

# WORLD

Zeitschrift für Medizinethnologie • Journal of Medical Anthropology

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**Kultur, Medizin und Psychologie im Dialog I  
– Bilanzen im interdisziplinären Arbeitsfeld  
Ethnologie & Medizin.  
Beiträge zur 21. Fachkonferenz  
Ethnomedizin 2008, Remscheid**

**Zum Titelbild:** Das Titelbild zeigt ein Exponat aus dem Essener Museum "Soul of Africa". Das im Ortsteil Essen-Rüttenscheid gelegene Privatmuseum von Henning Christoph besitzt unter Anderem speziell zur westafrikanischen Voodoo-Kultur vielfältige Exponate (Rüttenscheider Str. 36, 45128 Essen). Das Museum wurde während der 21. Fachkonferenz Ethnomedizin in Remscheid besucht. Die Abbildung wurde freundlicherweise zum Nachdruck zur Verfügung gestellt. [www.soul-of-africa.com](http://www.soul-of-africa.com) © by Soul of Africa e.V. mit freundlicher Unterstützung von [www.shikra.de](http://www.shikra.de)

**To the title:** The cover shows an exhibit from the private museum "Soul of Africa" in Essen-Rüttenscheid. This museum is specialized in voodoo culture from West Africa. An excursion to this fine museum was part of the Remscheid meeting.

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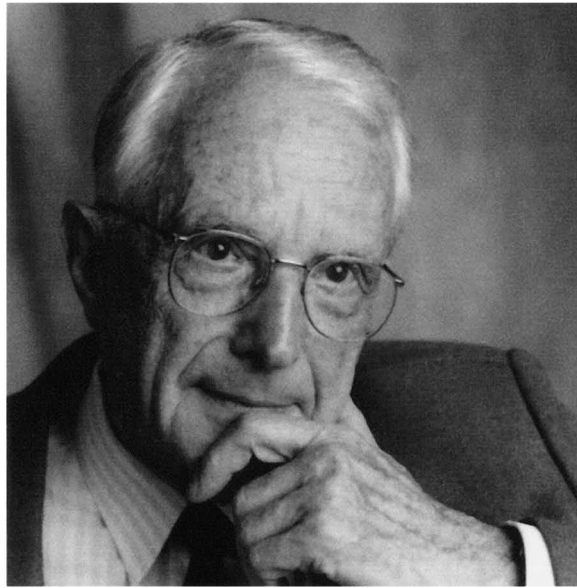
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*Die Arbeitsgemeinschaft Ethnomedizin  
widmet diese Curare-Ausgabe ihrem im 93. Lebensjahr stehendem Ehrenmitglied  
ERNST EDUARD BOESCH aus St. Gallen,  
dem bedeutenden Psychologen, Psychoanalytiker und Kulturtheoretiker*



**It is the dilemma of psychology to deal as a natural science with an object that creates history. Indeed, the being whose perceptions, thoughts, and emotions we patiently study in time-consuming experiments, is at the same time the inventor of electricity and atom bombs, carrying the names of Mozart, Picasso, Einstein, Churchill, Hitler, Stalin, or Pol Pot; it is the one who inquires, nurses, builds, tortures, kills, and seduces. The real actions of the object of our studies, their profit or loss to society, occupies only a small place in psychological publications. It seems as if there were two kinds of human beings, the ones in the aseptic laboratories of psychologists, and the other ones with whom we live as partners, friends, or enemies.**

**—E. E. Boesch, 1971**

Rückseite des Buches von WALTER J. LONNER & SUSANNA A. HAYES (eds) 2007. *Discovering Cultural Psychology. A Profile and Selected Readings of Ernest E. Boesch*. (A volume in "Advanced Studies in Cultural Psychology"). Charlotte, North Carolina: IAP, Information Age Publishing, 371 S. mit einer kompletten Liste der Veröffentlichungen Boeschs von 1942-2006.

## Whose Madness? Diverging Manifestations of Mental Illness in Dialogue

ARNE S. STEINFORTH

**Abstract** The manifestation of madness is specific for a given socio-cultural context which, in turn, is subject to processes of transformation and interaction. This dialogue between diverging ways of conceptualizing mental illness, however, reflects the experience and background of the individual patient, the specialized healer, and the community on different levels. Arguing on the basis of anthropological data from Eastern and Central African contexts, this article suggests that the social identification of madness—in the sense of socially recognized behavioural criteria—is less prone to adopt new notions than the interpretation of the condition as performed by local specialists. At the same time, the experiences and life histories of persons affected by mental illness have a strong impact on its manifestation, and historic as well as recent case examples demonstrate how personal exposure to different concepts of mental normality and abnormality has the potential of leading to their involuntary incorporation. In the face of globalization and transnational migration, the distinction between “own” and “foreign” manifestations of madness disappears, refocusing scholarly attention to more complex, dynamic processes of cultural exchange.

**Key words** madness – mental illness – psychiatric disease – psychiatry – migration – colonialism – cosmology – Eastern Africa – Malawi

### Wessen Wahnsinn? Divergierende Manifestationen von psychischer Erkrankung im Dialog

**Zusammenfassung** Die Manifestation von psychischen Erkrankungen ist spezifisch für ihren jeweiligen soziokulturellen Kontext, welcher seinerseits Prozessen der Transformation und Interaktion unterworfen ist. Die Erfahrungen und Hintergründe des jeweiligen Patienten ebenso wie die der Heilspezialisten und der Gesellschaft jedoch reflektieren diesen Dialog zwischen divergierenden Konzepten von psychischer Erkrankung. Auf der Grundlage ethnologischer Daten aus dem ost- und zentralafrikanischen Kontext weist dieser Artikel darauf hin, dass die soziale Identifikation von Verrücktheit im Sinne sozial anerkannter Verhaltenskriterien weniger aufnahmefähig für neue Ansätze ist als die Interpretation des Zustandes durch lokale Spezialisten. Gleichzeitig haben die Erfahrungen und Lebensgeschichten von Menschen mit psychischer Erkrankung einen starken Einfluss auf ihre Manifestation, wobei historische wie auch neuere Fallbeispiele unterstreichen, wie persönliche Berührung mit unterschiedlichen Konzepten von psychischer Normalität und Anomalie zu deren unfreiwilliger Inkorporierung führen kann. Im Zusammenhang von Globalisierung und transnationalen Migrationsbewegungen verwischt hierdurch die Unterscheidung zwischen „eigenen“ und „fremden“ Manifestationen von Verrücktheit und richtet sich die Aufmerksamkeit auf komplexere und dynamische Prozesse des kulturellen Austausches.

**Schlagwörter** psychische Erkrankung – Psychiatrie – Kosmologie – Kolonialismus – Migration – Verrücktheit – Wahnsinn – Ostafrika – Malawi

### Introduction

Continued migration from non-Western countries into Europe and Northern America has given rise to considerable awareness of cultural issues in the field of psychiatry, implementing the fundamental realization that people in or from other societies may have distinctly different ideas about what madness is—how it can be recognized, caused, and addressed in both therapeutic and social terms. Today, an African or other immigrant having a completely different understanding of his mental condition or even showing uncommon symptoms is part of everyday

practice for psychiatrists or clinical psychologists in Germany or elsewhere in the so-called Western world. The supposedly rigid demarcation between “our” and “their” kinds of madness, however, appears as the black-and-white rendering of a much more colourful and complex picture. In an African context, the introduction of Western concepts of psychiatry into local societies and their medical discourses affects these in various ways and on different levels. This form of cultural exchange, however, is not—nor was it ever—a unidirectional process,

bearing a high risk of conflict for the respective local settings.

In this article I illustrate the communication between diverging models of mental illness by focussing on the different dimensions of its social reception and interaction. A substantial part of my argument is based on data from anthropological field research in Malawi, East-Central Africa (cf. STEINFORTH 2009). Most non-English terms that appear throughout this article derive from Chichewa language spoken in Malawi as well as in parts of Zambia and Mozambique, whereas some terms of the Maasai language used in Tanzania and Kenya occur in the context of an additional case example.

### Madness between Own and Other

From the perspective of social psychology, mental illness and cultural foreignness resemble largely comparable concepts. In Erving Goffman's terms, both situations aggravate or even inhibit a given person's recognition as a normal member of society by implying social stigmatization (GOFFMAN 1967: 4). In the history of European psychology and anthropology, the "madmen" of one's own culture have long been rendered analogous if not equivalent with "primitives" from some distant continent. An obvious example for this approach is Sigmund Freud's well-known 1913 volume on *Resemblances Between the Mental Lives of Savages and Neurotics* which argued that certain mental states, surfacing only occasionally in Europe as an expression of neurosis, were still part of the accepted social norm in societies of the so-called "savages". Neuroses, in Freud's evolutionist line of thought, therefore resembled regressions to an earlier, "primitive" stage of mental development (FREUD 1964). His influential work even motivated early psychoanalysts to verify its results in concrete local contexts—such as Arnaldo Melo Sequeira who tried to apply Freud's theoretical concepts to the cultural realities he encountered among some ethnic groups of Inhambane Province, Southern Mozambique, in 1934 (STUBBE 2008: 111-118).

Later contributors have sought and found other ways of supporting Freud's perspective and, in doing so, have put whole parts of non-European societies under a general suspicion of insanity by interpreting selected local practices and phenomena as expressions of socially institutionalized madness. Åke

Ohlmarks infamously disqualified the ritual experts in Siberian shamanism as victims of an assumed "arctic hysteria" (OHLMARKS 1939; cf. HAAS 1976), while John CAROTHERS, on the basis of Kenyan child rearing conventions, collectively described the followers of the Mau Mau Uprising as lacking normal mental development (CAROTHERS 1954; *ibid.* 1970). With remarkable frequency, Africa has been used as a focal point of reference, leading Sander Gilman to point out the close association between African-ness and psychopathology within the discourse of colonial psychology (GILMAN 1985: 132; cf. MAHONE 2007: 48-51). Throughout this fundamentally racist debate, the idea of a *savage madman* therefore appears as tautological in itself because "If madness, in Porter's words, is 'a foreign country', what of madness in a colony?" (VAUGHAN 1991: 101).

In academic discussion, the cultural specificity of what is defined as normal or abnormal is now well-recognized, and scholarly debate has addressed the tenability of a universalist concept of a "normal" human state of mind at a comparably early point. In one of the first anthropological contributions to the discussion, Ruth BENEDICT (1934) compared local notions of epilepsy in North America and in Siberia, reasoning that the cultural meanings attributed to the phenomenon were dissimilar and, therefore, culture specific. In conclusion, she described concepts of normality and abnormality as social allocations reflecting locally approved values and behavioural norms. Erwin ACKERKNECHT (1971) later elaborated on this assessment, declaring normality—in the sense of a state of mental health—as a cultural specific variable rather than a fixed ontological category. This criticism on the alleged universal validity of Western psychiatry is mirrored in the anti-psychiatry movement which regarded cultural definitions of mental illness as an expression of social hierarchy and political power dynamics rather than clearly definable human qualities. From this perspective, mental illness would have to be looked at as a product of society and a reflection of its own suppressive and normative structure (cf. FOUCAULT 1989; SZASZ 1970).

To some anthropologists, this radical relativism may appear enticing. It is, however, arguably not a central interest of medical anthropology to falsify the ontological existence of mental illness as such. A more conciliatory approach is presented, e.g., by Ian HACKING who, in response to controversies be-

tween claims of universal realism of the natural sciences and the paradigm of social constructionism, developed a very instructive model that outlines the interdependency between biological and social processes in the manifestation of mental illness (HACKING 2000: 100-124). From such an integrative vantage point, the conceptual obstacles between psychiatry and anthropology become surmountable, and even more relativist concepts such as Yap's influential *culture bound syndromes* then translate and open up to the wider psychological discussion (YAP 1965; cf. KIEV 1972: 65-92).

The long-held Eurocentric belief in the universal applicability of Western psychiatric conceptions, however, still has a lasting and worldwide effect on local settings. In many parts of Africa, European colonization and the post-colonial influence of Western-oriented global health agencies have led to the development of a pluralistic, frequently stratified and hierarchical social perception of madness. In settings such as Malawi, Western psychiatric notions do not form the dominant frame of reference when it comes to dealing with mental illness, but they represent powerful—complementary as well as conflicting—additions to the broader social discourse.

### Identifying Acts of Madness

What does madness mean in a given local context? One perspective on this complex issue—its classification, explanation, therapy, and social perception—is to focus on the actual processes of identifying a mentally ill human condition. In many parts of Africa, madness is thought of from a community perspective, i.e. in primarily external terms as *something someone does* – rather than what he or she thinks, feels, sees, hears, etc. (cf. LITTLEWOOD & LIPSEGE 1982: 207). When conducting field research in rural Malawi, my repeated questions concerning what constitutes an illness of the head or the mind (*matenda a mutu kapena nzeru*) were therefore mostly answered by local people listing stereotypical patterns of insane behaviour—in contrast to what a normal person is expected to do. Mental illness was addressed by a lay discourse within the community, distinguishing right from wrong and normal from pathological actions on the basis of central albeit frequently implicit social norms and values.

Empirical data suggests that any given society has a conception of normal *versus* abnormal behaviour, and their specific characteristics are determined by cultural processes and conditions. Among the Nyanja, Yao, and Lomwe populations of Malawi, ideas about the typical presentation of mental illness are both well-defined and widely shared across ethnic and linguistic boundaries. In the densely populated, largely agricultural, ethnically diverse, and religiously heterogeneous setting of the Malawian Southern region, a key indicator of mental illness is inappropriately violent behaviour. Someone attacking his neighbour for no apparent reason or setting fire to somebody else's—or even one's own—house or field features as the textbook manifestation of madness (*misala*) and calls for immediate family and/or community intervention. If such a condition is not permanent but occurs in the form of sudden wayward swings of mood, it is addressed as a “spinning of the head” (*kuzungulira mutu*) which, likewise, requires therapeutic measures to be taken. Other locally prominent signs of insanity include a lack of physical hygiene and a general inability or unwillingness to comply with basic social norms. Long untended hair, needlessly dirty and torn clothing, or public nudity—issues which, in many European contexts, might be tolerated as expressions of adolescent nonconformity, social protest, or artistic avant-gardism—are described as clear signals for a psychopathological state of madness (*misala*) or, if connected to non-violent but explicitly apathetic behaviour, to an equally serious condition of foolishness (*kuzerezeka*). Social withdrawal and the neglect of societal obligations are also considered as symptoms of severe mental problems. In some European contexts, a lack of interaction with next-door neighbours, some degree of social isolationism, or dissociation from one's family is almost normative; in a Malawian setting, a person easily qualifies as mentally ill if he or she does not attend the funeral of a close relative, does not take appropriate care for fields and crops, or does not engage in community activities or socialize with family and friends.

On this level of identifying madness according to behavioural criteria, local Malawian notions seem to display no immediate signs of Western influence. The concepts of Western psychiatry are, especially among the rural majority of the population, virtually unknown, and their textbook presentations do not appear to have an immediate equivalent.

When trying to explain the hopelessness or even auto-destructive tendencies associated with severe states of depressive disorder, Maxwell Mponda and Richard Nkhanjera, two of my Nyanja counterparts, shake their heads and express their concern for the sanity of the Europeans (*azungu*). Richard later on remembers hearing about a case of suicide when he was in the far North of the country, recollecting that this incident was rumoured to be related to mental illness. In their Chichewa vocabulary, the closest resemblance to my description of depression is a condition of *kukhumudwa* or being upset. Such a case, however, is always connected to an immediate reason for worrying—e.g. the loss of a loved family member—and is therefore considered *not* as a pathological condition *but* as a normal human reaction to a personal crisis situation. Neither local healers (*asing'anga*) nor Western doctors (*madokotala*), Maxwell insists, have any treatment against *kukhumudwa* because none of them can reverse the situation causing worry or grief to the respective person; the only solution would be to come to terms and resolve or accept the problems one is facing. In a later interview, Stan Kutsamba and Cedric Mpomba, two nursing officers working in a governmental District Hospital, support this assessment, emphasizing that they hardly ever receive patients showing clinical symptoms of depressive disorders—recalling only one case over the last three months.

It is worth noting here that local discourse rarely focuses on the “internal dimension” of madness as a key indicator; a mad person (*womisala*) articulating his or her alleged delusions is frequently disregarded as talking nonsense (*kubwebweta*) which therefore is of little significance. In essence, the personal experience of the insane is not considered to be instructive for understanding his or her condition; their behaviour, however, is. Local healers (*asing'anga*) analyse a given person's specific patterns of behaviour—e.g. always walking up and down, salivating profusely, collecting garbage, etc.—in order to diagnose the reason for the particular condition (see below).

After all, emic notions of pathological behaviour constitute a negative blueprint of local concepts of socially normative conduct; the question *Who is mad here* reflects an implicit notion of *What is normal behaviour*. In Malawi, politeness, submissiveness, a good mental balance, self-discipline, and placidity as well as responsibility, reliability,

(re)productiveness, and a general adherence to the social role are central values that set the standards of ‘normal’ conduct. Public and deliberate deviations from this norm indicate a state of mental abnormality that, unless situational, is more than likely to be regarded as pathological. In this way, the apparently non-normative behaviour of white foreigners (*azungu*) is frequently described as some kind of mental condition. Half jokingly, many of my Malawian counterparts agreed that the Europeans' lacking knowledge and respect for basic cultural norms, their frequently unpredictable and unreasonable restlessness as well as their obvious social isolation qualify most *azungu* as being in some state of mental illness, usually described as slight cases of foolishness or *kuzerezeka* (STEINFORTH 2009: 142). It is, in fact, fairly common in everyday Chichewa to distinguish between *azungu* and *anthu* (persons).

### Questions of Causality

So far, I have argued that the ways in which mental illness is conceptualized in Malawi do not seem to easily incorporate elements of Western psychiatry—as long as we focus on the identification of how madness expresses itself in abnormal human behaviour. This, however, constitutes only one level of social interaction. As a second and, in some respect, complementary dimension of society defining madness, the level of interpretation and explanation also needs to be considered.

As in many parts of Southern Africa, Malawian cases of mental illness—defined as specific forms of behaviour—are not immediately associated with a corresponding cause. Two cases of *misala* madness, expressing themselves in virtually identical behavioural patterns, may be attributed to very different reasons due to circumstances that are invisible to the lay person. In order to determine the causative factors for a given case of madness, it is necessary to enlist the assistance of health professionals—including Western psychiatrists (*madokotala*) but, due to their limited availability, more often than not referring to the religious specialists of either Muslim or Christian groups (*ashehe* and *abusa*, respectively) as well as the omnipresent local healers (*asing'anga*). Especially the latter play a crucially important role within their local communities, acting not only as medical experts but also as communicators between the living and the spirits of their

ancestors (*mizimu ya makolo*), as mediators in cases of social conflict, and as preservers of local knowledge (cf. KAPAPA 1980).

The central expertise of these different health professionals (*ashehe*, *abusa*, and *asing'anga*) lies in their use of various divinatory techniques—i.e. by use of a *maula* divination gourd, by nocturnal communication with various spirits (*mizimu* or *majini*) as well as angels (*angelo*), or by diagnostic consultation of Qur'an and Bible. The outcome of these acts of divination then forms the foundation of the subsequent diagnosis which, in turn, establishes the cosmological semantics of the condition.

In medical anthropology, various catalogues of explanatory approaches to mental illness have been presented, and typologies of African models of explanation such as offered by Ezekiel KALIPENI (1981), for instance, are supported by numerous ethnographers. Classic Malawian notions such as the influence of angered ancestral spirits (*mizimu ya makolo*) or possession by other, wild spirits (*ziwanda*) as well as the effects of malevolent magic (*ufiti* or "witchcraft") therefore resemble showcase categories which, with minor regional modifications, feature broadly throughout the African continent. The historical introduction of cosmopolitan religions (i.e. Islam as well as Christianity) and Western science along with their respective approaches to illness and its causation, has added new ideas to the discourse on mental illness in Malawi. The will of God, for instance—being defined alternatively as divine punishment or indiscriminate demonstration of godly omnipotence—is currently gaining ground as an accepted cause for mental illness. The growing Charismatic and Pentecostal communities in Africa, on the other hand, support the notion that the deeds of Satan can only affect those who, due to their own sinfulness, do not enjoy the protection and healing presence of Jesus Christ in his function as the ultimate *sing'anga* (cf. SCHOFFELEERS 1994). Other interpretations, however, hold that certain cases of madness "just happen" (*zimangochitika*) without any actual reason. Moreover, drug abuse due to the excessive smoking of local Indian hemp (*chamba*) is frequently described as a common but, nonetheless, comparably recent factor in the causation of *misala* madness (CARR *et al.* 1994).

But local experts suggest a multitude of additional explanations derived from their personal expert knowledge of the inner workings of the human

mind. Doctor Sangwe, a local *sing'anga* from the Lomwe ethnic group, for example, insists that, in order to understand the complexities of the mind and its malfunctions, it is imperative to realize that human intelligence resembles a worm (*kachimbozi*), roaming freely in the brain and facilitating reasonable thought and action due to its movement therein. Miniscule obstacles within the brain, however, can make certain regions inaccessible to the mind-worm—and the resulting imbalance would then express itself in socially inadequate and obviously irrational behaviour classified as madness (*misala*). Other specialists explain certain cases of mental illness as being congenital, associating the given condition with the problems of other, older members of that same family group (*chibale*). Frank Chagoma, a Pentecostal *abusa*, therefore suggests that a person's madness (*misala*) may be caused by the evil deeds of his or her forefathers. The demonic spirits (*ziwanda*) called upon by this ancestor's actions are passed on through the line of blood (*magazi*) and will keep manifesting themselves in innocent members of that same family until these evil forces are finally driven out by divine power that can only be evoked through prayer.

### Discussing Processes of Interaction

On both above mentioned levels—that of expression and identification on the one hand and that of explanation and interpretation on the other—a certain amount of interaction between local and global conceptions of mental illness can be observed. The degree to which scientific, Christian, or Muslim ideas are incorporated into the Malawian discourse of madness, however, is specific for either of these two levels. When reasons for mental illness are addressed, it is increasingly difficult to distinguish a coherent frame of reference. While some "core concepts" (such as spirit possession or magic manipulation) clearly resemble genuinely local notions of mental illness causation, many others concepts show the incorporation of or interaction with Western ideas or motifs. Drug abuse as a reason for madness is described as a recent phenomenon which corresponds, at least superficially, with Western psychiatric assumptions concerning mental health risks due to cannabis consumption; the idea of a *quasi* random occurrence of mental illness stands in contradiction to the otherwise strong cosmo-

logical semantics of health in Southern Africa and therefore appears to imply adoption from Western medicine; local definitions of congenital insanity combine Western ideas of inheritance and genetics with the ancestor spirits of local cosmology; and seeing madness as an act of God clearly refers to the dogma of Islam and Christianity, cosmopolitan religious institutions which, from the mid 19<sup>th</sup> century onwards, exercise an ever growing influence on the mental health discourse in this part of the world. Local explanations for madness thus constitute a highly mobile discussion which is open to the introduction of new concepts and, therefore, to the effects of migratory processes.

The identification of madness, however, seems to follow more fixed “traditional” criteria that do not show the same amount of immediate references to external categories. Local ideas of what madness looks like do not seem to undergo the same processes of change. On closer observation, however, the assertion that the Malawian discourse on mental illness partly incorporates, partly rejects foreign ideas is by no means mysterious. The two different levels of local discourse—identification *versus* interpretation—interact with new influences in different ways, and this is to a large degree related to the specific social location of Western psychiatry in the African arena.

Across Africa, colonial mental health institutions were primarily concerned with custodial services, their facilities frequently developing as extensions of local prisons. While mentally affected Europeans—colonial administrators and settlers alike—were likely to be sent back to their home countries for psychiatric treatment or care, these asylums were designed to provide secure custody for the criminally insane native (cf. McCULLOCH 1995: 12-45, SADOWSKY 1999: 12-25). In Malawi, Zomba Lunatic Asylum (now Zomba Mental Hospital) was established in 1910 as an annex to the central prison. Most inmates admitted in the first years were charged with committing crimes such as murder or arson (VAUGHAN 1983: 221-222)—manifestations which still meet the local criteria for madness (*mis-ala*). Ever since, Zomba Mental Hospital remained the only governmental psychiatric institution in the country, and its admissions are diagnosed along the lines of Western psychiatric terminology: in 1936, its 84 all-local patients were categorized as schizophrenic (30 cases), psychotic (18), or epileptic (11)

while the condition of only one patient seemed to escape easy classification and could not be diagnosed (SHELLEY & WATSON 1936: 704). Schizophrenia continued to feature as the most common diagnosis, with 352 out of a total of 591 admissions being labelled schizophrenic by the year 1958 (SOW 1980: 16-18), and by 2005, schizophrenia was still described as the most common condition among persons admitted to the institution.

Ever since its establishment, Zomba Mental Hospital has received in-patients from a large catchment area extending across and, in part, far beyond the Southern region of Malawi. Interaction between the institution and local communities is very limited, and in most cases, these communities conceive of Zomba Mental Hospital as a last resort. To residents of the city, it is a common sight to see small groups of people arriving on the backs of lorries or *matola* pickup trucks in order to deliver a mad member of their community, hands tied behind the back, to the mental institution. After the handover, the community members return home, and the frequency of visits—depending on the distance between home and hospital, the availability of transport and funding, and the amount of damage that his or her madness has already inflicted on the relationship between the new inmate and his or her community—are generally described as low by the local nursing staff.

This observation clarifies a key element in my analysis of the “levelled” dialogue between diverging concepts of madness. As socially isolated institutions, asylums such as Zomba Mental Hospital have only minor impact on the identification of what manifests mental illness. Rather, they receive and keep persons whose condition has already been declared “mental” on the basis of local and mostly lay assessment and whose behaviour poses a threat to the social order within their respective communities. The explanations and management options they provide do not reach the majority of local society, but they are restricted to those few who come into direct contact with Western psychiatry—i.e. the inmates themselves and those relatives who take the pains of visiting and inquiring for the psychiatric diagnosis. Therapeutic specialists, on the other hand, have access to information concerning previous explanations given to their patients, and many of them make an effort to incorporate new ideas into their personal agenda. In the 1980s, Jerome Msonthi outlined the concentrated efforts to establish coop-

eration between Western and local health experts in Malawi for the sake of better mutual understanding and reciprocal learning. For some time, an organization of local *asing'anga*, the Herbalist Association of Malawi, was therefore admitted to participate in interdisciplinary research with the University of Malawi on the use of medicinal plants and other medical issues (MSONTHI 1983a, 1983b). Unfortunately, this ambitious project was discontinued after a few years without establishing more inclusive structures (cf. MORRIS 1996: 99-100), and some notable suggestions to advocate the incorporation of local *asing'anga* into Western psychiatric services in Malawi (cf. MACLACHLAN, NYIRENDA & NYANDO 1995: 84-85) have, so far, remained unsuccessful. Nonetheless, many local *asing'anga* express their explicit wish to cooperate with Zomba Mental Hospital and complain about the fact that they are not allowed on the premises in order to provide additional therapy. Nurses working at Zomba Mental Hospital, however, report that inmates frequently try to escape from the institution – not to return to their home communities, but to access alternative treatment options as provided by a nearby *sing'anga*.

It has been indicated already that this process of interaction is by no means a harmonious one. The pluralism created between the various actors is hierarchical and, in part, exclusive. In general, Western-trained medical professionals in Malawi tend to have little knowledge and even less appreciation of the *sing'anga*'s medicine, and their relationship to Muslim or Christian models of explaining mental illness is often dichotomous. Careful not to question the overall spiritual authority of both Islam and Christianity, most Malawian doctors and nurses nonetheless express their disbelief in the faith healing practices some of these groups perform. Their argument seems to reflect governmental policy which, in line with the agendas of international health agencies, supports the superiority of Western health facilities as the only appropriate means to overcome continual public health concerns.

The dogma of many religious communities, on the other hand, rejects local medicine as “satanic” and evil, and a number of them also question the moral integrity of Western health services. The aforementioned Frank Chagoma, *abusa* in a local Pentecostal church, therefore complains that “you do not have reliable medicine anymore these days because witchdoctors and scientists have joined

forces.” He admonishes his congregation not only to refrain from consulting a *sing'anga* but also to avoid the “evil forces at work in the hospitals” by seeking salvation exclusively in the healing powers of prayer and devotion to Jesus Christ. Whilst a broad and intensive dialogue between diverging conceptions of mental illness has thus been established, conflicting claims of superiority so far make eye-level interaction within this pluralism of medical systems a vision of the future.

### Going Mental, across the Border

Up to this point, my argument seems to be that people get mad according to the conceptualization of madness prevailing in their socio-cultural context, and that this must be regarded as a fairly static, inflexible concept. Such a conclusion, however, misses an important point. In social anthropology, the idea of ethnicity as a monolithic unit predefining a society's worldview has made way for a more process-oriented, generative notion of dynamic cultural interaction (cf. MORRIS 2000: 18-19). Paul KAPAPA (1977) has rightly outlined the different local interpretations of a given kind of abnormal behaviour among neighbouring ethnic groups in Central Malawi. The picture of a set of separate and homogenous cultural settings with their own distinct conceptions of madness—African *versus* European or, as in KAPAPA's case study, Yao *versus* Ngoni—increasingly makes room for a more complex reality. The relevance of ethnic distinctions as core indicators for the perception of madness has to be understood in a larger context of exchange across cultural, national, or regional spheres of influence. The controversial relationship between culture and specific notions of a *normal* and *abnormal* mental condition only becomes fully visible by transcending these imaginary boundaries between supposedly separate social units. The migration of persons as well as of ideas affects the way mental illness is conceived of, and it does so not only on the level of its local explanation—e.g. by introduction of categories such as schizophrenia or depression—, but also in terms of how it is experienced and expressed by the individual person.

In her brilliant article on madness in colonial Malawi, Megan VAUGHAN (1983) quotes a historical case study as reported in the files of the National Archives that shall be discussed here for better illustra-

tion. In 1904, the assistant colonial administrative officer R.R. Racey filed a report concerning his own mental illness which had affected him a few years previously at his station in Chikwawa in Southern Malawi, then part of the British Central Africa Protectorate. As he reports,

“I have seen the spirit of unchaste love which causes many to do things which they regret afterwards; in shape it was like a dolphin and absorbs the intelligence of its victims, also creates unlawful passions. Certain spirit power, I will not say that of Mbona, has been so strong at Chikwawa as to move my feet across the ground against my will, it also twisted my legs and took them away from under the table while at meals on several occasions. To me it appears that the stronger and purer in essential quality the individual is, so in proportion will he have influence, not only amongst the native and climatic conditions here, but also the world over” (quoted from VAUGHAN 1983: 218).

Obviously, Mr. Racey’s own experience was strongly influenced by local cosmological concepts, regarding both the explanation (i.e. possession by the spirit Mbona) and the expression (e.g. his “unlawful passions”, or his insinuations to dance rituals) of his madness. The mentioned territorial spirit Mbona, later investigated at length by Matthew SCHOFFELEERS (1972; 1992), was prominent enough around the year 1900 to not only come to the attention of a local colonial officer but even to affect his personal experience of mental distress. It is worth noting that Mr. Racey explicitly contradicts the assumption of him falling victim to some “native”, local form of madness, describing Mbona’s influence as overpowering all kinds of social as well as regional or “climatic” limitations.

In the same time period, moreover, accounts from Tanzania mention a virtual epidemic of an unknown mental illness among colonial administrators nicknamed *masai-itis*. Elspeth HUXLEY (1948) portrays the case of a British Colonial District Commissioner “going native” and insane at the same time when entering his superior’s office in Arusha capped and gowned in full Maasai attire—including the notorious red *shukà* gown, leather sandals, *alalém* machete, and spear. After his grand entrance, he reportedly fell into a shaking fit which resembled the ritual performance of a Maasai warrior (*morán*). Such incidents, accordingly, were interpreted as epi-

sodes of a serious yet unclassified mental illness that threatened to incapacitate British administration in certain areas of the colony because

“[...] officers often fall victim to a complaint known both in the Kenya and Tanganyika administrations as Masai-itis. [...] For fear of Masai-itis, it is unusual nowadays to leave a man in Masai country for more than two or three years” (HUXLEY 1948: 96-97).

According to shared contemporary explanations as reported by HUXLEY, the occurrence of masai-itis was triggered by close and prolonged social interaction with local Maasai groups, manifesting itself in loyal British colonial officers mimicking Maasai customs to the point of insanity.

Both historical examples outline the dynamic aspect of interaction between diverging concepts of madness. To my knowledge, there appears to be a lack of more extensive studies examining the incorporation of non-Western concepts of madness into the manifestation of mental illness in European immigrants in, e.g., African countries. It could be expected that more recent case histories show similar features as those of the abovementioned colonial officers in the early 20<sup>th</sup> century who, in a state of mental distress, adopted culturally foreign conceptions of madness in response to their changed socio-cultural environment—and in spite of Western scientific claims of superiority over local cosmologies.

This cross-boundary manifestation of madness works both ways. From a European perspective of psychiatry and migration, it may be less surprising that Western ideas of psychiatry find their way into how African people experience and explain their own mental illness. The more recent case of Janet Mkhanda, a senior NGO manager in Malawi, may help to substantiate this point. Born in the urban context of the capital Lilongwe, she had gone to live and study in Europe for some years before returning home, raising a family and pursuing her professional career. After the tragic loss of her husband as well as numerous other relatives, Mrs. Mkhanda learned about her own HIV infection, and even though she tried to cope with the situation, she soon described her condition as depressive, itemizing feelings of utter sadness, despair, inability to perform at work, unwillingness to interact with others, and a general tiredness of life. She rejected her family’s proposals of involving a local healer

(*sing'anga*) in order to find the reason for her mental condition but consulted numerous psychologists and relied on anti-depressives to keep herself going. After some years of therapy and with antiretroviral medication against HIV becoming more available, she gradually recovered and, by 2008, is back in her profession, describing herself as content.

This additional case means to demonstrate how personal affinity to and familiarity with Western concepts of psychiatry influence the way mental problems are experienced, expressed, and explained. While society as a whole tends to maintain certain ideas on the manifestation of madness, individual persons potentially adopt other, new and/or foreign concepts due to their own socio-cultural backgrounds and, more especially, personal histories of migration.

### Conclusion

It has been my intention in this article to stress the bidirectional translatability between apparently conflicting concepts of mental normality and abnormality. In so doing, I have found it necessary to differentiate two levels of interaction between diverging ideas of madness in order to demonstrate the dimensions in which a local discourse is affected by the introduction of new, "foreign" notions. In Malawi, the expert discourse of interpretation is much more likely to incorporate culturally heterodox ideas, showing a high degree of tolerance towards cosmological ambivalence. Here, the general availability of information may be identified as the limiting factor. Health specialists working from a strongly Muslim or Christian perspective (*ashehe* and *abusa*) are, due to their higher degree of formal education, usually familiar with the basic concepts of Western medicine as supported by local government and, through their work in the communities, have some information about the medical agenda of local *asing'anga*. These healers, on the other hand, are themselves exposed to the teachings of the larger religious groupings in and around their community, and they have likewise been shown to incorporate and transform the knowledge they obtain about Western medical concepts. Society at large, however, is also subjected to a wide variety of conflicting ideas about the causation of madness, and they usually deal with this contradiction in a pluralistic fashion by ignoring the various claims of

exclusiveness many of the professional health actors convey on them. But none of these focus on re-defining mental illness in terms of its presentation: local hospitals do not offer outreach activities to teach local communities about how to recognize, e.g., depression, and Pentecostal churches may visit remote areas in order to spread their message on the satanic influences that may lead to madness—but not in order to redefine how mental illness can be identified.

Western psychiatry, religious groups, and local healers provide treatment services for those sent to their institutions. The initial classificatory step of identifying madness on the basis of behaviour, however, precedes their involvement and is therefore mostly untouched by the various expert discourses, thus maintaining pre-existing local notions and showing resilience to the incorporation of global influences. A psychological study carried out in Zomba Mental Hospital has confirmed that most admitted patients defined the causative background of their own condition in "traditional" terms while some respondents combined local and medical/psychological ideas in their explanations (MAC-LACHLAN, NYIRENDA & NYANDO 1995). After all, it has been clarified before that non-Western people do not think of health problems only along the lines of categories used in their however defined societies of origin (cf. LITTLEWOOD & LIPSEGE 1982: 196). But even the actual expression of madness is, as the last case examples have shown, prone to incorporate new ideas. Here, however, the specific socio-cultural environment and history of the individual person acts as the dynamic factor, while the general lay knowledge tends to undergo only slow and more gradual processes of change.

On the basis of empirical data presented here, clear distinctions between "own" and "foreign" concepts of mental illness appear no longer tenable, and historical cases presented later make it questionable if indeed they ever were. Rather, diverging ideas of madness interact with each other and, like other expressions of human culture, may transform into innovative notions in spite of apparent conflict while migrating across boundaries both geographical and socio-cultural.

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