“Although 90% of the system is against us, we are able to survive”

An exploratory study of West-African Christian migrants living in the Netherlands on healing practices and sources of empowerment in times of social distress

Amsterdam Masters of Medical Anthropology 2006
By: Catharina J. Beijer

Supervisors: Rijk van Dijk, Afrika Studiecentrum Leiden and Ria Reis, Universiteit van Amsterdam
Foreword

This thesis is an attempt to shed more light on the healing practices of West-African Christians living in the Netherlands in times of social distress. The focus is on coping mechanisms of what Western people call a dysphoric affect or a depressive illness.

Most of the studies I have been reading about migrants coming from West-Africa are written from a Western point of view. The same is true for studies on depression. My aim is to give insight from another point of view. Narratives of healing practices are used to come to an understanding. Therefore Afro-Christian practices in the church are discussed as well as Western practices and so called traditional practices. But one must not read this thesis as a critical evaluation of all these practices. It is about how depression is brought to meaning and what sources of consolation and help are sought.

This is an exploratory research, on how people seek answers and find help and consolation, when they feel low, alone, worry all day and have sleepless nights and feel a lack of energy. I based this thesis on literature, observations, church visits, casual talks and discussions with professionals in the field of healthcare and West-African studies and my practice as a psychologist. This thesis is the last assignment of my Master Degree in Medical Anthropology.

Depression and dysphoric affects are of interest to anthropologists and psychologists alike. It is my belief that it is neither a simple reflection of personal experience of psycho physiological processes nor a culturally constituted phenomenon free of physiological constraints. In the Netherlands we follow our own medical and social science discourse in which we view and analyze clients coming from an other cultural background. But West-Africans have their own explanatory framework. We assume in the West that our way of solving problems is the best. Some times it is but not always. Solutions found in the West and in West-Africa can be compatible and even overlap at times They also might be used in addition to each other. But no aspect of West-African refugees and migrants is as overlooked by researchers and healthcare workers as their religious background. And by overlooking this field, views gets narrowed: solutions and coping mechanism that are possibly more healing than a Western based psychological treatment are not considered when people ask for treatment and help. Tapping from the healing wisdom of West-Africans themselves, their knowledge, beliefs and practices is a path that I try to explore in this thesis. There is much to learn from my West-Africans respondents about their beliefs and how it can help to cope in times of distress.
Acknowledgement

I want to thank Eno Inanga, Ria Reis, Sjaak van der Geest, Rijk van Dijk, Makorani Y’dhida a Mjidhido and Namonyah Soipan. They were the people that have broaden my view by showing me the narrow perspective of the Western psychological approach. I also want to thank my sister Annemarieke and Mieke Merckx who were a great help in correcting my “dyslectic” English. A special place in my heart is for the mother of my African son.

Carin Beijer
July 2006
Table of contents

Foreword

Table of contents

Chapter one : Getting started

1.1 my own quest and search
1.2 context and limitation of the study
1.3 getting started: introduction to the theme of the thesis

Chapter two : Culture and depression

2.1 Culture health and Illness
- Illness and disease
- Sectors of health care
- Explanatory models
- Identity, the self, individual and social bodies
- Culture bound syndromes

2.2 Culture and depression
- Introduction
- Definitions of abnormality
- The meaning of words
- Fear of stigma
- Depression as a culture bound syndrome
- The diagnostic weight of somatic symptoms in depression

Chapter three : Rhetoric’s of healing and disease

3.1 Introduction

3.2 The Western bio-medical discourse on depression

3.3 The discourse of Pentecostalism
- A brief history
- The popularity of these churches
- Psychotherapeutic ritual

3.4 A West-African discourse: traditional society and religion
- The spirit world
- Magic and Medicine
- Religious functionaries
Chapter four: Preventive and healing practices

4.1 Introduction

4.2 Somatisation, vocabulary and etiology
- Somatic symptoms in depression and vocabulary
- The aetiology of distress
- Witchcraft as causation
- The power of thoughts
- Family pressure
- Guilt, aggression and society
- Keeping harmony with one’s pre-life accord

4.3 Preventive and curing matters outside the church
- Resilience
- Society and family as shock absorbers
- Cleansing
- The help of the Koran

4.4 The African-led church as a healing community
- Syncretism
- The Holy Spirit and gaining of Spiritual power
- Sunday morning sessions: prayer, speaking in tongues, dance and singing
- Public confession
- Dreams vision and fasting
- Words of consolation
- Power and Prosperity
- The deliverance ritual
- The community: being part of a group
- Breaking with the past
- The need for clear direction

4.4 The choice of a healer

Chapter five: Some final thoughts

References

Annex
questionnaire
Chapter one: getting started
Telling stories can be healing.  
We all have within us access to a greater wisdom,  
and we may not even know that until we speak out loud.

Listening to stories can be healing.  
A deep trust of life often emerges when you listen to people’s stories.  
You realize that you’re not alone:  
You are travelling in wonderful company.  
Ordinary people living ordinary lives are sometimes heroes.

Dean Ornish, M.D.  
In the foreword to  
Kitchen Table Wisdom by Rachel Naomi, M.D.
1.1: My own quest and search

It was about twelve years ago that I started having dreams about Africa. I was not focussed on Africa at that time but those dreams were so vivid and special that I was sure they had a message for me. In one of the dreams appeared an African man that guided me through rituals. Seven years later when I gave a guest lecture on an international institute, I saw the man that appeared in my dream. He happened to be a Royal lineage, son of a tribal headman, bio-medical doctor and trained by his grandmother who was an indigenous healer. He promised me to show Africa in an African way. So he did. Although my trip was short it changed me. The fact we met was no coincidence; according to him it was the work of our ancestors, my mothers father and his mothers father. Gradually I learned to understand that there were more social realities and that besides the bio-medical reality healing was another reality as well. I also learned to understand that witchcraft was one of such realities.

Being back in Holland I hoped for more African learning’s. The ancestors had listened well and it was a year ago when I met Noah, an eighteen year old boy from Guinea. I attended an African dancing class with John, a dancer, anthropologist and an apprentice healer from Africa. After class we often sit together and talk. It was after class that one of my fellow classmates, working for the MOA in a AZC, came to me and asked me if I wanted to take care of an African boy once in a while. So she started telling me about one of her clients, Noah, she was really worried about. Noah had just turned eighteen and lost his AMA status. Turning eighteen in the world of young refugees living in AZC’s is an important age because most of the support stops: you are expected to take care of yourself. It took some months in fact till the first meeting with Noah was settled. But once we met, he visited us frequently and feels at home with his new sister, mother and father. So Noah came to our house and we became his guest family and I got more and more involved in problems he was facing.

Being a guest mother of a nineteen year old West African son and being a psychologist myself it became clear to me that help offered by RIAGG’s and other health care workers was not always very effective. To give an example; for his sleeping problems he was send to the RIAGG. But his sleeping problems due to excessive worrying only increased after a visit to the RIAGG. Another thing was that I was faced with his enormous distrust of the Dutch, who according to Noah always wanted to know everything. One day a RIAGG-helper phoned me and was literally saying: “I do not understand the boy, I do not know what to do with him he’s not easy to handle, he is anti-social”, (ik begrijp hem niet ik weet niet wat ik met hem moet doen, hij is geen lekkertje, hij is anti sociaal ”).I was not only furious about the labels that did not fit Noah in my opinion but I felt despair as well. If this was the level of understanding of a trained helper I decided it was better not to have help from a Dutch psychologist or psychiatrist. For me Noah was a social boy who felt at ease in our family. For me his attitude was a normal response to an abnormal situation. Another thing that became very clear for me was that context made such a difference. The whole AZC environment felt as a sick environment to me and anthropological term "thingification “crossed my mind in how people are seen and

-----------
treated. The MOA people I have to say were an exception. And of course, I knew, he is not always easy to handle especially in situations of felt injustice and anger. But having a weakness for people who are rebellious, I could also see the healthy side of the behavior. Hearing his personal history bit by bit I found it a miracle that he was full of humor and wanting to fight. If I had been the one going through these experiences I am quite sure I would have gotten very depressed.

There were many situations I did not understand or often I didn’t notice that “things” were going on. Such an occasion was last January when we crossed the Waddenzee by boat on our holiday trip to Vlieland. Noah felt such a fear and started praying and asked for help. There were spirits, I got to know later, spirits that could not be seen by us. But for Noah they were there and they were frightening.

I developed a sceptical attitude towards the limitations of the Dutch healthcare sections specialised in refugees. It made me realize that I, and most of the healthcare workers, are so embodied in a Western discourse based on values like self-development, independence, assertiveness and personal choice that it is difficult to think in other perspectives and other ways in finding relief from pain and distress. The contextual self is not understood nor is the invisible world of spirits and ancestors. In widening my perspective and asking myself the question: what is felt as supporting in coping with social distress I got interested in the role Afro-Christianity and Traditional religion.

1 MOA= (Medische Opvang Azielzoeker). Medical healthcare for Asylumseekers provided by the state
2 AZC= (Azielzoekers centrum). Asylum where Asylumseekers live. Mostly hospitals and military buildings that are not occupied anymore.
3 AMA = (Alleenstaande Minderjarige Azielzoeker) Name for the asylum seekers under the age of eighteen that came alone, without family, and asked for asylum.
1.2: Context and limitations of this study

Writing about West-Africans living in the Netherlands and their coping with social distress is a hazardous enterprise. A specific problem for me was limiting the scope of this study. Another problem was my Western terminology as depression and dysphoric affect as a starting point of my research. Once you start reading, talking and thinking about the subject there are so many ways to approach it. It was difficult for me as a trained psychologist to make good use of the very valuable anthropological insights: the internal fight between wanting to help and to act and maintain a distance and observe was one of them. Psychologists tend to be more practical and applied but in wanting to do the right thing they can do things totally wrong. Anthropologists on the other hand can be very theoretical and critical in their level of intervention and are not always concerned with applicability of their theories. The best of the two worlds is: knowing when we should act and when we should listen. Professor Sjaak van der Geest was a very wise teacher: he preached a humble attitude and described the anthropologist at work as a child who has to learn the codes on how to behave and the stupid mistakes one can make in the eyes of the Other. And indeed I often felt as an ignorant child during the whole process of setting up the thesis and searching for answers. But one has to take into account that this study is based on a six week fieldwork to familiarise with the anthropologist work, tools, limitations and dilemma’s. This whole process of reading, writing, talking with people and analysing helped me to find some direction in the answer on the question I had but I ended up with even more and other kind of questions.

My objective:

My main objective as formulated before was to come to a better understanding of the healing practices of West-African Christians living in the Netherlands. The focus is on coping mechanisms of persons suffering from a negative mood stage or what Western people call a dysphoric affect or a depressive illness.

My approach:

My approach in this research is the following: the first step was to externalize my inner dialogue. I asked myself: what kind of knowledge will support me to be a better professional? In the mean time I started to read literature and research on healthcare in Africa. Secondly, I picked out some topics that intrigued me most and were related to my work as a psychologist. Part of this process is written down in “my own narrative”. The search for literature led me to studies mainly by religious anthropologists and research in the Ghanaian community in the Bijlmer. This is also a limitation of this research: I took the Akan cosmology as a starting point. I am aware of the fact that their ways of regarding the world does not represent the whole of West-Africa. Nor do the churches and church leaders I visited represent all the Afro-Christian churches or all Afro-Christian believers from West-Africa. It takes time to distinguish different forms of Afro-Christianity and their ongoing adaptation in time and circumstances.
The dilemma of clinical and anthropological methods

A dilemma or struggle I want to address in this paragraph is that I experienced that anthropological and clinical methods are in tension with one another. The Medical point of view takes depression as a disease, as personality and as disruption of social functioning. Emic assessments -the evaluation of people from West-Africa- do not use the term depression and do not see it as a clinicians task to treat them. The concept of depression as a starting point of my research is a Western concept and made it difficult to ask the right questions and shifting the right data. The deeper I got into my research the more questions I raised, like: what data are relevant? How should I pose my questions knowing that my psychological language is not free of value? And what about my interpretation of the answers given by my respondents considering my own Western background and education and profession as a psychologist?

Theoretical orientation

The theoretical orientation I tried to use in this thesis is the critical medical perspective that incorporates both a political-economic perspective and cognitive symbolic approach. The critical approach deals with how people think about themselves, how they communicate with others and how they are controlled by others and put it in a political perspective of power. Illness affects both self-reflection and social dimension. The theory of the cognitive (or interpretative) symbolic school tries to uncover and interpretive deep emotional and psychological structures of society. It deals with meaning and interpretation. The interpretative school of anthropology says that every culture has its own way of doing things, it’s own view of the world, it’s own values. This uniqueness makes comparisons between different cultures misleading. The interpretive school has its roots in historical particularism that assumes that each culture is the product of many factors affecting the past. In this thesis I try to discover how West-Africans give meaning to their experiences.

Data collection techniques used:

This study was an exploratory, descriptive study. I used qualitative research methods as interviews, observation and participation. West-African friends helped me find respondents. Through networking I selected 12 respondents for in-depth interviews.

Respondents characteristics:
- age in years: 21-67
- male/female
- national background: Cameroon, Ghana, Nigeria, Guinea, Benin
- education level: 5 years primary school- PhD
- residence in the Netherlands: 2-12 years (citizenship and illegal stay)
- reason for migration: forced/own choice

Besides in depth interviews I had casual talks and participated in expert meetings and workshops relates to my objectives for research and was involved in a theatre project about the lives of West-Africans in Europe.
Interviews:

The interview style I used was a style used in narrative therapy based on social constructivism. Most of the interviews were semi-structured open interviews. The main questions focussed on the following items: general questions on cultural identity and the Christian identity, knowledge about the Western term depression, cultural explanations of symptoms of what Westerners call depression, support seeking behavior, the role of the church, family and significant others. The outline of the questionnaire can be found in annex 1. Most of the interviews were taped. From these tapes the interviews were transcribed and coded manually and subdivided in general themes. The interviews are based on willingness of the respondents to participate.

Observation and participation:

I visited the African-led church in Utrecht and participated in the services to get a better understanding of what issues are addressed in the church and which rituals are used. I also attended the Ghana workgroup of the African Study Centre in Leiden, attended expert meetings and conferences related to the subject and went to African parties and organised dinners.

The dilemma's of trust, secrecy and silence

A dilemma by getting more and more involved in the Guinean community is that I feel myself also part of some "circles of secrecy". Using this information and writing it down is in my opinion misusing information. I gained inside information that I do not want to write down: There is the issue of trust and being a silent witness. Another dilemma is how curious one can be. Western people always ask questions and are so nosy according to my African son and his friends. They, and others made clear to me how they despise this attitude. On the other hand I like to know and understand. And isn’t it partly the task of an anthropologist to break silence? Secrecy and silence have to be addressed in an ethical way. People will not reveal their deepest feeling of despair easily. And if they do, is it for my sake that they open up? What will be the consequences for them? And I know that a lot of things will never be told. What is not said matters as well. There are issues you do not mention because by mentioning the words out loud it gets materialized. And some experiences will be silenced because they are to painful to tell or are even unspeakable. They are beyond words. Other experiences are unspeakable because they are culturally or politically sanctioned. Van der Geest in his lecture (2001) puts it this way: "Secrecy is purposeful non-sharing: people may have good reasons to withhold knowledge or information. Anthropologist know there must be something to tell, yet that people cannot or may not tell".

Another problem is that I as a Psychologist am obliged to keep the information I hear as “private” information. I am not aloud to share information with others unless people give written permission to share this information. There are strict professional guidelines of the Government on this ethical issue. During the time I was researching for my thesis I received information is privacy, and sometimes and sometimes respondents told me to put my recorder off. People wanted to share with me but not
with others. Violating the rule of privacy has consequences for both the person at stake and me as a professional. The consequence for me as a psychologist is that I will be punished. But it has consequences for this thesis as well. This is one of the tensions between being a practicing psychologist and being a anthropological researcher at the same time.
1.2: Introduction to the theme of the thesis

Western trained psychiatrists and medical anthropologists have different approaches leading to different perspectives. But they share the same concern with the effects to migration. Studies carried out in various countries indicated that immigrants have a higher rate of mental illness than either the native-born population or the population in their countries of origin (Helman 2000:199). This is indicated by higher rates of admission to mental hospitals, higher indices of alcoholism, drug addiction and attempted suicide (Kleinman, Trimboslezing 2005). According to Littlewood (1989:133) and Helman (2000:210) migration mobilizes a mourning process with significant and lasting effects on an individual's identity. This mourning process can involve profound losses of family and beloved ones to giving up familiar foods, native music, unquestioned social customs and language. But there are gains as well; there is a possibility for growth, alternation, earning money, learning from new identification models and develop new ideals. But it will always be a mixture of emotions. The outcome of the process is depends on a large number of factors as the circumstances and reason for migration, the magnitude of cultural differences, reception by the new host country and the experiences and efficacy in the new country.

The West-African migrants arriving the Netherlands came for many reasons: most of them are in search for a better life and have more or less chosen to be here. Others came as refugees and felt they had no other choice to survive than leaving their home-countries. Some were sent by their families, others came for adventure. Some came legal others were illegally smuggled into the country. These reasons causes different levels of distress ranging from the stress of an adventure, racism, trauma’s from war and human right violations, torture and losing beloved one’s.

Much has been written by healthcare workers and social scientist about the problems these migrants face as ascribed above. But most of these studies and information are still written from a Western bio-medical point of view which means mostly looking at problems and describing pathology and difficult cases. Migrants take their own ways of coping, knowledge and problem solving strategies with them. So do the West-Africans that live here. Some of them formed new independent congregations. These congregations are important communities in terms of healing and support networks. To my opinion Western health care underestimates the healing knowledge of the migrant people and underestimates the role of religion and churches. I do not want to equate migration with problems, however it is my personal view based on my experience as a psychologist that even under the best circumstances migration is a process that mobilizes difficulties and mourning process. Besides the losses there are the gains: an inner power of people exists on how to deal with these losses and knowledge about how to survive in the Whitman’s world.
Another important factor to my opinion is that knowledge and sources of resilience of these migrants are not well explored yet. Solutions and coping mechanism that can be more healing than a Western based psychological view in times of distress are often not in focus when they ask for treatment by a Dutch health care worker. It has been my aim in this exploratory study to listen, exchange views and to tap from the healing wisdom of these West-African Christians. And explore how individuals in the contexts of African-led churches use traditional knowledge and religious ritual for psychologically and somatic beneficial purposes.

In the next chapter, chapter two the topic of culture and depression is introduced. There seems to be no doubt that depression is found by psychiatrists all over the World. This chapter describes how problematic researching this topic is. One major problem is the ethnocentric way in judging "the Other". One can only see and hear what is visible and known, and cannot see and hear what does not belong to one’s frame of reference. So even the questions we raise to uncover “the Others” perspective are questions originated from the emic perspective and easily lead to misinterpretations. The word “depression” is a typical western word that cannot be translated into a West-African language. Western idioms of distress as depression have their roots in a highly individualized society. Idioms of distress of West-Africans have a more social context and express more the economical and political situation at stake. The third chapter describes three different discourses of healing. My purpose in this chapter is to bring to public notice the existence of different forms of healing: the Western bio-medical discourse, the discourse among Pentecostals and the traditional African view on health based on the Akan cosmology. These concepts about health and disease of the Traditional and Pentecostal approach are different from the western Bio-medical approach. My focus in this paper is directed towards the Traditional and Pentecostal approach. They have in common that they work with faith and group support. Chapter four describes what is felt as healing by sufferers of distress. In this chapter I make use of observations, my experience as psychologist, interviews and literature. Respondents make a difference between curing and healing: man can cure but only by a divine intervention you can be healed. In Chapter five I wrote down some final thoughts based on the findings.
Chapter two: Culture and depression
2.1: Culture, health and illness.

Before going into detail of complexity of culture and depression in the next paragraph I want to clarify some concepts used by medical anthropologists to describe and explain health and illness. Medical anthropologists study people in different cultures and social groups and explain causes of their ill health, the types of treatment they believe in and to whom they turn when they do get ill. In this chapter I will describe the concepts illness and disease, individual and social bodies and the meaning of the term culture bound syndrome. But first I like to quote Kleinman about culture Kleinman is anthropologist and psychiatrist and Professor of medical Anthropology at Harvard: “In recent years, a much more sophisticated idea of culture has gained ground in anthropology. This is the notion that culture is constituted by, and in turn constitutes, local worlds of everyday experience. That is to say, culture is built up ("realized") out of the everyday patterns of daily life activities - common sense, communication with others, and the routine rhythms and rituals of community by life that are taken for granted -- which reciprocally reflect the patterning downward of social relations by shared symbolic apparatuses -- language, aesthetic sensibility, and core value orientations conveyed by master metaphors. In these local worlds, experience is an interpersonal flow of communication, interaction, and negotiation - that is, it is social, not individual - which centres on agreement and contestation about what is most at stake and how that which is at stake is to be sought and gained. Gender, age cohort, social role and status, and personal desire all inflect this small moral universe in different ways. The upshot is culture in the making, in the processes that generate action and that justify practices. Thus, the locus of culture is not the mind of the isolated person, but the interconnected body/self of groups: families, work settings, networks, whole communities(lecture Han ten Brummelhuis Kleinman in Mezzich at al 1996: 16).

Illness and disease

In Medical Anthropology the terms illness and disease are explained as follows: “Illness represents what a person feels when he goes to the doctor and disease is what the same person has on the way home from the doctor”. Disease is something an organ has. Illness is something a person has, it is a subjective response of the meaning given to that experience and the interpretation of it’s significance. The patient’s perspective on ill health is usually part of a much wider conceptual model used to explain misfortune. Question’s like” why me?” are often raised or " who has caused me ill health ? “.

Disease is a term used by the professionals who practice scientific medicine based on scientific rationality with it’s numerical measurement. Ill-health will be objectified by demonstrative physical changes in the body structure or functioning which can be qualified by reference to normal. Abnormal change is seen as diseases. The concept disease is also based on mind-body dualism and emphasis on the individual patient rather than the family or community.
Sectors of healthcare

In my classes Medical anthropology by Sjaak van der Geest three overlapping and interconnected sectors of healthcare were pointed out. The first sector is the so called popular sector this is the domain of the lay non-professionals and non-specialists. It includes in fact all the therapeutic options people utilize without payment and without consulting either folk healers or practitioners. They include self treatment and self medication, healing and mutual care activities in a church or consultation of lay persons who have some special experience the field. The second sector is a heterogonous group. They include individuals that are specialized in forms of healing that are either sacred or secular. Among them are bonesetters, midwives, herbalists and spiritual healers, clairvoyants but also healing ministries, faith healers and neighborhood prophets. Most folk healers share the basic cultural values and worldview of the communities in which they live. The third sector is the so called professional sector and comprises the organized, legally sanctioned professions such as modern scientific medicine Psychiatrist and psychologists belong to this sector. It is important to understand that western scientific medicine provides only a small proportion of healthcare in most countries of the world. These three sectors overlap and to separate them is artificial.

Explanatory models

Kleinman suggests the use of explanatory models ( Helman2000:85) as a useful way of looking at the process by which illness is patterned, interpreted and treated. Explanatory models ( EM ) are held by both patients and practitioners and they offer explanations of sickness and treatment to guide choices among available therapies and therapists. Five aspects are important;

1. the etiology or cause of the condition
2. the timing and mode of onset of symptoms
3. the physiological process involved
4. the natural history and severity of the illness
5. the appropriate treatments for the condition

Explanatory models of patients and /or family members can be assessed by asking questions as:

- What do you call this problem?
- What do you believe is the cause of this problem?
- What cause do you expect it to take? How serious is it ?
- What do you think this problem does inside your body?
  How does it affect your body and your mind ?
- What do you most fear about this condition?
- What do you most fear about the treatment ?

These questions can be used to open up a conversation on cultural meanings that may hold serious implications for care.

Naturalistic explanatory models are more concerned with issues of contagion, pollution, and environmental dangers. They are compatible with bio-medicine.
Personalistic explanatory models are more concerned with issues as witchcraft, sorcery, ancestral punishment, evil spirits, evil eye and jealousy. and Gods punishment. This way of explaining is less compatible with bio-medicine.

Immigrant patients may attribute their depressive disorder to family conflicts. Or use alternative and complementary medical practices from herbalism to religious healing rituals. These can affect both the process of the disease and the care given. Explanatory model solicitation can clarify these and other forms of treatment.

Identity, the self and Individual and social bodies.

In Western psychology one often speaks of the concept of identity. This construct introduced by psychoanalytical therapists refers to both the intrapsychic and the interpersonal and has many connotations.

Both medical anthropologists and clinicians struggle to view the experience of illness and suffering from a integrated perspective, they often find themselves trapped in the Cartesian legacy. The natural/supernatural, the real/unreal dichotomy has taken many forms in western history and civilization (Scheper 1998:349). Descartes argued the existence of two classes of substance that together constituted the human body: the body and the mind. As a devout Catholic Descartes preserved the soul as the domain of theology and the physical body as domain of science.

Anthropologists speak of individual and social bodies. An individual body self is acquired at birth and is both physical and psychological. A social body is needed in order to live within a particular society. Body and culture are not really separated from each other. To a large extent individuals embody the culture that they live in. Their sensations, perceptions and feelings are culturally patterned. Therefore the body is culture: an expression of basic themes as sorrow and grief. Geertz (lecture Har ten Brummelhuis) speaks of a “a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgment and action organized into a distinctive whole and set contrastively against other such wholes and against its social and natural background” . Csordas (2002:58-87) speaks of embodiment and says: “The self is neither a substance nor entity but an indeterminate capacity to engage or become oriented in the world, characterized by effort and reflexivity. In this self occurs as a conjunction of pre reflective bodily experience, culturally constituted world or milieu, and situational specificity or habitus. Self processes are orientational processes in which aspects of the world are thematized with the result of the self is objectified most often as a person with a cultural identity or set of identities”. And Scheper (1998: 366) quotes Geertz by questioning whether any expression of human emotion and feeling is ever free of cultural shaping and cultural meaning: “the most extreme statement of Geertz position would be that without culture we would simply not know how to feel”.
**Culture bound syndromes**

Each culture has its own language of distress bridging subjective experiences and social acknowledgement of them. A story about how and why a person gets ill take often the form of a narrative. The narratives of stories of sickness is a way of giving meaning to ill-health experiences. It often places the illness in a context of the individual’s life history. It also relates to wider themes of the culture and the society they live in. Narratives of personal suffering are not only personal. They also draw on the repertoire of language, idiom, metaphors, imagery and myths provided by the culture in which the suffering took place. In that sense they are culture bound. Healers of every kind take a major role in helping to construct their client’s narrative. This is characteristic for most forms of symbolic healing from shamanism to psychoanalysis and of most religious traditions (Helman: 2000:96). According to Carr (1978:289-90) one can speak of a Culture-bound Syndrome when there is a distinct repertoire of behaviors that has evolved as a result of a social learning process. The Culture-bound Syndrome is legitimated as an illness within the indigenous system and defines the conditions under which such behavior is an appropriate response.
2.2 Culture and depression.

introduction

There seems to be little question of depression being a disease found by psychiatrists working all over the World in all human populations. But this picture is not as clear as it seems. What seems to be the accepted by medical doctors is that neurotransmitters and a set of hormones are implicated in depressive illness. The history of psychiatry is strewn with systems of categorization of depression. Some of these etiological categories are called endogenous and reactive. The current knowledge on depression is represented by the American Psychiatric Association (DSM-IV). They say that if a person experiences a loss of interest in the things they once enjoyed and are feeling sad, blue, down or tired and worried for at least two weeks, and are experiencing at least five of the other symptoms of depression (feeling worthless or guilty, thoughts of suicide or death, problems in concentrating, thinking remembering, trouble sleeping or sleeping too much, headaches, digestive problems) they may have major depression. If a person experiences euphoria, irritability, or a feeling of being "high" with four other symptoms of mania for at least one week, they may have bipolar disorder. The medical model of depression sees suffering as pathological and prescribes medication in response. Their outlook is also partly pragmatic: call depression a disease and health insurance covers its treatment.

Anthropologists see these psychiatric categories and theories as cultural and no less than other aspects of our World view. Cross-cultural research offers evidence of cultural variation in depressive mood symptoms and illness. For Buddhists, taking pleasure from worldly goods and social relationships is the basis of all suffering. The first of Buddhism’s four central precepts is: suffering exists. Because sickness and death are inevitable, resisting them brings more misery. Nature shows that life is sadness. Hayao Kawai (Schultz:2004:5) a Japanese clinical psychologist said: “We do not have stories where anyone lives happily ever after. Mild depression is never considered as a disease. Melancholia, sensitivity, fragility are not negative things in a Japanese context”. It never occurred to Japanese psychiatrist that we should try to remove them, because it never occurs to us that they are bad. For Shiite Muslim in Iran grief is a religious experience associated with recognition of the tragic consequences of living justly in an unjust world (Kleinman 1985:3). So members of one society vary not only in how they express dysphoric emotion, they seem to experience forms of emotions that are not part of the repertoire of others. Describing how it feels to be grieved or in distress leads straight away into analysis of different ways of being a person.

In some African societies the first signs of illness are dreams that indicate a witch may be attacking one’s vital essence (Kleinman 1985:3). Dramatic differences are also found in expressions of bodily complaints associated with depressive illness.

In Judeo-Christian cultures depression is often associated with overwhelming guilt and feelings of sin and shamefulness. So restructuring of cognitive thinking patterns gives often relief. Nigerians complain that “ants keep creeping in parts of my brain” while Chinese complain of their nerves and their hearts being squeezed and weighed...
down. Because of all these differences, studying the same illness across different cultural societies is problematic. In the next paragraphs I will highlight some interesting point of views of cross-cultural researchers on the issue of depression.

Definitions of abnormality

Catherine Lutz describes in her essay “Depression and the translation of Emotional Worlds” (1985:70-93) that translating the concept of depression involves translating ethno-theoretical statements dividing the nature, causes, evaluations and responsibilities associated with abnormal states. What she finds most striking about the western view of depression is its implicit insistence that the normal state is the opposed of happiness. In the West psychologists place emphasis on the depressed person’s self and loss of pleasurable activities. What she finds particularly deviant about the depressive is the person’s failure to engage in the pursuit of happiness or in love of self that is considered to be normal and a basic goal of persons. This seemingly natural goal is in fact a culturally molded goal, one that contrasts with other possible definitions of normalcy in which, for example, primary emphasis might be put on taking care of children and other relatives or on experiencing morally correct but perhaps unpleasant emotions such as shame or righteous indignation. Ethno psychological notions are implied in the kinds of therapies adopted for depressive or related experiences. Theories of illness causation and therapy are related to each other, were social conflicts are seen as causative, therapies may involve group discussion or group treatment. Where intrapsychic, unconscious conflicts, are seen as the root of the problem. Individual therapy is used to reach the source of conflict. Where witchcraft is seen as the source of the problem cleansing rituals can be performed as the “therapy” to heal.

Questions often asked in cross-cultural (mostly psychological) studies on depression are questions as “what are you feeling?” These questions are based on the assumption that the ultimate psychosocial reality is internal and by viewing the world this way indigenous epistemological notions about what can be known, what is worth knowing and where the problem really lies are more easily ignored.

The meaning of words

One of the items in ethno-epistemological research is the fact that people originating from various cultures take different interpretations of speech. This has consequences in the relation language and distress or language and “depressiveness.” Ethno-epistemological researchers ask questions as; “Where do words come from?” or “Do certain words be interpreted as acts of internal events?” or “When stress is identified how are those words to be taken?” There can be a continuum of possibilities for West-Africans. This is different in the West were words are more rigidly dichotomized into “true” or “false”. Interesting is also the fact that none of my respondents none of them could translate the word depression directly in Ibo, Yoruba or Twi. Beck (Lutz 1985;74) who has drawn primarily on the ethnotheory of the American clinical population identified that the concept of depression is linked to the personal domain and hopelessness.
Fear for stigma

Morton Beiser describes in his study of depression among traditional Africans (1985: 286) that complaints about feeling of depression do not regularly enter into physician-patient interactions among Africans. One of the reasons is that different ideas prevail about what is legitimate to bring into a treatment encounter. While Westerners feel more free to discuss their dysphoric symptoms, Non-Westerners will downplay dysphoric symptoms and emphasis somatic ones. Maybe the core experience of depression does not vary that much among cultures but what is emphasized or reported in the Physician-patient interaction varies greatly. Beiser argues that each society creates its own threshold for the translation of troubling experience into illness. One likely determinant of the threshold beyond which depressive symptoms turns into illness is the dimension of sociocentric versus egocentric societies. Egocentric societies permit the expression of affect and legitimize such expressions. As societies become more egocentric the expression of inner emotional life becomes part of the repertoire of behavior for more and more people.

Depression a culture bound syndrome?

Obeyesekere quotes in his article “Depression, Buddhism and the Work of Culture in Sri Lanka” the work of Kraus (1968:26): “Yoruba really suffer from depression though they do not see it as such”. Depression presented a special problem in what while the symptoms were recognized as painful, unpleasant and disabling, they were seen as more or less ‘natural’ results of the vicissitudes of life. The general psychiatric attitude views this as a “conceptual problem. Obeyesekere (1985:135) argues that the conceptual problem does not lie with the Yoruba but with the Western psychiatrist. If Ashanti and Yoruba say that certain affects arising from life conditions as bereavement, loss, menopause, old age etc. do not constitute an illness, and furthermore if affects cannot be separated from their involvement in an existential issue such as the nature of life, could we seriously say that the Ashanti and Yoruba are deluding themselves and that they are in fact suffering from the illness called “depression”?

The diagnostic weight of somatic symptoms in depression

Somatization is the pattering of psychological and social disorder in an language of distress of mainly physical symptoms and signs. Somatisation can be seen as “speaking with the body” (Helman 2000: 182) or a language of distress. Somatic symptoms are common features of depression but their weight in the diagnosis of depression is uncertain. Somatic symptoms as “heat “ or “peppery” sensations, emptiness, skin-crawling, “ants creeping in the brain” might be culture specific. These somatic symptoms are well recognised but their quantification and weighting in depression have not been studied yet. There is no cultural sensitive list of measuring depression among West-Africans.
In this Chapter I discussed concepts of Medical Anthropology and the issue of comparing depression among different cultures. A large amount of factors make it difficult to make a comparison. Understanding of the vocabulary, belief system and perceptions is vital to understand the etiology and symptom presentation. How do people present their depression? What words are used? And how do they explain themselves the cause of their illness? None of my respondents told me that they were depressive or knew depressive people. But they recognized symptoms. They came with explanations about poverty, lack of financial resources. They talked to me about family pressure and the worries that made them feel “ants creeping in their heads”.

In the next chapter I try to describe rhetoric’s of healing and disease. What rhetoric’s are used by my West-African respondents? And what rhetoric’s will give Western healthcare workers the best understanding of what is helpful in times of social distress.
Chapter Three: Rhetoric’s of healing and disease
Perhaps Africans have so many gods because each is an abstraction of our different attributes and our different selves. We have to accept our many selves and our oneself. We need to be unified. All our different selves must breathe and be healthy. The side of us that dreams, the part of us that lives beneath the stream of forgetfulness, the body’s need for celebration and ecstasy, the soul’s need for work, the divine in us that quietly longs for higher union, the erotic in us that craves for mortality’s immortal joy.

Ben Okri
In :A Way of Being Free

Blessed are they who suffer, for the kingdom of heaven shall be theirs

Mathew 5:10
In The Bible

The method of the art of healing is much the same as that of rhetoric… Then this is the goal of all his rhetorician’s effort: he tries to produce conviction in the soul.

Socrates
In Plato, Phaedrus
3.1 : Introduction

For the mental health worker, it is a challenge to detect the different logics behind behavior in need of help. Physical and mental imbalance can be attributed to different factors ranging from poverty, a chemical imbalance of body fluids to spirit possession. The next paragraphs describe different discourses of healing practices. Paragraph 3.2 describes a Traditional way of healing among the Akan. I took the Akan cosmology as an example. The Akan people live in Ghana. Although The Akan cosmology does not represent the whole of West-Africa it gives a good insight in how healing and religion are entangled spheres and how different problems need different treatments. This is what I will refer to as the Traditional discourse. Paragraph 3.3 gives a short introduction to the new independent congregations founded by Ghanaian and Nigerians. These congregations are important communities in terms of healing and support networks. Most of the Ghanaian and Nigerian Christians who belong to a church in the Netherlands go to churches that are called Charismatic or Pentecostals. I will describe a brief history of Pentecostalism and their rhetoric of healing. This is the Pentecostal discourse. In paragraph 3.4 the western way of thinking about depression is briefly described and the biomedical diagnosis and options for treatment from this perspective. New developments as Acceptance and Commitment therapy ("mindfulness") are briefly described. This information is based on my education as a psychologist and my training in diagnostic work at Centrum ’45 during the period September 2003 March 2004.
3.2: The Western bio-medical discourse on depression.

In the Netherlands depression is primarily seen as a mood disorder with emphasis on psychological symptoms as, feelings of worthlessness and sadness, hopelessness and low-self-esteem, negative internal thought processing about the self. When a person is feeling depressed he often consults his general practitioner. The doctor will ask questions about symptoms and in order to make a diagnosis of depression a psychological/physical history and evaluation are made. According to the American Psychiatric Association, if a person experiences a loss of interest in the things they once enjoyed and are feeling sad, blue, or down for at least two weeks, and are experiencing at least five of the other symptoms of depression, they may have a major depression. If a person experiences euphoria, irritability, or a feeling of being "high" with four other symptoms of mania for at least one week, they may have bipolar disorder.

The symptoms of depression are:

- loss of interest in the things that the person once enjoyed
- feeling sad, blue, or down
- feeling slowed down or restless and unable to sit still
- feeling worthless or guilty
- an increase or decrease in appetite or weight
- thoughts of death or suicide
- problems concentrating, thinking, remembering or making decisions
- trouble sleeping or sleeping too much
- loss of energy or feeling tired all of the time
- headaches
- digestive problems
- sexual problems
- feeling pessimistic or hopeless
- being anxious or worried

In addition to listing to symptoms, the doctor will ask when the symptoms began, how long they have lasted, how severe they are, whether the individual has had them before, and if so, whether or not they were treated and which treatment was received, as well as whether or not other family members once had these symptoms. Furthermore, a mental status examination will be done to determine if speech, thought patterns or memory have been affected. The physical examination will either diagnose and/or rule out any medical conditions (such as thyroid disease, cancers or neurological diseases) that could be causing the depression. When the diagnosis is made, patient and general practitioner (G.P.) decide together what treatment is needed. Often a psychologist or psychiatrist is involved in the phase of diagnosis and gives advice to both G.P. and patient. It depends of the kind of the depression and the intensity of suffering if or what treatment is the most advisable. Although the DSM IV is divided into discrete categories: in reality there is no discernible line where moodiness crosses over in mild depression or mild depression in severe. Treatment of depression usually involves medication, psychotherapy or a combination of both. Medicines for treating depression are called anti-depressants and are given by the G.P. The medicines correct the chemical imbalance (serotonin) in the brain.
Psychotherapy is often given by a therapist (psychologist or psychiatrist) and involves talking to the counsellor about things that occurred or are occurring in a person's life. The aim of psychotherapy is to remove all symptoms of depression and offer a person a normal life again. There are three dominant psychotherapies available to treat depression: Psychoanalytical therapy, cognitive therapy or interpersonal therapy. Psychoanalytical theories focus on the past, cognitive therapy focuses on thoughts and thinking patterns, and interpersonal therapy focuses on current relationships. Although psychotherapy may start right away, it may take 8 to 10 weeks to effectuate results for some people.

Cognitive therapy is seen as the most successful therapy and is especially designed to treat depression and dysphoric states. Cognitive therapy is based on the theory that depressive mood is a result of distorted thinking. It therefore focuses directly on the depressive thought content rather than the emotional factors: the negative internal thoughts and feelings are the ones that are so painful. The therapist encourages the patient to adopt an attitude of rational self-observation in order to expose the unjustified assumptions and logical fallacies that result in conclusions hidden behind depressive thinking. ("I can do anything right...I am a failure...Nobody likes me...".). In so doing, the therapist attempts to invalidate the seemingly "truthfulness" of depressive thoughts. So that the client can recognize its falseness. The therapist trains the client to recognize unhelpful thoughts and encounter negative thoughts with more positive thinking. So the cure is to change the contents of problematic thinking. When people suffer from recurring depressions, Acceptance and Commitment Therapy (ACT) gains recently field. ACT cuts across traditional therapies and utilizes concepts of mindfulness and acceptance, a Western interpretation of Zen meditation techniques.
3.3: The discourse of Pentecostalism

Christian West-Africans living in the Netherlands become often members of congregations originally established by Africans dependent from former mission churches (the mainline churches). The most well known churches are the Evangelist churches, from which the Church of Pentecost and the Assemblies of God are off springs. In all its diversity these churches are the most dynamic and fast growing churches in Europe and Africa. Other churches are Charismatic and Gospel churches. A third group, the most isolated churches in an international context, are the spiritual churches often referred as African Churches, or Independent Churches (ter Haar 1998:5-19).

In the Netherlands the largest part these Charismatic churches are founded in the 1990’s and located in the big cities The Hague, Rotterdam and Amsterdam were African immigrants have settled down. Some of these places are hidden in car parks. The Pentecostal church, founded by Ghanaian is by far the biggest movement and for me as researcher the most important source of information for this thesis. In search for answers around the popularity of these churches and what they have to offer in terms of healing, I go into the syncretistic aspects of African-Christianity. Therefore I have to explain more about Pentecostalism and Charismatic churches and about the West-African traditional religion. I will start with a brief overview of these churches and what they have in common and describe their rhetoric of healing

A brief history

The first wave of Pentecostalism started in 1901 at Bethel Bible College in the United States when Agnes Ozman, received what she called, the baptism of the Spirit and spoke in "tongues". The practice then became part of the Holiness movement of the church. In 1906, tongues were spoken on Azusa Street in Los Angeles, California, and out of these two events in 1901 and 1906 grew the mainline Pentecostalism. The second wave is called the Charismatic Renewal. This is sometimes referred to as the New Charismatic Movement. It was like the old charismatic, Pentecostal movement by giving special emphasis to certain gifts, most notably the gift of tongues. The New Charismatic are not separatist but rather reformist in character. Their purpose is to stay in these churches and to renew them by their continued presence within. This is what is meant by Charismatic Renewal. The third wave is called the Signs and Wonders Movement. It has been a rapidly growing movement, drawing adherents from both charismatic and non-charismatic churches. The movement stresses "power evangelism" whereby the gospel is explained and demonstrated by way of supernatural signs and wonders. In the Signs and Wonders movement, tongues speaking can occur, but the gift of tongues is not stressed as much as it is in the Pentecostal and Charismatic movements. The Signs and Wonders movement does stress the gift of prophecy and the gift of healing. So one can say that essential for Pentecostalism is the baptism in the Holy Spirit and speaking with tongues. The Charismatic, the most recent form of Pentecostalism belief strongly in the power and gifts of the Holy spirit, but they do not believe in speaking with tongues as its positive affirmation (ter Haar 1998: 17-20). But both, the Pentecostals and the Charismatic strive for life in the Spirit, which emphasis
spiritual gifts and the importance of personal religious experience. Pentecostalism is not centrally concerned with theological articulation and dogmatic reflection but derives a specific identity from a shared perception of human encounter with the Divine. Pentecostals attribute high value to the individual and often deeply emotional experiences. Spontaneity is highly prized and attributed to the moving of the Divine Spirit. Spiritual churches are primarily marked by the indigenous roots of their ritual and doctrine. The Pentecostals and Charismatic have in common their interest in the Holy spirit, the significance attached to dreams and visions and the beliefs in miracles, signs and wonders and the importance ascribed to deliverance in the case of demonic possession.

The popularity of these churches

Why do so many Ghanaians and Nigerians become member of the Charismatic Pentecostal movement? The answer of this question can possibly be found in the fact that West-African believers have a view about the visible and the invisible or the material and the immaterial spheres of life that matches with the Pentecostal view and less with the view of the mainline churches. This issue of syncretism has the attention of theologians for long, especially the notion among African-Christians of a awareness of the presence and power of ancestors. Studying the healing character of these churches one sees that religion and healing are two entangled spheres of life that cannot be separated. But in order to understand the logic of syncretism, and why West-African believers find it necessary to operate with a religious worldview that includes belief in divinities, spirits, and ancestors, it is necessary to understand also more about the traditional religious beliefs and how "Pentecostalism provides a bridge between individualistic and family-centred concerns and allows people to express and reflect upon the tension between both (Meyer1999:212)."

Psychotherapeutic ritual among Pentecostals

Healing is conceived as a form of discourse that is both religious and psychiatric. There are three essential persuasive tasks to be performed (Csordas:2002:37)

1. to create a predisposition to be healed
2. to create the experience of spiritual empowerment
3. to create the concrete perception of personal transformation

This threefold process activates and controls healing processes endogenous to the client in healing and redirects the attention towards new actions and experiences or alters the manner in which he attends to accustomed aspects of those actions experiences. The result is a creation of both a new phenomenological world and a new affirmation of the self as a holy person (Csordas). As for therapy, the studies of religious healing indicate that many problems treated are not strictly psychiatric in nature at all and what is regarded as healing does not necessarily include the removal of symptoms, but change in the meaning of attributes toward illness or an alteration of the patient's lifestyle. In some cases the very goals of religious healing and conventional therapy are in fact quite different.
Kinds of healing are practiced by Charismatic Pentecostals:

Physical healing for specific symptoms and complaints.
The technique of physical healing consists simply of the laying the hands on the persons shoulder or head accompanied by prayer that the sickness be healed. Sometimes in cases of cancer and broken bones visualization of the healing process might be included. It often occurs in large group settings.

Religious healing
Religious healing (spiritual healing, healing of memories and deliverance) contains a direct concern with the well-being of the soul. Its rhetorical structure assures the recognition of sin as a possible cause of illness.

Spiritual healing
Spiritual healing has a special role as a hedge against the failure of prayer. It concerns the well-being of the soul.

Healing of Memories
Healing of memories concerns the Inner Healing, treats emotional hurts or scars. Persons can be asked to visualize a mental image or make a picture of any painful incident that is uncovered (Memory, insight, vision and visualization).

Deliverance (externalization)
Deliverance is healing of the adverse effects of demons or evil spirits on a person’s behavior and personality. The individual’s entire life is prayed for in phases, from the moment of conception to the present. Any events or unrecognized relationships that emerge in this review of life history are given special attention. Prayer of Deliverance requires the recognition of a chronic problem which is interpreted as the presence of evil in a person’s life. One can speak of possession, a rare state in which the demon takes total control of a person and oppression, in which the effects of the demon is felt in a limited domain of the person’s life. Evil spirits have names which are typical for various sins or unfavorable behavior. There are: the Sexuality cluster (Lust, Perversion, Masturbation, Homosexuality and Adultery) and the Falsehood cluster (Falsehood, Lying, Deceit, Exaggeration). Others are the Bitterness/Resentment/Anger Guilt cluster, Rebellion and Vanity Pride/Insecurity clusters.

Three steps have to be taken to be healed. First of all the spirit must be bound. Then the spirit must be addressed by it’s name (Bitterness, Vanity etc.). And third: contact is made in the name and the authority of Jesus.

Healing of relationships is not a technique but entails the recognition that strains in the interpersonal environment can contribute to the etiology of ills otherwise described as physical, spiritual, emotional or demonic.

Understanding how healing works, one should construct the discourse. Healing in Catholic Pentecostalism creates for the suffering individual a new reality or phenomenological world. The person is not healed in the state in which he existed before the illness but in the sense that he or she is moved into a stage dissimilar from
pre-illness. Healing occurs when the person integrates in the religious community and the purpose of this community goes beyond healing (Csordas 2000:27)

Power is a key motive for Charismatic believers. For ritual healing two aspects of empowerment are considered; the role of somatic symbols and physiological process and the interpretation of spontaneous expression of endogenous processes. The laying on of hands as an example of a somatic symbol, is an imitation of the healing touch of Jesus and a metonym of the solidarity of the Christian community. The gesture carries the connotation of shielding and protecting the distressed person who lays himself in the hands of the Lord. Other techniques du corps which manifest power is are the handling of fire or taking up of serpents. Another important aspect is spontaneity. In the course of prayer for healing, memories of past and recent visual imagery can occur. Spontaneity is believed to an effect of experiencing Baptism in the Holy Spirit and are named spiritual gifts. Two other important spiritual gifts are a “Word of Wisdom” that is a statement of advice regarded by the healer as beyond what he could have achieved through his own rational processes. Discernment, is a spiritual sixth sense for intuiting the concrete presence of evil and as a spiritually enhanced kind of judgment in guiding the proceedings and determine the roots of the supplicant’s problem. Speaking in tongues is seen as a direct manifestation of mystical power as a divinely inspired language.

The healing is completed when basic cognitive, affective and behavioral patterns are changed. The construction of a new life, or new past in the present constitutes the rhetorical key to personal transformation in the Healing of Memories. The goal is forgiveness and reconciliation with one’s past, reinterpretation as a part of God’s plan that led the person to his present relationship with Jesus.

Deliverance is a long term process. It is not enough for a person’s spirit to receive salvation and for a person’s body to be healed. The soul too is in need for deliverance (Birgit Meyer 1998: 182-201). In Ghana Pentecostalism is popular among people who want to liberate themselves socially and economically from their extended families. These people who want to have an independent and successful life, are mostly young or middle aged and are in business or international trade or dream of doing so.

The aim of deliverance is that one should be freed from the powers of Satan that hold people in bondage through demonic forces. The demonic forces are said to stay within the person’s immediate circle of family relations. Satan is particularly believed to work through ancestral curses which may become in specific problems such as barrenness, alcoholism, misfortune and tragic death (Rijk van Dijk 2002:55). Pentecostal believers are urged to be aware of manifestations of these forces. Deliverance consists of spiritual breaking of the bonds that keep people entangled in their past. In Pentecostal ideology ancestral curses result from blood covenants, which in the past have been established through and by ancestors with evil powers. The answer to such a problem is a complete break with the blood tie, this secures the person with a modern identity. Much attention therefore is directed to the past to get rid of the consequences. In this way Pentecostalism offers their members an intermediary space in which members can move back and forth between the way of life they wish to leave behind and the one they aspire (Birgit Meyer 1998:182-201).

In this paragraph I will discuss aspects of Akan traditional society and religion, in which religion and medicine are essential parts of the culture (Ventevogel 1996:13). This does not mean that we can speak of Akan traditional religion as representative of all West-Africans. However it is true that there are similarities among the traditional lives and ideas of the West-African people, and that these similarities are evident in traditional religions and particularly in the aspect of the concept of God. Also Owoahene-Acheampong (1998:53-54) concludes after examining other authors analyses and classifications of West-African religion and the religion of the Ashanti that there are components which returning in more or less the same form. These elements are mentioned by Munro whom he quotes: the belief in God, the belief in divinities, the belief in spirits, the belief in ancestors, and the practice of magic and medicine, each with its own consequent, attendant cult. Owoahene-Acheampong (1998:53-54) puts the firsts four elements under the heading of "the spirit world" and adds another element: the religious functionaries because by only speaking of God and ancestors, divinities, spirits, magic and medicine we one just considers the belief system.

The Akan traditional society

The Akan are a group of people who live in Ivory Coast and Ghana. They occupy mostly in the equatorial forest and the coastal areas that lie between the Black Volta River and the Guinea Coast in the south. Akan consists of Fante-Agona, Ahanta, Kwaku, Ashanti, Bono, Akyem, Wasa, Akuapin, Nzima-Evalue and Assen-Twifo and are ethnically closely related. The Akan society is matrilineal and the idea of matrilineal descent is derived from the Akan conception of human personality. In this view the individual is a composition of physical, the mogya ("blood") and spiritual (sunsum and okra) entities. The physical entity, the mogya, is received from the mother (Owoahene-Acheampong 1998:43) It is the mogya which makes the child a human being. The spiritual entity, the sumsum, is responsible for the individual’s personality and character. It is transmitted by the father to the child. A child is supposed to have the same temperament as its father (Ventevogel 1996:13). The okra is the life principle and the most important part of the human being; it is the divine spark in the individual which gives meaning to life and even more important: it is immortal. Akans do believe in reincarnation, for them death is not the end. When a person dies, the okra does not die but lives on and returns to its creator and the ancestors. The role of the throne of the chief is of crucial importance in this matter because it enshrines the community and the ancestral power. Success of the Chief is believed to influence the people the land and the animals. The spiritual power of the chief is derived from the ancestral spirits and embodies and gives meaning and force to all other traditional institutions (Owoahene-Acheampong).
The spirit world

For the Akan Nyame (Onyame) is the Supreme Being, the creator of the universe who has final authority in everything. We can call this Supreme Being God. God gives authority to other beings the *abosom* and ancestors, to act in his place, therefore *abosom* and ancestors can be seen as mediators through which people can encounter God.

Ancestors
A person with a good and respectful reputation in the community who fulfilled his or her spiritual duties while he or she is alive can become after death a “living dead” or spirit. Being no longer in his or her body he or she still retains features which describe him or her in physical terms so when he or she returns is recognized by the living. These ancestors can come from time to time to, symbolically, share meals with the family or warn for danger. They are also guardians of family affairs and tradition (Owahene-Acheampong1998:54-55). The ancestors have more power than the living in the sense that they impose themselves and have to be obeyed since their power is derived from God. The fact that they speak the language of the living as well as the language of God and that they possess the strength and the insight of both worlds enhances their power. The ancestors, as guardians of tradition can bring blessing abundance, health and healing as well as drought, famine, sickness and death. Disturbance in *mogya, okra* and *sunsum* can bring disease. Disease is not purely seen as a physical alteration of bodily functions but also as disturbance of mental, social and spiritual well-being (Ventevogel 1996: 17-20). The ancestor veneration can be compared with the Christian cults of Saints, who are seen as an expression of the moral ideas of society.

Abosom
The Supreme Being (*Onyame*) has sons and daughters who are called the *abosom* who are worshipped through shrines and priests. The *abosom* can speak through a possessed priest. This possessed priest can be consulted for many kinds of misfortune. Both Christian and Muslim adhere to Akan beliefs and believe in abosom. These abosom can be divided in river gods (*atano*) who make the community prosper and witch catching gods (*abommerafo*) taken from forests, stones, waters (Ventevogel 1996;14-15). While the ancestors belong to the departed, beloved ones, the *abosom* belong to the spirits. The abosom are also mediators between God and the living people but are personified in natural phenomena as stones, rivers, forests as just mentioned. It is not the objects itself which the prayers of the people are addressed to, but the divinity or spirit that is occupied by the object from time to time. *Abosom*, like ancestors can take care of the welfare of human beings. But they can punish as well when the situation demands it (Owahne-Acheampong 1998:56-60).

Honhom fi
African societies are pervaded by the belief of powerful evil forces who can afflict misfortune on human beings. The powers of these beings are not derived and are inimical to human beings: they frighten and can cause diseases. Ter Haar as well as Owoahene-Acheampong explain the rapid growth and popularity of African-led
Churches by the fact that these churches actively remove evil powers. Religion is directed to God, the Supreme Being, the one who can ward off evil and can give satisfaction and security. Owahene-Acheampong (1998:61) has a point to my opinion in the context of this thesis by quoting Simon Patten who says "Religion begins not with a belief in God but with an emotional opposition of removable evils."

**Magic and medicine**

Suffering, illnesses and other misfortune are part of every human life as is searching for solutions and the deliverance of misfortune. Solutions and deliverance in African societies are often found in the practice of medicine and magic and the performing of rituals. In their ritual performances certain things must be done according to definite prescriptions or certain words said in a repetitively and/or in particular order.

In principle every disease could be the work of evil forces. But not all diseases are explained in spiritual terms (Ventevogel 1996:15-18). Africans recognize a clear distinction between what is caused by spirits and what not. They can also make a clear distinction between good and bad magic. After studying the Akan Ventevogel (1998:20-25) concludes that their choices, in where to go to and find help for their illnesses are not the result of ignorance or simply unavailability of Western Medical care. People know well where to go and their choices are based on rational motives in the given cultural situation (Ventevogel 1996:18-27).

At this point it is important to emphasize that Akan people, as we in the West, do see natural causes for their illnesses and misfortune. Most of the illnesses are explained by natural causes. Ventevogel (1996:20-25) describes in his research a whole classification system for illnesses and their treatment. Also Pool (1994:108-111) describes in his book the discussion on personalistic and naturalistic causes of disease and warns us Westerners not to have a simplistic view of the African system.

Diseases of supernatural origin can be caused by *bayi* (witchcraft) or *aduto* (bad medicine). *Bayi* or witchcraft can be inherited and brings misfortune only to one’s own relatives. *Aduto* or bad medicine also called *juju* or sorcery are medicines with destructive power. They can bring misfortune to any person to whom they are directed. Most sickness, misfortune, accidents, deaths and other tragedies are believed to be caused by the use of bad medicine or mystical powers by sorcerers and witches on their victims (Ventevogel 1996:17).

An other concept of importance is the one about dirt; the cleansing of the body is very important and curative and preventive measures are taken to remove dirt from the body. Prevention in Africa means to put a fence around the body by bathing with medicine, visiting the family shrine, tabooing against food and obtain protective charm or suman. This suman is a manufactured object, mostly worn around the neck, waist leg or arm; or they are hung on posts or trees or buried in the ground where the presence and the efficacy of the power is being sought. Prevention is a very essential part of life and one could say that the traditional system is more a preventive than a curative one (lecture Sjaak van der Geest).
Religious functionaries

In the traditional setting, there are five types of healers: the herbalist, the priest healer, the exorcist or witch doctor the traditional birth attendant and the bone setter. I will discuss the first three because they are the most relevant for this research.

The herbalist
Herbalist are a diverse group of people that work with herbs. They have a wide knowledge of the medicinal properties of roots, herbs, leaves and minerals. He or she knows also the souls of plants and animals and of the deities and spiritual beings that are in nature. When he or she picks a plant that is believed to have a strong soul for medical use, he or she will pray and make a sacrifice. It will be clear that these herbalist do not look upon their treatment as strictly physical since illness has a spiritual dimension (Owoahene-Acheampong 1998:68-69).

Priest healers
Priest healers also called diviners, diagnosticians or akomfo forma uniform group with clear symbols of social and professional status. Their duty is to diagnose. The diviner learns to observe well whatever goes on in the community and therefore is able to accumulate a vast store of knowledge concerning human nature. The diviners careful observations helps him to operate on psychological levels. Through special techniques he tries to gather information and the details of the illness in terms of cause and effect. He is a counsellor and a judge and has knowledge from physiological, psychological, spiritual and social problems (Owoahene-Acheampong 1998:69-71). The most important characteristic is that they can be possessed by a spiritual agent (akom means lit. to dance wildly in a state of frenzy ecstasy.). They can do that in controlled manner. After the state of possession (dissociation) in which they reveal information about the illness, they do not remember what they have said. An experienced priest can discern cases of a vocation of deity from ordinary illness or madness. The priest -healers claim to have the ability to heal misfortune by supernatural mediation. Priest healers or priestess healers combine the role of being a religious specialist and a healer. In their personal history there is often a period of initiatory illness in which a person suffered from fits of convulsions of seizures. They are often called by the abosom and have to follow an extensive training course under the guidance of an older priest (Ventevogel 1996 32-35).

The witchdoctor or exorcist
After an illness or a misfortune has been diagnosed by the priest healer as the doings of a witch or evil spirit, it is the exorcist or witchdoctor, who liberates the person from it. The exorcist is an essential and highly respected person. He /she is able to point out who is a witch and is able to ward of a spell or a curse that has been cast upon an individual(Owoahene-Acheampong 1998:71).

In this chapter I described three different rhetoric’s of healing:
African-led church
- Holistic, personal, no-time constraint
- Health and religion are entangled spheres
- Praying, Fasting, Spiritual help, Faith healing
- Deliverance of ancestral curses
- "Who" did this? Clear direction and answers
- Support of and worth in the community
- Sharing and shared responsibility, Public Confession, Memory and Insight, Changing perceptions: Cognitive restructuring

Western approach:
- Duality body and mind,
- Individual responsibility, time-constraint,
- General protocol for everybody
- Health and Religion are separated realities
- Bio-medicine
  - Anti-depressants
- Psychology & Psychiatry
  - Cognitive restructuring
  - Mindfulness, Memory & Insight

Traditional approach:
- Holistic, personal, no-time constraints
- Health and religion are entangled spheres
- Spiritual help, Faith healing
- Deliverance of ancestral curses
- "Who" did this? Clear direction and answers
- Support of family
- Herbal therapies
Given these three perspectives one can see that the Traditional approach and the approach of the (African-led) Pentecostals have a lot in common. The syncretistic aspects of the African-led churches are providing a bridge between the Traditional and Christian way of finding relief from social distress. Among African-Christians there is an awareness of the presence and power of spirits. Significance is attached to dreams and visions and the beliefs in miracles, signs and wonders and the importance ascribed to deliverance in the case of demonic possession. Missionaries tried to wipe out all the beliefs that were according to them fetishes and superstitious. But the only way to be relevant and meaningful in the daily existence is to take these external forces seriously. This is what happened and still happens in the African-led churches and is the main reason why they attract so many people. These churches acknowledge that spirit possessions are realities, and that sickness and disturbed social relationships can be restored by faith in the Holy Spirit. So one could say that the Pentecostals give believers the opportunity to be a Christian without giving up the concerns of traditional religion.

On a theoretical level the Traditional approach gives the anchorage of West-African way of thinking in how to prevent and cure sickness. But what does this mean on a practical level for the West-African Christians living in the Netherlands? In the next chapter I try to give an answer on what support is sought and accepted by West-Africans in the so called Diaspora, the people who are in contact with Western values. Some of them received education in the Netherlands. What is felt as effective for them? Are they firmly rooted in West-African values and seek support how they used to do? West-Africans make a clear distinction between what is caused by spirits and what not: they recognize a more biomedical or spiritual cause of their diseases. They can make a clear distinction between good and bad magic as well. After studying the literature and talking to my respondents I like to conclude that their choices, in where to go and find help for their illnesses are not the result of ignorance. According to Ventevogel (1996:18-27) people know well where to go and their choices are based on rational motives in the given cultural situation. What does this statement means for West-Africans suffering from a depression living in the Netherlands?
Chapter Four: Preventive and healing practices
4.1: Introduction

In this Chapter I describe what was felt as healing or helpful by West-African Christians living in the Netherlands. This chapter is based on discussions, interviews, observations and participation in church services, literature, my experience as a psychologist, mother of an African son and training by Soipan, a psychologist initiated in the traditional Yoruba healing. Most of the West-African respondents make a difference in healing and curing. Curing is the work of man. But healing is the work of God. The Traditional approach was the best framework to understand how my respondents brought their mood stage to meaning. The Traditional approach has a spiritual/religious idiom of explanation and created a common field of understanding. This was less the case in the Bio-medical approach.

Examples of idioms of distress:

- According to two respondents can ancestral curses manifest in specific problems such as poverty, misfortune and illness such as depression.

- Respondent: “We do not say we are depressed. We say we have no car no money, no job that is why I feel not well”. The relation between economical problems, lack of material things and a depressed mood is stressed here.

- Two respondents told me that West-Africans do not speak about their troubles and they know stories of fellow West-Africans living in Amsterdam that killed themselves; because they could not cope with life anymore because of family pressure. One can see this kind of behavior as a result of distortion of harmony between the individual and his family.

- The manifestation of somatic symptoms are related to the head in particular, and include sensations of heat, heaviness, emptiness and skin crawling, among others. People report “peppery” sensations or “ants creeping in the brain “ “heat in the head “ “sensations of heaviness in the brain” as the somatisation of emotional distress. Ill health is always expressed in a physical way.

- Example of Idemudia: (Nigeria): Mr X, 32-years old, was mentally disturbed and contemplated suicide. He was convinced that his ancestors were out to kill him. Review of his case study revealed that he had engaged in illicit sex with one of his father's wives., a taboo in many African societies.
Reading the next paragraphs one will notice that some features of what is done by the church is also done in Western psychotherapy or by the Traditional approach. Local herbs and antidepressants can be seen as leaves from the same tree. “Pentecostalism provides a bridge between individualistic and family-centred concerns and allows people to express and reflect upon the tension between both (Meyer 1999: 212)”. Respondents confirmed this statement. Rather than simply providing emotional release, Pentecostalism is a significant way of perceiving the immigrant’s world. It provides a justification of present misfortune and sin, and guarantees redemption by divine grace both immediately and in the future (Littlewood 1989: 181). In the following paragraphs I will discuss several topics related to healing- and therapy choice. What is important for the West-Africans living in the Diaspora? How do they manage in times of distress? Criteria for choice depend on what is believed as the etiology of the illness, availability of resources and what they believe will help. In the paragraph 4.2. I discuss more detailed somatic symptoms, vocabulary and illness causations. Paragraph 4.3 focuses on preventive and curing matters outside the church. And paragraph 4.4 describes the healing practices of the African-led churches.
4.2: Somatization, vocabulary and etiology

Somatic symptoms in depression and vocabulary

According to Okulate (184:422-427), a Nigerian researcher in the field of somatic symptoms in depression, are somatic manifestations of depression more dominant among people in Africa and among Africans in Diaspora. This is the reason why there is a lack of recognition of depression among Africans compared with Western people. The manifestation of somatic symptoms are related to the head in particular, and include sensations of heat, heaviness, emptiness and skin crawling, among others. People report “peppery” sensations or “ants creeping in the brain “. Also Idemudia (2003:5) describes complaints as “worms crawling all over the body”, “heat in the head “ “sensations of heaviness in the brain” as the somatisation of emotional distress. The body is the mind and the mind is the body therefore physical complaints are used to describe feelings of the mind. Ill health is always expressed in a physical way and according to him treatment is expected to be physical as well. The above mentioned somatisations are well recognised according to Okulate but their weightings in depression have not been studied because no culturally sensitive instruments to weigh depression are available.

It is also possible that the somatic symptoms around the head reflect a type of somatisation particular for Africans. Different psychopathologies in the Ibo culture are by Nzwezi classified as “Onye nla ” ( mad person ) “isi Mmebi” ( diseased head) “Mgbaka” ( sour head ).

Obeyesekere (1985:135) quoting Kraus in his review of Margaret Field's data on Ashanti, says :“Her salient point seems to be that there is a high incidence of involutinal psychotic reaction of the depressed type among Ashanti women. This type of depression seems, in fact, not to be thought of an illness but accepted as the inevitable loss of most women (1968:25)”. So according Kraus there is the refusal of the Ashanti to conform Western Psychiatric norms of depression. It was also found among Yoruba according to Kraus (1968:26); “depression presented a special problem in what while the symptoms were recognized as painful, unpleasant and disabling, they were seen as more or less “natural “ results of the vicissitudes of life”. Obeyesekere (1985:135) argues that the conceptual problem does not lie with the Yoruba but with the Western psychiatrist. If Ashanti and Yoruba say that certain affects arising out of life conditions as bereavement, loss, menopause, old age etc. do not constitute an illness, and furthermore if affects cannot be separated from their involvement in an existential issue such as the nature of life, could we seriously say that the Ashanti and Yoruba are deluding themselves and that they are in fact suffering from the illness called “depression”?

According to my respondents the word depression is a rare word in the West-African context. The word itself does not exists in Twi or Ibo.
The etiology of distress

According to Kleinman (Trimbos lezing 2005), you can find depressed people all over the world. It is not difficult to recognize severely depressed people in completely different settings. But mild depression is a “totally different cattle of fish”. He also pointed out the direct relation between poverty and depression. According to Kleinman are the economically unfortunate are twice as much vulnerable for depression. The relation between economical problems, lack of material things and a depressed mood are also mentioned by my respondents. “We do not say we are depressed. We say we have no car no money, no job that is why I feel not well “.

Dr. Njenga, president of the African Association of Psychiatrist on the other hand reported in a BBC interview on November 5th 2002 the following

“until recently, nobody thought that Africans had anything to discuss at the mental health level. We now realise this is completely untrue. There is a misconception that it is impossible to recognise different types of mental disorders - that it is all just guessing. This is completely untrue. It is possible for a properly trained individual to actually recognise the different types of mental disorders. Just like you can prevent your teeth decaying by brushing them morning and evening, there are some very interesting mental exercises you can do that will make it less likely for you to suffer from these conditions. “

Also the links between conflict/stress and breakdown have been recognised in indigenous theories of causation. Idemudia an African clinical psychologist from Nigeria quotes Nzwezi (1989: 208) who studied the Ibos of Nigeria. In the etiology of health among the Ibos the emphasis is placed on good/moral behaviour and social harmony. Disruptive behaviour and breaking taboos are punishable through misfortune and ill-health. Among the Ibos of Nigeria Nzwezi (1989: 208-216) identified five different ways of classifying psychological disorder.

1. beneficial reciprocity is out of balance.
The need to get along with each other is a major concern. When a person is unable to socialize adequately with his family or neighbours it will be a source of imbalance

2. absence of shame:
Well adjusted people experience some degree of shame when he or she deviates from the norm of society. Absence of this feeling of shame is seen as indicative of mental illness

3. irregular/bizarre speech and motor behaviour including disorientation to time

4. inappropriate affect

5. poor family relationship
When the symptoms of the person interfere with the fulfilling with family responsibilities
Witchcraft as causation

When Africans attribute causes to psychosocial disorders this results from both natural and unnatural causes according Idemudia (2003:5). Physical and mental illnesses must be seen as a continuum with one affecting the other. Physical and mental disorders can be attributed to:

* breach of taboos/customs
* disturbances in social relations
* hostile ancestral spirits
* spirit possession
* demonical possession
* evil machinations
* intrusion of objects
* evil eye
* affliction by gods and sorcery

Olu Sule (1987:254) describes in his study two types of therapeutic approaches in curing depression in Nigeria: Traditional and Western medicine. The rationale for choosing the Traditional approach is based on the following factors:

1. when people are victims of witchcraft
2. when people are victims of machinations and evil-doers
3. when people have violated some taboos forbidden by local practices
4. when people inherited mental illness from past ancestors and that their children are probably liable to the same attack. Among this group it is believe that mental sickness has hereditary channel which is of either patrilineal or matrilineal source of origin.

Based on the assumptions identified above that herbalists venture in the realm of herbal-oriented therapy. The choice for the herbalist is usually based on his achievements in the past. Herbalist are common and popular for successes.

Preceding treatment, the traditional physician consults with his oracle for the purpose of specifically pinning the symptoms down to a particular source of origin when a
person is brought for treatment. This traditional mental therapy is still very popular in rural areas in Nigeria. Most relatives prefer that a person is treated this way.

According to Dr. Njenga (BBC, 2002) there is a misconception with regard to causation: “At the African level, there are misconceptions with regard to causation - so-and-so was bewitched, or something was put under his bed, or he didn't slaughter at the right time. This is actually a question of linguistics - what one person would call demons may also be a form of deep depression. Demons and spirits are a way of understanding distress. Interestingly, those psychiatrists who have Western-style training are only able to handle a small number of these conditions. So what we have deliberately and consciously done is to develop partnerships - firstly with traditional healers. They are the ones who come face to face with the huge majority of people who suffer from mental disorder. And we try to get them to understand that there are some conditions they treat better than we do, and some conditions we treat better than they do. We do know as psychiatrists that those with a spiritual existence get better quicker than those without.”

This is part of a conversation I had with one of my respondents about witchcraft and how misunderstandings arise through lack of knowledge.

Respondent: “In my village came one day nomadic people. They were very tall and they came with their cattle. The cattle had long horns. But these nomadic people came with long sticks to guide their cows. Because they were very tall we thought they came from a different planet, they were not normal human beings. We thought they used their stick to turn people into animals. So if they touch you with their stick you turn into a cow. Not until I was educated I realized they came from another tribe I learned to understand later in life when I met the same kind of people on the campus. So prejudice and misunderstanding are created.

C: “Does your thinking in terms of witchcraft change as well when you got educated?

Respondent: It is possible that witchcraft exists. You cannot say that the devil does not exist. When there is good there must be evil. The mind is very powerful. If you believe in that you can perform miracles. Witchcraft is another kind of religion.

The power of thoughts

Thoughts are powerful and can hurt the other. In my teachings by Soipan I learned that energy rebounds. When you put an unkind thought or action into the world its manifestations return to you. Evil is something within you. You need a right mind to remain pure. By having “evil “thoughts you can hurt others. To illustrate this I quote a part of a conversation I had on this issue:

Respondent: The mind is powerful like telepathy. Occasionally I think of something as a wish, internally and than it comes to me.

C: Is that your psychic energy?
Respondent: Yes, I do not want to think evil of any one.
C: Because you can hurt somebody with your thinking?
Respondent: Yes

So one can say that thoughts are seen as form, they have energy. Thoughts give rise to manifestation.

**Family pressure**

Especially the financial pressure of families on people is seen as a major cause of distress:

*Respondent*“Family pressure is the number one problem of all the problems”.

*Respondent: “Most Africans are caught by the expectations of their families: They have to bring money. They think that in Amsterdam the money grows on the trees. The expectations of family is the number one problem of all the West-Africans. You have to built a lot of inner strength. You have to persist. I had to cut for 8 years all the family ties. The pressure is so high that you can collapse. I have to draw a line in terms of financial matters “.*

When West-Africans come to Europe they find it difficult to save because the costs for living are so high. Even finding a job was difficult. There were stories of well educated woman that became prostitutes to save money for the family. In Ghana everybody thought she had a “descent “ profession in the Netherlands. And there were stories about high expectations of the family and feeling ashamed to return home without money. “Back home they think that money grows in the trees here. They really have no idea....”

Two respondents told me that West-Africans do not speak about their troubles and they know stories of fellow West-Africans living in Amsterdam that killed themselves; because they could not cope with life anymore because of family pressure. One can see this kind of behavior as a result of distortion of harmony between the individual and his family. But usually omitted in the chain of events are the economic realities as poverty which interact within the individual. According to Idemudia (2003:5) many symptom reports of depression among Africans do not result in suicides.

**Guilt, aggression and society**

It has been suggested that some cultures educate children by shaming techniques and others by guilt techniques. Guilt inducing societies would be likely to have a greater amount of depression than shame inducing societies. All cultures however, probably use both methods to a greater or lesser extent. It has been suggested (Littlewood 1989: 79) that children who have been disciplined by punishment tend to direct their aggression outwards and hold others responsible for difficulties they later encounter (the seeds of paranoia) while children from whom affection is systematically with-drawn are likely to hold themselves responsible (the seeds of depression). Witchcraft beliefs have been said to facilitate paranoid thinking by enabling individuals to blame others when things go wrong. Aggression is thus diverted to others and the individual himself does not feel responsible and hence is
not likely to become depressed. However witchcraft beliefs are compatible with a strong cultural encouragement of the experience of guilt. In Ghana (Littlewood 1989: 79) women frequently become depressed and accuse themselves of being witches. Belief in witchcraft and witchcraft accusations are not necessarily a very emotional matter: they can be a mundane, almost banal way of regulating everyday affairs.

**Keeping harmony with one’s pre-life accord**

Illness and health may depend on keeping harmony with one’s pre-life accord or destiny. When a person is born he or she lives the life that has been predetermined for him or her. Deviations can result in mental imbalance. The concept of “Ogban-Nje” (pathological reincarnation) can explain mental illness/possession particularly among females in southern part of Nigeria according to Idemudia (2003: 4).
4.3: preventive and curing matters

Different etiologies create different choices of were to go for help. My respondents told me that depression did not exist except for a few really “crazy people” while psychologist and psychiatrist see depression all around the World. The reason by West-Africans given for the low amount of what I was calling “depression” is the preventive system of African society. The family and society is serving as a shock absorber: they preventing people to get worse. In this paragraph I describe what was felt as helpful preventive- and curing matters outside the church.

Resilience

What strikes me as a researcher are the stories of resilience and the power within. These answers come from people with very different backgrounds in education and economical status. When I asked about protective factors in their lives that made them less vulnerable for depression. One of my respondents put it this way:

Respondent: “ too often Africans are seen as powerless. But we are not .Although 90 % of the system is against us .We are able to survive. We are strong .”

Or another one gave this answer

Respondent: “ How I stay balanced ?” “Like the fingers of my hand ,they are equal but each of them has a specific function as human beings we can not be all the same .It is important to recognize your own abilities and limitations. So never try to be some one else. Be yourself. Be contented with what you have and recognize you weaknesses.”

According to Paul Linde (2001:263) it is the laid-back perspective and seeming stoicism that helps people to be resilient and accept suffering and hardship in their often spiritually rich but economically poor lives. However this mindset can slide into downright passivity and create a sense of fatalism that can work against an individual recovering from depression. It was Linde’s experience that individuals with strong religious beliefs(2001:266) recover more fully from serious illness like depression.

On the question “ What gives strength in your live, what is your Philosophy of life I got the following answer:

Respondent :“ I believe in what I sometimes refer to as human trinity. Any human being , that makes him different from the animal-should have the body mind and spirit.: they work together they should be in harmony to be normal and healthy. And when you believe in them you can take control of your mind . Take good care of your body. Keep in touch with your creator and you will live comfortably. You will be at peace with yourself. I know I can control my temper. I do not get annoyed. If you fail to control your temper your whole system will be de-stabilized. So I avoid situations that get me destabilized. So when there is a problem I channel my energy in something productive. You should control your mind and your emotions. We human beings distinguish ourselves from animal . Animals react on instinct . We have a free will. We can choose what we want to do. “
Respondent: “In the West there is more internalizing…you start yourself telling you are not good, criticizing yourself. That is were I think depression really starts. If we have a problem it is something you can touch we express it as “I have no mattress, I have no car that is why I am unhappy.”

Dealing with problems: the society and family as shock absorbers

Last year there was a research measuring “happiness in different countries world wide. According to this research were Nigerian people were the happiest in the world. When I ask people if they heard of the research they react very different some say that this research is not done well others say

Respondent:“ Coming to think of it I think it is true. Because there are many things happening in Nigeria ..if they should have happened somewhere else.. In Nigeria there is such a resilience .When we move to the brink of collapse we bounce back. Like hunger: It is possible in a weekend to go somewhere there is a party and to get fed. If you dress properly. You can sit and eat without being invited ”.

Also Olu Sule (1987:245) writes about the generosity of people. And others mention the way of problem solving in their village as a most helpful way to get rid of tension between people. In the literature (Marsella1985;312) but also by my respondents the strong family structures are mentioned as the main source of coping with stress.

Respondent:“ In most African countries the family absorbs the shock. Here you need psychologists to talk about what happened. There are aspects of life we do not want to disclose to others .For Africans it is different: your problem is a family problem. Elderly people are part of the family, poverty is solved within the family.”

Or another respondent“ How I stay balanced ? “ I go to Ghana, to my family each year to release tension “. The common idea among my respondents is that individuality in the Western society leads to depression. And because West-Africans are almost always part of a group they are less vulnerable towards depression.

Spiritual Cleansing

In usage of ritual cleanings you are directly transforming negative energies. Energy is alive and if energy in our environment is stuck life also appear stuck. Cleansing methods can be used to remove negative energy. One method mentioned by a respondent was egg cleansing. Eggs have the ability to absorb negative energy. For instance put raw and unbroken eggs in the corners of your house. After 7 days you can remove the eggs and put them in the garbage outside your house. Soipan describes in her book ( 2005 :17 ) Ifa, a spiritual practice of the Yoruba. The tradition of burning a seven days candle after the space has been cleaned helps to maintain the psychic and balance in your home. She also mentions cigar smoke to clean dense energy. “ You hold the lit part of the cigar in your mouth and blown the smoke out of the other end.” This smoke can be blown over an individual or items “. After cleansing it is important that you do not wear street shoes into the space.
Another way of cleansing in the Yoruba tradition is putting rhododendrons, dandelions, roses, eucalyptus and Florida water together in a jar of water and let it soak for a day. Afterwards the elixir can be poured into your bath. As you bathe you say your prayers and the blessings you seek will be in your life.

The help of the Koran

I had conversations with two healers who are working according the lessons of the Koran. They both had West-African clients and explained to me that as well Christians as Islamic people came for help: “The Koran is above all. It is open for Christian believers as well”. It was explained to me that: “The Koran can be read as a book with different layers …but you need the pin code of the Koran to get the right sutra (Koran verse) that is healing. To learn the pin code is a long process of studying. The texts are found by pin code and have to be recited or carried with you.” Herbs are also used: “Sometimes a cure of herbs is given as well, or the texts of the Koran are cooked with herbs.” Most problems are family problems and should be solved within the family context. When the family problem is healed the patient will be cured”. Another healer explained his way of working as follows: “What I need as a healer is the date of birth, the month and hour of birth. This is like a blueprint to find the right sutra in the Koran. The Koran works as a telephone; you have to dial the right number to get the right connection.”

The presence of spirits was for one healer an important aspect of loosing balance: “You feel that there is a an entity around you….you get either very cold or very warm. Djinns only come when they are called by rituals. Seventy five percent of the Djinns is good and 25 % is not good. Jealousy is often the cause of evil. Jealousy cause negative feelings.”

Furthermore the advice was given to seek always for healing. “Allah did not approve of illnesses without a cure”. And “The good thing of the Islamic approach is that illness is giving a meaning or explanation to people why some things happen in your life”. In times of a more technical approach towards healthcare. The Koran gives a more holistic approach of healing and answers existential questions. The same is true for Christian believers. The most difficult thing is to find the right healer. According to them these healers tend to come to your house for their practices and are hard to trace. They also promise you a 100 % guarantee and make use forbidden magic. Their healing practices are seen as exaggerated: they act like magicians to impress their patients.
4.4: The African-led churches as healing communities

Syncretism

Why do so many West-Africans become a member of the African-led church? The answer to this question can be found in the syncretism. Aspects of what is felt as healing or seen as a preventive matter not to get ill, is covered by these churches. Studying the healing character of these churches one finds that religion and healing are two entangled spheres of life that cannot be separated. "Pentecostalism provides a bridge between individualistic and family-centred concerns and allows people to express and reflect upon the tension between both (Meyer 1999:212)". The church both prevents and heals from illness.

The Holy Spirit and the gaining of Spiritual power

Evil is believed to manifest itself through spiritual agencies in the form of evil spirits or through human beings in the case of witches. Some witches are believed to have travelled all the way from West-Africa to the Netherlands. To counter these evil forces African Christians call upon the power of the Holy Spirit. The African initiated churches address this issue explicitly. Believers from West-Africa who often live in a permanent state of insecurity which affects their psychological and physical well-being see problems and misfortune as products of the evil. The evil is a tangible force which has to be defeated. Spiritual techniques such as fasting and prayer are important instruments for gaining spiritual power from the Holy Spirit and defeat these evil forces. That is one of the reasons why praying has such is so important. Spiritual empowerment is based on the belief of real tangible forces.

Sunday morning sessions: prayer, speaking in tongues, dance and singing

Praise singing is a very important part of the services. Through prayer there is healing. During the services there is a lot of praying and dancing. Everybody is encouraged to speak out their problems and fears in public: they ask for testimonies. Miriam Matola (1988:193) who followed five women that went to a church in South-Africa and five women that went to an African-led Zionist church. Both groups attended church only on Sunday mornings. The group that followed the Zionist churches felt more emotionally and spiritually uplifted, they said they released tension and frustration through dancing singing and public confession and reported that external circumstances appeared to have a lesser effect on their emotions. Also respondents said that the singing and praying relieve the tension.

One respondent who “speaks in tongues”. For him it feels as a healing experience because while he “speaks in tongues” he is feeling closer to God. He told me about his speaking in tongues experience:

Respondent: “In do not understand it myself. He (God) is the only one who understands.. maybe you speak Dutch or Japanese or an language that does not exist on earth.. I do not know what I am saying when I speak in tongues. Some
people have the gift to interpreter tongues. Others have the Gift of healing. Speaking in tongues is not liberating as such.. but it is like you are confused.. you really do not know what area you focus on. Something comes into your mind.....and you can not focus well....but you come into a certain mood....You feel that you are concentrating and that God has something to tell. The Bible it says that even before you start praying He knows all your problems. So you speak in tongues and something keeps you going.....that gives you the energy to continue praying. You are monotonous … your mind will be shifting that keeps you focussed on your prayer: it does not move your attention to other things.. you can also pray for a longer time.”

The speaker in tongues is not out of control: he can stop it and start it.

From a psychological point of view ( Littlewood1989: 175 ) speaking in tongues is a trance- like condition: a disssociative state. Although Psychiatrists might interpret it as an abnormal state: it is, however, a highly controlled social behaviour which occurs at specific points in the church services. Its benefits are supposed to be distributed to all even though it is a personal experience. Glossolalia includes utterances of varying lengths, sometimes lasting up to an hour. Participants ( Littlewood 1989 :175) report that the experience is accompanied by feelings of freedom tranquility and happiness. It could be that, like meditation or jogging, it generates endorphins that generate a sense of well-being.

Public confession

Through public confession a sharing of emotions and strengthening of social bonds are emphasized. The practical significance of such a process is significant .After having a shared emotion people report often positive feelings and say that it helped them to clarify issues and find meaning. Benefits can be on the intrapersonal side but also on the social and collective side. Emotional episodes easily spread across social networks and community members keep track of the person involved. A group sharing knowledge about emotional events is also seen as an efficient preventive tool. And as the pastor puts it: “without tests from God there are no testimonies ”.

Dreams ,visions and fasting

Another way to communicate with the spirit world is also through dreams and visions ,the channels between the visible and invisible world. In Africa dreams tend to have more lucidity. Those lucid dreams are seen as a gift of God, who is transmitting unknown information to someone . Visions are comparable with dreams but stem entirely from God. Fasting is an important means to enter into an altered state of consciousness and to receive dreams and visions. Dry-fasting especially is meant to build a person’s own spiritual power and is a way of having spiritual encounters during nighttimes that will inform about the good or bad of things and people ( van Dijk 2002:53). Respondents confirmed that they were getting through fasting a clearer “sight “: they see there own problems but are also more aware of the problems of others. It was also mentioned that fasting is not meant for sorting out the problem as such . “Fasting helps to concentrate and focus in my relation to God”

53
Words of consolation.

Irregularity in attendance does suggest that people attend the services at unique times in their lives. People go to church to show their gratitude to special blessings but they also go to seek help in particular when life is difficult.

A Pastor told the following about coping with distress:

“ What do you do when the foundation of your life is destroyed…When your faith is shaking ….. In the darkest hour in crisis…when we feel out of control …what do you do when life does not make sense ?

“ People come to me in distress and ask me “ Pastor what do I do?”

And I tell them: Tell God how you feel…

unload your frustrations and feelings….poor out your emotion …..let go !!!!! Poor out your heart like water before you face the Lord. How can you put your eyes on Jesus when your eyes are full of tears ?

Do not act like an Angel! It is all right to be angry sometimes. Not to be angry is apathy. Anger can be transformed . It means there is love in your heart.

But do not use your anger to do crazy things.”

“Tell God how you feel. God can handle it. Do not contain it . Then you become like a pressure cooker and you will explode! Honesty is the best policy. You can say “ I believe but… my life sucks. It sounds like a contradiction but it is a statement of faith! “

On a big screen the following words are projected:

1. Tell God how you feel
2. Praise God in spite of circumstances
3. Ask God for strength
4. Keep focused on his promises

The pastor goes on with words of consolation :

“ Do not always search for explanations . There are things you cannot explain. All your trouble is temporarily. The problems are here today but not always. It will pass. Problems come and go. The problem is working for you when you keep an eye on God. You are not the only one. People have been there before….”

Power and prosperity

Spiritual and material prosperity accompany one another. In Africa material prosperity has always been an important object of communication with the invisible world. People’s welfare is believed to be dependent on the powers inhabiting the spirit world ( lecture Rijk van Dijk ). Prosperity originates from the invisible world and in the relation of reciprocity the spirit world receives their share of human prosperity in the form of offerings. Generosity in reciprocal relations is rewarded in the invisible world and in the visible . Generosity is a standard for moral behaviour as well as reciprocity. People are expected ideally to depend on each other and share their prosperity. But the demands of the family, especially for the one’s who travelled to
Europe can be high. To control these demands the deliverance rituals help to create a distance to one’s family. Although this is not the spiritual aim of the deliverance ritual. Pauline Tichelman (1996 :316) who attended Pentecostal services for her research quotes Owusu Tabiri during the service:

“Money is good. But love for money is bad. Poverty is a contagious disease. Without money you can make no development. God wants you to be rich. Let us pray that you become rich. Let us pray that you become rich. If you want to break the power of the demons over your poor finances, give your live to Jesus! God wishes you prosperity in your finances!”

During one of the services I attended the same kind of remarks were made. Tichelman also quotes (1996:316) Owusu Tabiri when he talks about illegal stay in the Netherlands and the poor situation of some of these Ghanese. He gives this group hope by saying:

“Maybe they have written to you that you have to leave the country. Maybe you are not qualified to stay here. They make it difficult for you to find a job or to get a contract. You must believe in God! God has an answer to all your problems.”

The community: Being part of a group

Belonging to a church is also social strategy and gives a sense of belonging. In the mainstream churches in the Netherlands little was invested to get their black brothers and sisters in. This combined with a hostility towards immigrants the African-led churches became also a shelter and a place were people are not treated as being different. Being among one’s own group is very important for well-being. Recent studies on schizophrenia under migrant populations show that schizophrenia and racism are interrelated items and emphasize the importance of being in contact with your own cultural group( Kleinman Trimbos lezing 2005). The element of identity important in this respect. Whenever people live in a Diaspora, identity becomes a crucial issue. Africans in the Netherlands are a relatively small minority and have little or no power as a group. For many their religion helps them to achieve a degree of security and inner strength. The identity of African -Christianity gives this feeling of security and inner strength (ter Haar1998:69). Services are held in Twi and English. It also brings the followers back to the concept of community in their home countries. It has been said that Descartes wrote” I think therefore I am: Africans would say I am related therefore I am. The church incorporates its followers as the family back home. The family of Christ has no ( or less ) racial and national boundaries (ter Haar 1998:69)

The churches seem to appeal especially to an emotionally isolated group in an urban society because they provide a universal theme, a structured worldview…the gifts of the Spirit compensate for the lack of material gifts and the gift of “tongues” provides the inarticulate with an opportunity to speak…. religious status is substituted for social and racial status(Littlewood1989 : 180).
Psychologists sometimes use the term refuelling. The term refueling refers to the possibilities of a person to have renewed perceptual input which recharges the person and enhances the confidence. Separated from the motherland most migrants feel the need for refueling. Refueling exists in different forms: phone calls and mail, contacting family members who are migrated, visiting ethnic market places, celebrating original festivals, attending services and religious centers. The churches are certainly a place for refueling. There are widespread notions that minority groups have strong extended social networks and family connections that minimize the effects of health problems. In fact the reality is far more complex. One respondent confirmed this and told me that a lot of people do not know to whom they have to turn to…” and when you have no money and you need help the church is the only place to go. Also at one of my Sunday morning visits in church the Nigerian pastor tells:

“today society is disconnected, we even do not know our neighbors. It is not good to be alone. We are made by relationships…for connections…when you are connected you have a purpose in life. When you are emotionally disconnected you will die an earlier death……you will suffer from emotional burnout, depression or mental disorder”.

Also respondents confirm that the church is a community apart from a spiritual place. You can share your problems -not with everybody - but you can always find one or two people you can talk to when you have no family and friends.

“it is healthy to stay in contact with others”.

Community and congregation participation is also felt to be very supportive and highly meaningful when it comes to rituals as public confession. Not the individual alone that takes responsibility but the whole community is involved. The effects of rituals are considered to be a form of anxiety reduction and therefore healing.

**Breaking with the past**

The deliverance ritual that claims to untie with the past is a helpful step to go to the West. For the individual West-African it helps to streamline family connections. After all migration is a spiritual problem as is prosperity. The deliverance ritual is an opportunity for the individual to create more autonomy without losing connection with the past (van Dijk 2002: 57).

In Ghana Pentecostal churches emphasises on breaking completely with the past. This breaking with the past happens in the context of the deliverance ritual. In this ritual people are brought to realise that they are in the grip of the past which is represented as something coming from Satan. In coming to terms with the past and gaining control over ones individual life people are told to untie themselves from the ties of the past. Here Pentecostalism brings together two contradictory notions of identity and gives a way out. On one hand people are products of the past, their families. On the other hand identity is regarded as a modern person who is fully in control of herself. Through remembrance the past identity is constructed in terms of links with the family. Yet the identity constructed through remembrance is labelled as a negative identity. The new identity emphasises the need to find positive roots in the
past. Pentecostalism offers their members a discourse and ritual practice to deal with their past identity with emphasis on family ties and it offers a new identity: the birth of a new type of person (Birgit Meijer 1998:201-202). In this way members are able to cope with the ambiguity of their past and new identity.

The need for clear direction

I asked a respondent to explain to me why Nigerian people prefer the help of the church instead of talking to a psychologist or psychiatrist he explained to me that:

Respondent: “Psychology is about deep thinking...it is too complicated it is more about how you enter the circle of power. Compare it with a computer system: Is it science? Science comes out. Is it religion? Religion comes out.”

Respondent: “We Africans think according different lines. If you had a simple education, you need simple lines, a simple structure. You need guiding in a structured way.

Respondent: Simple people want direction. Clear direction. The Bible gives a clear direction: the Bible has an answer to all your questions.”

Also the Pastor says clearly that psychologists can not solve all problems but God does: “To be weak is not a sin, do not hide your weakness. Pray for each other...Power is the ability to deal with pain...there are problems psychologists can not solve. Turn to God He can heal you”
4.5 The choice of a healer

A Ghanaian respondent told me that when symptoms of what Western people call depression are noticed they will first try to solve it within the family. They try to detect if the problem is physical or spiritual. If it is physical they can give you herbs or western Medicine. Herbs and western Medicine are according to him compatible. But when the family thinks the problem is spiritual they will bring you to the fetish priest. The fetish priest will heal you. People make still very much use of fetish priests. But by the arrival of Christianity the role of the fetish priest became forbidden by the church. The arrival of Christianity goes hand in hand with Western Medicine and the decline of the fetish priests according to my respondents. This point was emphasized by the following remarks:

“The Bible got to Ghana. Missionaries brought the Bible ...before that Ghanaians had their way of healing. We have African Medicine and Priest and Chieftaincy. There are mechanism by which to communicate to God for healing. We use trees herbs and spiritual Fetish Priest to protect ourselves.”
We have to bring chickens, a goat or eggs ”

And

“Medicine men were also the priests and they believe that God has appointed this priest for healing. For example there is a tree in front of the house. The ordinary man will not collect from that tree. But when the fetish priest takes from the same tree it works. He will be believed and trusted. They have their own way of healing before Christianity came. “By the coming of Christianity and Western medicine they decreased the role of this Priest. Morality of society was also based on this man (the fetish priest) because he was also saying things or telling to do certain things. They also brought in morality, for example they told you not to work on Thursdays... you can not work all week and so they took some rest...they made the people rest.”

“The arrival of Christianity was side by side of the Western medicine, The doctors in Ghana diagnose but God heals. That is their motto”

“the traditional side is now covered by the church. It merged. Some healers are really good. Others take your money. A good healer is strict does not take too much money. He will say “why?” “I do the work of God “

Maurice M. Iwu from the national Centre for Ethno-medicine and Drug development in Nigeria (Smet;1999:8) is emphasizing the fact that pharmalogically effective herbs do possess beneficial effects in the treatment of several physical components of existence, but they are hardly useful for disorder that involve the core of a person’s innermost being and reality, or when the non-tangible self is in disequilibrium. “From a distance one might imagine that one might perceives the pattern. But, as one is not challenged - or more precisely, menaced-by details, the pattern maybe nothing more than one imaginations.”

“Traditional healers can cure sometimes better. The western people do not always
have the best way. Western and traditional style are both here. Before the western people came we were surviving.”

According to my teacher Soipan, an American psychologist, Ph.D. and initiated into the spiritual practices of the Yoruba in Nigeria, is healing not something that requires years of therapy, and verbal therapy alone cannot heal all wounds. Some wounds are tangled in places within us where words cannot reach. If we are pulsing deep enough healing can happen instantaneously. Whatever unfinished business remains from personal pain, suffering and trauma that you carry needs to be resolved within your self. Only when you heal your unfinished business you are not distracted anymore by dense negative energies that prevent you from accessing spiritual frequencies and transmission. “ Primal medicine people have taught that through sacred rituals one can heal at a mythical level (ritual and spirit) and the disease will not reach the literal level (physical and body) ”.

Can the distribution of problems to evil spirits be interpreted as a kind of escape from responsibility to one’s own emotional well-being? This is a critical note is often coming from clinical psychotherapy. No, in healing there is forgiveness as central element: the person has to forgive those who have injured him or her.

The person who suffers is made aware that he is not alone in his suffering, but that his struggle takes place in a larger arena of spiritual forces. Evil represented by the devil is not an essential part of his own being that means that the person’s sense of his basic goodness and self-worth is affirmed. In participating in the Phenomenological World created by religious discourse the person is altered from his egocentric Western style to the sociocentric style in which the individual is subsumed in the religious community and by definition relinquishing some degree of responsibility for his emotional well-being to the community.

Conclude this chapter one can say that the Traditional approach and the African-led church are both preventive and curing and experienced as helpful. They include an holistic approach and hold space for the individuals who seek for help. The Traditional approach is even more preventive than curing. This in opposite to Western Bio-medical approach which focuses mainly on mental illness and curing the patient. They do not separate the living and the non living, the material and immaterial. The Western approach, rooted in mechanical philosophy, has separated body and mind and is overlooking the spiritual dimensions.

The holistic approach fits better in the West-African way of thinking: the relationship between the body and mind relationship is understood in contrast with Western thinking where body and mind are separated. Also the spiritual and material realm are felt as connected and more understood. Problems as unemployment, poverty and lack of success in life are generally more explained in terms of illness caused by the presence of evil.

In studying the impact of culture on coping with distress. We have to understand what is defined as normal and abnormal and what etiology is behind the cause of loosing balance. We have to listen carefully to the vocabulary of clients and how symptoms are expressed. These are important aspects to understand what treatment is experienced as helpful.
Chapter five: Final thoughts
The white man came to Africa primarily to heal himself ……
Why should we remain passive while white man
searches the world for the means to save himself  
We are together in this struggle.
All our souls need rest in a safe home.
All people must heal, because we are all sick.

A shaman as quoted by Malidoma Patrice Some
In : The Healing Wisdom of Africa

They try to learn the practices of a healer
as if they were only formulas. Europeans and Africans
educated in the West try to mix African medicines
with Western medicines. African medical science
presupposes involvement of the community and religion.
These western experiments fail,
or a vital element is lacking : faith

Afrika centrum Cadier en Keer,Netherlands
Thoughts and dilemma’s

1. Curing and healing

Curing is the work of man. Healing is the work of God. Healing is restoring the balance physical, emotional and the relation towards others and God. The Western approach has two ways of curing depression: the mechanistic approach, that treats depression as a malfunctioning of the chemical balance in the brain and the psycho-therapeutic approach. Psychotherapy has many features in common with what is happening in the church or by traditional specialists: searching for the deep root of the disorder as well as giving a meaning to the experienced suffering. The underlying assumptions of what these deep roots are differ immensely. Western psychotherapy will focus on the individual and participation of family will be limited. The focus will be on the individual cognitions and empowerment and will often look for guilt based schemes. West-African Traditional and Church interventions will seek for help from the spiritual worlds. The family or community will be a point of departure in seeking relief.

The advantages of Western medicine are acknowledged. Therapeutic drugs and herbal medicine are seen as interchangeable. But modern medicine has no answer to the increasing loneliness. Societal problems are being solved on an individual level. The strength of the West-African approach is that problems are less individualized.

In summary in the Western approach the individual is point of departure, the participation of the family is limited and the care often is in hands of strangers. The doctor puts a label “disease” on the sufferer based on quantifiable evidence of questionnaires and procedures. In the traditional West-African approach the personal care will be in hands of the family and the cause of Illness will be determined through divination. Witchcraft and evil forces are tangible realities.

In both the traditional West-African and the Pentecostal approach healing takes place by getting in touch with the spiritual world. Faith is an essential element both in the healer and the treatment. They have in common that their approach is holistic, involve the family- or group support. The African churches in the Netherlands can be seen as bridging “the old way” and Western psychotherapy. The success of healing depends in certain cases of ones expectation. It is believed that psychosomatic patients respond well to faith healing (Appiah-Kubi 1981:85).

The question is what makes healing effective? Some elements are common in healing whether it is religious or biomedical. The primary interpersonal aspect of treatment is the emotional support of the suffering individual and reaffirmation of his or her worth in the community or society. The basic healing processes of the Pentecostalism church are not unique. Memory/insight is a key component of psychoanalysis. Vision and visualization is the key component in shamanism and in some forms of psychotherapy.
Understanding the nature of this way of healing, one should construct the discourse of healing. Healing means creating a new reality. A person can be released from his or her "evil spirits", whether these are real spirits or evil thoughts about the self. The person is not healed in the state in which he existed before the illness but in the sense that he or she is moved into a stage dissimilar from pre-illness. Kleinman says that through healing a symbolic bridge between the personal experience, social relations and cultural meanings are established (lecture Han ten Brummelhuis). The problem of the patient is redefined and the transformation is confirmed.

Another point to be mentioned is that the search for spiritual power as the followers in the churches do cannot be completely compared with the Western search of healing through psycho-therapy as a way of healing fundamental problems. Churches claim to be able to answer the how, why and who of the troubled person. Answers can be found outside the self, and rituals help you to solve the problems. The role of praying is significant here. "Praying is hard work" (Rijk van Dijk) and through prayer there is healing. The Holy spirit is seen as the healing power. This is very different from the way Western psychiatrists operate: they often conclude that your problem is part of you, and only by talking and answering intrusive questions you can find relief. For West-Africans the question "who did this?" is of importance. Besides Western help is often felt as impersonal. Clients complain about the limited consultation time and little interest in personal background. The help the church offers is personal and time is given to people who ask for it.

2. Anthropological and clinical viewpoints

1. Anthropological and clinical methods kept being in tension with one another for me. The Medical point of view considers depression as a disease and a disruption of social functioning. Anthropological or emic assessments -the evaluation of the sufferers from West-Africa themselves - evaluate depression rarely in terms of disease. Most of the time they do not consider it to be a clinicians task to treat them. The concept of depression as a starting point of my research is a Western concept and made it difficult to ask the right questions and shifting the right data..

2. Failing to recognize cultural assumptions built into our Western concept of depression leads often to misleading characterizations of the emotional lives of cultural others. If we do not consider the differences we tend to view depression for everyone as a biological disorder triggered by social stressors and reflected in a set of symptoms or complaints. The dramatic differences in the social organization of West-Africans in the Netherlands produce different forms of social realities and explanations for emotions as sadness, grief, withdrawal, passivity and helplessness. For west-Africans the body is the main source of idioms for the expression of distress. In depression the social sources of misery, the persistent experience of organic distress and social problems interact. How despair has meaning in other cultural systems tells us about the social construction of the reality. By one person depression will be interpreted in somatic terms and by others in a religious idiom (a punishment of God). This has implications for prognosis and appropriate treatment. "Medicalization" of depression makes it difficult to believe in any treatment but medicine.
The problem in the practices is the ethnocentric way of judging the Other. We can only see and hear what is visible and known to us, and cannot see and hear what does not belong to our frame of reference. So even the questions we raise to uncover “the Others” perspective, are questions originating from the emic perspective and lead easily to misinterpretations. Physicians, psychologists and psychiatrists impose often unconsciously their own cultural values, assumptions and experiences on their patients, that phenomena could be termed as an example of cultural counter transference. The word “depression” is a typical Western word and cannot be translated in a West-African language. Western idioms of distress as depression have its roots in a highly individualized society. Idioms of distress I heard by listening to West-Africans have a more predominant context and express the economical and political situation at stake.

3. The boundary between pathology and normality.

1. To write about the understanding of depression among West-Africans includes a risk to romanticize suffering. But not writing about it contributes to silence. According to my respondents severe symptoms of depression were perceived as a real disease. But it did not happen often that people were getting in such a mood. What in the West is diagnosed as a mild depression is never considered a disease. When I asked people to explain symptoms of mild depression they explained them in the context of family problems, poverty, financial pressure, housing problems, jealousy or other demands of the family. To make a differentiation between the severe and the mild depression: the second kind of might be a culture-bound syndrome of people living in the West.

2. Cognitive symptoms, especially guilt and low self-esteem, are less evident in the West-African context than in a Western context. In contrast there are more complaints about somatic symptoms as fatigue, loss of weight, and headaches. Western psychologists and psychiatrists often say that non-Western people put too much emphasis on somatic symptoms and are reluctant to look at the inner psyche. I will put it differently: Western psychologists and psychiatrists put too much emphasis on the inner psyche and by doing so they emphasize psychological constructs to explain negative mood stages.

3. I suggest the boundary between pathology and normality should be more open for negotiation. To be liberated from a DSM-IV stigma can be a constructive step forward in feeling “healthy”.

4. One of the major developments in the treatment of severe depression in the Netherlands is that people are trained to be more “mindful” or have a more accepting attitude towards their own mood stage. This is something we can learn from the West-Africans: to cope with uncertainty instead of thinking that one can control all aspects of life including our “happiness”.
5. Members of Western societies have to be aware that collective or societal problems as increasing loneliness, being part of an economical underclass or discrimination cannot be solved on individual level or the level of acceptance alone. This is the risk of our highly individualized society and of Medicalization of problems. We label a huge number of things as depression and learn to believe that it is our problem to solve them solitary.

4. Towards a more anthropological-informed care

In summary searching for help and consolation there are different roads to travel. These different roads overlap and are traveled and complete each other. According to my respondents Western psychotherapeutic discourse does not really apply to West-Africans: it is too individualized too different in a conceptual way. The Western Way of thinking is not felt in the line of thinking of West-African thinking. What was felt in line and helpful is empathy and opening up to their emic perspective. Revealing the need of the people themselves, which family members should be involved and what rituals are needed felt as helpful. Showing that you are in contact with the vital force of life as well. The primary interpersonal aspect of treatment is the emotional support of the suffering individual and reaffirmation of his or her worth in the community or society.

It is my believe that healthcare workers have to get out of their narrow perspective of thinking about care. They should learn to act as ethnographers: open to alternatives and complementary practices from herbalism to religious healing practices. The explanatory model of Kleinman and building a network with trustworthy healers will facilitate this process. After all the patients and family are the ones that can explain what is helpful or not. So listen to their stories and learn from them. And last but not least accept that there are other and maybe better ways to cure- and prevent depression than the Western one alone.
My own further quest and search

The period I was studying Medical Anthropology, I lost my idealism or maybe my naivety. I managed simultaneously while studying Medical anthropology and working to get my degree as “gezondheidszorg psycholoog” (health care psychologist). At the same time I became more critical about the stigmatizing diagnostics and the technical approach of protocols as are promoted by the Dutch government. Both psychology and medical anthropology shaped my way of thinking and acting. Both disciplines will continue that in the future. They are a fruitful but also paradoxical mixture. The next step I am taking in my professional life will be an apprenticeship from people who challenge the Western Biomedical assumptions by bringing in new ideas and ways of working. I hope I will be challenging others as well in the future. The African wisdom I gained so far was for me an enriching spiritual experience.

“We plan our lives according a dream that came to us in our childhood, and we find that life alters our plans and yet, from a rear height, we also see that our dream was our fate. It is that providence had other ideas as to how to get there. Destiny plans a different route, or turns the dream around, as if it was a riddle, and fulfils the dream in ways we could not have expected. How far back is our childhood? twenty years? thirty? fifty? or ten? I think our childhood goes back thousands of years, farther back than the memory of any race. When we yearn, our yearning comes from deep below. It comes from remembering, from the forgotten dreams of our mingled ancestry. They are weaving enchantments for us so that we may step through the invisible mirror in the air and enter the fairy-tale we are meant to live, but which we forgot “

From: Astonishing the Gods
Ben Okri

Carin Beijer
Utrecht, July 2005
references

Agger, I

Appiah-Kubi, K

Akhtar, Salman M.D.
1999 Immigration and identity: turmoil, treatment and transformation. Jason Aronson Inc.

Babatunde, E D

M.V. Buhrmann
1988 Religion and healing: the african experience
In: G. C. Oosthuizen (eds) Afro-Christian religion and healing in southern Africa The Edwin Mellen Press, Lewiston, NY USA 14092

Becken

Beiser, Morton
1985 A study of Depression among Traditional Africans, Urban North Americans, and South Eastasian refugees
In: Culture and Depression. University of California Press

Csordas, Thomas J.
2002 Body Meaning Healing. New York Palgrave

Csordas, Thomas

Csordas, Thomas J.

Csordas Thomas J
2002 Embodiment as a paradigm for Anthropology. winner of 1988 Strirling Award. paper for contributions in Psychological Anthropology. In Ethos 18:5-40
Csordas Thomas J and A. Kleinman.

Csordas, Thomas J.
1988 Elements of charismatic persuasion and healing. In : Medical Anthropology Quarterly 2 (2)121-142

Csordas Thomas J.

Van Damme, W

van Dijk, R
2002 The Soul is the stranger; Ghanaian Pentecostalism and diasporic contestation of “flow” and individuality” In :Culture and Religion, Vol 3,no1 RoutledgeTaylor& Francis Group.

Van Dijk , R
2003 Een schijn van Voodoo, Affrika Studie Centrum feruari 2003

Evans -Pritchard

Feierman, S

Galanter, M
1977 Evangelic religion and meditation: Psychotherapeutic effects In Journal of Nervous and Mental Disease, 166 (685-691)

Griffith, E.E.H
1977 Possession, prayer and testimony: therapeutic aspects of a Wednesday night meeting in a black church. In Psychiatry,43, (120-128)

Griffith, E.E. H
1981 An analysis of the therapeutic elements in a black church service. In Hospital and community and psychiatry. 35,(464-469)

Griffith, E.E.H
Haar, G ter  
1998    *Halfway to paradise African Christians in Europe*  
Cardiff Academic Press

Helman, C  

Hofstede, Geert  

Horowitz, M.J.  

Jakobs, Annemiek  
2000    *Ghanese jongeren en religie*. Universiteit van Utrecht

de Jong, Joop  
1987    *A descent into african psychiatry*. Royal tropical institute, the Netherlands

Kleinman, Arthur and Byron Good  
1985    *Culture and Depression*. University of California Press

Kleinman, Arthur and Kleinman, Joan  

Kraus, R.F.  
1968    Cross-Cultural Validation of Psychoanalytical Theories of Depression.  
Pennsylvania Psychiatric Quarterly 3 (8) 24-33

Linde, Paul R.  
2001    *Of Spirits and Madness: An American Psychiatrist in Africa*  
McGraw-Hill new York

Lutz, Catherine  

McGuire, M.B  

Mahler, M.S.  
Malidoma, Patrice Some
1999 The Healing Wisdom of Africa. Thorsons London

Mkhize, H

Motala

Meyer, Birgit

Munro, J

Ngubane, H

Nzewi, Esther
1988 Cultural factors in the classification of Psychopathology in Nigeria. In The clinical Psychology in Africa. WGAP (208-216)

Obeyesekere, Ganannath

Okulate, G. T.
2003 Somatic symptoms in depression: evaluation of their diagnostic weight in an African setting

Olu Sule, R.A.

Owoahene-Acheampong, S

Pool, R
Scheper-Hughes, Nancy

Schulz, Kathryn
2004 Antidepressants depress Japan? source unknown

Schweder, Richard A
1985 Menstrual pollution, Soul loss, and the Comparative study of Emotions
In: *Culture and Depression. University of California Press*

Smet, Peter

Soipan, Namonyah
2005 Mystical Journeys Sacred Return. Inkwaterpress USA

Tankink, M
2000 *Beyond Human Understanding*, doctoraalscriptie Culturele Antropologie Universiteit van Amsterdam

Tichelman, P
1995 “The devil is going to be blown away”, doctoraalscriptie Culturele Antropologie faculteit Sociale Culturele Wetenschappen Vrije Universiteit

Tichelman, P
1996 God has an answer to all your problems. In: *Medische Antropologie* jaargang 8 nummer 2

Van der Geest, S.

Vaughan, M.

Ventevogel, P
1985 *Whittemen’s things: Training and detraining healers in Ghana*. Amsterdam Het Spinhuis

Ward, C

Zeller, G.
The charismatic movement
Unknown paper ("The Charismatic Movement: 35 Doctrinal Issues") by Pastor George Zeller, The Middletown Bible Church, 349 East Street, Middletown, CT 06457 [(860) 346-0907].

internet sources:

>http://www.Afrikaworld.net/afrel/sarpong.html
>http://cehd.ewu.edu/faculty/ntodd/GhanaUDLP/KKAntiAfricanWomenReligion.html
>http://www.Cwru.edu/artsci/anth/professors/Csordas.html

Notes taken from Lectures/Conferences Workshops and Discussions

- Marian van Duyl /Afrika Studie Centrum 18 March 2004
- Annemiek Richter/ Conference:Cultuurintensief werken met DSM IV /2003
- Roberto Lewis Fernandez/ Conference:Cultuurintensief werken met DSMIV /2003
- Sjaak van der Geest / AMMA /2002
- Ria Reis/AMMA2002-2005
- Victor Irgreja/ AMMAI/2002
- Arthur Kleinman/ Trimboslezing 2005
- Kristine Kraus/Afrika Studie Centrum/2004
- Rijk van Dijk/Afrika Studie Centrum/2003-2006
- Cor Hoffer/expert meeting november 2005
- Joop Visser /expert meeting november 2005
- David Engelhard/expert meeting november 2005
- Han ten Brummelhuis/ Culture ,Psychology and Psychiatry 2001/2002

Theater project:chezacheza .www.chezacheza.com
Annex 1

research questions healing practices of West-African migrants;

General questions on cultural identity

What is your name / how can I call you:

To which ethnic group do you officially belong?

What language do you speak?

How long are you in the Netherlands?

Do you still see /involved in culture of origin / family relations (here / elsewhere)? Could you explain?

What are the most important values in your culture:

( family / beliefs / rituals ) ?

To what extent is it possible to for you to follow your culture’s way of life here in the Netherlands?

Are there any aspects of your culture which bother you or which you find less attractive?

Do you feel involved in the Dutch culture?

If so, which aspects do you like

What aspects do you not like?

Do you have children / what are things you teach them?

The Christian identity

How long are you a Christian / belong to a church?

Did you have another religion before?

How does Christianity show in your life?
Coping with depression (western term)

- Low energy
- No appetite/not wanting to eat
- Not enjoying life
- Not interested in sex/having sex
- Worrying about the future
- Sleepless nights
- Closed/not open for others/isolation
- Not wanting to live anymore
- -worrying about past/future is dark

Words translation:

Do you recognize it? by yourself by others/family friends?

Cultural Explanations

What is the name you give to it?/one name different names

What do people say in your language?

Do you know the expression "ants keep creeping in part of my brain"?

How do you think symptoms started?
(one answer: ask for more explanations)

What is the explanation given by you?

How does your family explain this?

How will other people of your culture explain the symptoms?

(social stressors/evil spirits etc?)

Do you felt you were understood?/the person felt s/he was understood.

Practices

What do you do normally when you feel this way (name symptoms)?
or the person you know./or someone in your community/culture group/
How will you try to help him or her?
(pray/medicines etc.)
To who of what do you turn to? In what situation?

What was helping you / the other?

What did you/the other prefer to receive (talking / medicines / advice / rituals done by the church / Rituals done by others)

Foods / fasting

**Help seeking behaviors**

To who do you turn to? (self / family / church / doctors / others)

Do you know examples of others?

What do you suggest others in the same situation?

What helped you / others?

**Psychosocial environment & help**

Family in the Netherlands?

Position in the family?

The person who gives advice in the family?

**The church**

How can they help?

Church here / in Ghana Nigeria

What practices were employed?
Bible reading
Testimonies
Prayer sessions
Visualization
Fasting
Food

**The bio-medical approach**

Do you think that western doctors / psychologist can help you?

understand your situation / situation of the other?
What do you think they do?
When will you turn to them? with what kind of question/problem?
What will you suggest they will do?

**Traditional approach**

What will be the traditional approach?

Breakdown of patients accepted as victims of witchcraft.

**Islam**

Do you think that their knowledge can contribute
Making use of a Marabout./ Koran
Good or not? Why?
When helpful?
Examples?