

A Southern African-centred account of mental disorder

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In this article, the author propose and argue for a Southern African-centred account of mental disorder that defines this mental condition in both evaluative and causal terms. It argues that mental illness must be understood through value judgements and primary causal factors. According to this account, for a condition to qualify as a mental disorder, it must meet three individually necessary and together sufficient criteria: (1) it must affect the mental state of an individual (beyond normal emotional responses), (2) it must be evaluated negatively by both an individual and the community and (3) there must be an identifiable non-physical cause(s).

Contribution: This article proposes a Southern African account of mental disorder, understood as a pathological condition, that differs from existing theories of disease, namely naturalism, normativism and hybridism in the philosophy of medicine. It draws on the cultural perspective of *amafufunyana* within the Southern African context and explores the implications of this account for consultation practice.

Keywords: Southern Africa; evaluative; non-physical causes; community; individual; mental disorder.

Introduction

How we should conceptualise the concept of disease is an important question pervasive in the philosophy of medicine. How this concept is understood has social, economic and political implications. For instance, if a person can qualify for medical insurance, social assistance, legal prosecution and so forth (Cooper 2002; Reznek 1987; Smart 2016). Whilst most commentators have proposed their conceptual analyses of disease designed to hold ubiquitously, it is worth noting that the semantic content of the concept can vary from one context to another (Fagerberg 2023).

The conceptual accounts that attempt to define concept of disease fall into several categories. Crudely, these are naturalism, normativism and hybridism. These accounts are considered by their authors as universally applicable because they provide a comprehensive conceptual analysis of health and disease for medicine. However, I contend that their analysis may not be suitable for every pathological condition,¹ and a prime example is mental illness (or mental disorder – I use these interchangeably henceforth), particularly in a Southern African context.² Importantly, this is one of the key aspects this article aims to demonstrate.

In the philosophy of medicine, conceptual analyses are typically descriptive, aiming to explain what a disease is rather than what it ought to be. As Smart (2023:194) notes, this approach 'helps us identify conditions that are mistakenly considered diseases' as well as those that are genuinely pathological. I adopt a similar descriptive approach, focusing on articulating a Southern African account of disease. This is not to suggest that such a conception should be adopted in clinical practice, but rather to highlight that the concept of disease is culturally relative.

In this article, I propose and argue for a Southern African-centred account of mental disorder that defines this mental state in normative and causal terms. This account argues that we must consider value judgements and the primary causal element/component when categorising conditions as

1. Pathological states are negative medical states, and these include both bodily and mental conditions (Reznek 1987). In philosophical and medical usage, 'it has become usual to use "disease" to refer to all pathological conditions' (Cooper 2002:263).

2. I acknowledge that a Southern African context is culturally rich and has several cultural traditions. As such, the account provided in this article should not be taken to apply to every cultural group, and I mostly draw the views from a Nguni culture.

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mental disorders. According to this account, for a condition to qualify as a mental disorder, it must meet three individually necessary and together sufficient criteria: (1) it must affect the mental state of an individual (beyond normal emotional responses), (2) it must be evaluated negatively by both an individual and the community and (3) there must be an identifiable non-physical cause(s).³

The significance of this proposal is that it clearly articulates how the concept of disease, that is, by examining mental illness, is viewed and understood in a Southern African cultural context, highlighting the importance of not fixating on naturalist, normativist and hybrid accounts in the philosophy of medicine. In this respect, I acknowledge that the literature contains numerous accounts of disease beyond these mentioned, such as Fagerberg's (2025) domino theory of disease. However, I consider only the historically influential accounts alluded to here to be relevant, and consequently, I examine a proposed account only in relation to the naturalist, normativist and hybrid accounts later in this article.

There is a limitation to this kind of proposal in that it is intentionally limited to a Southern African cultural context, especially their cultural perspective of *amafufunyana*,⁴ avoiding any attempt to extend its findings to other African cultural contexts, such as those in Western, Eastern or Northern African cultural contexts. In my viewpoint, this prevents the problematic generalisation of African notions of mental disorder without considering the essential cultural nuances. Of course, I acknowledge that existent, past and future concepts of mental disorder, and indeed of disease in general, may differ substantially and be large in number.

To outline this article's sections, firstly, I explore a Southern African cultural perspective on the common causes, method of diagnosis, symptoms and treatment of *amafufunyana*. The advanced account is extracted from this cultural viewpoint. Secondly, I examine a Southern African-centred account, focusing on its value judgement criterion and the primary causal element. Thirdly, I present a potential objection to the Southern African-centred account of mental disorder and offer a response. Fourthly, I expand a perspective that a Southern African-centred account cannot be viewed as a form of naturalism, normativism or hybridism. Instead, I contend that a Southern African-centred account is a value-laden and spiritual causal account. Finally, I outline some of the possible implication of this account on the practice of consultation.

3. Non-physical causes are primary causal entities, such as spirits, deities, witchcraft and other stress-induced phenomena.

4. *Amafufunyana* 'is a serious [mental] disorder described among Zulus and Xhosas' (News24 2004). I acknowledge that *amafufunyana* represents only one of many culturally significant mental conditions in the Southern African context. Other culturally embedded conditions, such as *esenyama*, a form of psychological dysfunction (Sodi 2009), also exist. However, I focus on *amafufunyana* for the purpose of developing the account proposed in this article.

Research methods and design

A Southern African cultural perspective on the causes, method of diagnosis, symptoms and treatment of *amafufunyana*

Before I present a proposed Southern African-centred account of mental disorder, with its value judgement criterion and primary causal component, I consider the causes, method of diagnosis and treatment approaches for *amafufunyana* from a Southern African cultural perspective from which this account is extracted. According to Molot (2017 in Ngubane & De Gama 2024:4), culture significantly influences the 'explanation of mental disorders; viz., causes, diagnostic methods, and treatment approaches in traditional healing practices'.

Causes of *amafufunyana*

From a Southern African cultural perspective, the common causes of *amafufunyana* are believed to be ancestral calling and witchcraft (Ngubane & De Gama 2024:8). This view suggests that this mental disorder is often attributed to supernatural causes, such as ancestors calling an individual to become a Traditional Health Practitioner (THP). However, this does not exclude other non-supernatural causes, such as substance abuse, confusion and stress-related factors. It is simply a prevalent cultural belief in a Southern African context that *amafufunyana* often has a supernatural causal factor, which is based on the experiences of THPs and patients.

I believe a key reason for not considering non-spiritual causes as common causes is the belief that these causes are, according to traditional healers, themselves influenced by ancestors or witchcraft. For example, an individual affected by witchcraft might be said to be possessed by evil spirits, which increases their likelihood of substance abuse. As such, this justifies traditional healers' focus on spiritual causal factors, which are believed to influence all aspects of an individual's mental condition.

Traditional method of diagnosis

The method of diagnosis commonly used by THPs is divination, which involves consultation with the ancestors. As one THP explains, 'You first consult with ancestors, and that is where you will get the answers and how you need to help your patient' (Ngubane & De Gama 2024:9). In this process, the THP seeks guidance from the ancestors regarding the patient's mental disorder, particularly on how to help them. A key part of this process is that a THP throws 'a set of objects (*tinkhlolo*) onto a grass mat', and the THP 'reads' these objects when they are on the mat to infer the divine meaning (Thornton 2009:23).

Common symptoms of *amafufunyana*

According to a Southern African cultural perspective, common symptoms of *amafufunyana* include hallucinations, aggression, speech difficulties, unresponsiveness, incoherence and hysterical screams (Ngubane & De Gama 2024:9,10).

Treatment approaches

Treatment approaches for *amafufunyana* typically include inhalation, drinking herbal remedies, induced vomiting and enemas (Ngubane & De Gama 2024). Traditional medicine used in these treatments is harvested from the forest and prepared according to ancestral guidance. Traditional Health Practitioners often have dreams where they are shown the locations of these herbs and how to use them effectively (Thornton 2009:25). These treatment approaches are aimed at addressing both non-physical and physical causes, such as witchcraft, substance abuse and confusion.

A possible question may arise regarding how treatment approaches can address non-physical (or spiritual) causes like witchcraft, especially when the treatments are physically administered by someone afflicted with *amafufunyana*. In response to this question, in the African metaphysical thinking, the universe is viewed as an interconnected web of entities, including nature, humans and spirits (Dime 1995). These entities influence one another, meaning that events in the spiritual realm can impact human beings and nature, and vice versa. In other words, in this relational universe, any change in one entity can affect the other entities.

Simply put, when a person afflicted with *amafufunyana* consumes herbal remedies provided by a THP, the physical act of drinking these herbal remedies can affect the evil spirits that are believed to have possessed a person due to witchcraft. In other words, the herbs are thought to affect the spirits within the spiritual realm. From a Southern African perspective on causation, this process is explainable in non-mechanistic terms.

In sum, a Southern African cultural perspective on the cause, diagnosis, symptoms and treatment of *amafufunyana* highlights the central role of non-physical entities, particularly ancestors and witchcraft. *Amafufunyana* is commonly attributed to ancestral influence or witchcraft. Diagnosis typically involves divination, a form of communication between the THP and the ancestors. Finally, treatment approaches, primarily using traditional medicinal herbs, are guided by ancestral instructions.

As it will become clear, a Southern African-centred account of mental disorder incorporates the central role of non-physical causal entities into its understanding of what constitutes a mental illness.

Results

A Southern African-centred account of mental disorder

A Southern African-centred account of mental disorder proposed in this article defines this condition using evaluative and causal terms. According to this account, a mental disorder is a state disvalued by both an individual and the community, and it involves at least one non-physical causal factor, such as spirits, deities, witchcraft and other stress-induced phenomena.

This implies that this account incorporates value judgements and considers the primary causal element when defining mental disorder. These aspects are both necessary conditions for mental illness.

Value judgement

The value judgement criterion suggests that normative considerations are essential in conceptualising mental disorder; specifically, a condition must be evaluated negatively by both an individual and the community if it is to count as a mental disorder.

An individual afflicted by mental disorders, such as depression, bipolar disorder, post-traumatic stress disorder (PTSD), neurodevelopmental disorders or schizophrenia, typically experiences significant distress. For example, someone with schizophrenia may suffer from 'persistent delusions, hallucinations, disorganised thinking, highly disorganised behaviour, or extreme agitation' (World Health Organization 2002). These symptoms disrupt their daily life, making the condition clearly unpleasant for the individual. Unsurprisingly, some have argued that for a condition to be considered a mental disorder, it must be evaluatively judged by an individual as an undesirable mental state, such as Rachel Cooper in her 2002 article.

Furthermore, an individual with a mental disorder should be normatively viewed by the community as having a negative mental condition. This aligns with Wakefield's (1992:374) value criterion, which is a 'value term referring to the consequences that occur to the person because of the dysfunction and are deemed negative by sociocultural standards'.

These evaluative considerations form the value judgement criterion of a Southern African-centred account of mental disorder. Essentially, a mental illness must be disvalued by an individual who is afflicted, and the community (as opposed to society at large) must view the condition as harmful. I speak more about why both an individual's and their community's perspectives are considered shortly.

Primary causal element

Primary causation emphasises the need to consider non-physical causal entities when conceptualising mental disorder. These entities include factors such as spirits, witchcraft, deities and stress-induced factors in understanding the causation of mental illness. For example, when examining an individual with *amafufunyana*, it is important to consider the potential role of witchcraft and ancestral calling as possible causal factors.

This component is essential to understanding the causation of mental disorder, as it identifies the causal factors leading to an individual experiencing a disvalued mental illness, such as *amafufunyana*. According to a Southern African-centred account, a mental condition is considered a mental

disorder if it is disvalued by both an individual and the community, and also primary causal factors should be taken into account.

African metaphysics and African view on causation constitute and underpin the primary causal component.

I contend that the primary causal component is constituted and underpinned by African metaphysical thinking and perspectives on causation. This element adopts an interconnected conception of the universe, viewing it as composed of interconnected entities, including nature, human beings and transcendent spirits (Dime 1995). This means that this element acknowledges that physical reality is unified and comprehensive, requiring consideration of all its components when identifying the causes of mental disorders. For example, in diagnosing the cause of a mental disorder, we must recognise the relational nature of the universe, which may include the influence of transcendent spirits.

The primary causal component uses a teleological perspective on causation (Teffo & Roux 2003), suggesting that a mental illness has an underlying purpose or aim driven by ancestors or deities, such as destabilising an individual's life. This implies that no mental disorder is random; each serves a specific purpose. For example, a mental illness affecting an individual can be understood as serving a purpose that necessitates appeasing the ancestors.

The causal element employs one basic notion of causality: primary cause instead of secondary cause. Primary causes are factors explained in non-physical terms, such as witchcraft, transcendent spirits, deities and other stress-induced factors (Sogolo 2003). When identifying causes of a mental illness, it prioritises these primary causal factors, reflecting the traditional African perspective that emphasises them (Teffo & Roux 2003:197).

A relational conception of the universe, a teleologically oriented view of causation and a primary idea of causality constitute and underpin the primary causal component of a Southern African-centred account of mental disorder. These aspects form the background for understanding causation, requiring their consideration to fully grasp the causes of a mental disorder according to the primary causal element.

From my standpoint, this account effectively accommodates a Southern African cultural perspective of *amafufunyana*, which has an influence on the perceived common causes, symptoms, diagnostic methods and treatment approaches of this condition.

The three necessary and sufficient criteria

A Southern African-centred account of mental disorder can be formally stated as saying that for a condition to be considered a mental illness, it must meet three individually necessary and together sufficient criteria, namely:

It must affect the mental state of an individual (beyond normal emotional reaction)

A mental disorder must significantly alter an individual's mental state, beyond 'normal emotional reactions', placing them in a worse condition compared to their previous, healthier mental state. For example, someone with depression experiences a decline in mental well-being, making it difficult to perform their usual daily activities.

This criterion separates this harmful state from other conditions that afflict an individual with identifiable spiritual cause(s), such as male infertility or general misfortune (such as losing a bet or being made redundant). The 'beyond normal emotional reaction' qualifier is necessary, since losing bets and being made redundant will of course affect one's mental state – though not necessarily to the level of disorder.

It must be evaluated negatively by both an individual and the community

A mental disorder must be negatively assessed by both an individual and the community. An individual views the condition as unpleasant or harmful, wishing to be in a better mental state. The community also deems the condition undesirable, especially when comparing the afflicted individual to those who are not. Thus, it is not enough for the condition to be unpleasant for an individual; the community must also consider it a negative mental state.

The idea that both an individual and the community should agree in evaluating a condition negatively reflects the African moral concept of *ubuntu* in a Southern African context.

According to Mugumbate and Nyanguru (2013:83), *ubuntu* emphasises 'being human through other people' and is encapsulated in the phrase, 'I am because of who we all are'. As such, this agreement is rooted in the collective understanding that individuals with mental disorders do not see themselves in isolation but in relation to the community (or others). Given that an African individual's identity is comprised relationally, a condition harmful to them is harmful to their community.

The concept of community is grounded in the dominant moral framework prevalent in the Southern African context. It reflects a shared evaluative practice rooted in a communitarian ontology that understands 'being' in relational terms. Within this framework, mental disorder (as a form of disease) is 'understood within a relational context as the disruption of social and cosmic harmony' (Tosam 2025:35).

There must be an identifiable non-physical cause(s)

The adverse mental condition must have an identifiable non-physical cause(s). Non-physical causes may include ancestors, spirits, witchcraft and other stress-induced phenomena.

It was shown that these non-physical causal factors cannot be explained in mechanistic terms (Sogolo 2003) and are a primary focus in African thought, especially when explaining causation (Teffo & Roux 2003).

These are evident in a Southern African cultural perspective of *amafufunyana*, where the common causes are believed to be non-physical, e.g. witchcraft and ancestral calling (Ngubane & De Gama 2024). Traditional Health Practitioners focus primarily on these spiritual causes, which cannot be explained in mechanistic terms. Though present, non-physical causes are seen as influenced by spiritual causal factors, such as confusion caused by ancestral influence. Thus, spiritual causes are considered to significantly impact all aspects of a person's afflictions, including the physical causal factors.

This clarifies the intent of this criterion that it also acknowledges that mental health disorders with possible physical causes, such as depression, neurodevelopmental disorders and PTSD, are mental illnesses. However, physical causes are excluded from this criterion because of the THPs' primary focus on non-physical causes, especially when treating mental health disorders like *amafufunyana*. In the Southern African tradition, these physical causes are themselves taken to be influenced by spiritual forces. Ultimately, this aims to prevent a dangerous viewpoint that suggests that mental illnesses without non-physical causes are not mental health disorders.

The scope and necessity of non-physical criteria within a Southern African-centred account is to recognise that, in the South African context, certain mental disorders, such as *amafufunyana*, are understood as caused by non-physical factors, including ancestors, witchcraft, etc., and should be acknowledged as such. This approach demonstrates that mental illness is not always conceived in purely physical terms (namely, mental dysfunctionality), as is often assumed in mainstream medical theories of disease. I examine these dominant theories, which use purely physiological terms, particularly naturalism and hybridism, later in the article.

According to a Southern African-centred account, a condition must meet all these three criteria to be classified as a mental health disorder. These criteria are individually necessary and together sufficient, meaning that each must be fulfilled for a condition to be considered a mental illness.

Discussion

A Southern African-centred account is a value-laden and spiritual causal account

A form of naturalism?

Can a Southern African-centred account be viewed as a form of naturalism? In my view, it cannot be categorised as naturalism. To support this perspective, I examine a Southern African-centred account in relation to Boorse's (2014) biostatistical theory (BST) and Schwartz's (2007)

frequency and negative consequences (FNC), particularly with respect to how they can conceptualise a mental disorder.

A Southern African-centred account conceptualises mental illness by considering both value judgements and the primary causal element. These are crucial in categorising a condition as a mental disorder. For example, a condition is defined as a mental illness when it is disvalued by both an individual and the community and there is at least one non-physical causal entity, such as ancestors, witchcraft, deities or stress-induced phenomena.

In BST, health and disease are defined in physiological terms (Boorse 2014). When conceptualising mental disorders, this account would focus on the functioning of internal mental mechanisms, particularly whether they operate normally and contribute to survival and reproduction. According to this view, 'the overall aims of the organism are to survive and reproduce, and the different sub-systems function so as to contribute to the attainment of these goals' (Cooper 2002:264). Therefore, a condition is considered a mental illness if these internal mental mechanisms are impaired in their normal functioning and fail to support the organism's natural goals of survival and reproduction.

In Schwartz's FNC account, an additional dimension emerges in defining health and disease: the inclusion of negative consequences resulting from an organ's impaired functional ability (Schwartz 2007).

This account would consider not only the departure from normal functioning, but also the impact of this impairment. It can be contended that when conceptualising a mental disorder, the FNC account would focus on the consequences of impaired mental mechanisms, such as the individual's inability to perform daily activities that require sound mental health.

Given these divergent conceptualisations of mental disorder, I argue that a Southern African-centred account cannot be classified as a form of naturalism. A Southern African-centred account incorporates value judgements and the primary causal element, giving it a normative and spiritualist character. From this perspective, this account can be seen as distinctly anti-naturalist.

A form of normativism?

Can a Southern African-centred account be considered a form of normativism? In my view, it does, but it is not a purely normativist account – involves value judgements, but that is not all.

To support this perspective, I examine a Southern African-centred account in relation to Cooper's tripartite account of disease (TAD), particularly how TAD can conceptualise mental disorder.

In Cooper's normativist account (TAD), health and disease are defined in evaluative terms, meaning that it 'believe[s] our uses of "health" and "disease" [should] reflect value judgements' (Ereshefsky 2009:221). It can be contended that when conceptualising mental illness within this account, it would focus on the evaluative aspects of the condition, particularly whether it is considered undesirable to an individual, if the afflicted person is seen as unfortunate, and whether the condition is potentially medically treatable (Cooper 2002).

Firstly, a mental disorder is detrimental to an individual, in that it is a harmful mental state for a person. However, this condition may not be considered bad by society.

Secondly, a person afflicted by mental illness is considered unlucky because they are worse off compared to the majority of people in (to borrow from Boorse) their reference class. According to Cooper (2002:276), 'unlucky as judged by the uninformed laymen, that is, roughly, worse off than the majority of humans of the same sex and age'.

Finally, a mental disorder should be potentially treatable with medical intervention. This does not imply that a treatment must be immediately available or currently exists, but rather that there is a possibility that effective medical treatments could become available in the future.

Cooper's TAD conceptualisation emphasises the importance of value judgements in defining mental disorder. It suggests that mental illness involves evaluative considerations, such as being inherently negative for the individual. Similarly, a Southern African-centred account also incorporates value judgements when conceptualising mental disorder. Therefore, this shared emphasis on value judgement illustrates how a Southern African-centred account has a normative quality.

However, it cannot be considered a 'pure' form of normativism. Just as Wakefield's account incorporates an additional 'explanatory' criterion to pure normativism, a Southern African-centred account extends beyond value judgements by incorporating the primary causal element into its conceptualisation of mental disorder.

A form of hybridism?

Can a Southern African-centred account be considered a form of traditional (Wakefield's) hybridism? From my perspective, it does insofar as it is a hybrid of several conditions, including a normative component and an explanatory, but Wakefield's naturalist explanatory condition is replaced by a spiritualist explanatory condition.

Jerome Wakefield's disorder as harmful dysfunction (DHD) account defines mental disorders in scientific and value terms. In this account, dysfunction is the 'failure of an internal mechanism to perform its natural function for which it was

designed'. On the other hand, harmful is the 'consequences that occur to the person because of the dysfunction and are deemed negative by sociocultural standards' (Wakefield 1992:374).

This means that in Wakefield's DHD, both physiological and evaluative components are considered in conceptualising mental illness. Similarly, a Southern African-centred account also incorporates value judgements when defining mental disorders. This overlap in considering the normative element suggests that a Southern African-centred account aligns with hybridism in terms of evaluative consideration.

However, a Southern African-centred account cannot be considered a form of hybridism in Wakefield's sense. It extends beyond value judgements and physiological explanation by including the primary causal element (which is essentially spiritual), which Wakefield's hybridism does not account for. If it is a form of hybridism, a Southern African-centred account has a normative component and a spiritual causal component.

It is important to clarify what I mean by the preceding statement, particularly regarding whether this view constitutes a form of hybridism. In the philosophy of medicine, hybridism refers to theories of disease that combine physiological and evaluative elements in defining disease. I have argued that a Southern African-centred account of mental disorder includes evaluative and spiritual components. The inclusion of spiritual elements challenges standard naturalistic and hybrid assumptions, which typically rely on physiological dysfunction and negative value judgements.

In this account, spiritual factors are incorporated to explain mental disorders that are not understood as arising solely from physiological causes or evaluative judgements, such as *amafufunyana*. In this sense, the view may be considered hybrid, as it integrates evaluative and spiritual dimensions. More importantly, it broadens the scope of disease theory to accommodate conditions that are conceptually and culturally specific to contexts such as Southern Africa.

A possible implication of this account to consultation

At this point in the article, I believe my Southern African-centred account has been fully developed and substantiated. I now turn to its possible practical implications for consultation, particularly how it can inform this practice. Ultimately, I contend that this account should be considered as an indigenous approach to consultation in the Southern African context.

However, it is important to first illustrate the pivotal normative role of this account, particularly in promoting health and well-being in a Southern African context, where a mental disorder may simultaneously have evaluative and spiritual components. In other words, I emphasise the

significance of viewing a Southern African-centred account of mental disorder as a value-laden and spiritually grounded causal account of mental illness.

The normative component shows how both individuals and communities evaluate a condition such as mental illness. It highlights that an individual disvalues the condition because it leaves them worse off than before, whilst the community similarly views the individual as being in a worse state compared to others who enjoy better health. For example, as noted earlier in this article, a person afflicted with mental illness is perceived as suffering in contrast to healthier members of the community. From my perspective, this is crucial for the effective treatment of mental disorders in psychological practice. Practitioners must understand how individuals and communities conceptualise a condition, as this guides diagnosis and treatment in the right direction. For instance, when practitioners understand how conditions like *amafufunyana* are perceived by both the individual (the sufferer) and the community (the observers), diagnosis and treatment can be carried out in ways that promote the mental health and well-being of both the individual and the community.

It follows: How should a Southern African-centred account of mental disorder be understood as an indigenous approach to consultation? Throughout this article, I have shown that the account draws on a Southern African cultural perspective of *amafufunyana*, particularly in its beliefs about causes, diagnosis and treatment approaches. This viewpoint shows an indigenous perspective about *amafufunyana*, particularly as the indigenous knowledge system consists, amongst many aspects, of traditional culture, healing, medicine and values (Dondolo 2005).

I argue that this account provides the cultural assumptions underlying mental illness within counselling practice. It offers a theoretical framework for consultant interacting with individuals affected by mental illness. Through this framework, consultant gain insight into how mental disorders are understood by both the individual and the broader society, including the spiritual causes of certain conditions, such as *amafufunyana*. This awareness ensures that consultants consider the local context in their practice, leading to more appropriate diagnoses and treatments. For example, in the case of *amafufunyana*, a consultant using this theoretical framework can understand the assumptions that shape how the condition is perceived and thereby determine the most appropriate treatment to promote the mental health and well-being of both individuals and the community. This aligns with Vogel's (2009:182) concept of indigenous psychological practice, which 'arise[s] out of the social and cultural realities – values, concepts, belief systems – of the people concerned', and aims to address the mental health needs of the local context, such as that of Southern Africa.

An anticipated objection

I anticipate an objection that a single culturally specific condition, such as *amafufunyana*, cannot ground a convincing

general account of mental disorder, particularly for consultation practice. This is a serious concern. However, the aim of my proposal is not to generalise indiscriminately from a single case, but to challenge a pervasive assumption in the philosophy of medicine: that diseases can be defined only in purely physiological and/or evaluative terms.

In contexts such as Southern Africa, spiritual elements play a significant role in understanding disease, especially mental disorders. As shown in this article, conditions such as *amafufunyana* are defined in explicitly evaluative and spiritual terms. This suggests that dominant theories of disease may be ill-equipped to account for conditions that are conceptually embedded in particular cultural contexts. My use of *amafufunyana* is therefore illustrative rather than exhaustive; it highlights important conceptual nuances in the disease debate that deserve serious attention. Moreover, practitioners operating in Southern African contexts should be attentive to these nuances to avoid misdiagnosis or inadequate treatment of mental illness. In fact, they should acknowledge that in this context:

... diseases are not merely caused by empirically distinct entities [neurological and behavioural factors], which can be perceived through scientific diagnostic tools, but also have paranormal causes which fall beyond the range of modern scientific, evidence-based, medical logic. (Tosam 2021:256)⁵

In my proposed account, the central focus is on spiritual factors that fall outside modern medicine's scientific and evidence-based model, as well as on the relational understanding of society prevalent in the Southern African context, which grounds the evaluative dimension of the conception of mental disorder.

Conclusion

In this article, I proposed and argued for a novel Southern African-centred account of mental disorder. It defines mental illness using evaluative and causal terms. In this account, a mental disorder is a state that is disvalued by both an individual and the community, and there is at least one non-physical causal factor, such as spirits, deities, witchcraft and other stress-induced phenomena. This account highlights the importance of value judgements and the primary causal element in conceptualising mental disorder.

It was demonstrated that this account can be formally stated as saying that for a state to be deemed a mental illness, it must meet three individually necessary and together sufficient criteria: (1) it must affect the mental condition of an individual (beyond normal emotional reaction), (2) it must be evaluated negatively by both an individual and the community and (3) there must be an identifiable non-physical cause(s).

Furthermore, I demonstrated that a Southern African-centred account cannot be categorised as naturalism, normativism or hybridism, particularly by examining how each approach

⁵Originally, Tosam uses this passage to describe a physical disease condition; however, I believe it also applies to mental disorders.

can conceptualise mental illness in relation to this account. As a result, I argued that it is a value-laden and spiritually causal account.

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CRedit authorship contribution

Nhlakanipho Hlengwa: Conceptualisation, Writing – original draft and Writing – review & editing. The author confirms that this work is entirely their own, has reviewed the article, approved the final version for submission and publication, and takes full responsibility for the integrity of its findings.

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