Mental illness in Culture, *Culture* in Mental illness

An anthropological view from South Africa

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De auteur bespreekt de relatie tussen cultuur en geestesziekte. Hij vraagt aandacht voor het probleem van universalisme versus particularisme waar antropologen mee geconfronteerd worden bij interdisciplinaire studies van psychiatrie. Het thema is misschien niet nieuw, maar de beschouwing komt voort uit de reacties van Zuid-Afrikaanse postgraduate studenten in de medische antropologie die deelnamen aan een onderzoek naar problemen van geestelijke gezondheidszorg. Het interview schema van dit project was puur medisch georiënteerd. Het probleem van universalisme versus particularisme krijgt een nieuw betekenis in de context van de gediscrimineerde stedelijke en rurale gemeenschappen van Zuid Afrika. Diverse voorbeelden van het Afrikaanse continent komen ter sprake.

[geestelijke gezondheidszorg, cultuur, universalisme, particularisme, cultuur-specifieke ziekte]

This paper presents an anthropological understanding of mental illness.[1] The context in which the paper was written, is an on-going interdisciplinary study of service utilisation, barriers to care, and cultural beliefs about mental illness in a historically disadvantaged urban and rural community in South Africa. The aim of this research was to investigate mental health care as it developed in two previously historically disadvantaged communities following the adoption by South Africa in 1994 of the primary health care policy. The paper was prompted by the reaction of post-graduate medical anthropology students on the project to, and discomfort at, the bio-medically driven structured interview schedule, reactions which – given the contribution of medical anthropology to psychiatry – would seem to reflect some broader issues of conceptualisation in interdisciplinary study of this kind which has been on the increase over the decade. At the core of the students' discomfort is the relatively small degree of cultural sensitivity in psychiatry. The rather more 'white-coat' approach to the study of mental illness was seen as problematic by the young black South African post-graduate students of medical anthropology fed on a diet of the theoretical advances made in the discipline to psychiatry. Undoubtedly, with the increasing attention to the mental health system in many parts of the world and its transformation in South Africa, the cultural basis of interventions to promote mental health and reduce the incidence of mental ill-

ness require a culturally sensitive psychiatry. This paper discusses the relationship between culture and mental illness as a theoretical contribution to the study, which is an interdisciplinary effort to fulfilling the needs of the patients and communities for culturally sensitive mental health policy and services. It draws attention to the problem of universalism and particularism faced by anthropologists involved in an interdisciplinary study with psychiatrists. Far from reiterating what has been extensively discussed in the literature, it takes specific examples to illustrate the relationship. The core problem around which the discussion is framed, is presented at the outset.

The issue of universals and particulars

Anthropology is a Janus-faced discipline. It attempts to explain, on one hand, human universals and on the other, cultural particulars. These two sets of demands create tension and it is from this that it derives much of its creativity. Given this tension, mental illness would seem to provide one of the most challenging problems to be dealt with, for it appears to be considered in some quarters in psychiatry, to those who cling to what Littlewood (1991) refers to as the 'old trans-cultural psychiatry', as one of the *true* universals, a pan-cultural fact. Yet, within the supposedly pan-cultural fact, the specific cultural conceptions and symbolizations of mental illness are remarkably diverse. As Kleinman and Goody (1985) suggested, for example, the somatic symptoms of endogenous depression do seem to be universal, however, it does not follow that the name given it, depression, is the appropriate one. What appears to be the case is that in the western culture, the everyday experiences of what is labelled as depression comes to the fore in this illness and, consequently, has become for psychiatrists its most characteristic feature. Further, the diversity of the conceptualisation and symbolization becomes manifest, as an assortment of studies have shown, in the actual treatment of mental illness. This varies enormously from culture to culture, and over different periods in history of particular cultural traditions. We see in the history of psychiatry the constant shifting of the confines of psychiatric conditions. For example, in medieval Europe the cultural schemas of that time structured mental illness around the concepts of demonic possession and witchcraft. Then, the prevailing view of nature and life in general was informed by Christianity. Accordingly, life was seen as a constant struggle between the forces of God and Satan. Thus, in this sense, the mentally ill were culturally schematised as either demonically possessed or the victims of witchcraft. Over time, there was a shift from this conception of mental illness to a disease-centred view, which assumes a strong relationship between the rise of science and the 'true' biological nature of mental illness. Science, in effect, yielded a generalized knowledge concerning fundamental determining conditions for the occurrence of various types of illnesses that fall under mental illness and methods for their treatment. In a much clearer way, the chapter headings of Zilborg's classic *A History of Medical Psychology*,[2] would seem to summarise the shifting conception of mental illness.

Some problems with universalism

The universal 'fact' and the cultural variation constitute problems to be explained. Can one define forms of mental illness – for example, affective disorders or disorders of mood[3] – with criteria that can be assessed in any cultural setting? Or are nosological systems (elements of broader medical system and a still broader total culture – a society's system of ideas, values and ways of doing things [Hahn 1995]) culture-specific or culture-bound, appropriate only to the setting in which they are formulated? These questions are hardly new ones: they arise throughout anthropological enquiry and they will, at any rate, continue to arise not least because of what, as I pointed out in the introduction, has now become a regularity: the meeting of the disciplines of anthropology and psychiatry brought about by the quest for interdisciplinary approach in research work on mental illness. The meeting tends to pose problems for both. For psychiatry, there can be little doubt that there are those psychiatrists, who, in an attempt to emphasise their medical identity, readily would view psychiatry as an objective science focused on the assessment of clearly specified associations among precisely defined variables through measurement. They would be disposed to see less of culture at "medicine's core". To them, there is 'too much culture at the margin of' the nosological scheme of anthropology (Hahn 1995), often regarded as a subjective discipline devoted to understanding the inner worlds of others by means of empathic encounters. These psychiatrists, as Busfield (1986) very rightly observed in her exploration of the history and theory of psychiatry, see themselves as believers in the scientific, rational and human basis of psychiatric work and as purveyors and interpreters of a body of scientific expertise.

Some anthropological comments on universalism and particularism

For anthropology, as many writers have commented, it is a problem of universalism or culture-specificity. As anyone who peruses the literature will notice, the anthropological account of mental illness tends to reflect two of the three broad categories of anthropological theories: the universalist and the particularist. Both and the third category, the comparative (that which seeks to explain the differences between one people and another on the basis of some overarching general principles (Adams 1998) have long co-existed, though in what seems to be a competitive way. The universalist theories – *the Other as Us* – seek to discover and explain what is common to all peoples and the particularist theories – *the Other as not Us* – seek to understand the different qualities of each culture. Yet, in most anthropological accounts, both views are hardly mutually exclusive. This is because, as Hahn (1995: 104) explained, anthropologists speak of *etics* and *emics*. Both are understandings of culture first propounded by Kenneth Pike (1954).[4] Pike used "*etics*" to designate categorical distinctions made by the ethnologist, for example, between law and religion that might have no meaning for members of a given society. "*Emics*" was used to refer to understandings and distinctions meaningful to the members themselves. Since the aim of ethnography is to describe each culture in terms of categories and distinction meaningful to its members (Goodenough 1970),

"*etics*" thus serves as a universal grid that allows them to record their observations in different cultural settings in a search for the *emics* – the set of distinctions that make a difference to people in those settings. *Etics* is an external framework applicable anywhere; *emics* is an internal, local one. The anthropological task, we are told, is to use a universal framework of observation in order to achieve an understanding of the local framework. Anthropologists regard themselves as translators (Hahn 1995). They 'translate' the data collected from social life in a setting in which they immerse themselves for the purpose of understanding. But as pointed out by Leach (1984: 22), somehow echoing psychiatry's charge, "the data which derive from fieldwork are subjective and not objective".

Anthropology meets psychiatry

If this general characterization of the fundamental problems in the psychiatrist's and anthropologist's work and thinking on mental illness is at least crudely correct, then, it is hardly surprising that at the point of contact between the two disciplines, despite the increasing collaboration, there still remains uneasiness sharpened, in no small measure, by their different methods. The psychiatrist's method subscribes to positivism, in turn expressive of the epistemological enterprise of establishing objective knowledge represented as regularities, even laws (Polkinghorne 1983). The entity being researched is treated as an 'object' that can be universalised. The psychiatrist develops instruments and looks for reliable data. The instruments are the standard procedural means by which information on the subjects is collected. The instrument becomes a reliable one if results generated remain constant on repeated examination of the same phenomenon. But for the anthropologist, research is derived from various phenomenological, pragmatic, hermeneutic, critical and postmodernist traditions and the tendency is to stress the particulars of human experience and social life while taking history, language and culture into account. The anthropologist seeks to describe the world of others as it appears to him/her, striving as much as possible not to impose his/her own view. In other words, the anthropologist tries to understand and represent the experience and actions of people as he/she encounters, engages and lives through situations. To achieve this, questionnaires are seldom used because "questionnaires presume that what is relevant to ask about setting can be known in advance" (Hahn 1995: 103). Rather, attempt is made to understand the phenomena under study based as much as possible on the perspectives of those being studied. Anthropologists believe that their self-reflective attempts to 'bracket' existing theory and their own values allow them to understand and represent their informants' experience and actions more adequately than would otherwise be possible.

With this substantial divergence in the methods of psychiatry and anthropology, the discomfort of the anthropology students on the interdisciplinary project would seem clear. They have been trained in generating material for analysis that was not pre-structured according to a model of supposed 'objectivity'. However, the interview schedule that they were supposed to work with, requires that they administer it in homes, with the subject alone, and following specified rules. For them, materials to be

generated must allow for the documentation of multiplicity, variability and indeed contradictions within accounts. They highlighted a number of ambiguities in reading the questionnaire, which was drafted by the project leader, a psychiatrist, during the first of a series of research meetings before the pilot study. For example, there was a question on how often respondents have headache, which the students find unclear because headaches in Xhosa – the language of the respondents – have several meanings. Attempts were made to resolve such ambiguities by the research team, but at the level of text rather than in relation to a broader context, the social setting of the respondents circumscribed by cultural boundary. What this highlights is the uneasiness of the anthropologist when psychiatry 'meets' anthropology. Yet, it has been through this 'meeting' that anthropology has proved itself to be a creative discipline and has been able to provide psychiatry with additional understanding. This understanding is set out in the section that follows.

Psychiatry

Clearly, the practice of medicine has long been based on rigorous biological determinism. Western medicine or biomedicine,[5] which has come to influence the health and healing practices worldwide, is often thought of (in general) as rational and systematic based upon notable empirical evidence and inductive and/or deductive logic. Its nosology is formally classified in the *International Classification of Diseases* (World Health Organization 1978) now in its tenth revision, known as the ICD-10. Included in ICD-10 are places for 999 conditions from "001, cholera" to "999, Complications of Medical Care, Not Elsewhere Classified",' Psychiatric conditions are included between ICD-10 codes 290 and 31, followed by "Diseases of the Nervous System and Sense organs" (from which psychiatric conditions are thus, presumably distinct).

As a speciality that developed within medicine to provide help and treatment for the mentally ill (one group of the sick), psychiatry has a shared framework of beliefs and assumptions with medicine[6] that is generally referred to as the 'medical model'. In this model, the body is seen as a 'series of functioning systems whose efficiency is maintained by homeostatic mechanisms. Sickness or pathology exists when functioning deviates from normal efficient levels (Mishler, Anarasingham, Hauser et al. 1981). Accordingly, mental disorders were thus considered by the psychiatry profession to be caused primarily by "chemical imbalances" in the brain stemming from genetic abnormalities. Reflecting further the dominant characteristics of medicine, mental disorders were conceptualised as brain disease with the same ontological status as diabetes or cancer.[7] This disease-model assumes that the presence of some physical entity, the infectious micro-organism, is the cause of pathological bodily changes and consequently attention is turned to what goes on in the body.

But adopting the medical model has not meant a single universally accepted list of mental illnesses or even modes of classifying them. A case in point is schizophrenia. A look at most typological classifications mention schizophrenia and anxiety states, but there appears to be differences in the precise delineation of these conditions in the glos-

sary. Of course, this is scarcely surprising given the differing theoretical approaches in psychiatry, like any other discipline, and the different ideas about the causes of particular mental illness and also about the precise value and desirable characteristics of classification schemes.

In a recent editorial in the *British Journal of Psychiatry,* (1999) the authors lament the diagnostic confusions stemming from the co-existence of the ICD-10 and DSM-IV: *"in the English-speaking world, psychiatric classification used to be governed by one system, now there are two"* (Andrews, Slade, Peters et al. 1999: 3-5). First and Pincus (1999) share this lament arguing that the introduction of ICD-10 criteria is the main source of confusion among researchers. The ICD uses a typological classification of mental disorders along Kreapelinian lines and aims to achieve an international standardization of diagnostic categories both for statistical and clinical purposes. But there is a considerable reluctance to follow this international schema from the US, which still continues to use the DSM, considered as the *de facto* standard. The reluctance reflects the differences in the criteria sets, which "stem from different conceptual frameworks underlying European *v.* American diagnostic concepts (e.g. in schizo-affective disorder, the American definition relies on the temporal relationship between mood and psychotic symptoms whereas the European definition stresses the relative significance of the mood and psychiatric symptoms)" (First & Pincus 1999: 207). In South Africa, the DSM is the instrument that is used.

Given the difficulty of assessing symptoms of psychiatric pathology in any very precise way and of making diagnostic inferences, would it therefore not be the case that the universality of psychiatric disorder is problematic? Critics of the medical-model psychiatry, perhaps, will not hesitate to answer in the affirmative. After all, they would argue, the labels for mental illness is implicitly western. But does it preclude a commonality within each culture regarding the different mental illnesses? How can one describe conditions described in one system with the conditions described in another? When are two conditions found in different cultural settings equivalent – for example, depression? These questions are all closely related and they are difficult ones brought out sharply in many of the conditions described as psychiatric. In disease-centred psychiatry, for example, depression is an affective disorder, an emotional problem within the individual's psyche. An epidemiological study concluded that "*generalization* of hopelessness . . . forms the central core of depressive order" (Brown & Harris 1978: 235), which, Obeyesekere (1985), in a remarkable way, found rather out-of-the-way. So-called affective psychoses are described as follows:

> Mental disorders, usually recurrent, in which there is a severe disturbance of mood (mostly compounded of depression and anxiety but also manifested as elation and excitement) which is accompanied by one or more of the following: delusions, perplexity, disturbed attitude to self, disorder of perception and behaviour; these are all keeping with the patient's prevailing mood (as are hallucinations when they occur). There is a strong tendency to suicide (World Health Organisation 1978: 29-30).

Within this general heading come the various manic and depressive conditions including manic-depressive psychosis, mania and endogenous depression. Endogenous or

psychotic depression has been distinguished from 'reactive' or neurotic depression partly in terms of aetiology through the presence or absence of precipitating events, such as death in the family, and partly in terms of symptom (Busfield 1986). The symptomatological contrast has been described as follows:

> Hallucinations, delusions, agitation, retardation, weight loss, early morning waking, feeling worse in the morning (diurnal variation), and constipation seem generally to be judged as indicators of psychotic depression. Indicators for neurotic depression have been feeling worse in the evening, crying a great deal, being a worrying type of a person, finding it hard to make decisions, as well as a variety of non-symptom features such as being younger (Brown & Harris 1978: 24).

The attempt at treating this array of mental disorders is based on psychotropic medications. The assumption is that this reversed the effects of a genetically based brain disease leading, as many researchers have pointed out, to conclusions in assessment and diagnosis that were unwarranted. For example, there was, in the case of schizophrenia, the conclusion that complete recovery from it was unlikely if not impossible. But studies have shown this as not necessarily the case; complete recoveries are not unknown in many industrialised societies (Angst 1988; Harding et al. 1987; Mcglashan 1988) and cross-cultural studies show that a complete recovery is possible, and that schizophrenia needs to be conceptualised in a more complex, holistic fashion (Jablenski & Sartorius 1988; Jablensky et al. 1992; Karno & Jenkins 1993; Leff et al. 1992; Sartorius et al. 1986; WHO 1973, 1979).

Attributing mental disorders primarily to diseases in the brain is, in some quarters, now considered rather simplistic and many argue, may be responsible for the limited success obtained from treatment using psychotropic medications, the chance discovery of which transformed psychiatry in the mid-1950s. As some writers have pointed out, the psychotropic medications currently in use treat *symptoms*, not *diseases* (Guttmacher 1994). This is hardly surprising because, while psychiatry adopts the medical assumption of disease entities, mental illnesses are largely distinguished descriptively in terms of symptom syndromes even though aetiological assumptions may be involved in making certain decisions (Busfield 1988). This traditional disease-centred psychiatry is, in many senses, being replaced by a more holistic view of mental disorder as encompassing a highly complex construction of experience and biology involving many factors, with no clear boundaries between mental illness and mental health.[8] The aetiology, structure, course, and outcome of mental disorders are now seen as far more integrated, including social and cultural factors. These factors are said to combine and interact to produce an actual illness experience in a given person (Castillo 1991, 1994, 1995; Fleck 1995; Gaines 1992; Gaw 1993; Good 1992; Hinton & Kleinman 1993; Kleinman 1986, 1988, 1992; Kleinman & Good 1985, Lidz 1994; Littlewood 1991; Lu et al. 1995; Mezzich 1995; Mezzich et al. 1992, 1994; Mezzich, Honda & Kastrup 1994; Mezzich et al. 1996). Nowhere is this better demonstrated than in the official manuals of the American Psychiatric Association known as the DSM – *Diagnostic and Statistical Manual of Mental Disorders* (APA 1952, 1968, 1980, 1994). Here, one is referring to the DSM-IV published in 1994, which is analogous to DSM-II published in 1968.

The DSM-II in fact saw the shift in emphasis from psychological and social etiological factors to the more biological paradigm that occurred following the introduction of lithium and neuroleptic medications in the 1950s and 1960s. By the 1980s the assumption that mental disorders were based 'in brain diseases' took hold in psychiatry culminating in the DSM-III which instituted a descriptive approach to the classification of mental disorders rather than the etiological approach in DSM-I and DSM-II. It was a "defense of the medical model as applied to psychiatric problems", as Spitzer, chairman of the DSM-III Task Force, was quoted saying (Wilson 1993). Underlying the goal of DSM-III was the attempt to provide accurate classifications of mental disorders, in particular, for laboratory researchers looking for discrete brain diseases. But with the uncertainty caused by the discovery of brain plasticity and adaptation, as well as alterations in brain biochemistry resulting from mood changes, the direction changed to looking beyond biology. The inclusion of social and cultural factors in DSM-IV reflects this change in direction. Many writers believe that anthropological studies and theory played a role in the composition of DSM-IV, however minimal (Castillo 1994). It is to the anthropological understanding of mental illness that I turn to in the section that follows immediately.

Mental illness in Culture

Mental illness has long been a subject of the discipline of Anthropology (Marsella 1993). There is a vast anthropological literature on culture and mental illness. It is not my intention to provide a review as I mentioned earlier in the introductory section. Rather, my goal in this section is to look at how mental illness is perceived in various cultures. One could say, that mental illness is, as indeed, the vast literature on it reveals, a complex system of *meanings.* It is, surely, one of the various entities created by various cultures and thus a cultural entity. As Kleinman (1988) has described, cultural meaning systems create cultural entities – that is, objects that exist solely because of the collective social agreement that something counts as that entity. In a broad sense, culture has been defined as the totality of knowledge passed from generation to generation within any given society. It includes language, forms of art and expression, religion, social and political structures, economic systems, legal systems, norms of behaviour, ideas about illness and healing. This body of knowledge is always organized in a systematic fashion so that it can be easily passed on and is internally logical. These systems are referred to as cultural meaning systems (D'Andrade 1984). A cultural meaning system generally structures cognitive reality for an entire society. It allows individuals within a cultural group to represent the world symbolically[9] to themselves and to others. Consequently, people create cultural entities. Accordingly, a cultural entity is something created by the social agreement that something counts as that entity. Cultural meaning systems construct things – things that would not exist without the meaning system that created them, for example, gods.

The culture of a society thus constructs (Berger & Luckmann 1966) the way societal members think and feel about illness and disease. Cognitive schemas are learned

structures of cognition used by individuals to make sense of and construct, to some extent, their experience of the world. Categories of experience are embedded in cultural meaning systems and these vary among societies. In this sense, it is argued, universal categories of experience may be valid in some instances, but not all. For instance, cultural schemas can cognitively construct a particular behaviour as an episode of mental illness, whereas a different set of cultural schemas can cognitively construct a similar behaviour as something normal and normative. For this reason, is it not the case that what counts as mental illness may differ from society to society, and given conditions of mental illness are understood in very different ways? But, again as Hahn (1995) asked: does this mean that mental illness does not have an essence? This is akin to asking whether or not sickness has an essence. For Brody (1987) there is no point in searching for an essence of sickness as "suffering is produced, and alleviated, primarily by the meaning one attaches to one's experience" (1987: 5). He proposes that, instead of seeking a single definition, we look for a loosely connected 'family resemblance' among the variety of phenomena referred to as "sickness". He thus suggested five themes that might connect the members of the family:

1   To be sick is to have something wrong with oneself in a way regarded as abnormal when compared to a suitably chosen reference class.

2   To be sick is to experience both an unpleasant sense of disruption of body and self and a threat to one's integrated personhood.

3   To be sick is to have the sort of thing that medicine, as an evolving craft, has customarily treated.

4   To be sick is to undergo an alteration of one's social roles and relationships in ways that will be influenced by cultural belief systems.

5   To be sick is to participate in a disruption of an integrated hierarchy of natural systems, including one's biological subsystems, oneself as a discrete psychological entity, and the social and cultural systems of which one is a member (Brody 1987: 22 c.f. Hahn 1995).

When one looks closely at the characteristics chosen to distinguish among specific sicknesses (such as symptoms or causal agents), one finds that they are arbitrary and vary among societies and historical periods. But if one were to choose different characteristics, this might lead to different groupings of sickness events (Hahn 1995). As such, Clouser, Culver and Gert (1981), inclined towards the realist position, argued that "there are objective definitional criteria, and that they apply equally to mental and physical conditions" (1981: 29). They note that sickness conditions lie within the self – they are of the self, physically and/or mentally. "A person", they write, "who has a malady if and only if he or she has a condition, other than a rational belief or desire, such that he or she is suffering, other than a rational belief or desire, such that he or she is suffering, or at increased risk of suffering, an evil (death, pain, disability, loss of freedom or opportunity, or loss of pleasure) in the absence of a distinct sustaining cause" (1981: 36).

Turner's Ndembu

But this definition which includes disease, illness and injury see maladies as the same for all persons in all cultures and at all times (Hahn 1995) and restricts suffering to conditions unwanted by everyone. This is unlike Hahn's proposition in which sickness is seen as allowing suffering according to unique personal, cultural and historical circumstances. In Hahn's definition, sickness may vary by person, culture, and time. Turner's study (1967) of the Ndembu of Zambia shows how the Ndembu regard sickness as one of several kinds of misfortune, which also include "bad luck at hunting, reproductive disorders, physical accidents, and the loss of property". He describes twenty-two examples of Ndembu diagnostic categories and their therapies. The categories are distinguished on the basis of symptoms – for example, *mbuba yaluzong'a*, a disease that cause people to lose toes and fingers (most likely leprosy in the biomedical classification), *kaseli kamashi*, a disease with bloody urine (most likely schistosomiasis), and *musong'u wachingongu,* a disease that leaves pockmarks (most likely smallpox).

The Ndembu diagnosis of sickness clearly looks at the hidden forces behind the sickness condition. As Turner notes, "The Ndembu, like the Azande, consider that calamities and adversities of all kinds are caused by mystical forces generated or evoked and directed by conscious agents. … Ndembu talk of different kinds of *nyisong'u*, 'illnesses' or 'diseases', and recognize that specific symptoms are connected with each of them" (1967: 300-01).

A classic example: the Hausa

In Hausa (of Nigeria) culture, there are two basic aetiologies of illness: inanimate non-conscious forces in the physical environment or the result of some conscious malevolent power (Oloyede 1997). The former category consists of ailments that "just happen", those are sent as a result of the ineffable will of God and may be loosely categorised as *ciwon Allah* (illness of God). The second category comprises those afflictions, which arise from the influence of witchcraft (*maija*), sorcery (*sammu*), or evil spirits (*adjanmu*, *isoki* etc). Illnesses stemming from these sources are referred to as *ciwon miyagu*, "illnesses of evil".

The word *ciwo* is one of two words used in describing conditions of morbidity. The other is *cuta*. The former is the most commonly used and refers to any pathological condition. *Ciwo* describes 'pain', 'soreness', 'aching'. It refers to a painful disordering of a particular body and the impairment of its normal functioning: the signs (objective physical manifestations) or symptoms (subjective feelings) that occur in the course of an illness. So, when the Hausa says *ciwo kirji*, ('chest pain') for example, what he or she is saying is pointing out the 'chief complaints' not the 'disease', which may lie behind it. A person suffering from chest pain is thus considered to be afflicted by chest pain. The way such pain is handled in Hausa culture reflects an epistemology that includes the overlapping domains of divination and religious practices (Oloyede 1997). To be afflicted by chest pain in Hausa culture is to have an absence of *lafiya* which is a correlate of the moral order of the world and which describes a metaphysical state of

'correct being' as well as conditions of good health. The chest pain is thus a symptom or a sign of the disruption of 'well-being' by the intrusion of occult powers as well as the forces of the physical environment. These conscious malevolent forces, which disrupt *lafiya* to bring about the chest pain, are appeased to by specialist medicine men. Last (1976) notes that spirit appeasement are achieved through sacrificial blood of chickens, goats, and sheep. In his study of sickness among the non-Muslim Hausa, he points out that diagnoses of spirits as cause and treatment (curative or preventive), are more public than what he refers to as 'soul attack'. That is, an attempt by a soul to entice a living kinswoman or her child to join in its wandering. Spirits as cause and as treatment require specialist treatment, but 'soul attack' is treated more personally.

On the other hand, chest pain could be considered an act of Allah. Since man/woman is intrinsically sinful, his/her *lafiya* is a special blessing from Allah and one has to constantly ask for Allah's blessings. The absence of *lafiya* requires that one asks for Allah's mercy. The mercy may come in different forms: for example, Allah may give the medicine man/woman the knowledge to mix the right herbs to cure the pain or aid the medicine man in his 'surgical treatment' of the pain as in common practice of cupping (*kaho*) to remove the black, dead body by village barbers (*wanzamai*). Bad blood is considered to be a result of the pernicious influence of *sanyi* (damp cold) and *zaft* (heat). Too much blood leads to the build-up of *mataccen jinni*, 'dead' blood and pain is usually attributed to this. In sum, illness in Hausa culture is the product of cosmic disharmony brought about by sorcery or breach of taboos.

A classic example: The Yoruba

What has been observed among the Hausa, is similar to various non-Western settings as the literature shows. Sickness is connected to two broader phenomena: cosmological or religious forces and social relationships and interpersonal conflict. In a paper on the cultural understanding of epilepsy, Oloyede (2001) describes the response to the illness among the Yoruba of Nigeria. In Yoruba belief, there is a demon that causes convulsion. In some cases, an epileptic paroxysm is said to betray illicit sexual affairs, a jealous spirit is believed to have surprised its rival, seizing him or her by the throat and attempting to choke the person – hence the lapse in consciousness. The point emphasised in the paper is that the supernatural looms large in the Yoruba understanding of epilepsy and *Esu*, who in Yoruba pantheon has the status of the devil, plays a prominent role in this regard. His role, Oloyede writes, can be seen in terms of his ambivalent nature, which guarantees that certain antisocial powers in humans are revealed and checked. She illustrates this with the case of a 16-year old girl who suffered seizure on her way home back from school. She describes how passers-by were afraid to touch her for fear of falling prey to the demon. The girl was later taken to the local hospital where the seizure was diagnosed as epilepsy. The persistence of the seizure, despite continuous use of medication, convinced the parents to take her to a local healer who suggested that *Esu* be appeased as he was responsible for the child's state. Why was *Esu* implicated, Oloyede asked? "Why was what would seem to the western-educated psychiatrist to be a biomedical problem, one in which was seen as being the

handwork of a supernatural force?" She put this down to the Yoruba belief, which sees *Esu* as having a supernatural connection with productivity, growth and exchange in general. "He is considered a suitable character for market places and economic transactions, an area of insecure and not always honest transactions, where profit and loss depend on accidental events. Money and markets are a necessary part of society, and like *Esu,* have hidden structures and functions, which can be ambivalent. So, *Esu's* role in the child's condition was one of 'helping' one person to destroy another". Those who were jealous of the mother's success in the market had invoked *Esu* who then made the child epileptic. The Yoruba, Oloyede concludes, see epilepsy not as a mental illness, not a chemical imbalance in the brain, but a possession of the body, of the soul by the demon as a result of the deed or act of wickedness of the sufferer.

Cross-cultural comparison?

Again the question arises: when are two conditions found in different cultural settings equivalent? If, as pointed out earlier, anthropologists were translators of data derived from fieldwork, would it not therefore be the case that anthropological evidence would be circumscribed by cultural boundaries making it difficult for such data to be objective? This is indeed a difficulty of translation, which would seem manifest in the attempt to translate conditions described as mental illness in biomedicine (Hahn 1995). I mentioned earlier the experience of the students when faced with a question on headache. To use the example of depression once more, in biomedicine, it is an affective disorder, an emotional problem within the individual psyche. It would seem clear that many non-Western cultures do not attribute sickness to internal states of the mind. For example, the Hindus and Buddhists believe that the point at which an individual realizes the utter hopelessness of life in the world, is a sacred moment (Hahn 1995). It is at this point that the person is ready to renounce worldly life and take up the path of asceticism and meditation. Obeyesekere (1990) describes the Buddhist "meditation on revulsion" in which laymen deliberately contemplate death, decay, and filth in order to recognize the transitoriness of the body and the world and to develop contempt for bodily pleasures. Traditional forms of meditation thus serve to instil in the person the idea of the hopelessness of life in the world and to promote emotional detachment from all persons and physical objects, including one's own body. For them, profound depression is a good thing, a profound insight into ultimate reality.

Cross-cultural studies indicate that depression can involve differential subjective experiences, idioms of distress, culture-based diagnoses, treatments and outcomes (Hahn 1995). Regarding the translation of depression, Lutz argues that one should examine "indigenous definitions of situations of loss and the blocking of goals, and the social organizations of responses to them" (1985: 92). If, as these studies show, diagnosing depressive episode outside of western culture is problematic, then, depression, as Obeyesekere (1985) and Lutz (1985) argued, is a western cultural construct tied, perhaps, to "the peculiarly western notions of Cartesian dualism" (Castillo 1998). The Cartesian mind-body split permeates western thought. This, according to Manson (1995), tends to make westerners very mind- and mood-oriented as opposed to body-

or group-oriented. And as Castillo (1998) notes, it goes back to the traditional importance Christians placed on the "conditions of the soul" and the idea that sin exists in the mind or soul of the individual. He adds, "This Christian emphasis probably also influenced the idea of Descartes' *cogito* "I think, therefore, I am" and resulted in a mind- and mood-centred emphasis in western culture. During the 18th century Enlightenment, this preoccupation with mind and mood became codified in the inalienable right to individual's "pursuit of happiness." The pursuit of happiness has become the primary goal of western culture. …. In western culture, if persons are not happy, or at least pursuing happiness with some degree of initiative, it is presumed that something is wrong with him" (Castillo 1998: 207).

If the meaning of depression is structured by the egocentrism of western culture, and it is not the case in sociocentric societies where self-sacrifice for the good of the group is regarded as the greatest virtue and responsibility (O'Nell 1993), then the recognition of the symptoms of depression as an illness appears to be mediated by cultural schemas that are internalised during an individual's formative years. In effect, the subjective experiences would be different from the concept of depressive disorder in disease-centred psychiatry. Of course, it does not mean that in these societies the somatic symptoms might not exist: they may be more meaningful and therefore primarily experienced by individuals (Castillo 1997). However, the symptoms would be structured by non-western cultural schemes, and the subjective experience would be different from the concept of depressive disorder in disease-centred psychiatry. For example, generalized hopelessness, a major depression in western culture, can have a completely different meaning in South Asia Hindu and Buddhist cultural schemes. In this cultural context, depression is not an illness but an accomplishment, a spiritual insight about the true nature of the world (Obeyesekere 1985). What this implies, is that in some societies, a depressive syndrome is not recognised as an illness and people have no concept for it in their set of cultural schemes (Furnham & Malik 1994; Leighton et al. 1963; Marsella 1979; Marsella et al. 1985). Those psychiatrists that are labelled "cultural psychiatrists" would be inclined to this view and given this cultural bent, may add, in agreement with anthropologists who have been studying mental illness in non-western societies, that cultural schemas can in fact construct culture-bound manifestations of mental illness. In this view, some of the mental illnesses are considered to be cultural entities; they exist in particular cultural contexts and are responses to certain precipitants in the indigenous meaning system.

Within anthropology there is a huge body of work, which has linked a variety of behavioural syndromes to local conditions (Simon & Hughes 1985). These mental illnesses have been labelled culture-bound syndromes (Levine & Gaw 1995) and some of them are included in the appendix of DSM-IV. The notion of a culture-bound syndrome suggests that there is *culture* in a variety of behavioural syndromes or what I would want to refer to as *culture* in mental illness. That is, there are a number of culturally specific details in a group of behavioural conditions that is thought of as constituting a discrete entity. The *culture* in mental illness is complex and requires far more than what follows. Swartz (1998) presents several South African cases on depression. He argues that depression in South Africa may be overlooked or misdiagnosed because

paranoid features may mask features of depression. Besides, he states, psychiatrists in South Africa wish to diagnose depression in Xhosa-speaking people without having to deal with language difficulties. However, for the purpose of this paper, the discussion in the next section would seem sufficient to highlight the culture-specific aspect of mental illness.

Culture in mental illness

When Western anthropologists were confronted with seemingly strange behaviour in non-Western cultural settings, they tried to make sense of such behaviour by ascribing to them the term "culture-bound syndromes". The attempt by anthropology to universalise and foreground the particular underlies the logic by which the generic diagnostic label "culture-bound syndrome" is ascribed to some conditions and not others. When Kraepelin, having delineated among 'German patients certain syndromes,' was faced with a similar situation in Java, at the beginning of last century, he resorted to the 'common 19th century distinction between 'form' and 'content', once 'used extensively in literary and art criticism, but now largely abandoned because of the arbitrariness of deciding what was form, what content (Littlewood 1981, 1991).

The assumptions arrived at by Kraepelin remain the dominant paradigm in comparative psychiatry (Littlewood 1991).[10] But Kraepelin was concerned with universals and the 'production' of a biological core of psychoses unlike the anthropologists who attempt to understand concepts and theories and values that underlie forms of sickness and healing that are not part of their own tradition (Hahn 1995). Both approaches are similar: a form of reductionism, the explanation of a single phenomenon by a single principle or body of knowledge with the implication of denying the relevance of any other mode of analysis.

What is particularly striking is that those who analyse culture-bound syndromes have "attempted to keep their syndrome while reducing it also, by showing how social, cultural, and psychological conditions are so configured in the local scene as to make this particular syndrome unlikely to occur elsewhere" (Hahn 1995). The syndrome becomes culture-bound because cultural conditions necessitate its occurrence. Particular cultural conditions are considered sufficient for syndromes to occur, while others are unlikely to trigger it.

The syndrome cannot be physiologically explained for it is culturally specific. As Kenny (1983) argues in the case of *latah*, the cultural context provides its best explanation. The assumption is that to understand *latah*,[11] one needs to connect it to other local phenomena and patterns of meaning rather than to phenomena and patterns elsewhere. Concerning Simon's definition of *latah* behaviour, Kenny writes: "Simons is working within a bio-medical paradigm which stresses human biological and etiological universals and which requires concepts which are cross-culturally applicable" (1983: 161). This is "impossibly superficial" because each definitional element "would ideally have to be understood in its cultural and social context before any claim could be made to truly comprehend the whole" (1983: 161).

Culture-bound syndromes do not lend themselves to universal, causal principles. Kenny (1983) illustrates this point further using '*startle*'. He suggests that *startle* cannot be a true or valid explanation for a behaviour if it is not part of the indigenous explanation for a behaviour; only local explanations provide sufficient explanation for local action. As Cassidy (1982: 326) indicates, culture-bound syndromes cannot be understood apart from its specific cultural or subcultural context. Secondly, its aetiology summarizes and symbolizes core meanings and behavioural norms of that culture. Thirdly, diagnoses of a culture-bound syndrome rely on culture-specific technology as well as ideology and finally, only participants in that culture accomplish successful treatment. So, what makes a mental disorder culture-specific? In general, the context does. If an illness is widely distributed in a specific context with very little distribution outside it context, the likelihood is that such an illness will be considered to be context specific. However, should the illness be more cultural, that is, if particular cultural conditions are "necessary for the occurrence", then it is considered culturally specific. The logic is that such an illness is "thought not to occur in the absence of these cultural conditions" (Hahn 1995: 42).

The cause for *amok*,[12] for example, is indigenously attributed to interpersonal conflict, personal abuse, intolerable embarrassment, shame, and loss of honour (Carr 1985; Carr & Tan 1976). It is necessary to know that Malays are highly sensitive to loss of honour or respect. An insult to a Malay man's honour leads to an intense sense of grievance and loss of self-esteem because he feels he has been treated with disrespect (Carr 1985). Running *amok* is a way for him to achieve revenge or restitution for a perceived loss of honour. However, the *amok* man is not responsible for his actions because he is possessed by a spirit, and because he has no memory of the events. These are obvious cultural entities constructed by indigenous meaning systems.

Concluding remarks

A key problem of the anthropology of mental illness is the conflict between universal-Hism and particularism. At a general level, this was a problem faced by the students. How could they administer a questionnaire that contained 'universal labels' in psychiatric studies but which, when translated into Xhosa (their language) hardly carried the same meaning? They acknowledged that there are patterns of behaviour that are 'out of place' within their society but these have to be understood within the cultural meaning systems of their society. However, as Hahn puts it; "if local phenomena and labels for them can be understood only in terms of other local phenomena and their labels, then research across localities, as in much of anthropology, becomes impossible" (1995: 54). On this issue, it is worth noting straightaway that human behaviour displays regularities and the recognition of this is the starting point of much sociological and anthropological research. Similarly, most anthropologists use regularities as evidence for the existence of something in society. The question is: how does one conceptualise that something from a cross-cultural perspective? Is it something with different cultural

shapes? Or is it several different something categorised by a single name? Or is it a culture-bound something related to a specific culture?

To conceptualise that something in the first place is to recognise it as an entity. The recognition is a collective social agreement that that something exists as an entity. The recognition of the entity and its conceptualisation can only take place within a cultural meaning system. In this sense, the cultural meaning system defines that something as an entity. Once defined, it becomes a cultural entity. Various cultural meaning systems define many cultural entities and mental illness is one of these. In effect, cultural meaning systems structure reality, that is, cognitive reality, for a people or society, and embedded within them, are 'categories' of experiences. Castillo (1997) described four functions of the cultural meaning systems.

The first entails the representation of the world symbolically by individuals within a cultural group. Every cultural meaning system must fulfil this function for the persons in a group to operate as a social organisation (Castillo 1997). Cultural meaning systems enable individuals to communicate information. The information is encoded in symbolic systems; it is arbitrary in its arrangement and meaning and only makes sense within the cultural meaning system. It is the ability to communicate that makes us function as a group. What results from this communication of information by means of systems of symbol is a creation of cultural entities. That is, the agreement that something counts as an entity. But that something counts as an entity because the cultural meaning system constructs it to be so. This is the constructive dimension or as Castillo puts it, the constructive function of cultural meaning systems. *Lobola* (bride price) is very common in some African cultural groups, the Xhosa, for example. To pay *lobola* is to go through the ritual of marriage. The ritual is culture-based and has a set of constitutive rules, which, if followed, have the power to bestow the reality of being married. The couple involved see themselves as married; people see them as such and behave towards them accordingly. Now, through their actions and intentionality, marriage has been created. Thus, the cultural meaning systems created the marriage.

The cultural entities that are created become part of the cultural environment and thus impact on people's lives directing their behaviour. This is the directive function of cultural meaning systems. And because cultural meaning systems create cultural entities which in turn direct behaviour, they evoke certain emotions. This Castillo refers to as the evocative functions of cultural meaning systems.

From this, it follows that the anthropology of mental illness recognises what passes as 'mental illness' in different cultural settings. It attempts to understand the meaning of behaviour within the cultural setting in which it occurs. However, there is also the recognition of the aetiology of mental illness in social and cultural as well as physiological and environmental conditions. The students understand this. In their experience as members of a cultural group, they know that to function in the group, they need to learn to communicate, that is, speak the language of the group, learn the belief system, learn social roles and the appropriate behaviour. Only by acknowledging this can mental illness be assessed.

Notes

1   It serves as a background theoretical paper for the UWC-UCT-UTRECHT project titled *"The Development of Community Mental Health Care in South Africa: A study of service utilisation, barriers to care, and cultural beliefs about mental illness in an historically disadvantaged urban and rural community."* The project, as defined in the Project Proposal, seeks to investigate mental health care as it developed in two previously historically disadvantaged communities following the adoption by South Africa in 1994 of the primary health care policy. With its aim to promote more accessible and culturally appropriate mental health care to historically disadvantaged populations in urban and rural settings, the research project is linked to the SANPAD themes of "Social Empowerment" and "Culture Identity and a New Society."

2   See G. Zilborg (1941). Some of the chapter headings are as follows: "The Restless Surrender to Demonology", "The Blow of the Witches' Hammer", "The First Psychiatric Revolution", The Age of Reconstruction" and so on.

3   In the psychiatry literature, affective disorders or disorders of mood include a wide range of abnormalities, from mild states to severe and even life-threatening conditions. Minor affective disorders are said to consist of conditions of mild symptomatology and of generally good short-term outcome; Major affective disorders are characterized by severe symptoms. They include depressive disorders, when the prominent mood is low, and manic disorders, when the mood is elevated. See Catalan 1988: 61-72.

4   The two terms were derived from the concepts of phonetics and phonemics in linguistics. The former refers to sound differences within a language that can be recognised by a hearer, without knowing the language, but that have no semantic significance to speakers of the language. The latter, refers to sound differences that have semantic significance to speakers of the language.

5   Anthropologists and other observers use the prefix' *bio-* to highlight the biological focus of Western medicine, medical practitioners use medicine which is defined in *Stedman's Medical Dictionary* as: A: a drug. B. the art of preventing or curing diseases; the science that treats of disease in all its relations, and C. the study and treatment of general diseases or those affecting the internal parts of the body, distinguished from surgery' (1976: 836).

6   According to Busfield, psychiatry diverges from medicine more in terms of its object of interest and its institutional location than in its objectives, values and approaches. It draws heavily on psychology rather than the natural sciences. A substantial amount of psychiatry's work has been with chronic rather than acute sickness (Busfield 1986). And as Fulford points out, there are differences between diagnosis in psychiatry and in physical medicine. For example, diagnosis in psychiatry is based on disease categories which are mainly symptomatically defined rather than etiologically; diagnosis is dependent on the clinical skills of history taking, mental state examination and physical state examination rather than on laboratory and other special tests. Fulford 1988: 5–16.

7   Nancy Andreasen (1984): '*The major psychiatric illnesses are diseases*. They should be considered medical illnesses just as diabetes, heart disease, and cancer are … *These diseases*

are caused principally by biological factors, and most of these factors reside in the brain … As a scientific discipline, psychiatry seeks to identify the biological factors that cause mental illness. This model assumes that each different type of illness has a different specific cause … The *treatment of these diseases emphasizes the use of "somatic therapies" ...* The somatic therapies used most frequently are medications and electroconvulsive therapy (ECT). Because these diseases are considered to be biological in origin, the therapy is seen as correcting an underlying biological imbalance (pp. 29-31, emphasis in original).

8   In the 1994 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* known as the DSM-IV, the introductory section states concerning mental disorder:

Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual … In DSM-IV, there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder (pp. xxi-xxii).

9   A Symbol is a technical term in semiotics, the study of signs (Pierce 1962). Signs 'are objects that represent something else. In semiotics, there are three kinds of signs: *icons, indexes* and *symbols*. An *icon* looks like the thing it represents. An *index* does not look like what it represents but has a direct connection to it. A *symbol* has no logical connection whatsoever to the thing it represents. It is an arbitrary sign used simply out of convention, and its use results primarily out of historical accident.

10 Kraepelin developed a classification of mental disorders on the basis of his clinical observations of the natural history of diseases: aetiology, onset, symptomatology, course and prognoses. It distinguished two basic types of mental illness: exogenous psychoses – those with external causes – including febrile delirias, psychosis due to exhaustion, intoxications, thyrogeneous psychosis, general paresis, psychosis resulting from cerebral tumour or abscess and dementia precox; and endogenous psychoses – those with internal causes – such as degenerative psychosis, manic-depressive psychosis, paranoia, the neuroses, which included hysteria and epilepsy, psychopathic states, compulsive neuroses, idiocy, homosexuality and imbecility (Menninger 1963).

11 Latah is a trance syndrome (usually thought of as a Malay-Indonesian syndrome, although it is possible to find similar syndromes somewhere else) characterized by 'an extreme response to startling stimuli. Attention becomes highly focused and the person exhibits anxiety and trance-related behaviour such as violent body movements, assumption of defensive postures, striking out, throwing or dropping held objects, mimicking observed movements, and sometimes extreme suggestibility or obedience (Geertz 1968; Kenny 1978; Simons 1985).

12 Amok is a Southeast Asian trance syndrome usually 'characterised by a short-lived (a few minutes to several hours) sudden outburst of unrestrained violence, usually of a homicidal nature, preceded by a period of brooding, and ending with exhaustion. There is typically dissociative amnesia for the episodes. Dissociation is characterized by a loss of integration of faculties or functions that are normally integrated in consciousness. This lack of integration or division in consciousness can affect memory, sensory modalities, motor functions, and personal identity or sense of self. Cultural schemas affect the subjective experience and expression of dissociation. According to the yogic cultural schemas, there is the personal self, jiva, and the spiritual self, atman. All persons do have this dual nature but hardly aware of it. In yogic cultural schema, it is necessary to separate out the spiritual self from its assimilation by the personal self for the individual to realize this dual nature in its subjectivity. Hence, the goal of the yoga meditation is to separate these two selves in the subjective

awareness of the individual. By accomplishing this, the yogi becomes a dual personality or a person with divided consciousness (Castillo 1991).

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