The concept of mental disorder: an African perspective

Frank Njenga
Upper Hill Medical Center, Nairobi, Kenya

The concept of mental disorder is determined by many factors, including the historical context, cultural influence, level of scientific knowledge and capacity to carry out scientific enquiry, level of education in certain circumstances, as well as many others. In putting together a method of classification of mental disorders, the expert's duty is primarily that of capturing and remaining faithful to the current level of knowledge in the subject, acknowledging that, in a matter of time, some or all the above factors could change to variable degrees, making what was clear as a mental disorder a few decades previously less clear in the next edition of the classification system.

In the earlier editions of the DSM, homosexuality was clearly categorized as a mental disorder and, by extension, a condition demanding or at least requiring medical treatment. In Western cultures, any suggestion that being gay or lesbian is anything but normal would now attract the wrath of society. The situation in Africa is quite the opposite, and many Africans still view gay and lesbian people as "mentally sick", because their sexual orientation is against the order of nature. In this regard, one could view the Africans as "uncivilized" or as holding a cultural belief that may or may not change in the course of time, much as it did in Western countries.

A similar but opposite position holds with respect to the circumcision of women, a practice also described as female genital mutilation (FGM). There are still very strong pockets of Africans who practice FGM, presumably in part as a cure for what Victorian physicians would have called "clitoral orgasm", a condition then requiring preventive surgery. Many Africans defend the cultural position with equal vigor to those who find it abnormal. There are those who would consider it a mental aberration to mutilate the genitalia of young women and children.

Anorexia nervosa is one of the leading causes of morbidity and mortality in adolescent girls in Western countries. Crisp et al (1) found a prevalence of one severe case in 200 girls in independent schools, while, among girls aged 16 years and over, the rate rose to one in a hundred for severe cases. In Africa, the condition is hardly known. Njenga and Kang'ethe (2) reported on a study in Kenya and concluded that "in a cumulative period of 320 years of practice, Kenyan psychiatrists had seen twenty cases of anorexia nervosa". Hulley et al (3) studied a sample of Kenyan and British female athletes and concluded that "the effects of cul-

ture were clear, women in the UK were more dissatisfied with their weight and shape and demonstrated significantly more eating disorder cases and associated psychopathology compared with the Kenyan women".

So, who is deluding who? Is refusal to eat food by "spoilt white girls a disease or simple foolishness?". Trying to explain to the hungry African mother and child that there are girls who die in Western countries because they refuse to eat food goes beyond reason and logic and would not make sense as a mental disorder, and yet in the West, there is no room for such a discussion.

Anorexia nervosa in fact raises many questions regarding its cause and origins. Is it primarily genetic, or is it a social construct of a search of thinness as required of females in Western societies, or is it a combination of both? Should we conclude that pursuit of a cultural belief, such as the belief that to be thin is good, is evidence of a mental disorder because it causes mortality and morbidity? How much is the desire for a thin body "normal" and how much of the same is abnormal, and who decides anyway? Are these cultural or biological conditions? The issue of dimensional and categorical systems of classification comes sharply into focus. The African is however clear! When food is available, one must eat to the full!

Historically, the African were believed to function as "lobotomized Europeans" (4), because of a smaller brain, and the desire to free himself from French colonialist rule was evidence of a mental disorder, a "fact" taught in French Universities in the 1960s (5). Few if any psychiatrists would now believe "the facts" as stated above, but in the 1950s and 1960s, these were the facts as understood by well educated, well meaning men and women of science. It is therefore with this knowledge that we must approach the subject of mental disorders with caution and humility, as we could, in a generation or two, be viewed much as Carothers is now viewed by many.

That said, however, we must pick up the courage of our conviction and do what man has done through the years, which is to create order from chaos, which is, after all, the whole purpose and function of a classification system. Our duty to posterity, therefore, is to use the best available tools, to carry out the ordering process and, even if we get it "wrong" in the eyes of the next generation, we will be able to stand firm and tall in the knowledge that no system of classification will remain unchanged for all time. It therefore stands to reason that the concept of what is and what is not a mental disorder is a dynamic one, which will change from time to time, from culture to culture and, as in the case of homosexuality, from generation to generation.

References

1. Crisp AH, Palmer RL, Kalucy RS. How common is anorexia nervosa? A prevalence study. Br J Psychiatry 1976;128:549-54.
2. Njenga FG, Kang'ethe RK. Anorexia nervosa in Kenya. East Afr Med J 2004;81:188-93.
3. Hulley A, Currie A, Njenga F et al. Eating disorders in elite female distance runners: effects of nationality and running environment. Psychology of Sport and Exercise 2007; 8:521-33.
4. Carothers JC. Frontal lobe function and the African. J Ment Sci 1951;97:12-48.
5. Fanon F. The wretched of the earth. London: Penguin Books, 1963.