Introduction

Monotheism and Mental Order

So, mental order, not mental disorder.

Ever since the three disciplines of anthropology, psychology and psychiatry differentiated themselves out of a more general nineteenth-century 'human science', many have argued about the question of normality or pathology accorded to certain novel patterns once observed by colonial officials, missionaries and travellers in non-European societies. Such patterns as *amok, Iatah, koro, kuru, witigo* or various spirit possession states were often picked up and observed by the European because they seemed bizarre and exotic, maybe even insane. They were initially simply observed and described, but then Western psychiatrists wondered if they might be included in the pattern of mental illness then described in European and American mental hospitals. Most notable among these was *amok*, a Malay word which has passed into English for indiscriminate and unmotivated violence by a person against others.

In one of the first discussions of the problems of comparing psychiatric illness across societies, the German hospital psychiatrist Emile Kraepelin, after a brief trip to Java during which he collected accounts of amok and observed hospitalized patients, noted that 'reliable comparison is of course only possible if we are able to draw clear distinctions between identifiable illnesses' (Kraepelin 1902). This proved difficult given the wide variety of local patterns together with the intention, which Kraepelin enthusiastically shared, to fit them into the restricted number of categories identified in European hospitals. He happily included various local patterns into

this clinical nosology, arguing that whilst their 'content' may differ from Western illness, their essential 'form' remained the same. As Kraepelin's pupil Karl Birnbaum put it, the pathoplastic envelopes of culture just gave 'content, colouring and contour to individual illness whose both form and character have already been biologically established' (Birnbaum 1923). Wittgenstein critically likened this sort of approach in the psychological sciences to our picking away the leaves of an artichoke, in a hopeless attempt to uncover some real artichoke, on the assumption that (to use the anthropologist Clifford Geertz's sarcastic aphorism) 'culture is icing, biology cake. . . difference is shallow, likeness deep'. Even our later, statistical attempt to develop an international nomenclature favoured by epidemiologists in the 1970s and 1980s resulted in circular and quite varied arguments about categorization and universality.

Multitudes of colonial doctors, journalists and other commentators described local patterns of ritual, distress and therapy as if they were Western illnesses: shamans and prophets were regarded as severely disordered, even mentally ill. Possession cults and revitalist movements were considered hysteria, bodily transformations as self-mutilation, gender-based ceremonies as perverse sexuality, metaphysical speculations as delusion. Local treatments were useless superstition and dumb acceptance. This all ignored the possibility that certain reactions such as eating disorders, parasuicide, depression, obsessions or multiple personality disorder might be understood in (Euro-American) social or cultural terms. In other words, 'psychopathology' was considered devoid of any meaning and could only be explained as a biological contingency.

Anthropologists however continued to debate possession states and so on in non-pathological language until the pervasive influence of psychoanalysis in the United States academic world resulted in the Culture and Personality school of the 1930s to 1950s. This presumed that variant patterns could be understood on the basis of individual psychological development as presumed by Western psychodynamic theory. A generation of American cultural anthropologists became dominated by psychoanalysis. In the most extreme case, whole societies came to be identified with psychological patterns which were characteristic of severe mental illness in Western societies (e.g. Benedict 1935). The occasional social anthropologist objected that whole cultures could not be identified through individual psychological norms and that patterns of infant weaning – a favourite idiom of the C&P School – could not be said to determine the adult personality expected in a particular community, although they might exemplify it (Harris 1957).

By the late 1950s American psychiatry and anthropology had gradually found psychoanalysis less persuasive and the newly dominant McGill school of transcultural psychiatry in Canada, with its influential journal,

was founded on a more descriptive and less normalizing basis. This was exemplified by the World Health Organisation's purely empirical studies as to whether schizophrenia was a universal disease or whether it could be explained by certain patterns of Western family life, as some argued. Those 'exotic' reactions which had appeared as possibly pathological were now classified as 'culture-bound syndromes' (Yap 1967) which were variously regarded as exaggerations of local culture or specific reflections of local culture, or as psychological conflict between the two. Patterns which could be more easily fitted into international universal classification or which seemed 'organic' (biological in origin) were generally excluded from this new category and from the developing area of cultural psychiatry.

Social anthropologists generally continued purely descriptive studies of diverse social roles and institutions or religion, based on eclectic sociological theory rather than on clinical or psychoanalytical presumptions, though they occasionally referenced an appropriate psychological theory. By the 1980s the American Arthur Kleinman had announced a new cross-cultural psychiatry which would emphasize the full exploration of local patterns and local explanations before one attempted to fit them into a medical framework. It was in this period that we both trained in social anthropology (before the separate speciality of medical anthropology developed) in a pattern earlier advocated by W.H.R. Rivers, the English anthropologist and psychiatrist in 1916. (He is now more generally remembered for his work on 'shell shock'.)

The area between anthropology and psychiatry remains a murky area. Social anthropology and psychiatry are two different modes of thought, each with their particular paradigms and methods. They often deal with the same phenomenon from their different starting points, but we cannot reduce one to the other, any more than we can reduce interpretation to explanation – or the reverse. Both remain necessary in what we once called an 'ironic simultaneity' (Littlewood 1993). In some of the chapters here we have generally emphasized the descriptive social anthropological side; in others we have offered a more pathological and medical explanation.

Why psychiatry at all? We have revisited some of those traditional patterns and motifs which are of interest to cultural psychiatry without presuming an explanation necessarily rooted in pathology – patterns such as messianism, bereavement, local categorizations of illness and cure, the history of syndromes, bodily stigmata, sorcery and suicide. Indeed, we have previously argued against the very utility of the pathological idiom at all in psychiatry (Littlewood 1991). These interests just come under a general rubric of medicine because they are often undesirable and painful, whether we consider them abnormal psychologically or statistically, but to announce them prematurely as a disease entirely (as pathology) is not helpful. In some cases, such as in our Druze chapter, we argue that a pattern which strikes the

European rationalist as bizarre may be considered as having some therapeutic value, i.e. in reducing suffering. We bear in mind the (hypothetical) Proto-Indo European term *tarpen ali*, or 'ritual substitute', the conjectured root of our term 'therapy', to derive some equivalence between the social and the medical. We tried to hold both in play.

Given the salience of religion in those societies studied by social anthropologists, the background of cultural psychiatry frequently indicates 'religious' cognitions and actions. Contemporary research into religion and psychiatry largely focuses on healing psychological troubles (e.g. Koenig 2015).

And on the prevalence and outcomes of mental illness in those who are religious, we build upon the work of James (1902) and note that the overlaps between normative religious experience and psychopathology have attracted recent academic attention (Dein 2010). Both psychiatry and religion focus on the understanding and amelioration of suffering, providing different epistemological frameworks in which redemption and healing can occur. Both attempt to deal with the nature of human agency and its displacement in religious experience and mental illness, and thus with questions of self-harm and its boundaries. Beyond these lie certain moral issues and their possible resolution. In forensic psychiatry, evil and illness run perilously close together.

The papers we have chosen here for reprinting for a wider audience are limited to those from the so-called 'Abrahamic tradition' – from Western monotheism, whether Judaism, Christianity and Islam – or at least from cultures strongly influenced by these. Our use of the term 'monotheism' is not to suggest theology or high doctrine. Perhaps 'vernacular monotheism' might be a better if rather clumsy term. We are dealing with the everyday perceptions of ordinary people, not the esoteric deliberation of churchmen or clerics. While there are many similarities between the Abrahamic religions in terms of notions of the Divine, salvation, afterlife and understandings of suffering, our choice of papers reflects our ethnographic interests rather than any overarching theological or psychological framework.

We have selected these papers out of our various interests and have not proposed here to reprint our earlier work on racism and mental health, pathomimesis, the dramaturgical model of neuroses and spirit possession, on the Albanian 'third sex', euhemerism, Haitian zombification, or recent work on Hindu conversion to Christianity. The papers included nevertheless employ a variety of different approaches apart from general descriptive psychiatry and anthropology: interpretive semiotics, phenomenology, psychodynamics, the history of psychiatry, evolutionary psychology, even – in one case – patristic theology. We strongly adhere to an exploration of the psychiatry/anthropology domain which uses a diversity of methods and theories. We employ here both the naturalistic and the personalistic in a complementary antinomy. Neither is true, nor false.

The first section is dedicated to healing and redemption in Judaism – more specifically to practices among one ultra-orthodox Hasidic group in Brooklyn and east London. Chapter 1 looks at how they deal with sickness and their recourse to biomedicine and religious healing. According to their key text – Tanya – there is an intrinsic link between religious words and the physical body. At times of sickness Lubavitchers communicate with their leader, the Rebbe, whose manipulation of religious words results in bodily healing. This conforms with the anthropologist Malinowski's suggestion that the symbolic comes into play when the pragmatic fails. Mediated through the person of the Rebbe, testimonials offered by sufferers evoke images of exile and restitution which derive from Kabbalistic texts. Both Kabbalah and medical anthropology attempt to transcend not dissimilar epistemological dualisms: here those characteristic of monotheism and of contemporary science. Yet the 'lower root' of Kabbalah affirms a material reality known through immediate sensory experience which recalls the rationale of biomedicine.

The second chapter considers the local situation after the death of the Rebbe, the spiritual leader who was frequently identified as the Jewish Messiah, and who would supposedly reveal himself as such, ushering in the redemption. When he died in 1994, he had not fulfilled his followers' messianic expectations. We look at the role of phenomenological experience and embodiment, the prophetic milieu, and modern communication media in maintaining a sense of the Rebbe's continuing presence. This ritualized reaffirmation of belief seems to provide the bereaved followers with social and psychological meaning in the wake of 'failed' prophecy and thus render their experiences less distressing.

The next chapter deals with popular Christianity. 'Does Christianity Lead to Schizophrenia?' argues that our most devastating psychiatric illness, schizophrenia, has not been a constant over history, nor is it universal across contemporary societies. Using some phenomenological arguments, we suggest that a more affectively-laden psychosis, probably close to manic depression (bipolar disorder), which we term here proto-schizophrenia, is modified under the self-reflection and self-directed scrutiny of Christianity and modernity into an illness now recognized in the west as clinical schizophrenia.

The next chapter in this section describes our encounter with a southern Italian religious stigmatic and visionary, who at Easter time physically demonstrates in her body the signs of Jesus' crucifixion. We review the psychiatric concept of 'hysterical conversion' and consider Natuzza's experience in the light of her personal history. Since we wrote the original paper, she has died and there is now a more detailed account of her life and fame published in Italy (Turi 2009).

Two chapters come from the Islamic tradition. 'Jinn, Psychiatry and Contested Notions of Misfortune' records a project among the east London

Bangladeshi population as to their understanding of *Jinn* spirits; whilst all Muslims are presumed to accept the idea of *Jinn,* our informants showed a variety of opinions concerning them. 'The Use of Traditional Healing in South Asian Psychiatric Patients in the UK: Interactions between Professional and Folk Psychiatries' explores the use of traditional healing among psychiatric patients from India, Bangladesh, Pakistan or Sri Lanka living in London. Individuals with a range of psychiatric problems deployed both Western psychiatry and traditional healing concurrently, with little understanding of (nor interest in) how these treatment modalities worked.

Chapter 7 examines 'Two Responses to Loss in Albania and Kosova'. Social anthropology has proposed that social institutions and psychological reactions may at times be alternative ways of dealing with similar situations; and that at a high level of generality, they may be conceived of as variants of similar (psycho-social) phenomena. Response to sudden bereavement in Albanian Kosova may follow two routes: the customary law arguing stoicism but retribution, and the psychological idiom of 'trauma' recently introduced by Western European aid agencies. Similarities and differences between what at first appear two quite distinct responses are outlined.

The chapter on Druze reincarnation in Lebanon concerns a community which derives from Islam but should now be considered as a separate religion. The Druze adhere to a very non-Islamic idea of reincarnation which we argue attenuates the grief the family experienced about the members who died in the Lebanese civil war. We might compare this to responses to the death of the Rebbe in Chapter 2, both denying the finality of death.

The next three chapters deal with more general themes. 'Apocalyptic Suicide' criticizes purely psychological explanations of mass suicide, charisma and millennialism, to emphasize eschatological dualism in monotheistic and post-monotheistic communities. Chapter 10 considers the introduction into certain religious therapeutic systems of a second and contrary principle which has implications for our understanding of complementary opposition. 'Religion and Psychosis' uses ideas from evolutionary psychology, anthropology and the Cognitive Science of Religion – taking 'religion' in a more general sense than we have used it so far – as the recognition of something like human sensibility and agency in ultrahuman entities. We emphasize theory of mind and agent hyper-identification as significant in normal cognition, and hence in religious and psychotic cognitions.

The last two chapters reflect a number of concerns in medical anthropology relating to explanatory models, trauma, forgetting and medical pluralism. Chapter 12 considers how two societies deal with forgetting the recent past. A millennial community in the Caribbean have a centrally directed policy of ignoring the modern industrial world. By contrast a post-Communist village

in Albania gradually let the Hoxha period just slide away, allowing buildings and institutions of that time to decay without referring to them, with no rancour or recriminations. The final chapter discusses the limitations of the explanatory model paradigm, most importantly the neglect of the socio-political context of health seeking and the often observed discrepancy in ethnographic fieldwork between what informants say and what they actually do in practice.

These chapters thus take a wide variety of traditional motifs, with theoretical positions emphasizing a plurality of methodologies, the naturalistic and the personalistic each encroaching on the other in recursion not in essence.

We do not attempt to produce new definitions of this area of 'cultural psychiatry', but rather we presume forays into the area from each side until they disintegrate, sometimes emphasizing the individual and psychological, sometimes the social anthropological and cultural, in a way that recalls George Devereux' somewhat different notion of complementarity (Devereux 1978). In either case we hope to provide new insights into a fascinating area: fascinating and confused.

We owe an enormous debt to our own patients and critics, and to our fieldwork and informant hosts: there are far too many to list here, but we would like to pay an especial tribute to Dr Maurice Lipsedge of Guy's Hospital, our former clinical teacher, who many years ago did so much to encourage us to venture into the contested but fertile ground between anthropology and psychiatry.

References

Benedict, R. 1935. *Patterns of Culture.* London: Routledge and Kegan Paul.

Birnbaum, K. 1923. 'Des Aufbau der Psychoses', trans. as 'The Making of a Psychosis', in S.R. Hirsch and M. Shepherd (eds), *Themes and Variations in European Psychiatry.* Bristol: Wright.

Dein S.J. 2010. 'Judeo-Christian Religious Experience and Psychopathology: The Legacy of William James', *Transcultural Psychiatry* 47: 523–47.

Devereux, G. 1978. *Ethnopsychoanalysis: Psychoanalysis and Anthropology as Complementary Frames of Reference*. Berkeley: California University Press.

Geertz, C. 1968. 'The Impact of the Concept of Culture on the Concept of Man', in Y.A. Cohen (ed.), *Man in Adaptation.* Chicago: Archive.

Harris, C. 1957. 'Possession "Hysteria" in a Kenyan Tribe', *American Anthropologist* 59: 1046–68.

James, W. 1902. *The Varieties of Religious Experience*. New York: Simon & Schuster.

Kleinman, A. 1987. 'Anthropology and Psychiatry: The Role of Culture in Cross-Cultural Research on Illness', *British Journal of Psychiatry* 151: 447–54.

Koening, H.G. 2015. 'Religion, Spirituality and Health: A Review and an Update', *Advances in Mind-Body Medicine* 29: 19–26.

Kraepelin, E. 1904. 'Vergleichende Psychiatrie', trans. As 'Comparative Psychiatry', in S.R. Hirsch and M. Shepherd (eds), *Themes and Variations in European Psychiatry.* Bristol: Wright.

Littlewood, R. 1991. 'Against Pathology', *British Journal of Psychiatry* 159: 696–702.

_____. 1993. *Pathology and Identity.* Cambridge: Cambridge University Press.

_____. 1996. 'Psychiatry's Culture', *International Journal of Social Psychiatry* 42: 245–68.

Rivers, W.H.R. 1924. *Medicine, Magic and Religion.* London: Keegan Paul, Trench and Trubner.

Turi, A.M. 2009. *Netuzza Evolo La Mystica Di Paravati.* Rome: Edizioni Mediterranee.

Yap, P.M. 1967. 'Classification of the Culture-Bound Reactive Syndromes', *Australian and New Zealand Journal of Psychiatry* 1: 172–79.