Stressed, depressed, or bewitched? A perspective on mental health, culture, and religion

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Mental illness, in its broadest sense, is one of the commonest afflictions affecting humankind. The World Bank report on health and development (1993), though criticised for the unreliability of some of its data, identified 'europsychiatric' disease as the second most important non-communicable cause of disability in the developing world (Blue and Harpham 1994). Of these diseases, depression was the single most important diagnosis. The report emphasises an aspect of health which is intimately related to a community's overall health status and development, and which has been ignored by development agencies and Health Ministries faced with the pressing priorities of communicable diseases and maternal and child health problems. However, it is impossible to separate the mental and spiritual components of health from physical illness, in particular when dealing with chronic illness and maternal and child health problems. It is likely, and desirable, that future health-related development work will, and should, include mental health among its priorities. With this future in mind, we focus in this article on the close relationship between mental health, culture, and religion. We hope to inform those who are involved in mental-health services in sub-Saharan Africa (SSA) of the problems in simply translating concepts developed in the very different societies of Western Europe and North America (referred to as 'Euro-American' in this article), whence the bulk of development funds originate. Instead, we will attempt to highlight that community health problems and health-care delivery must involve understanding and assisting those with mental-health problems from within the context of the society in which one is working. Although we focus on SSA nations, owing to our personal experiences in Zimbabwe, we believe that much of what applies to these settings may also apply to other less developed countries.

The article begins with a description of what is meant by the term 'mental illness' and moves on to examining some of the ways in which culture and religion influence mental illness. We end with our views on how culturally appropriate mental-health services should be developed.

What is mental illness?

It is of great importance for all health and development workers to recognise that the term 'mental illness' does not refer to a homogeneous group of problems, but rather to a number of different types of disorders. It is even more important to recognise that although every society has people whom it views as being mentally ill, the use and construction of this concept may vary considerably from one society to another. The group of disorders most often associated with mental illness are the psychotic and affective disorders, such as schizophrenia and mania. There is little doubt that such severe disturbances, which affect virtually all aspects of a person's mental and behavioural life, are recognised in most cultures and societies in SSA (Patel 1994). It is this group of disorders which occupy so much of the time and expense of mental-health services in Euro-American societies, and for which psychiatric drug treatments have proven to be of considerable value. Despite the powerful evidence of a genetic role in the aetiology of these disorders, the environment plays at least as great a role in determining the course and outcome. For instance, schizophrenia seems to have a better outcome in developing countries, despite the fact that mental-health services are underdeveloped in these very settings. In other words, even though Europe and North America have extensive mental-health and social-welfare services, persons in those countries with schizophrenia fare worse than those in India or Nigeria. Recognising that the course of even the most 'medical' of all mental illnesses is so profoundly influenced by socio-environmental factors gives cause for concern for those who wish to recreate a mental-health service modelled on the Euro-American system of health care, without evaluating the possible therapeutic ingredients already existing in some SSA societies, such as the role of the extended family and traditional treatments.

Another group of disorders classified by Euro-American psychiatry as mental illnesses have been historically called 'the neuroses'. This group of disorders may be thought of as exaggerated forms of normal reactions to stressful events. Thus, anxiety, depression, and physical

symptoms in the absence of a physical disease are experienced by many people in response to stressful events; in neuroses these experiences become more intense and often out of proportion to the stressors (Gelder *et al.* 1983). Over time, such problems have been conceptualised as mental illnesses, not least because of the Cartesian dichotomy which has influenced biomedical thinking for over a century. This dichotomy holds that the body and mind are distinct, and although contemporary health practitioners are encouraged to consider the integrated role of both mind and body in their patients, if patients present with symptoms for which there are no corresponding physical signs or findings, many practitioners will conclude that they must be mentally ill. As psychiatry and its allied professions have evolved in the North, such vague and poorly defined illness entities have become reified into precise categories; the latest WHO classification of mental disorders includes no fewer than 60 categories of illnesses previously classified as neuroses, including phobias, anxiety disorders, and mild depressions (World Health Organisation, 1992). Neurotic disorders are the commonest group of mental illnesses and are particularly common in primary care and community settings; recent studies in Zimbabwe suggest that up to a quarter of clinic attenders may be distressed. In this paper, we refer to this group of problems as 'psychosocial distress', because, as we will discuss later, referring to them as a mental illness is fraught with conceptual problems.

There are several other areas of health problems in which psychiatry has claimed an expertise. Childhood problems such as behavioural disorders, abuse, and mental handicap; abuse of substances such as alcohol and drugs; mental disorders associated with HIV infection; and the psychological consequences of violence and trauma are some examples. While each type of disorder has its own unique characteristics, there are a number of common features such as, for example, the influence of adverse socio-economic events on these disorders as well. Thus, many of the general points made in this article would apply to these disorders.

Religion, culture, and mental illness

This is a complex area which has been of great interest to anthropologists, and more recently to mental-health professionals. Within the scope of this article, we will focus on some areas to illustrate how religious and cultural factors are intimately related to mental illness in the community. While we recognise that culture and religion are

complex and dynamic concepts, in focusing in this article on the relationship between mental illness and culture and religion, we have taken a unitary, and perhaps simplistic, view of these concepts.

Concepts of mental illness

The medical speciality of psychiatry has its roots in Euro-American professional views of mental illness. This is vividly demonstrated by WHO classifications of mental illness which, although purporting to be 'international', consign illness types described in non-Euro-American cultures to be regarded as either 'culture-bound' or not even worthy of recognition (Patel and Winston 1994). The commonest neurotic disorders, in this classification, are depression and anxiety. Patients in Euro-American societies increasingly understand that concepts such as 'depression' relate to a state of psychological distress. Over time, both the health worker and the patient acquire a similar explanatory model for the distress state. In many SSA societies, such disorders are recognised as being distress states but are not understood in the same way, i.e. the concepts used to understand and explain their causes and nature may differ widely. Thus, similar states of distress evoke recognition from local community and health workers in Harare, but the causes are closely linked to the interaction of social, economic, and spiritual problems (see later) afflicting the person (Patel *et al*. 1995). The same concept, semantically translated, can be elicited in this and other societies, but may mean something quite different; for example, rather than being viewed as a mental problem, it may reflect the patient's assessment of his or her socio-economic and spiritual state. The difficulties in translating even basic concepts are illustrated by this example. We attempted to translate an apparently simple question, asking patients about any previous history of emotional or mental illness. In Euro-American societies, a substantial proportion of persons would understand this to include depression, anxiety, or indeed many stressful situations which resulted in them consulting a health worker. In the Shona language, it was virtually impossible to translate this adequately without giving the impression that we were dealing either with 'madness' (and thus alienating most of our patients) or with 'stress' (which many of our patients experience, owing to adverse socio-economic circumstances). Although this is a seemingly trivial example, it represents the very heart of the issue of mental health and development. It is for this reason that we refer to neurotic mental disorders as psycho-social distress states. In many societies, then, such

states of distress are not viewed from a medical standpoint. If depression is not considered to be a 'mental illness' (as psychiatry understands it), then should we attempt to change the entire meaning of the term so that it conforms to the dominant Euro-American paradigm? Is there any evidence to suggest that the 'medicalising' of such distress states, as opposed to socio-spiritual models, has produced any significant benefit to patients? While recognising that the fundamental experience of a distress state is universal to all humans, we believe that the contextual meaning of the distress is of singular importance. Such meanings should be respected and understood, rather than referring to an imposed foreign model to explain the problem.

One area which illustrates the complex interaction of personal misfortune, religious beliefs, and cultural values is that of witchcraft. Although witchcraft is outlawed in many African societies, beliefs in its power remain alive, and sociologists have argued that such belief systems play a role in making misfortune understandable (Chavunduka 1994). From a Euro-American perspective, what does feeling bewitched mean? Can it be reduced to a psychiatric 'symptom'? Or is this belief a way that some communities have developed to explain why life has its difficult moments? Should the diverse, and unproven, psycho-theories of the North, such as psychoanalysis and general systems theory, be imposed on other cultures?

Idioms of psychosocial distress

Beyond these broad concepts is the issue of idioms used by people in psychosocial distress. A fundamental difference between mental health and physical health is that in the assessment of mental health one relies almost entirely on what a person tells the health worker. Language becomes the very essence of expressing distress, and emotional terms such as 'sadness' and 'fear' cannot be translated without examining the overall context of the use of these terms in a community (Lutz 1985).

Idioms, for example 'feeling sad', have over a period of time become professionalised by medical personnel into 'symptoms' and then taken one step further into becoming 'criteria' for diagnosing specific types of 'mental illness'. This process is intimately related to the historical evolution of conceptualising human distress in Euro-American culture. However, much mental-health research and development in SSA societies has assumed that the idioms of mental-health problems,

as defined in Euro-American settings, can be applied simply by a semantic translation of terms. The following examples show how this approach may confound the process of interpreting how psychosocial distress is manifested in different cultures.

The idiom of 'hopelessness' is central to the Euro-American model of depression, and questions such as 'Do you have hope for the future?' are often asked of the patient. However, in the context of Buddhist cultures in Sri Lanka, Obeysekere argues that this deals not with 'a depressive, but a good Buddhist'. Thus, 'hopelessness lies in the nature of the world, and salvation lies in understanding and overcoming that hopelessness' (Obeyesekere 1985). In this context, then, eliciting the idiom of hopelessness would yield positive responses, but the contextual meaning of the term is very different. In the Shona language, the term for sadness is *kusuwa*. This term not only implies personal sorrow and grief but is also used in the context of describing an emotional state which is a prerequisite for sympathy, empathy, and reaching out for help and is, in this context, a positive emotion.

Another example is the spiritual experiential events which occur in many religious movements in African societies. Thus, hearing or feeling the Holy Spirit, feeling that the ancestral spirits wish to come out or express themselves, or sensations of being possessed by such spirits are not only commonplace among members of some religious groups but indeed are highly valued personal experiences. If a mental-health worker was unaware of the contexts of these experiences, she or he may consider them to be symptoms of a mental illness.

Priests, prophets, and psychiatrists: what do people do when in distress?

In Zimbabwe, religion is inseparable from health, and this relationship applies to both traditional and Christian religions. Let us consider the relationship of traditional medicine and religion first. Traditional medical practices of the indigenous people have a religious foundation which is based on the local views on the creation of humankind, the life cycle, concepts of growth and development, and the purpose of life in the Creator's scheme of things. In Zimbabwe, and many other sub-Saharan African societies, there are extensive beliefs in a spiritual world inhabited by ancestral, alien, clan, and evil spirits. These beliefs play an important role in guiding what people can do when they are distressed (Mutambirwa 1989). Traditional healers are recognised by many as being able to heal the sick by virtue of their intimate knowledge

of herbal medicines and their special ability to be possessed by or communicate with spirits. When seen in a Euro-American context, traditional healers assume many roles, including those of priest, legal adviser, social worker, and counsellor (Staugard 1985).

Christianity is the most popular denomination of organised religion in Zimbabwe. The origins of Christianity are historically tied to the colonisation of this region. Christian missionaries believed that traditional religion was pagan, and since beliefs in spiritual causation were inextricably interwoven with misfortune and illness, traditional medicine was also unacceptable. The repression of traditional beliefs by missionaries, in collusion with the colonial administration, led to large numbers of people taking up the Christian faith and being taught to shun traditional healers. Many Zimbabweans today claim Christianity as their main religion, but in practice many such Christians continue to believe in the power of witchcraft and of their ancestral spirits, seeing little conflict between these beliefs and official Church doctrine (Bourdillon 1987). Furthermore, Christianity is practised in this region in diverse ways, with a wide range of 'independent', Pentecostal, and Evangelical churches, some of which syncretise Christianity and indigenous religious beliefs. It is not uncommon to see charismatic pastors, in particular from the Apostolic churches, who assume the role of a spiritual healer and heal the sick with the power of the Holy Spirit, make prophecies for the future, and encourage the congregation to join in spiritual experiences, including trance states and speaking in incomprehensible 'tongues'. Interestingly, some of the Apostolic churches shun both biomedical and traditional medicine, relying instead on the prophets and faith-healers within their church for healing.

The dichotomy between biomedical and traditional approaches is rooted in the frequently held belief that biomedicine is superior when applied to physical and bodily aspects of health, by virtue of prescriptions of scientifically prepared medicines, operative procedures, investigations, and hospitalisations. On the other hand, traditional medicine and faith-healing are often viewed as providing a holistic health-care service. Thus, health problems associated with the physical body as well as the mind-soul and the social and spiritual environments are addressed (Chavunduka 1978). While psychosocial distress states have become medicalised and are increasingly treated by the growing legion of mental-health workers, ranging from counsellors to psychiatrists in Euro-American society, in Zimbabwe and many other SSA societies

these distress states are often inextricably linked to spiritual and social factors. In keeping with these beliefs, a significant number of people suffering from psychosocial problems consult religious leaders such as pastors, priests, prophets, and traditional healers in search of emotional relief.

Helping people with psychosocial problems

In Euro-American society, theories to explain personal distress have moved from the spiritual realms to the psychoanalytical realms and, more recently, to a host of new theories, including cognitive, behavioural, systemic, social, and interpersonal theories. Each of these conceptualises distress states or illness categories according to certain theoretical postulates, which are then extended to actual therapeutic interventions to alleviate the distress. Success with such a therapy is then used as a validator of the theory itself. One example of such a therapy which has gained prominence in Euro-American society is cognitive therapy, in particular for depressive states. Like many other contemporary approaches, it emphasises the personal responsibility of the patient in attaining the cure. Cognitive theory postulates that the fundamental problem in conditions which manifest as depression or anxiety is maladaptive thinking. The treatment is aimed at assisting the individual to recognise the maladaptive nature of their thinking and then to attempt to change this. This theory is firmly rooted in the introspective individualism of the North, and is in sharp contrast to the external models of distress prevalent in communities in SSA. To date, we are not aware of any studies attempting to evaluate the effectiveness of these psychotherapeutic models in SSA. Furthermore, it is well recognised that one of the most powerful predictors of response to psychotherapy is the 'congruence' or sharing of models of illness by therapist and patient, so that those patients who are 'psychologically minded' are the ones most likely to respond. We would argue that the same principle may be applied to other cultures, so that therapies whose theoretical models are congruent for patients and healers are likely to be successful, such as spiritual rituals being effective for spiritual problems. This, of course, would be at odds with trying to change the patients' view of their problems so as to suit an alternative, often imported model used by the therapist.

One example from Shona culture is the behavioural state of *kutanda botso*. This state, which is characterised by a person wandering away from his or her home dressed in rags and begging, may be seen to be

similar to the psychiatric category of 'brief reactive psychosis'. However, it is often a traditionally sanctioned ritual to cleanse a person who has committed a grievous social crime, such as striking one's parents. By adopting such a vagrant role, the perpetrator will absolve his or her misdeeds and correct the spiritual imbalance caused by his or her actions. Is family therapy superior to this form of traditional treatment? Or is the increasing use of 'therapy' as a judicial recommendation for persons who break social codes and laws, such as sexual offenders in the North, in fact an analogy to Shona sanctions?

Many imported models employ techniques which are not culturally acceptable to patients in other societies. For example, many patients expect to be told what to do to alleviate their distress, and the role of the silent facilitator, typical of some Euro-American psychotherapies, may be inappropriate in many counselling situations. This is clearly evoked by the '*guru–chela*' relationship between counsellor and patient described in India, in which the psychotherapeutic relationship mimics that between a teacher and student, with emphasis on the counsellor providing direct advice and guidance to the patient. Indeed, dependence on others in the Indian context is a desirable state of existence and does not have the negative connotation which it carries in Euro-American society (Saxena 1994).

Developing appropriate mental-health services

In the previous section, we have demonstrated some of the ways in which culture and religion are profoundly intertwined with mental health and illness. In this section, we consider how mental-health services may be developed in a manner which is culturally appropriate.

Most development activity in mental health imitates Euro-American models of illness and health-care delivery. These ignore the contextual meaning of such culturally defined terms and categories of illness and the role played by non-'professional' persons in the alleviation of distress. When seeking to fund or provide new services, agencies concentrate their efforts on creating new counselling positions, and on training counsellors in methods that have been developed in altogether different settings. All too often, this is done without examining what was already happening in the particular setting, as if persons with psychosocial problems were previously unattended to. Development activity catering for vulnerable groups of individuals, such as those suffering from HIV infection or refugees, identifies counselling as one of the ways of alleviating their distress. However, it

remains unclear whether this has involved working with the pre-existing network of 'informal' counsellors. In Zimbabwe, it appears that some of the counselling approaches mimic imported methods, such as systematic therapy, and employ counsellors with a professional background modelled on Euro-American health-care approaches. Only rarely does one encounter any published structured evaluation of what impact these counselling techniques have had on the life of the patient. It seems that this issue is often taken for granted, on the assumption that if it works in Euro-American society, then it must do so in other societies.

In this context, we wish to point out that 'cultural spectacles' affect not only Euro-American workers but also growing numbers of people in SSA, who by virtue of education and/or religion modelled on Euro-American societies are equally in conflict with the majority of their kin. For example, professional 'scientific' medicine has taken firm root throughout the world, and its practitioners in Zimbabwe, although themselves coming from a society with rich and extensive beliefs in ancestral spirits, will often suppress these traditional beliefs because of the dismissive attitude taken by what is historically a Euro-American discipline of health care. Such health workers, although integrated within the biomedical approach to health delivery, are not necessarily representative spokespersons for the community at large. An example of this is a recent epidemic of measles which led to the death of several children from a particular Apostolic church whose congregation shun biomedical treatment and immunisation. The bulk of the health-care policy makers and health workers were appalled by this apparent neglect by the parents, quite oblivious of the power of religion and culture in influencing treatment choices in Zimbabwe.

The close bonds between religion, culture, and mental health in many societies in SSA have important lessons for development and health workers involved in mental-health care. In attempting to provide mental-health services, including counselling, to any population, development funds should be targeted at what the culture finds acceptable and workable, rather than trying to recreate a Northern model. The first step must be to form a close understanding of the religious beliefs and social structure of the society and to investigate the pre-existing network of informal counsellors. Research into the nature and cause of psychosocial distress is an essential prerequisite to delivering services. Collaboration with local professionals with professional backgrounds akin to their Euro-American colleagues

must be extended to local priests, traditional healers, village chiefs, community workers selected by the community, and so on. For any mental-health initiative to be successful, it must reach out to the ordinary person and must be sensitive to his world-view. And most important, one must refrain from imposing an invalid foreign category, since this will only alienate the people whom it is meant to help. Thus, questions such as what the community means by mental health and illness, priorities in mental-health care, what the community believes are the ways in which such problems can be tackled, and so on need to be understood. Idioms of distress need to be generated from the language of the people, rather than simple translations from a foreign language. There is little doubt that there are 'universals', i.e. that many themes of distress are universal to humanity; but it is equally important to recognise those characteristics of distress unique to a particular community. Any intervention must be evaluated from the context of the individual and the health-care worker. New measures, such as the Shona version of the WHO Quality of Life instrument (Kuyken *et al.* 1994) and the Shona Symptom Questionnaire (Patel *et al.* 1994), may be used to evaluate counselling and other interventions for psychosocial distress.

The influence of religion and culture on mental health is being recognised in Euro-American society, where increasingly professionals are writing about the importance of recognising the spiritual dimension of a person's health (Cox 1994; Sims 1994). We would go further in stating that this dimension is of importance not just for mental health, but for physical states as well, in particular for severe illnesses (such as AIDS) for which medical treatments remain unaffordable, unavailable, or ineffective. These spiritual issues are rarely accessible to biomedically trained health workers; they should admit to this and allow open access to such patients by religious and traditional healers. This is already taking place in facilities for terminally ill and psychiatric patients in Europe and North America (Stephens 1994). Ironically, in those societies where spirituality and health are inextricably linked, health and development workers seem to resist or ignore this need for their patients.

Conclusions

Mental illness is a significant cause of disability in the developing world and has been largely ignored in health-related development activity. In many SSA societies, the impact of economic structural

adjustment in impoverishing the people, the breakdown of traditional community and family relationships due to urban migration, and the devastating effect of AIDS are likely to cause an even greater impact on the psychosocial health of individuals. There is abundant evidence that most of these problems are not adequately dealt with in government primary health-care settings. In such a situation, our most urgent message is that mental health should be firmly on the agenda of development activity. It is important to recognise that mental illness as defined in Euro-American society does not translate with the same contextual meaning in many African countries. Thus, what is often included as a mental illness is to be found in the broader realms of socio-spiritual problems which we prefer to refer to as psychosocial distress. Such distress is intimately related to a community's overall sense of well-being and development, to its economic strength, to the network of social and spiritual relationships, and to the indigenous health carers and religious leaders in that community. In delivering mental-health services, development activity should recognise these important interactions between mental health, culture, and religion.

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