individualistic, mirroring the Western lifestyle. According to Manganyi (1973), these changes also led to an altered value system. Black people started to adopt a materialistic approach to objects (an approach which is typical of individualistic societies). The relationship to materialism, which was imposed by colonial individualism, was not deemed healthy for black people, who were deprived of many privileges. As Manganyi (1973) states, under normal conditions, people relate to material objects based on both their attractiveness and utility value, but this is violated when those people have been robbed of their dignity, self-respect, and spirituality. Their sense of being-in-the-world-with-objects becomes distorted, and they tend to validate themselves in terms of (external) possessions. Naim Akbar (1981) expands on this notion, stating that this evaluation of material wealth and worth in terms of material possessions are indications of the assimilation of the Western value system, and a denial of historical factors which have led to people's dehumanisation. Another consequence of being a dehumanised subject is what Akbar (1981) coins "anti-self-attitude". This describes the attitude displayed by individuals who are motivated by the desire for approval from the white population. Their behaviour is mainly influenced by this desire, and their standards are based on what is deemed acceptable by white society. Notably, they tend to be more critical of members of their own population group. Another important consequence of being dehumanised, is self-destructiveness. According to Akbar (1981), this entails engaging in self-defeating activities, resulting from the frustrations of existing in a systematically oppressive society. Behaviours such as substance abuse and criminal activities could be associated with individuals suffering from self-destructiveness.

Colonial dehumanisation has even resulted in a distorted understanding of what is fundamentally wrong. Often, illnesses are perceived from a surface level, and symptoms are treated, instead of dealing with the source. African cosmology is founded on the total healing of the environment that permeates illnesses, not just the symptoms of the illness.

3.4.1 Healing: *Ukuva/Ho utlwa*

Africans believe illness is a consequence of disharmony, resulting from a misalignment between the body and the psyche. In the healing process, efforts are focused on realigning the person to his/her whole self. This realignment centres on the sense called *ukuva/ho utlwa*, which can be loosely translated as 'to hear', but it is more about feeling than audition; hence feelings are referred to as *maikutlo* (Sesotho) or *imizwa* (isiZulu). *Maikutlo/imizwa* (feelings) are defined as that which you hear/feel when listening to your psyche/soul, or that which your psyche/soul communicates with you. As such, Africans encourage people to take time to *ukuzimamela* (isiXhosa) or *o aimamela* (Sesotho), which means taking time to listen to oneself. This is a diagnostic activity and an illustration that African Psychology is embedded in culture. In African cosmology, a healthy person is expected to be in conversation with his/her psyche/soul at all times. Hence, when someone is not feeling well, they say *andiziva kakuhle/ha ke ikutlwe hantle*, meaning something has interrupted the connection between the individual and his/her psyche/soul. Healing involves returning a person to the state of *ukuziva kakuhle*, which involves hearing oneself again, or realigning one's body to one's psyche/soul. We wish to clarify that African spirituality is not delinked from the body. As mentioned earlier, the body is simply the physical part of the spirit, since *ukumila* is essence immersing itself with flesh.

The realignment of the body with the soul necessitates the involvement of the whole family, including one's ancestors. This is usually achieved through family/clan-specific rituals, as each clan is believed to carry its own medicine, dispensed through its own unique rituals. Only when the matter is beyond the comprehension of the family, are diviners consulted.

Ukuva/ho utlwa is an all-encompassing sense, as is evident in the use of the term to describe various other senses such as taste, hearing, and physical sensation. This means that African cosmology requires a person to be in touch with the inner conversation with which the psyche/soul is constantly engaged.

Members of South African black communities often experience an unusual problem during episodes of illness: they are faced with a choice between consulting a Western or a traditional health care system, or some combination of the two. Urbanisation, industrialisation and other social forces have brought about a more rational and individualised lifestyle which, in many ways, contrasts with Africans' group-oriented, traditional lifestyle (Vilakazi, 1997). This dramatic change has resulted in experiences of uncertainty, confusion and conflict about whether to follow Western or traditional approaches to healing. The problem of choice is often worsened by deficiencies in (and the associated inability of) the modern health care system to solve prevalent health problems. People therefore often turn to the traditional health care system as an alternative (Staugaard, 1991). The Western approach is disease oriented, thus a patient who adopts this approach is inclined to focus on the symptoms, and consequently places less emphasis on social issues; s/he is also more rational and makes decisions on his/her own, without needing consensus or support from family members. The traditional approach, by contrast, is socially oriented in its interpretation of health and illness, and requires consensus among all concerned about what constitutes both health, and abnormal symptoms/signs (Helms, 1990, as cited in Vilakazi, 1997). In a multicultural society such as South Africa, the challenge facing many therapists is how to work with people from diverse cultural backgrounds. As most mainstream psychology is based on Western philosophy and principles, how would you, as a Western-trained therapist, treat a culturally different client who believes that (a) his/her mental problems are due to spirit possession, (b) only a traditional healer with supernatural powers can deal with the problem, and (c) a cure can be effected via a formal ritual and a journey into the spirit world?

As an example, Draguns and Tanaka-Matsumi (2003) suggest that the African population exhibits depressed states via general physical complaints. That is, African patients frequently present with symptoms of pain, to communicate their depressed state. Depending on the cultural influences in operation, depression is often reported as a psychological representation (e.g., guilt) or a physical complaint (e.g., a headache) (Trujillo, 2008). Discussing deep-seated emotional trauma is perceived to be threatening

for many African patients. The discomfort of sharing private experiences with an outsider in an unfamiliar venue leaves the patient feeling vulnerable. Often, presenting somatic complaints appears to be less threatening, because the symptoms are related to the outer self (Draguns & Tanaka-Matsumi, 2003). While these dynamics may be true for many patients in general, one wonders about the difficulty some African patients experience in dealing with the woundedness of the inner world.

This leads to a discussion on the concept of empathy, which is the ability to understand and share the feelings of others. It begins with mirroring behaviours, such as yawning when someone else yawns, or feeling sad or happy in the presence of others who express these emotions strongly. When empathy expands to feeling another person's feelings as if they were your own, this, in turn, encourages sharing and generosity, ultimately resulting in a more equitable distribution of food and resources within a group. From an African perspective, empathy is derived from the word *ukuva*, and *ukuvelana* is taken to move beyond empathy as it is understood in the Western worldview to encompass the reciprocal, with such reciprocity being communicated by the suffix '-ana'. It not only requires the therapist to put him/herself in the client's shoes, but to become *umntu* (that person). That means, as therapists we are in conversation with the people and everything they bring to the table. The healing relationship is not hierarchical: as a therapist you are not just the expert bringing the healing, but the situation engulfs you, and you come to understand the client's situation from his/her level. In our healing, a healer is on a constant frequency of humility, because s/he needs to be within reach of those whom s/he is called to serve.

3.4.2 Misconceptions about illness and African healing

Colonial demonisation and distortions of African cultures have resulted in many misconceptions about African people's conceptualisations of illness and healing. Much of what passes for indigenous knowledge on these subjects, is in fact a distortion. For example, some scholars believe in the concept of "angry ancestors" who punish their kin

by sending out illness and disharmony. Such myths have unfortunately been adopted as truths by many indigenous people. With the culture of commodification, where indigenous healing has been turned into a money-making business, many indigenous people fall into the trap of spending vast sums of money on practices meant to appease the “angry ancestors”. This has led to the further demonisation of African practices. For that reason, it is important to be cautious about any information which is disseminated on indigenous healing practices.

Individuals are carriers of culture, and their behaviour and interaction with others are influenced by the beliefs, customs, thought patterns and symbolism of their community (Schlebusch et al., 1990). As such, individuals have to be viewed within their cultural context. All individuals exist in their own cultures, with their own cultural backgrounds, and thus tend to see things against that background. Culture therefore acts as a filter not only when we perceive things, but also when we are thinking about (and interpreting) events. All cultures experience psychopathology (Draguns & Tanaka-Matsumi, 2003). In mental health, an understanding of culture is critical for accurate and complete diagnoses, as well as psychiatric treatment. This is because psychopathology and culture are intertwined (Sam & Moreira, 2012). People gain insight into how to build systems to process and integrate psychological suffering as a result of culture.

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