

Cultural Notions of Psychopathology: An Examination of Understandings of Spiritual Healing and Affliction across Cultures

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Abstract

Culture has a vital impact on how individuals and professionals view psychopathology. What some cultures view as a gift of spiritual mediumship and healing, others condemn as psychosis. In many cultures, this idea of spiritual healing, or shamanism, may exist side by side with a belief in more negative altered states, such as demon possession or spiritual affliction, which are often viewed as punishment for wrongdoing. This article will examine varying views of the meaning associated with phenomena that, in the Western world, would be referred to as delusions, hallucinations, or dissociations. The beliefs, practices, and experiences that characterize shamanism will be outlined and will be juxtaposed with a Western psychological understanding of the same phenomenon based on the symptoms presented. In addition, the article will examine what some cultures view as "spiritual affliction," a condition often treated by shamans. Similarities between shamans and therapists will be explored and conclusions will be drawn about what Western psychology may learn from traditional healing models.

Cultural Notions of Psychopathology

Several years ago, during a semester abroad in Ghana, West Africa, I had the opportunity to meet a traditional Akan priestess and observe a possession ceremony. I observed her being physically taken over by a spirit. Her eyes became wide, and her entire demeanor took on a different quality. She danced, grunted, and yelled, and then without hesitation returned to her earlier state. The priestess explained to us that as a child she was chosen by the spirits. At that time, the spirits took her into the woods for 2 years and taught her how to use her powers. She made clear to us that one who gets the calling but not the education is just a "plain old crazy person." Immersed in the culture at the time, I believed completely in this woman's powers. But as I sat in a psychology class in the United States months later, I began to wonder: Was this woman in fact having a dissociative episode? Was this period of two years in the woods actually a euphemism for some kind of traumatic experience? What was it that she learned there that made her different from just a "plain old crazy person?"

Mental health professionals should be aware that mental illness exists in a cultural context. Some might have immediately diagnosed the Akan possession ceremony as a psychotic or dissociative episode. Others, such as a Ghanaian acquaintance of mine who was studying traditional religion at the time, would disagree. When I inquired about this issue in a letter to this friend, he responded:

On the superficial level, one might want to agree to some extent because different spirits and personalities are revealed at different times. But possession to me is an entirely different ball game. Possession is highly religious and very spiritual and of course a physical manifestation of spiritual bodies. Although it can come by itself, it is also invoked and the individual is only used as a medium of communication to the people when the need arises. (Y. Gwamfi, personal communication, July 29, 1999)

For Mr. Gwamfi, there is no question that this phenomenon is religious rather than psychological.

Culture, therefore, has a vital impact on how psychopathology is viewed. While some cultures esteem these experiences as a gift of healing, others condemn them as psychosis. This article will examine varying views of the meaning and pathology associated with phenomena that, in the Western world, would be referred to as delusions, hallucinations, or dissociations. In some cases altered states are used in a therapeutic way. Yet in many cultures this idea of spiritual healing, or shamanism, may exist side by side with a belief in negative altered states, such as demon possession or "spiritual affliction," which are often viewed as punishment for wrongdoing. The beliefs, practices, and experiences that characterize shamanism will be outlined here. They will be juxtaposed with a Western psychological understanding of shamanic experiences, which is based on viewing them as symptoms. Spiritual afflictions will also be discussed, including a comparison of the ways a shaman and a Western psychotherapist might treat them. It will be argued that Western psychotherapy may learn from these traditional, shamanic healing models and that viewing mental illness through the lenses of both cultures may yield greater understanding of the impact of cultural norms and beliefs on definitions and diagnoses of mental illness.

Shamanism from the Perspective of Shamanic Cultures

Walsh (1997) defines shamanism as “a family of traditions whose practitioners focus on voluntarily entering altered states of consciousness in which they experience themselves, or their spirit(s), traveling to other realms at will and interacting with other entities in order to serve their community” (p. 103). In some cultures, shamanism is esteemed as a valuable healing tool for treating medical and psychological crises of community members. The term “shamanism” thus encompasses varied cultures that share a belief in spiritual possession and in the power of healing through mediumship. This article will include examples of shamans from two such cultures: the Akan priestess from Ghana, and a Kashaya healer from Alaska.

Walsh (1996) found that while shamanism thus exists in a multitude of cultures, it often consists of three main qualities: an initiation crisis, mediumship or spirit possession, and the shamanic journey. The initiation crisis takes place when an individual is first “called” by the spirit world, much as the Akan priestess was when she described being “chosen by the spirits” as a child. In this state, the individual does not yet know that this experience represents being chosen by the spirits, and he or she may be frightened and disoriented. As Walsh describes,

At this time shamans-to-be may experience themselves as tormented and controlled by spirits. They may exhibit considerable confusion, emotional turmoil, withdrawal from society, and a range of unusual and bizarre behavior such as going naked, refusing food, and biting themselves. (p. 111)

This experience is understandably one that would be interpreted by many Western psychologists as being problematic. We might understand this as a significant impairment of consciousness and cohesiveness of self. Many have interpreted this behavior as reflecting a dissociative state or as a sign of schizophrenia or psychosis. Silverman (as cited in Krippner, 2002), for example, viewed shamanism as a state of acute schizophrenia, characterized by non-reality oriented ideation, abnormal perceptual experiences, emotional upheaval, and bizarre mannerisms.

Though, as with schizophrenia, the “calling” to become a shaman is often not voluntary on the part of the individual, the ability of the shaman to *recover* from this crisis distinguishes this experience from one that would lead to mental illness (Walsh, 1996).

In the case of the Akan Priestess, perhaps this “recovery” occurred through her 2-year education in how to harness her spiritual powers. Whatever it was that the Akan priestess learned during those 2 years in the woods, her experience somehow allowed her to return to the society, not as a “crazy person,” but as an esteemed healer with a special gift. Unlike in the case of severe mental illness such as schizophrenia, in which an individual may become more limited cognitively and affectively after a psychotic break (Gabbard, 2000), shamans seem to return from an initiation crisis with an enhanced ability to experience the world in new ways that are valued by their culture and seen as useful to their society. It could be said that people with schizophrenia may also experience their world in new ways, but Western culture does not view these hallucinatory experiences as valuable to society. This concept of gaining strength through suffering psychological disease is one that is foreign to Western society. Seldom do we conceive of mental illness as an enriching and revelatory experience that, if endured, could lead to greater enlightenment. One exception to this might be the view that psychological crisis is often the root of great art.

Thus, in shamanism it is through the ability to respond to and live through this crisis that a shaman gains power. According to one academic studying this population, those who “refuse the call” may “sicken, go mad, or die” (Walsh, 1996, p. 116). Walsh therefore suggests viewing these disturbances during the initiation crisis as “developmental crises” that can be precipitated by stress and that can lead to “individuation, self-actualization, self-transcendence, and eros” (Walsh, 1996, p. 115).

A shaman who has experienced this initiation crisis and who “heeds the call” often experiences “mediumship,” in which spirits or ancestors will speak or act through the shaman while the shaman is in an altered state of consciousness. Similar to mediumship is the “shamanic journey,” in which the shaman enters into a trance-state, “becomes less aware of the environment, and experiences journeying to other worlds to contact a rich range of spirit beings and visionary experiences” (Walsh, 1996, p. 109). A Kashaya healer from Alaska described this experience:

You hear voices that tell you what to do, and hear songs. When you look at your patient – it’s like the voices are tellin’ you things, and your eyes become like x-ray. It’s really something! You don’t feel your body. You just feel like you’re all brain. Your whole body feels like it turns into a brain – a spirit brain. (Mertz, 1994, pp. 3–4)

Other shamans may describe this experience as one in which spirits speak through them or work through them, using special powers in order to heal the afflicted. When this occurs, the spirit may displace the shaman's personality, and body posture, movements, and voice can change dramatically (Walsh, 1996).

Shamanism from the Perspective of Western Psychology

In western psychology, these experiences are often seen as a form of dissociation, and spirits are conceived of as split off factions of the psyche (Walsh, p. 108). Some have described this state as "dissociative trance disorder," which, in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., Text Revision; American Psychiatric Association, 2000), falls under the category of Dissociative Disorders Not Otherwise Specified and is described as:

Single or episodic disturbances in the state of consciousness, identity, or memory that are indigenous to particular locations and cultures. Dissociative trance involves narrowing of awareness of immediate surroundings or stereotyped behaviors or movements that are experienced as being beyond one's control. Possession trance involves replacement of the customary sense of personal identity by new identity, attributed to the influence of a spirit, power, deity, or other person, and associated with stereotyped "involuntary" movements or amnesia. (pp. 532–533)

Though the DSM-IV-TR understands this to be a culture-bound syndrome, some may still find its inclusion in the manual pathologizing. If a "mental illness" is not considered to be an illness and in other cultures and may even be seen as valuable, should it truly be understood as an illness in Western culture? What makes it pathological in one culture and worthy of great esteem in another? As Grof (1985) points out, "What should be seen as sane, normal, or rationally justified depends critically on circumstances and on the cultural or historical context" (p. 298). While shamans might be diagnosed with a psychotic disorder in a Western cultural context, Grof notes that common Western characteristics of "insatiable ambitions...obsession with technology...[and] the modern arms race...would be seen as symptoms of utter insanity by an East Indian sage" (p. 298). What is socially desirable even in Western culture can be easily viewed as pathological in another culture.

Some researchers have defined shamanism as a

non-pathological form of dissociation ("What is dissociative trance disorder?," 1995), though few have recognized it as a possibly culturally *beneficial* form of dissociation. Yet, it is worth questioning whether this trance-like state even fits the definition of a dissociative episode—pathological or non-pathological, beneficial or non-beneficial. According to ego psychology, dissociation is a defense mechanism. It is used to faction off experiences or parts of the self that are too painful for the individual; it is used adaptively to avoid some form of psychological pain (Gabbard, 2000). According to Gabbard, dissociation is often linked with a history of trauma and serves the adaptive function of splitting of the traumatized self in order for the full self to retain an illusion of psychological control. Dissociation thus occurs as a "vertical split," in which "disparate self schemas...must be maintained in separate mental compartments because they are in conflict with each other" (pp. 270–271).

The Western conception of the underlying nature of dissociation and dissociative disorders is thus very different from how shamanic experience may be conceived of by non-Western cultures. In the existing literature (Walsh, 1996; Walsh, 1997; Mertz, 1994; Krippner, 2002), few authors note shamans as having experienced a trauma, beyond perhaps the initial trauma of the initiation crisis. Furthermore, though one might argue that what shamans experience as spirits constitute multiple self schemas, these schemas are generally not in conflict with one another. Dissociative disorders are associated with a sort of internal strife and denial of various parts of the self, but these aspects are not seen in shamanic trances. Walsh (1996) distinguishes mediumship from dissociation, stating that these spirits are not experienced as aspects of the *self* but as distinct entities that possess knowledge or power outside of the person being possessed. Thus, the "alters" are not factions of the individual's self but are outside of him or her entirely (Walsh, 1996). Similarly, the shaman is not *victim* to these spirits but has complete control over the process. The mediumship experience is not conceived of as an unconscious defense in order to avoid the recognition of pain. Instead, as Walsh points out, "shamans deliberately open themselves to either their own pain and suffering, that of their people, or even that of the 'spirits' in other worlds, and thereby attempt to find a resolution to that pain" (Walsh, 1997, p. 110).

Thus, the shamanic experience differs from dissociative disorder in important respects. Further, researchers have found that these individuals often

show few other signs of psychological impairment. As Ripinsky-Naxon states, “the world of a mentally dysfunctional individual is disintegrated. On the other hand, just the opposite may be said about a shaman” (as cited in Krippner, 2002, p. 966). One group of researchers administered Rorschach inkblots to a group of non-shamans, shamans and “pseudo-shamans” (individuals who considered themselves shamans, but were not viewed as such in their communities). Researchers found that the shamans had a high degree of reality testing potential, and their mental approach was found to be less “hysterical” than other groups. Similar studies described shamans as having a mental state that was simply “freer, and more creative” (Krippner, 2002, p. 966).

The most important distinction between shamanism and mental illness is the curative nature of this power. Though some of these experiences may resemble psychosis or dissociation, shamans are able to use these symptoms for the good of the people around them. Shamans often take on the role of traditional healer, medicine man, folk doctor or even therapist. Frank and Frank (1991) have even traced the roots of psychotherapy back to shamanism. In addition, the “spiritual afflictions” described in the next section are often only effectively treated by shamans and other forms of traditional healers.

Spiritual Afflictions and Demon Possession

Many cultures view the concept of possession as twofold. While shamans receive the call and are able to use their gift for the public good, there are others who are thought to be chosen and tortured by malevolent spirits or to suffer from a variety of different forms of spiritual affliction. These people are often conceived of as haunted, possessed by demons, dispirited, or cursed. They may seek help from various forms of shamans or even Western doctors, psychologists, and social workers. In contrast to shamans, these individuals are often suffering and in search of relief, so likening their experiences to mental illness may be more legitimate.

People who conceive of themselves as possessed by demons of one sort or another are in great distress. In some cases, the complaints are somatic, leading to a form of physical pain for which they seek treatment. One patient of an African Ndembu healer describes being invaded by the tooth of a dead hunter:

If ihamba comes to you, you can't even eat your daily mush. It just gives you pains. You will think it is just pains, but the way it hurts you is a sign. You will hear something biting. If it comes

through the arm, leg, ear, or eye, you will see it moving through the veins of your body. (Mertz, 1994, p. 2)

In other cases, a spiritual affliction can manifest in more psychological symptoms that Westerners would see as a form of mental illness. Mertz (1994) provides an account from a traditional healer of a “dispirited” Alaskan man who had lost his mother early in life. According to this healer, Lorin Smith, the man had three spirits that were not integrated into a whole self; the spirit bodies had split off and wandered away from his material self. As Smith describes it,

The same person's kind of like in three person-ages, but they're supposed to be all together. But, for him, they're all like, they're following each other...the main part of him was up front, another one was following, hoping somehow to get himself together so he could be a whole person again. (Mertz, 1994, pp. 7–8)

These individuals often seek help from healers or shamans, who use a variety of methods for treatment. In the case of the Alaskan man above, the healer's method resembles a sort of talk therapy, in which he talked to each of the spirits and attempted to figure out the cause of the fracture.

This sense of a fractured identity would likely be understood by Western psychologists as some sort of mental disorder (e.g., dissociation) resulting from an early trauma such as the death of the man's mother and the resultant blame he experienced from his father. What is interesting is that as he describes the man, Smith provides what could easily be a psychodynamic understanding of a patient. He states that the man's father “couldn't understand what his role was, or what as a parent, he should've done, showing love to that son of his, so the boy didn't have anything” (Mertz, 1994, p. 8). He describes in detail the feelings of aimlessness and loss of self that could be connected to such an early object loss. Smith seems to possess an understanding of this dispiriting as a coping mechanism for internal pain, and he recognizes the great suffering of this man, stating that “it's hard – it hurts” (Mertz, 1994, p. 9). He even seems to acknowledge a process of projective identification in saying, “when I was talking to him, I used to hurt” (Mertz, 1994, p. 9). In expressing this, Smith demonstrates a sophisticated understanding of the psychodynamic view of what it means to truly be with a client, so as to “learn in [his] bones” what the client is experiencing (Berzoff, Melano, Flanagan & Hertz, 2002, p. 169).

So what is it that makes this case different from a traditional Western treatment model? The first difference lies in the cultural understanding of the affliction. While Smith seems to touch on many of the same qualities that a Western therapist would, his understanding of the cause of the affliction and the way that the individual copes with this affliction are fundamentally different. Mertz (1994) describes this in terms of differing concepts of the self across cultures. In Western culture, the self is thought to be a distinct and cohesive entity. We possess an individualized view of the self, valuing autonomy and self-agency over communalism. Many other cultures, however, conceive of what Mertz refers to as the “sociocentric self,” in which the boundaries between self and other are more diffuse. Mertz states that in these cultures, “the boundaries of the self are constantly under negotiation because the sociocentric self is experienced as permeable, subject to intrusion of malevolent intentions” (Mertz, p. 5). The illness is thus conceived of as having an external and intrusive component that may have little to do with the individual’s direct experience. This, therefore, leads to a treatment that addresses these external sources of mental anguish through exorcism ceremonies or trance-like states.

In the case illustrated above, the patient sought services with a healer within his own culture. But what happens when someone from a similar culture seeks services in a Western mental health context? Al-Krenawi & Graham (1997) describe a case in which a Bedouin patient experiencing symptoms was brought to a mental health agency and diagnosed with schizophrenia. This man described hallucinations of characters trying to hurt him. He made little sense at the time of referral and appeared disoriented and confused. The psychiatrist, seeing these as symptoms of psychosis, diagnosed the man with schizophrenia and commenced treatment with anti-psychotic medication. Though the medication helped the man somewhat, it did not eliminate the hallucinations, and he remained in serious distress.

Later in therapeutic treatment, the man stated that the hallucinations were demons, referred to as *Jinn*, who looked like the elders in the Bedouin tribe. Furthermore, he revealed that these voices were not always persecutory, and that “sometimes they are funny and make me happy, and at other times they pressure me to do things. They force me to do things that are embarrassing; but they also prevent me from committing suicide” (Al-Krenawi & Graham, 1997, p. 215). The man further attributed these visits with the *Jinn* to punishment for his sinful behav-

ior towards his mother. Thus, as the patient continued to reveal his cultural understanding of his experience, the diagnosis became questionable, and as a result the treatment changed. Eventually the clinician solicited the help of a *Dervish*, a traditional Bedouin healer, and it was through an exorcism-like ceremony that the *Dervish* was able to finally heal the man.

The case of this Bedouin patient demonstrates the importance of understanding illness within the context of one’s own culture, for successful treatment is unlikely until this occurs. Al-Krenawi and Graham explain that in understanding these situations, a necessary distinction must be made between “form” of the symptom and “content,” or meaning, of that symptom within a patient’s cultural milieu. In the case above, the form would be the hearing of voices, while the content would be being visited by demons as a punishment for wrongdoing.

Practical Implications for the Western Therapist

In our ever more global society, Western mental health professionals are likely to treat an increasingly diverse population of clients. When clinicians work with clients from cultures different from their own, it is important for them to understand that mental illness can be a culturally bound phenomenon. In line with the social work value of “starting where the client is,” clinicians should view the nature of a client’s complaint through the lens of the client’s own culture and be open to meanings beyond those Westerners may typically attribute to symptoms. Social workers need to explore a client’s own cultural understanding of his or her symptoms. Whenever possible, social workers should consult with a healer of the client’s culture to gain a greater understanding of the client’s experience. These are key skills for culturally competent practice, and for effective treatment of symptomatic clients from non-Western cultures.

Conclusion

This examination of shamanism and spirit possession raises interesting questions about how Western society understands mental illness. Why is it that other cultures are able to see value and use in symptoms that would likely precipitate hospitalization in our own culture? Perhaps the ability to see these experiences as potentially beneficial rather than threatening is the very factor that allows these individuals to gain mastery over their own afflictions. The Akan priestess I met in Ghana told me

that she would take me on a spiritual journey, but that my mother would not approve. In saying this, I wonder if the Akan priestess understood something about how my cultural boundaries would prevent such a journey. Perhaps she understood something about the cultural relevance of mental illness from which we all can learn.

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