

example, how could we define what is a “disorder” cross-culturally? Was it, for example, a disorder that I myself as a 14-year old boy used to spend many hours a day in isolation, in a quarter of our apartment, writing a novel which grew to 127 pages over a few months, all by hand in calligraphy? I rarely shared in so-called normal, i.e. age-specific group activities. At school I was rather inconspicuous, however, so I did not attract the attention of the teachers, and school psychologists were not yet part of regular employment at that time. That I dissociated myself from the interests and activities of peers was of no one’s concern. So I escaped the possibility of diagnosis that would have labelled my behaviour as “socially withdrawn” and perhaps prescribed some kind of therapy.

The question of what is to be called a “disorder” and what demands intervention by a therapist cannot be bindingly resolved from a transcultural perspective, contrary to the implications of the DSM-IV in which 16 categories of mental or psychological disorders are distinguished, claiming universal applicability. In the DSM-IV, the diagnostic assessment of a patient proceeds from the idea of classification by sets of symptoms. But delineation of such a syndrome is intimately connected to ideas that are articulated in only a few specific languages and cultures. They cannot be translated into very many other languages outside those used in Western-style education. What is considered to

be abnormal thereby depends to a great extent on cultural conventions. As long as societies were relatively isolated, a basis of agreement always existed intra-culturally. This applies even to some modern culturally separatist group formations, such as New Age movements, Rastafari culture, adherents to Wicca cults, or the Raelians, all with their own value systems and ideas about what is appropriate in their life styles. But there is no way that their concepts could be reconciled with any of the definitions found in the DSM-IV or its sequel, the DSM-V. In the south-east African language spoken in Malawi, eastern Zambia and parts of northern Mozambique, for example, we categorize persons who seem to be socially withdrawn or otherwise maladjusted by a range of terms. Some we class as *wamisala*, some others as *ozungulira mutu*, a third group simply as *opusa* and so on. But the semantic field of these terms would have to be bent considerably in order to be equated with any of the categories used in Western psychiatry.

Apart from terminology, a more serious aspect relating to our topic is how to reach consensus transculturally, about who or what needs to be treated at all, and what had better be left to take its own natural course, whatever the results may be, spontaneous healing, solutions due to a sudden external stimulus, such as a trip to a Tibetan monastery, or some other way out. Cultures also change in the diachronic dimension with their prevalent value systems.

Western cultures in the 1950s differed considerably from the kind of culture to which many young people cling nowadays, worldwide. They are connected almost every minute, by cell-phones, e-mail, BlackBerrys, i-phones, Twitter, Facebook etc., earphones on, eyes fixed on a screen. Some display signs of an attention deficit syndrome. Psychologist Sherry Turkle (2012, p. 6) has called this behaviour “the flight from conversation”. She says: “In our rush to connect, we flee from solitude, we turn to other people but don’t experience as they are. It is as though we use them as spare parts to support our increasingly fragile selves. We think constant connection will make us feel less lonely.”

It sounds like the description of a real psychopathological problem. And yet no internet addict, I understand, has ever been gently transferred into psychiatric care. Once again culture, and with it economic interests, determines what is normal, and usually all forms of behaviour shared by a majority of people, whether it is in a mass rally or in the destructive, concerted action of war, are excluded from the qualification “disorder”.

In her lecture series given in America in the 1950s, Anna Freud would still hold that homosexuality was a condition requiring treatment, e.g. by psychoanalysis. Today, we tend to believe that a person’s sexual orientation is his or her own affair. Only if the person perceives the condition in terms of an inner conflict generat-

ed by incompatible tendencies which create extreme unhappiness, may therapeutic intervention be indicated; provided that the person desires such an intervention, or if he or she becomes a public nuisance, which includes many forms of behaviour that are not necessarily in connection with sexual orientation. Western society, for example, targets all forms of pedophilia, homo or hetero, as punishable, but the reactions within Western societies to specific cases seem to be ambivalent, as was demonstrated a decade ago by the case of former Cardinal Hermann Groer in Vienna. An institution such as the Catholic Church reacts in a certain way, investigative journalism and the media in general react differently, and popular thought – to express it this way – often reacts with a joke (Kubik, 2006). The philosophy and secret message of such jokes is to express satisfaction that humans’ hidden sexual tendencies have once again achieved a breakthrough, and that a person’s sexual preferences including pedophilia are in any case the result of early conditioning and can never be changed.

An important point for transculturally oriented psychotherapy to take note of is that each culture demands from its adherents, and from all individuals within its sphere of influence unconditional surrender to its value system. This is not so because cultures are perhaps intrinsically authoritarian, rather it is so because as long as a culture is a closed system within a geographical expanse, there are no alternatives

for its adherents. Doubts only begin with culture contact.

Transculturally oriented psychotherapy, however, cannot share a culture's demand for submission, it cannot unilaterally subscribe to the mores of just one culture. That of course includes Western cultural mores as well. It cannot be its aim to streamline the behaviour of individuals according to what in a specific culture is thought to be right. Basically, psychotherapy helps the individual to come to terms with inner conflicts. It is therefore, EGO-oriented, rather than a society's tool for social "correction".

That is different with intraculturally oriented psychotherapy. In all societies there is some kind of consensus about what should be called "normal", or rather what is acceptable, so that the established order may continue. Continuity is the intrinsic tendency of any order tested out long enough. Social systems therefore tend to be conservative; any new idea is potentially a threat to their coherence. (Malamusi, 2006)

In all societies there exist not only forms of psychotherapy, but there is also something like a program of therapeutic prophylaxis directed at specific age-sets, e.g. children approaching adolescence. It may also include other stages in human life, for example moments of so-called "life crisis". The individuals concerned are then subjected to a process of intervention described as educational. Many so-called secret

societies have this function of age-specific and usually also gender-specific education. Such interventions are tools to prevent the rise of tendencies which EGO could no longer control.

There are many such systems of prophylactic therapeutic intervention. The most important ones include a) religious rituals in which either some sections or all of a society's members are involved, b) initiation rites as well as c) institutions that promote abreaction or psychocatharsis, such as those focussing on the channeling and control of male aggression. There is also the system of installing taboos. Like jokes, taboos are ultimately created by individuals; however, the originators remain anonymous, leaving a verbal formula behind to operate like a digital device implanted into people's brains. Violation of a taboo triggers punishment, but it is always endo-psychic. A genuine taboo is not part of a law installed and protected by society. It is a magic device, capable of infecting everybody from the moment of hearsay. After I had first learned in Africa that it could be harmful to a person, if someone tore his or her photograph or threw away their handwriting, especially a signature, I discovered that I began to internalize that taboo after some time, and be over-careful with anything written by close friends or relatives. That a signature equates an individual's identity may even be a universal, transculturally valid idea. In Hayao Miyazaki's Oscar-winning 2001 film *Chihiro* the children Haku and Chihiro who are captives in the em-

pire of a witch called Yubaba, are deprived of their identities by deleting their signatures.

In transculturally oriented depth psychology we observe the original meaning of the Polynesian term *tapu* which James Cook had picked up on the Tonga Islands in 1777 and written down in the spelling “taboo”. Sigmund Freud (1913) also emphasized that taboos are prohibitions of unknown origin and that their violation triggers a mechanism of self-punishment. In Angola I discovered in 1965 that local terms such as *chizila* in Mbwela and related languages are virtually identical in meaning with the Polynesian term.

The various methods employed to save individuals from developing serious psychological problems are handed down in many non-Western societies by oral tradition. Specialists are always involved. The instructors, such as for example elderly, specialist women guiding a girl’s initiation in African societies, such as *chikula* in eastern Angola, draw upon resources that include verbal instruction, song, dance and symbolic acts, to help their clients to cope with the new situation of adolescence. Such instructions include warnings and the naming of taboos. All these taboos are symbolic, which means what is really forbidden is not said. It is hidden behind the nominal prohibition, such as certain food avoidances, or certain places, acts etc. from which the girl should shy away.

For this reason the wanton destruction of so-called traditional initiation, male or female in non-European societies, has produced serious consequences, and an increase in various forms of so-called disorders, all of which would be abhorred by those who are responsible for the destruction in the first place. The most prevalent “disorder” in southern Africa, for example, is the extreme rise of male criminality during the last three decades, robbery, homicide etc. This cannot be explained vaguely by the stereotypes of poverty, migration, urbanization etc. The minimization and elimination of African initiation schools, each with a long tradition and periods of seclusion for the novices, was a main deteriorating factor. *Mukanda* in eastern Angola is an example (Kubik, 2002). Its diminution has left a void in this transition of male children from their latency period into adolescence. The formation of violent gangs in townships can in part be understood as compensatory. This observation even applies to guerrilla groups and other heavily armed factions in eastern Congo, up to the excesses of the infamous Cony from northern Uganda, now at large somewhere in the Central African Republic.

In a situation in which “things fall apart” – to quote the title of Chinua Achebe’s widely read novel – the ethical question that arises in transculturally oriented psychotherapy is under which circumstances would intervention be indicated? Here, however, what applies to

prophylactic intervention does not necessarily apply to intervention in an individual case.

There is perhaps one universal condition that may be acceptable ethically as a pretext for intervention: if the person suffers so much, due to her or his condition that they are seeking advice, normally first from friends or relatives, or in the case of a conversion neurosis sometimes from standard medical doctors. The later, however, are often at a loss and diagnose migraine, or fatigue or something else; often they also try to win time by sending the patient for numerous tests, or right away to a colleague. In more fortunate cases a psychotherapist is then suggested.

In eastern Angola, during my first research among Mbwela- and Nkhangala-speaking people in 1965, the normal procedure would be to arrange for a preliminary consultation with a *mukwakutaha*, a diviner, who – in front of his *ngombo* or divining basket, filled with a hundred little figures, ideographs so to say – works from the principle of free association. Both the patient and the diviner talk to each other freely about the former's problems, and the diviner with the help of these little images arrives tentatively at a psychological assessment of the possible root causes of the patient's bewilderment. In contrast to a Freudian psychoanalysis, however, his methodology does not include the rather long-winded process of bringing the roots of the patient's inner conflicts to the lat-

ter's consciousness. In just one session, he or she works out an arrangement to find a forum for the patient to give symbolic expression to the problems.

The *mukwakutaha*, with his library of ideographs draws upon a large diagnostic panel that is based on the idea of disease-inflicting forces. He names those forces symbolically, watching the patient, whether his constructions trigger some kind of reaction. For example, repressed libidinal or aggressive ideas, if the diviner thinks that these are behind the patient's symptoms, will be symbolically presented as adversary forces in nature, sometimes as dissatisfied spirits (*mahamba*). Very often these entities are archetypal figures such as the mythological woman who died in pregnancy, but even a plane flying over the area can be a *lihamba*, disease-inflicting entity. The therapeutic schedule which is then drawn up is based on the idea that these forces which have afflicted the patient should be granted some form of articulation. This is done with the help of a professional medium. A *mahamba*-eliciting ceremony is organized, usually in several sessions over some weeks, in which the medium articulates the spirit's complaints in the presence of the patient and many other members of the community. I have described one of these meetings in an article in the book *Hysterie* published by the Vienna Psychoanalytic Association (Kubik, 2003).

During my comparative work in Brazil, Angola, Nigeria and Togo in the 1970s, on *orisa*, *vodu*, and *umbanda* reunions, I found that local psychological theory can often be neatly translated into the language of psychoanalysis. “Spirits” stand for forces of the ID, either for repressed ideas that are perceived as negative and morally controversial, or they stand for archetypal entities that threaten the individual in its coherence, in the sense of C. G. Jung’s archetypes of the collective unconscious. In both cases, the patient is unable to understand the forces haunting him or her, since they are unconscious. The meetings arranged under the supervision of a *chimbanda* (professional healer) and a medium are designed to help the patient to “speak up”, to articulate symbolically his or her inner conflicts. In some cases the patient is able to do that by himself or herself within the larger therapeutic group circle, assuming for a short period an altered state of mind called trance in the literature. When such a state is reached with the help of incessant exposure to acoustic stimuli such as drumming (Rouget, 1980), consciousness is temporarily attenuated allowing the unconscious contents to rise to the surface, obtaining control of motor and speech organs. Bystanders have to watch the patient and prevent injury. If an archetype is the cause of the problem, the person may even speak in a strange language. The next day, when normal consciousness has returned, he or she will not know what has hap-

pened, and if shown a video, will be very surprised, even find it all funny.

As long as people are attached to a single culture in their habitual social surroundings, all forms of psychotherapy will draw upon the medical and psychological resources available locally. However, in a world of increased travel, and worldwide transculturation, a totally different situation arises due to culture contact, and with it cultural learning. For this reason we no longer proceed today from the fiction of cultural membership, but speak of an individual’s transient cultural profile (Kubik, 1994, pp. 17-46). This implies that individuals modify their cultural allegiances gradually throughout life. And yet, many Western psychotherapists still tend to pre-categorize their patients as to alleged ethnic or cultural memberships, besides gender and age-group. This can seriously obstruct the therapeutic process.

By contrast, from a transculturally oriented perspective, we have learned that a human being is defined by nothing more or less than the sum of his or her experiences, up to the present moment, adding tiny new components every second. That is all that is in us. This does not exclude of course the echo of pre-natal experiences and the effects of DNA-steered motor, perceptual and cognitive programs that are inherited, but it implies that the directions taken in life come from an incessant exposure to often unforeseeable impacts with which we

have to cope. No two individuals therefore, are culturally identical. At every moment we can present ourselves mathematically as a set, in the form of a Venn diagram that partly overlaps with the Venn diagrams of others, from Hokkaido to Patagonia (Kubik, 2010, pp. 61-65).

From this also follows, that an individual never represents a culture, or nation or profession, whatsoever, because no one can absorb the contents of his or her cultural surroundings in toto.

In times of increasing migration and global contacts new expressions of psychological problems have become familiar. For example, someone happens to live and study in a community different from that of her birth-place and early up-bringing. After ten years of voluntary acculturation in the new social environment, her cultural profile will have considerably changed, and so will her emotional attachments. As a result, there may be, for example, less libidinal investment in longstanding relationships with former family members who live in distant places. In such cases a sudden visit or return to her former home can trigger a so-called reverse culture shock; because relatives and those who are ethnic associates of the person will claim her as a returnee belonging to their ethnic group and family, and expect certain forms of behaviour in accordance with that society's conventions. But the individual can no longer fulfil their expectations.

This happened to a 29-year old unmarried woman in Dakar, Senegal, who had spent over seven years in France and become a successful business entrepreneur with a University degree. Kumba – that is her code name – was the daughter of a Senegalese specialist in internal medicine. While studying in France, her cultural profile changed decisively, and she adopted for herself a life style embracing rationalist and scientific values, perhaps in some kind of identification with her father and his professional role. This might explain why she also remained unmarried.

Precisely that, however, was considered unacceptable for a 29-year old woman by members of the society in Senegal where she had originally come from. When she returned to Dakar, she found herself under immense pressure by relatives to marry a “nice-looking Wolof man” selected by them. This was the start of a serious emotional conflict which she was unable to handle rationally, because she was not conscious of all the motivating details. On the one hand there was this feeling not to be considered as a runaway from her cultural roots, on the other hand there was the completely different value system she had adopted for her personal life, oriented towards material and intellectual success, while in Paris. Undecidedness and feelings of guilt, abandonment and despair began to dominate her mind.

Since the conflict developed subliminally, and without any chances for Kumba to discuss the details of the problem with anyone, her feeling of guilt towards her relatives and her former culture in opposition to her desire to continue her present ways of life and not get caught up in marriage with a Wolof man, were incompatible.

Two days before the date of marriage which was fixed by the relatives, Kumba broke down in front of everybody, lying on the floor in a kind of stupor, not communicating, and in that condition she was taken to a psychiatrist, Moussa Ba, who later wrote an article about the case published in *Psychopathologie Africaine*, 29 (3): 275-286, 1998-99.

Here I should perhaps mention that Dakar is a celebrated city in transculturally oriented psychotherapy. It was here that Henri Collomb (born 1913, died 1979) founded what came to be known as l'École de Dakar in ethnopsychiatry, and he was also founder of the journal *Psychopathologie Africaine*. Collomb's own background and cultural experiences are a good illustration of transcultural learning. He gathered experiences in Djibouti, in Ethiopia, learned Arabic and Amhara, until in 1958 he became lecturer in neuro-psychiatry at the medical faculty of the University of Dakar. Very early, Collomb tried to integrate the experiences of local healers in Senegal into Western-style psychiatry, and this tradition was contin-

ued by his disciple and successor Moussa Diop and many other students. (Reichmayr, 2003, pp. 85-90).

However, in the case of the young woman Kumba, the psychiatrist in Dakar committed a serious mistake. Kumba's conversion neurosis was never seriously analyzed as to the nature of the underlying conflict. She was categorized by appearance as a native Senegalese woman, acculturated though, who had come back home and would have to be reintegrated. Thereby, almost a third of her quite different life experience was deleted from psychological consideration.

In the tradition of the School of Dakar, combining local medical practice and Western-style psychiatry, Kumba's condition was diagnosed as "psychose nuptial". It was then suggested that she should undergo a ritual treatment called *ndëpp*. A healer from the ethnic group of her father was called upon to look at her case.

Here the problem was that the traditional healer, just like the members of Kumba's family did not have the comparative cultural experiences to understand, that this young woman, in fact, no longer belonged completely to their culture and that she had already demonstrated her rejection of the culture's dictates by a desperate action, breaking down in front of everybody, shortly before the date of the proposed marriage.

If the final part of the report is to be trusted, then it seems that some kind of compromise was eventually achieved, probably driven by her own strength of rational thought. She did marry that man, who was proposed by her relatives, but it looked more or less like a certificate marriage. Kumba did not fulfil many of a wife's obligations in Wolof culture; instead she continued her successful business life.

We could call that kind of intervention enforced reintegration of a person into a culture she no longer shared, prescribed by a system of psychotherapy that operates from the ideology of (inherited) "cultural identity". But Kumba's cultural profile was no longer Senegalese, she was mostly French. The same damaging strategies are also applied at the other end of the cultural spectrum, due to immigration policies in the European Union. An individual is expected to immerse himself or herself exclusively into the cognitive system of the host culture, i.e. through language training. This is particularly worrisome when children are affected. If the child rejects enforced integration (perhaps because of demeaning or aggressive treatment by its peers), psychotherapy is recommended. Some of the associated psychotherapeutic interventions even run under the title "ethno-psychoanalysis" as is demonstrated in a recent article jointly written by Gesine Sturm, Maya Nadig and Marie Rose Moro for the journal *Transcultural Psychiatry* 48 (3): 205-227, 2011.

My present paper cannot be a venue for discussing those authors' theoretical concepts and their ideas about "hybridity", "métissage" and a relatively new term "décentrage". What I would want to discuss briefly is the ways a group of less than a dozen therapists was handling the alleged "problem" of a small boy named Amadou, whose Bambara-speaking parents had migrated to France from Mali.

The notes of the child psychiatrist who was consulted, present Amadou as "a five-year old boy who has recently entered his second year in a public preschool program." Then it is stated that in school "He does not speak French. His teachers comment that he does not speak at all, even with his peers, and they observe that he is often involved in quarrels in the schoolyard. Concerned about Amadou's development his primary teacher asked the school psychologist for his expert opinion of the young boy's emotional, intellectual and linguistic capacities. ..."

By contrast, Amadou's mother seemed to be surprised by this assessment and stressed that the boy talked at home, using his mother tongue Bambara in a manner which was appropriate for a boy of his age.

After the mother's statement, the school team was even more concerned and posed the question: "Did Amadou's parents ignore the importance of early language apprenticeship?" meaning the need for learning French.

Amadou's father was summoned and seemed to be annoyed. After listening to the teacher's explanations, he commented that his son might just stay at home, if they did not want him at school. Amadou was then submitted to undergo some kind of psychotherapy in the presence of his parents, in a sort of systemic approach.

Obviously, in this case psychotherapeutic intervention was based on an ideology rooted in two prevailing assumptions:

- (1) That French as a language was superior to Bambara and other African languages, and that in France it was the only acceptable medium for communication;
- (2) That it was a requisite for all immigrants to be integrated into French culture and learn the command of the French language at an early age.

This policy is understandable and well motivated, but psychologically questionable. For those of us engaged in historical anthropology it evokes images of forceful eradication of people's first language as in slavery, or some colonial practices, when children were even punished for speaking their own language at boarding schools.

If little Amadou in the kindergarden did not want to talk to his peers or try to do so, even if he did not want to associate at all with the other children, there was little need for drama-

tizing and ringing an alarm bell. Amadou, who – as was claimed by the parents – spoke and behaved normally at home, had a human right also to reject the social environment imposed upon him.

Instead of creating a problem – although it may have been a golden opportunity for a dozen psychotherapists to demonstrate the indispensability of their profession – a less dramatizing approach could have allowed the little boy to develop a more durable solution by himself after some time. I believe that, if his aversions had not been declared worrisome, and subsequently the boy given so much psychiatric attention, he would perhaps have discovered by himself sooner or later an interest in the wider world around him, outside his parent's home, and developed ways of adapting to the challenge and cope with it, provided, of course, that the native French children would have accepted him. Here, perhaps was the real problem in the kindergarden which would also explain Amadou's quarrelsome behaviour.

A question that was not answered, neither by the psychotherapists nor the school teachers, was in which language did he quarrel? He was portrayed as not uttering a word in French, but then it is said that he quarrelled with others.

The case demonstrates that psychotherapeutic intervention, let alone psychiatric intervention, requires a lot of cogitation before any program should be drawn up. Psychotherapy should not

be abused as a political instrument, nor should it be used as a tool for social engineering to streamline individuals' behaviour. A good background in the intricacies of comparative transcultural psychology is certainly recommended.

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