

Popular conceptions of schizophrenia in Cape Verde, Africa

Concepções populares da esquizofrenia em Cabo Verde, África

Mário Dinis Mateus,¹ José Quirino dos Santos,²
Jair de Jesus Mari^{2,3}

Original version accepted in English

Abstract

Introduction: It has been well documented that schizophrenia presents a better clinical course in developing countries. Although there are many epidemiological studies showing this association, little research has been conducted to investigate the local representation systems for schizophrenia in these countries. **Objectives:** This study focuses on cultural factors of schizophrenia, namely the local representation systems for the disease, as well as what is locally understood as deviant behavior and its acceptability, and mechanisms of social-cultural insertion or exclusion of patients with schizophrenia in Cape Verde, Africa. **Methods:** Randomized open interviews were carried out with the relatives of patients under treatment at the mental health out patient service of the Batista de Sousa Hospital (São Vicente Island) between the years 1994 and 1995. Interviews dealt with patients' life histories and disease related to problems, strategies employed by the family to cope with such problems, and comments on the social and family burden. **Results:** 20 interviews with close relatives of 10 patients were analyzed. The study focused on three main categories explaining schizophrenia: "tired head" (cabeça cansada), "nervous" (nervoso), and supernatural categories (like "sorcery" or "witchcraft"). The interviewees expressed their opinions, either explicitly or not, on whether their relatives truly had a disease. **Conclusions:** Characteristics of local categories for schizophrenia found in Cape Verde can be regarded as a less stigmatized way of dealing with the disease. It is reasonable to suppose that the understanding of such cultural factors could lead to better outcomes in the treatment for schizophrenia in this country, and also in others, where similar conditions can be identified.

Keywords: Schizophrenia/ethnology; Schizophrenia/diagnosis; Social adjustment; Africa; Interviews

Resumo

Introdução: Tem sido bem documentado que a esquizofrenia apresenta um melhor curso clínico em países em desenvolvimento. Ainda que haja muitos estudos epidemiológicos demonstrando essa associação, poucas pesquisas têm sido realizadas para investigar os sistemas de representação nacional de esquizofrenia nesses países. **Objetivos:** Este estudo está focado nos fatores culturais da esquizofrenia, a saber: os sistemas de representação nacional da enfermidade, bem como o que se entende no país como comportamento desviante e sua aceitação e os mecanismos de inserção ou exclusão sociocultural dos pacientes com esquizofrenia em Cabo Verde, África. **Métodos:** Foram realizadas entrevistas abertas aleatorizadas com parentes de pacientes em tratamento no serviço ambulatorial de saúde mental do Hospital Batista de Sousa (Ilha de São Vicente), entre 1994 e 1995. As entrevistas avaliaram os históricos da doença dos pacientes em relação aos problemas e estratégias utilizadas pela família para lidar com tais problemas e comentam sobre a sobrecarga social e familiar. **Resultados:** Vinte entrevistas com parentes próximos de 10 pacientes foram analisadas. O estudo foi focado em três categorias principais para explicar a esquizofrenia: "cabeça cansada", "nervoso" e categorias sobrenaturais (como "bruxaria" e feitiçaria"). Os entrevistados expressaram sua opinião, seja de forma explícita ou não, sobre se seus parentes realmente tinham uma doença. **Conclusões:** As características das categorias nacionais da esquizofrenia encontradas em Cabo Verde podem ser encaradas como uma forma menos estigmatizante de tratar a doença. É razoável supor que a compreensão desses fatores culturais poderia levar a melhores desfechos no tratamento de esquizofrenia neste país e também em outros onde similares condições podem ser identificadas.

Descritores: Esquizofrenia/etnologia; Esquizofrenia/diagnóstico; Ajustamento social; África; Entrevistas

¹ Universidade Federal de São Paulo (UNIFESP, Federal University of São Paulo)

² Department of Psychiatry, Universidade Federal de São Paulo (UNIFESP, Federal University of São Paulo)

³ Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPQ, National Counsel of Technological and Scientific Development)

Correspondence

Mário Dinis Mateus
Universidade Federal de São Paulo
Departamento de Psiquiatria
Rua Botucatu, 740
04023-900 São Paulo, SP, Brasil
Phone: (11) 5055-8230
E-mail: mdmateus@ig.com.br

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Introduction

Demographic projections for the year 2000 estimate that 24.4 million people with schizophrenia live in underdeveloped countries.¹ Along with fear and disorganized behavior, common traits in this mental disorder, stigma is attached to patients and their family. Moreover, in poorer countries, these problems are increased by the scarcity of resources for treatment and lack of social security. There is no evidence linking the etiology of schizophrenia to social and cultural factors.² However, as demonstrated by Lin, Kleinman, cultural factors play an important role in the outcome of the disease.³ In the two comparative studies sponsored by the World Health Organization, dealing with the occurrence and course of schizophrenia in ten countries (grouped as "developed" and "underdeveloped"), it was shown that the clinical course was better in the underdeveloped group. Cultural differences between these two groups of countries could potentially offer explanations for these findings.^{4,5} A number of hypotheses have been tested to elucidate the possible influences of culture on schizophrenia, i.e., topics such as family structure,⁶⁻⁸ opportunities for social inclusion,⁹⁻¹¹ and experience of the illness and its meaning for the patient.¹²⁻¹⁴

Jenkins⁷ studied close relatives of patients with schizophrenia in the Mexican-American community of California and observed that "the disease of the nerves", a common affliction affecting the family member, carried a much more tolerant attitude towards their abnormal behavior in daily life, less social stigma and also a more optimistic outlook on healing. Villares et al¹⁵ interviewed relatives of patients with schizophrenia in Sao Paulo, and presented three main categories for the family conception on the nature of their relative's illness: "Nervous Problem", "Head Problem" and "Spiritual Problem". Redko¹⁶ also accomplished an ethnographic study in Sao Paulo with patients who were having their first psychotic episode, using the concept of articulation of the experience of psychosis and cultural influences in the negotiations involved in the re-articulation of this experience by the carer of the illness and his/her contacts, especially the influence of religion upon this process. In Salvador, following the same approach of the experience of falling ill (getting sick), Alves, Rabelo and Souza,¹⁷ emphasized, among other aspects, the cultural determination concerning the therapeutic itineraries of patients with mental illness. Peluso,¹⁸ by means of vignettes describing psychiatric cases and a structured questionnaire, performed a survey with 2000 interviews in the city of Sao Paulo, and found that, for the vignette that had described a case of schizophrenia, there were both negative reactions, such as the perception of the risk of violence linked to the disorder, and the vision of the illness as being a problem that could be possibly treated. The present study focuses on cultural factors of schizophrenia, namely the local representation systems for the disease, as well as what is locally understood as a deviant behavior and its acceptability, and mechanisms of social-cultural insertion or exclusion of patients with schizophrenia in Cape Verde, Africa.

Methods

Between the years 1994 and 1995, all adult patients under psychiatric or psychological treatment in São Vicente Island were registered at the Mental Health Section,¹⁹ totaling 1048 patients, from which 113 had a diagnosis of schizophrenia according to the ICD-10;²⁰ of the 113 patients 76 were male, with a mean age of 31.2 years, and 37 were female with

mean age of 39.0 years.

Of all patients undergoing mental health treatment at the Baptista de Souza Hospital Mental Health Department, 12 were randomly selected, six of each gender, with the following inclusion criteria: 1) a positive diagnosis for schizophrenia, based on the DSM IV; 2) patients undergoing treatment at the outpatient unit during the years 1994 or 1995 (at the time of this study); 3) residents in the Island of São Vicente, along with a relative; 4) aged 18 to 45 years; and 5) absence of associated pathologies (mental deficiency; dependency on alcohol or drugs and organic disorders).²¹ Relatives were requested to talk about the patient's problems. Patients and their relatives gave their informed consent to the interviews and their being recorded.

The diagnosis was checked according to the DSM-IV criteria for schizophrenia for each patient included in the study.²² Twenty-three relatives of 12 patients were initially selected. There was one refusal and one patient with bipolar disorder who was excluded subsequently, due to misdiagnosis, along with his two family members. Sixteen interviews were accomplished at the outpatient clinic, after office hours, and another four at the patient's homes. Interviews took 40 to 150 minutes to be completed and some needed an extra session.

Some relevant social characteristics of the relatives included in the study are described in Table 1. Most of the relatives were parents or siblings, and aged between 20 and 75 years. Although most of them considered themselves as Catholics, they were affiliated to other religious persuasions.

Table 1 – Social, religious, educational, and age data of patients' caregiver relatives

Patient	Interviewed relatives	Age	Religion*	Education
1	Mother	62	Christian rationalism	None
2	Mother	75	Catholic	None
	Former husband	38	None	High School
3	Sister	31	Catholic	None
	Stepmother	51	Catholic	High School
4	Mother	50	Catholic	Elementary School
	Father	58	Catholic	Elementary School
5	Brother	27	Catholic	Junior High School
	Father	70	Catholic	Elementary School
6	Father	53	Pentecostalist	Elementary School
	Mother	51	Pentecostalist	None
7	Sister	25	Catholic	Junior High School
	Brother	23	Catholic	High School
8	Mother	62	Catholic	None
	Sister	20	Catholic	High School
9	Father	63	Christian Rationalism	Elementary School
	Sister	20	None	High School
10	Sister	23	Catholic	Junior High School
	Brother	36	Catholic	Junior High School

*Spontaneous answers not reflecting double affiliations, a not uncommon fact.
Christian Rationalism is a spiritualistic sect.

1. The interview

The in-depth interview consisted of a list, defined *a priori*, of topics and themes to be discussed with the patient's relatives. The interviewer decided, at the moment of the interview, which was the sequence of questions for each interview. Guidelines for the interview with relatives are described in Table 2. Besides the official Portuguese language, Creole is the colloquial language in Cape Verde.²³ Interviewees could choose which language to use.

Table 2 – The script of themes and topics of the interviews for caregiver relatives

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- Interviewer's conception of the disease;
 - Personal conception of treatment, medical and alternative;
 - The patient's insertion in the family's routines, and the adaptations introduced by the patient and his or her family in these routines;
 - Notion of patient's social insertion and general performance (also their satisfaction with it);
 - Expectations about the patient's performance;
 - Strategies to stimulate the patient;
 - Strategies for the patient's vigilance and control;
 - Coping with situations in the relationship with the patient (aggressiveness, inappropriate sexuality, etc);
 - Feelings of guilt, shame and burden.
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In order to facilitate the interview and to maintain rigor while grasping obscure thoughts, interviews were transcribed and translated into readable Portuguese by native Cape Verdeans living abroad (college students living in Brazil). Analysis of the interviews began by dividing the subjects into themes and categories; these were examined and compared to one another, and were then either discarded or became part of the pillars of understanding, i.e., as regards the terms and accounts shaping the notions of the disease in the narrative.

Results

Each relative was invited to continually express an opinion about the patient's problem with the disease. Sometimes openly, often in a reserved way, the relative disagreed with the treatment received at the outpatient unit, which was described as insufficient or not efficacious, given the perceived nature of the problem. In other instances, the interviewee tried to explain the problem as not being as severe as mentioned by neighbors. In both cases, the relative was protecting the ill relative, and the entire family, from hearsay. Therefore, what was said was not neutral. Quite the contrary, relatives were strongly committed for or against, the patient's acts.

Nevertheless, during the course of an interview, the disease could undergo many explanations, shifting in apparently contradictory manners, making it clear that the interviewee was drifting from the speech he/she thought should be delivered to the researcher. Besides that, this move to other meanings shows that the many labels and explanations for the problems can become accommodated without exclusion, and are not always totally unveiled by the interviewee. For instance, the different causes mentioned for a given disease can alternate as being supernatural and organic, during the course of the talk with the same person.

1. The "Tired Head"

The majority of the relatives interviewed do not consider their kin under study as being "mad". Relatives usually state that the patient's problem is less serious than those of the

"really mad". In fact, examples of really insane people include people who live on the streets, are abandoned by their families, and people who cannot talk coherently, and those who are dirty and can be aggressive in a sudden and inexplicable way. The Creole expression "tired head" (translation of *cabeça cansada*) is often used indistinctly as a synonym for madness, in one of its varied local denominations (as in the examples: *crazy people*, or *mad*, with *unsound minds*, with a *mixed-up head*, *dazed*, or "confused").

"...he is a fellow that you don't even need to ask to take a bath by himself, and those people, I think, with a messed-up head, they practically will not even use water by themselves. They don't even change clothes, they don't do anything. (...) Confused people, people with a dazed head, I think Rafael is not this kind of person. He is different, not because he is my brother, but he's different. At least he changes his clothes, likes to take a walk, sometimes he's got a little money, ok, and he takes the bus and goes for a ride. Very often the driver recognizes him, he doesn't even want to receive the fare money, because Rafael is not the kind of person who insults or bothers other people, he takes his ride, rides the bus and then gets off. So he doesn't mess with other people's lives, which is what happens to those people who have a troubled mind. Pretty different from those on the streets, he greets everybody, and everybody respects him."

There are more specific definitions of "tired head" in other interviews. It means a problem, caused by excessive concern, doubts, fears, unpleasant ideas and privations that continually undermine mental functions which end up destroying the mind: *wrecks the head* (*dar cabo da cabeça* or *levar a cabeça*); *head* here being a metonym for mental abilities. Thus, the "tired head" is a serious problem; a drastic reaction and the consequence of past difficulties, possibly affecting irreversibly the mental performance. Therefore, it is somewhat broader than simple weariness of the mind, as the expression could lead us to believe.

In Cape Verde the expressions "exhaustion", "fatigue", "to tire", besides meaning weariness caused by an effort, are also used to convey the meaning of annoyance, contrariety and irritation. Semantically, the appropriate translation for this expression would be *weary head* or *perturbed head*, thus better conveying the meaning Cape Verdeans give to the word *cansada* or tired.

"When there are things... in the family... disagreement, one can get a little dazzled, then we say: 'that person has got his head tired'. (...) he starts saying many things, that's what I reckon a tired head is."

So it is...this thing, because, of course, I'm here now, tomorrow I have no work, I come here and lay down and get up in the morning, have no coffee to drink, I've got to get out and walk, (...) no shirt to wear, no place to stay...feeling that thing here, and that's why I say, this thing of tiredness and head is about a poor afflicted fellow in need; but we [our family] don't need to wear out our heads."

The causes for "tired head" are often reactions to excessive concern associated with living in despair, for a person deserted by family and friends. Sometimes, stories of students under pressure for results in exams were mentioned, in which suffering and great concern, together with the lack of rest,

food, and sleep may lead to the weary head. As a result, those students forget what they have studied, even basic learning is forgotten; they become restless and neglectful of their personal appearance, then go walking around in the streets, and many times do not even recognize other people.

"...I don't know if she felt ashamed at school... Something. Because there are many teachers who are too demanding. I don't know if my daughter's illness... She never told me anything, but maybe she felt ashamed because of something at school, in the middle of some class, she felt, it could be like this, too. Because there are many school children who ended up with their heads like that".

These statements evoke the brain fog syndrome, described in the literature as a culture-bound syndrome particularly affecting West Africa teenagers at school, who have problems when under pressure, both at school and at home.²⁴⁻²⁵ However, the brain fog syndrome shows somatic and anxious complaining, typical of neuroses,²⁶ while the "tired head" is known in Cape Verde for its clearly psychotic manifestations and not specifically described as a consequence of stress at school.

2. The "nervous"

The words "nervous" and "nerve" are not always linked to the patient's illness itself. They also apply to cases of disease caused by ordinary, everyday situations.²⁷ Sometimes, this term is used to describe crises of restlessness, with or without violence. In this case, it may be said that someone is "nerve stricken" (*atacado de nervos*), meaning more a state than a cause. Thus "nervous" usually applies to understandable and acceptable situations that can occur in anyone's life, indicating precisely that this specific patient has never suffered – or is not presently suffering – from anything serious, something more than a simple case of "nervous" affliction.

"But when he is in those days, or something... Well, I think that for everybody, life is like this, isn't it? Everybody has this 'nervousness', some more than others."

As in "the tired head", "nervous" can also be considered as a way of expressing reactions to problems and traumatic events. At the same time, this "nervous" is vaguely located somewhere in the body. The "nerves of head" and "nerves through the body", (especially those nerves located in the limbs) are affected, overexcited, "stiff, rigid", altering the body regulation, blood pressure for instance.

3. Supernatural categories

"Disease of the land" (*Doença-da-terra*), in Creole, is a local term alluding to disturbances, in the context of popular medicine.²⁸ This term refers to supernatural causes, like sorcery or witchcraft, and to the necessary intervention of a healer or medicine man, or other equally committed people, skilled in the art of those "remedies of the land" (*remédios da terra*). Considering the patient's problem as emerging from evil forces whose origin is supernatural can bring up a variety of elements that are constantly mixed. These elements convey a group of negative values that represent "evil": dirtiness, impurity, disrespect to moral rules, envy, greed, rancor, etc. Table 3 refers to supernatural causes mentioned by the patients' relatives.

The rationale for the negative or malign forces follows

Table 3 – Supernatural causes mentioned by patients' relatives

Supernatural cause	Observations
Envy	The term envy acquires a broader meaning, meaning the same as greed, hate, rancor or malignity, suggesting a previously relation (envy) and its consequence.
Evil eye	The most typical way through which envy causes evil is the evil eye. It is through the evil eye — a very similar notion can be found in Brazil ³⁸ and other cultures — also called evil eye ("olho ruim"), ill rancor, ("mau rancor") or ill will ("má vontade"). Foster mentions that the association between looking and envying is common to several cultures, also reminding that "envy" comes from the Latin <i>invidia</i> , (from <i>in</i> , into; <i>videre</i> , look) to envy is to look into something.
Sorcery and witchcraft	Sorcery is differentiated from evil eye because the person who wants to do evil to another makes use of his or her special power and knowledge or hires a sorcerer (also called "master", "cordêro", or "canjerista") to do it. The term "witch" can be used as a synonym for sorcerer, but it is also understood as someone with intrinsic evil powers, who "eats" people (steals their vital energy) cunningly. The interviews cover two ways by which the sorcery can be done: by photos and clothes of the victim or by potions prepared by the sorcerer.
Spirits	The main reference of the interviewed when they mention the spirits' influence in their relative's problem is the "Racionalismo Cristão", a spiritualistic religion. ³⁹ The manifestations are of the so called inferior spirits that wonder in the earth and can speak to people or attract negative forces, and they can also mention the presence of a spirit without the reference to the "inferior spirit".
The devil	It is little spread the reference to the devil or to Satan, whom by way of possession could take one to behavioral changes (what wouldn't be properly a disease), or whom could plot a series of misfortunes — among these, the disease — an idea that can be found among the Pentecostal Churches, most of them of Brazilian origin, as the "Igreja Universal do Reino de Deus" or "Deus é Amor". ⁴⁰

vectorial relationships as in physics: a sum of negative forces is cancelled out by an opposite force, therefore a positive protective force, which can also bounce or reflect evil to another human target.

"It could happen, when I am... If I am doing evil to this person and if this person is not in debt, then evil may drop by at your house, as the elder say, it could fall inside my house, striking someone there, and the one to whom it was directed at will be at ease. Yes, it happens, it happens."

The patient, when at greater risk of receiving these negative forces due to a greater vulnerability, is considered to have a spiritual weakness, as a consequence of being "weak or low spirited", thus preventing the patient from repelling those negative forces or fighting the influence of lower spirits. This susceptibility was also found in people who keep bad company and develop "bad habits".

"(...) That man [healer] just glanced at the T-shirt and said 'your sister suffers hard; you must take care of her'. He even said that her relatives had put her in that situation... That is, the disease she [the sister-in-law] put to my father, my father was not walking around late at night anymore... Andréa [the patient], as she went to a shindig or something, the disease struck her."

4. "Mental Illness"

In this category, distinction was made between statements of causes or treatments for problems, as told to doctors, to the hospital, and to the pharmacist²⁶ besides problems "of the head", the latter being related to the body, and somehow linked to regular medical care. Since all the cases under study had been seen at the hospital's mental health service, most of them for many years, we assumed that their relatives were more familiar with medical concepts than the average layman. In effect, their vocabulary included terms like mental illness, a troubled mind, and mental imbalance. Actually, these words were used completely out of the biomedical context, having no precise meaning, being used in popular sayings and vocabulary. Interviews often revealed a relationship of the troubled family member under treatment, with bodily affections or bad functioning, such as a nerve problem, or as visible signs that can appear as a sign of body dysfunction. Cases of trauma, swelling, headache, nausea, vomiting, and fainting, are considered by them signs of trouble in the head.

"...but I reckon Andréa was stricken with a stone, Doctor, I don't know, doctors should know better. But that was induced. She said to me: dad, I feel such a headache (...) The difference is that Andréa with that stoning thing, that is, it's blood [cause] or something, I don't know."

Further extending the argument, interviewed relatives said the patient was sick because basic healthcare was not followed-up. Therefore, the body was then suffering the consequences of that "imprudence". The term "imprudence" appears here and there as the non-compliance with standards and health care, which can lead to illness. Among the examples mentioned, one is also found in other cultures,²⁹ referring to woman's care in bathing and dealing with water, particularly washing the head, during menstruation and the puerperium.

"I think she is somewhat imprudent, I don't know. Because she has bathed since the very first period, I didn't let her go get water, or do anything. After that she started bathing in hiding, washing her head, and then she started showing irritation. I think it was since that time."

Local mental disorder prevention includes also [mothers who are] breast-feeding. In many situations breast milk may be considered as "dirty", or "mixed and bad" or "stolen".³⁰ In the following example, milk was deemed responsible for transmitting "the tired head" from mother to daughter.

Question: "Do you think there is any relation between the problem you had, in that period, and the problem Fernanda has nowadays?"

Answer: "I think I felt that disturbance at the time I was breast-feeding her... It could do her some harm... That's what I thought"

Question: "Through the milk?"

Answer: "Yes".

Another expression with the same usage as to act imprudently (*fazer uma imprudência*) is to put the disease with your hands (*pôr a doença com sua mão*), that is, to be the cause for disease through one's own acts, when acts are contrary to the necessary care to preserve health. Abuse of harmful

substances, such as alcohol, tobacco, and drugs, could also lead to the disease or worsen it.

5. Absence of the illness and the multiplicity of the illness

The majority of those with schizophrenia are seen as suffering from one or more problems that are attributed to an illness. However, in other interviews, or concurring with the above affirmation, the illness no longer exists (it existed in the past) or the problem of the sufferer was never really an illness. Illness denial does not appear in our interviews as an idea that was categorically expressed, but, in fact, the denial appears through comments that reflected doubts and contradictions.

On the other hand, the notion that the problems confronted by the sick person throughout the years had been related to a single pathological process is not present in the statements of those interviewed. At times, the successive periods of violent behavior or inadequacy shown by patient – especially in the cases of those sufferers with a short illness span and with a fewer number of occurrences in the illness's course – are viewed as different illnesses, with distinctly different causes and peculiarities. Similarly, periods in which the inhibited behavior predominates, can also be looked upon not as part of the illness but as another problem, as if one was dealing with laziness or reluctance on the part of the patient, or with another illness that had afflicted him/her.

Discussion

The influence of culture upon the prognosis of schizophrenia is complex and has only been scarcely studied. Factors such as the inclination to search for, and stick with, a treatment; the degree of tolerance towards different clinical manifestations of the disease; beliefs about its causes and evolution; stigma and chances offered for the social re-adaptation of the patient, among others, can have a decisive influence on the patient's prognosis and not vary only in accordance with the patient and his/her family, since they primarily depend upon the socio-cultural environment to which this group of people pertain.

In a community, individuals remove from their arsenal of norms and principles that compose their culture, instruments in order to understand and react within their world, and at the same time they are constantly adding to their culture new elements.³¹⁻³² On studying the local concepts regarding individuals with schizophrenia, we investigated which cultural resources were available to the community in order to deal with these people. Interviewed family members are examples of people especially involved in the manifestation of schizophrenia and, on defending or criticizing their family member who has the illness; they find themselves at odds with the concepts and values from their culture and very rarely from psychiatric concepts related to the illness.

Several authors highlight what can be called a cultural negotiation surrounding the labeling of a health problem and the search for alleviating it.³³⁻³⁵ Culture is not the only a determinant factor for community tolerance or hostility to the problems surrounding a patient with schizophrenia, but could well provide favorable elements to its social adaptation or otherwise. In our study, culture provided to the patient, family members and others involved a repertoire of justifications for a posture that is more optimistic and tolerant towards a deviation. One may consider that the patient's illness depicts a case of nervousness, and consequently something that occurs frequently and is not so serious; or a case of tiredness, which, being caused by intense suffering can bring about greater

tolerance, thus propelling family and community towards understanding and support.

Supernatural causes can procrastinate the feeling of guilt, consequently uniting the family against an external aggressor. The disease is also only supposed to be temporary and may stop as soon as the negative force in action is suppressed.

Many schizophrenic manifestations can be more acceptably interpreted generating less tension between the patient and the community. In a very poor and agricultural community, with high unemployment, the patient's non-productivity can be minimized, as waiting years for a job or a chance to immigrate is a relatively common situation, as well as remaining dependent upon parents and siblings. Frequently one may see entire families being supported by money sent by a relative living abroad.³⁶

Disengaging from old acquaintances and from a busy social life, can be seen by relatives and the patient himself as an attitude to avoid envy and enemies; spells and evil-eyes; and therefore not as a problem, but a prudent behavior. Symptoms such as hallucinations and delusions are relatively well accepted, especially when the interviewee's relative demonstrates a non-scientific understanding of the disease, e.g. hallucinations understood to be the presence of spirits. Delusional ideas can be seen as stubbornness or a fixed idea concerning a certain subject.

Relatives, even in cases of patients with severe and long-term histories, usually mentioned the expectation of a cure. There is a distinction between inborn diseases, which would be hardly curable in an adult, and other diseases that show up later. In their perception the latter might be cured. ("She wasn't born this way, so she can be cured", said one mother about her daughter).

Not all the characteristics of the local categories for schizophrenia found in Cape Verde can be seen as a less stigmatized way of dealing with the disease when compared to westernized countries. On the contrary, sometimes the patient is seen through his/her disease expressions as someone psychologically regressed, childish, or even bestial, consequently bringing about reactions such as their tying-up, muzzling, locking up for long periods, which involve hostile guarding and confrontation.

Similarly, they blame the patients for the acquisition of the disease or for "not wanting to get better" by not taking the positive attitudes expected from a patient, such as cordial social relationships; the running of errands; the minding of rules (e.g. adequate sleep, avoiding smoking or drinking too much coffee). Patients with prominent negative symptoms could then be seen by society as lazy and rude.

Another factor may be seen as a protective factor for patients. In Cape Verde the negative values ascribed to the illness are related not only to the seriousness of the symptoms, but also to the sufferer's abandonment and misery. The most serious cases are always quoted as those concerning homeless (street dwellers), abandoned by their families. Therefore, the community is concerned to demonstrate that all possible support was and is being offered, so that a socially negative image of disregard and egotism does not fall upon the family.

The observation of the importance of the specific cultural context of the patient (bearer of the illness) and his/her social network can especially apply to the organization of mental health programs, aimed to improve the access and compliance to the treatment as well as to diminish the illness's stigma. Programs such as those of the World Psychiatry Association

which work against the stigma of schizophrenia,³⁷ must consider, in their implementation in local context (each separate location), the benefit of using positive valuations and strategies of social insertion existent in the community, instead of negating their existence or ignoring them as vestiges of misinformation and prejudices to be corrected.

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