SEVEN
publicações acadêmicas

Contributions of traditional knowledge to mental health

Crossref doi
https://doi.org/10.56238/sevened2023.007-049

Georgina Carolina de Oliveira Faneco Maniakas
Post-Doctorate from the Center de Recherches Psychoanalyse et Médecine - Université Paris VII.
Federal University of São Carlos – UFSCar

ABSTRACT
Researches of the World Health Organization to evaluate the clinical evolution of mental disorders - including diagnosis, treatment and prognosis - since the 70s shows that different social contexts determine different clinical outcomes. Differently from the mental disorder classification and treatment model, in force in the technicist and hyper-industrialized Western culture, the approach to the same phenomenon among people of traditional cultures takes place in a way that does not segregate or isolate the individual from his group, while promoting acceptance of his suffering. To illustrate such practices, we present the approach to mental suffering in three different traditions: Nigerian Yoruba, Umbanda and Kardecist Spiritism. We conclude that the care received by the individual based on the cultural framework of each of the different traditions allowed the resignification of events that had became unbearable and enabled the reordering of disaggregating psychic tendencies, corroborating the position adopted by the World Health Organization, which considers the care given to the mental disorder as crucial to the prognosis of the disease itself.

Keywords: Mental health, Traditional knowledges, Yoruba, Umbanda, Spiritism.

1 INTRODUCTION

Mental disorders do not have a homogeneous definition within science itself. There are even thinkers who, at one extreme, doubt their own existence. The problem is understandable, since mental disorders have characteristics that bring them much closer to a sociocultural explanatory model than to biological models. Even among researchers who recognize the full legitimacy of mental disorders, there are disagreements regarding their diagnosis, treatment, and prognosis.

Although the reality of psychic distress is an undeniable and observable fact, the phenomenon itself has a long history of different meanings, including notable cultural variations in the same era.

After a brief explanation of the recent Western conception of madness, whose diagnoses have multiplied in recent decades, we will present examples of coping with mental disorders in three different cultural traditions: the Yoruba of Nigeria, Umbanda and Kardecist Spiritism in Brazil.

When we consider the efficacy of the reception given to psychic suffering by traditional knowledge in comparison with increasingly compartmentalized and technicist treatments that, in contemporary society, depersonalize the subject and serve dominant economic and political interests, we find the importance of the "context effect" (SARACENO, 1999) in the evolution of the disorder itself.

1.1 THE SYSTEMATIZATION OF "MADNESS"

The attribution of a medical meaning *to madness* only occurred to the extent that this phenomenon was appropriated by more organized forms of knowledge, based on the parameters that define psychiatry and its different theories. As classificatory medicine evolves, mental disorders are included in this evolution and become part of diagnostic and statistical manuals.

In the mid-nineteenth century, mental illness in Europe already had the definition attributed to it by medical knowledge. Unlike other diseases, whose cause could be concretely observed (*post-mortem* examinations of injured tissues, for example), the lack of a concrete circumscription for mental illness allowed the most varied practices to precede reflection on its causes and origins. When institutionalized, these practices defined madness as a "natural fact," attributing to a selected set of aspects the objectivity required by the rigors of scientific thought.

Despite the absence of observable organic "causal" correspondents, the idea of naturalization of mental illness persisted and left little room for overcoming the dominant ideologies that pervaded the culture. The reflection on the lack of definition of therapeutic boundaries, confirmed by cross-cultural studies in different regions of the planet (India, Asia, Europe), has only recently been considered relevant for the research of mental disorders.

By permeating the practice, the dominant ideology defines, in each time and place, the treatment of mental illness. Known are the nineteenth-century paintings that depict Phillipe Pinel (1745-1826) freeing the insane from chains. If Pinel changed the way in which the mentally ill were treated in the most important hospitals in Paris (Bicêtre 1793, Salpêtrière 1795), he did so by introducing into medical practice the ideals of the French Revolution, and not a physiological discovery about madness.

The formulation by Charcot (1825-1893) of the idea of "trauma" or "traumatism", present in hysterical phenomena as an unhealthy psychic mark, paved the way for Freud to defend the psychic origin of hysterical conditions and, later, to extend it to other mental disorders. However, even though psychoanalysis identifies non-organic causes at the origin of disorders and considerably expands the importance of the sociocultural context and the subjective dimension for the explanation of psychic suffering, the technicality in which contemporary society is immersed - which disregards the meaning of social relations and depersonalizes existence - has enabled the rise and domination of practices whose objectivity overrides the subject who suffers.

The very history of the development of diagnostic and statistical manuals demonstrates this tendency[1].

[1] The first classification of causes of death, known as *the Bertillon Classification of Causes of Death, was systematized in 1893 by the Frenchman Jacques Bertillon* (1851-1922), head of the Statistical Services of the City of Paris. Revised in 1885, Bertillon's classification was first adopted in North America on the recommendation of the *American Public Health Association*. Bertillon's classification would undergo its first revision in 1900, at an international conference promoted by the French government, in which twenty-six countries participated. From then on, several revisions of the publication that we now know as the International Classification of Diseases, or ICD, currently ICD-11 (ICD: International *Statistical*

Prior to the DSM-III, the goal of psychiatry proposed by the APA (American Psychiatric Association) was to understand the fundamental problem of symptom origin. The intention was to treat the problem, not the symptom. However, at that time, the U.S. government reduced investments in psychiatric research, and health plans saw psychiatry as "a bottomless pit, with inadequate evaluation and treatment methods" (GRINKER, 2010, p.124).

From the DSM-III onwards, the focus becomes the symptom itself, and its presence, constancy and intensity become sufficient criteria for diagnosis. If, on the one hand, the standardization of diagnostic classifications offers the clinician greater pragmatism in treatment, on the other hand, it meets the demands of health insurance companies and the pharmaceutical industry. Consistent with the classification criteria practiced by the APA, the treatment of the disorder becomes the elimination or mitigation of its symptoms.

Far from minimizing the importance or efficacy of drug treatments to alleviate psychological distress, however, it is necessary to remember that mental disorders do not evolve apart from their context.

2 COPING WITH MENTAL DISORDERS THROUGH THREE DIFFERENT TRADITIONAL TYPES OF KNOWLEDGE

Colonialism, responsible for the hegemony of Western medicine throughout the world, qualified the medical systems of traditional peoples as primitive, irrational, based on magic and superstition. Traditional healing practices were marginalized or studied as curiosities, while Western practices claimed to be grounded in science. This colonial machinery imposed explicit hierarchies and norms on health systems and their respective treatments.

However, as European studies were carried out in different regions of the world, these hierarchies and norms began to be questioned. The *International Schizophrenia Pilot Study* and the *Collaborative Study on the Determinants of Outcomes of Severe Mental Illness* (WHO, 1973; WHO, 1979; JABLENSKY et al., 1992; LEFF et al., 1992), of the World Health Organization, demonstrate that the ubiquity of schizophrenia, for example, does not correspond to similar evolutions, but that different social contexts determine different social and clinical outcomes. Such variables, therefore, should never be ignored in the consideration of the course and prognosis of a disease.

Studies in clinical epidemiology (STRAUSS et al., 1977) reveal that the evolution of mental disorders is strongly dependent on the individual's social functioning (either before or during the disease), evidencing a better prognosis for subjects living in developing countries, and confirming

Classification of Diseases and Related Health Problems) followed. In the United States, the American Psychiatric Association would separate mental illnesses from the International Classification of Diseases and develop its own Manual, known as the DSM (*Diagnostic and Statistical Manual of Mental Disorders*). The first edition of the DSM would be a variant of the clinical descriptions of mental disorders in the sixth edition of the ICD.

studies carried out in the late 70's that already pointed out that the best prognoses of schizophrenia occurred in non-industrialized countries (WAXLER, 1979).

Therefore, the variation in the evolution of schizophrenia in relation to environmental conditions is confirmed, that is, the weight of the "context effect" as a strong determinant in this process (SARACENO, 1999, p. 30).

According to Saraceno (1999), among the elements that influence the evolution of psychoses are the family context, the density and homogeneity of the individual's social network (the number of people who share the same social values). These results allow us to affirm that both the chronicity and the impoverishment of the psychotic life are due, not only to the psychopathological picture, but also to variables that can be modified and guided in the intervention process. As the author notes:

> As can be seen, most of the time, these variables are linked to microsocial contexts (family and community) and presuppose environmental management strategies that are far from the common strategies proposed by the biomedical psychiatric model. In the last twenty years, this evidence has reinforced the hypothesis that an intervention on psychosis makes sense, if it is conducted over "the whole field", thus influencing the complex constellation of variables that constitute risk and protective factors. (SARACENO, 1999, p.30)

Although mental illnesses may indicate alterations in brain activity, they afflict individuals who live in personal, social, political, economic, and cultural contexts, and treatment must be provided in these contexts, since therapeutic interventions result from an interaction between therapy and the environment in which it is performed, meaning the scope of a service and its *modus operandi*.

A study carried out in 1983 on the African continent, in the field of ethnopsychiatry, clearly demonstrates that the rapid social reintegration of patients with mental disorders into a given culture is intrinsically related to the treatment provided to them by traditional African medicine. The research aimed to verify the variations in the frequency and symptomatology of mental illnesses.

At the time of the study – in the late 1970s – the dominant ethnicity among Nigeria's population was the Yoruba, who numbered 15 million inhabitants and inhabited southwestern Nigeria.

Yoruba society possessed great cultural, linguistic, and political homogeneity, but had undergone an extremely rapid process of modernization and westernization. To the traditional way of life was added the "modern world", whose maximum representation was the hospital and Western medicine. The city of Idaban, located in the central region of Oyo State, had 900,000 inhabitants, and had 145 doctors, 4 hospitals, as well as clinics and private practices.

In the traditional neighborhoods, the population was divided between Western medicine and traditional practices. Western medicine was considered more efficient in cases of infectious diseases, major surgeries, and childbirth. On the other hand, traditional medicine, previously applied to all diseases, continued to be the most sought after in cases of impotence, sterility, diseases attributed to witchcraft, magic, and, especially, in cases of mental illnesses.

In the classification of diseases of the Yoruba culture, psychic and organic elements are mixed, and there is no strict delimitation between organic and mental diseases. And unlike the Western understanding of illness and the psychic mechanisms involved in morbid functioning, for traditional Yoruba medicine "evil" does not come from within the individual, but "from without." The person affected by a mental disorder is being the victim of an external aggression (like any other disease caused by viruses, bacteria, or accidents). Among the causes of disease are the secondary deities neglected or forgotten by the sick person in question (*Osira*), the curses, and Soponna, the god of smallpox and madness.

To delineate the treatment, the traditional Yoruba doctor considers the psychosocial aspects involved in the disease process. It does not only deal with the individual, but also analyzes the conflicts inherent in the kinship group, and treats the deteriorated relations between its members. It does not isolate the patient, it does not deprive him of intersubjectivity. Without the support of the group, the Yoruba doctor may even give up on the treatment. This is because, while the manifest objective of the therapy is to cure the patient, the latent objective is to allow the expression and structuring of the community's censored desires, promoting the circulation of *the unsaid*.

As the subject's hallucinatory and/or delusional productions find continuity in the group imaginary, their messages are understood and welcomed by the group. The result is that 90% of patients recover quickly, and reintegrate into everyday community life.

More than techniques and specific medical knowledge, the reception received by the patient in the process and group integration are essential for a favorable prognosis.

In Brazil[2], similar practices can be identified among groups that cultivate traditional knowledge through their religious practices.

In an in-depth research on mental illness, Magnani (2002) describes the process of diagnosis and treatment in one of the most traditional Afro-Brazilian religions: Umbanda.

According to the author, the classification of diseases in Umbanda considers: karmic diseases (resulting from unexpiated faults), symptoms of mediumship (which include visions, weakness, fainting, headaches, and even convulsions), disturbances caused by other people (negative influences because of envy, spells, enchantments) and, finally, diseases caused by *Encostos* (or *Quiumbas* = spirits without light), which are expressed by mental disturbances, headaches, fainting, compulsion to suicide, convulsions, and physical disturbances. The mental disorder, therefore, is caused by *backrests.*

[2] Brazil only reformulated its mental health care model on April 6, 2001, when President Fernando Henrique Cardoso sanctioned Law 10,216, which provides for the protection and rights of people with mental disorders and redirects the mental health care model.

The backrest crisis occurs suddenly: for no apparent reason, the person has visions, compulsive ideas of suicide, temporary bouts of madness – fights with family members, fits of rage with the breaking of objects in the house – or is also affected by some physical discomfort.

The treatment presupposes the removal of the *backrest*(s). This process includes identifying them, naming them, and performing a series of rites, according to the degree of control of the *Backrest* over the person. If the possession is not total, a few *passes* and the succession of ritual gestures will suffice. The patient is barefoot and devoid of metal objects, in the space intended for the practice of Umbanda: the terreiro. Surrounded by *mediums* embodied by his entities (caboclos or others), he receives passes from head to toe, puffs of tobacco, and is led to spin around himself. If the spirit resists, there is a *discharge* or *disobsession* (which is the transfer of *the Backrest* from the body of the affected person to the body of the *medium*). Herbal baths, gunpowder discharges, smoking and other auxiliary resources are also used. If, in the process of identification, a relationship is discovered between *the Backrest and the affected person, it is necessary to find out the reasons why the* Backrest *took possession of it in order to detach it from the person (MAGNANI, 2002).*

When analyzing the characteristics of the treatment process in Umbanda, Magnani refers to the relationship of contiguity with everyday life (the house, the warehouse, the bar, the streets of the neighborhood) that the space of the terreiro evokes, unlike the impersonal and bureaucratized space of the hospital, which is much closer to spaces that are seats of power (police station, city hall, etc).

In the yard, the space evokes the familiar, the known. There are clothes hanging on the clothesline and garden. But if you look more closely, you can see the marks *of the sacred*: rue, guinea, sword of St. George; one or two lit candles, and next to the gate the little house of Eshu, the guardian, lord of the paths and crossroads.

As in the Yoruba culture, also in Umbanda the messages of the patient have continuity in the group imaginary, and, therefore, the psychic productions are understood and welcomed. Their strategy is not to eliminate madness, but to make room for it to express itself. The treatment is not intended to suppress the conflict, but to make it intelligible by endowing it with the meaning whose foundation is found in the religious system.

In academic research carried out by Bovo e Silva, Loenert Neto and Maniakas (2006), it is also possible to observe how the reception and treatment given by Kardecist Spiritism to a person with hallucinatory symptoms influenced the development and evolution of the psychic disorder itself.

Mrs. X., at the time of the research as a medium in a Spiritist Center of Kardecist tradition in a *medium-sized* city in the interior of the State of São Paulo, had a previous history of hallucinations. The disturbing visions began after Mrs. X. survived a serious car accident in which she lost her entire family. After years of undergoing conventional psychiatric treatments, and without showing significant improvement, he underwent treatment at a Spiritist Center. Such treatment included passes, lectures

and other activities, always carried out with the support of the group. From this treatment, the visions began to be circumscribed to the so-called *spiritist sessions*. Since the time of the treatment, Mrs. X. has not suffered any more hallucinations.

Although we cannot say whether or not the psychiatric diagnoses received by Mrs. X. were wrong, we can say that the conventional treatments she received for years were not effective in making her deal with the suffering triggered by an extreme situation. The treatment she received at the Spiritist Center, on the other hand, taught her to live with suffering through her acceptance in a group of practitioners who did not see her as someone abnormal. The authors' conclusion was that religion - in this case, Spiritism - offered an integrating principle for the traumatic events experienced by Mrs. X., which, before the welcome received, were unbearable and disconnected from any meaning. To the extent that religion offered points of reference and support in relation to the unpredictability of everyday life, the suffering experienced by Mrs. X. became intelligible, endowed with meaning, which allowed a reordering of the disintegrating psychic tendencies.

3 FINAL THOUGHTS

The conviction that treatments derived from traditional knowledge are ineffective seems to be based on a form of rationality that demonstrates alliances and commitments with knowledge systems and/or institutions that offer specific healing practices. In contemporary society, the dominant cultural meanings of medical practices are shaped by broader social, economic, and political agendas. Mental health is no exception to this determination.

While the Western medical proposal of classical treatment of madness is marked by technicality, by the isolation of the individual from the conviviality of the "healthy", the treatment offered by the practices of traditional knowledge is integrative, providing a language for the subject to express his madness.

But how can ritual action and storytelling treat psychic disorder? Probably, by allowing a symbolic closure, these treatments promote a sense of formal completeness and a coherence between the fragmented and chaotic elements of the disease experience. In this way, they transform the meaning of experience by conferring metaphorical qualities and/or mixing representational spaces. They build a sense of solidarity with others through shared, understandable and socially valued suffering.

These representational spaces, preserved and invested by traditional knowledge, seem to access levels of meaning that involve emotional, sensorial, and gestural qualities. The efficacy of word healing, valued by Freud since the early days of psychoanalysis, can be attributed to several levels of effect. Among them, we highlight the creation of new possibilities of representational symbolic arrangements and the establishment of relationships of support and comfort through the reception of those who suffer.

The premise that the suffering of mental disorders has a meaning that goes beyond the individual allows them to be understood and faced not only by an isolated subject, but by the entire community.

REFERENCES

AMERICAN PSCYHIATRIC ASSOCIATION. *Manual diagnóstico e estatístico de transtornos mentais: DSM-5*. Porto Alegre: Artmed, 2014.

BOVO E SILVA, M; LOENERT NETO, V; MANIAKAS, G. F. *A importância do contexto sociocultural na investigação de fenômenos psíquicos em psicopatologia: um estudo de caso*. In: XIV Congresso de Iniciação Científica. São Carlos: Universidade Federal de São Carlos, 2006.

BRASIL. Lei 10.216 de 6 de abril de 200l. Brasília, DF: Presidência da República. In: https://www2.camara.leg.br/legin/fed/lei/2001/lei-10216-6-abril-2001-364458-publicacaooriginal-1-pl.html

FREUD, S. *Estudos sobre a histeria*. In: Obras Completas de Sigmund Freud, vol. 2. Buenos Aires: Amorrortu Editores, 1992.

GRINKER, R.R. *Autismo – Um mundo obscuro e conturbado*. São Paulo: Larousse do Brasil, 2010.

JABLENSKY, A.; SARTORIUS, N.; ERNBERG, G.; ANDKER, M.; KORTEN, A.; COOPER, J. E.; DAY, E.; BERTELSEN, A. *Schizophrenia: manifestations, incidence and course in different cultures. A WHO Ten Country Study*. In: Psychological Medicine, 22, suppl. 20, 1992.

KAWA, Shadia; GIORDANO, James. *A brief historicity of the Diagnostic and Statistical Manual of Mental Disorders: issues and implications for the future of psychiatric canon and practice*. 2012. In: https://peh-med.biomedcentral.com/articles/10.1186/1747-5341-7-2

LEFF, J.; SARTORIUS, N.; JABLENSKY, A.; KORTEN, A.; ERNBERG, G. *The International Pilot Study of Schizophrenia: Five Year Follow Up Findings*. In: Psychological Medicine, 22 (1), 1992, pp. 131-145.

LÉPINE, Claude. *A doença mental entre os Iorubas da Nigéria. In: D'Incao: Doença mental e sociedade.* Rio de Janeiro: Graal, 1992

MAGNANI, J.G.C. *Doença mental e cura na umbanda*. Revista Teoria e Pesquisa – Programa de Pós-Graduação em Ciências Sociais da Universidade Federal de São Carlos, v.40/41, pp. 5-23, 2002.

MANIAKAS, Georgina F. *Relatório de Estágio Pós-Doutoral*, pp. 47-56. (Visita técnica ao *Karl Jaspers Centre for Advanced Transcultural Studies*, Universidade de Heidelberg). São Carlos: UFSCar, Departamento de Psicologia, 2016. Relatório técnico não publicado.

SARACENO, Benedetto. *Libertando Identidades: da reabilitação psicossocial à cidadania possível.* Te Corá Editora/Instituto Franco Basaglia. Belo Horizonte/Rio de Janeiro: 1999.

WAXLER, N. E. "*Is the outcome for schizophrenia better in non industrial society*?" Journal of Nervous and Mental Diseases, 167, 1979, pp. 144-158.

WHO (World Health Organization). *Report of the International Pilot Study of Schizophrenia.* Geneve: WHO, 1973.

WHO (World Health Organization). *Schizophrenia. An International Follow Up Study.* Chicester: Wiley, 1979.