

EMOTIONS, SOMATIZATION AND PSYCHIATRIC SYMPTOMS AMONG THE AKAN

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INTRODUCTION

It is commonly held that in non-Western societies psychological distress is 'somatized', whereas patients in the Western world 'psychologize' their emotions (Mumford 1993: 237). The term somatization was first introduced into trans-cultural psychiatric literature by Kleinman (1977), who defined somatization as the "expression of personal and social distress in an idiom of bodily complaints with medical help-seeking". However, the term has been used to refer to different types of phenomena. Kirmayer and Robbins (1991) suggest that three forms of somatization can be distinguished in current research approaches: (1) "functional somatization", which refers to a count of the number of medically unexplained somatic symptoms during one's lifetime; (2) "hypochondrical somatization", which refers to the worry or belief that one has serious illness despite the absence of demonstrable disease; and (3) "presenting somatization", which refers to the presentation of exclusively somatic symptoms despite the presence of a psychiatric illness. In cross-cultural psychiatric literature, the term somatization usually refers to presenting somatization. It is argued that bodily complaints predominate over psychological complaints in patients suffering from depression and anxiety disorders in non-Western societies (Kleinman 1988: 25). There are several reasons why somatic symptoms appear to be more common in non-Western, and particularly in African patients. In this article I will discuss cultural and linguistic factors that influence the presentation of psychiatric symptoms. First, I will review research literature on somatic symptoms in sub-Saharan Africa. Second, cultural factors which affect help-seeking behaviour in various African societies will be described. Third, the expression of emotions will be discussed. And fourth, I will discuss emotion talk using Akan somatic metaphors as an example. In the discussion of Akan culture and emotion terminology, I draw on data which I gathered during a total of seven months of field work in Ashanti Region, Ghana, between December 2000 and May 2002.

SOMATIC SYMPTOMS

Psychiatric disorders are often accompanied by somatic symptoms such as headache, vague aches and pains, dizziness and fatigue. Somatic presentation of mental disorders is not restricted to non-Western societies. Within Western cultures, working class people tend to present predominantly somatic symptoms (Bebbington 1993: 147). But apart from the common somatic symptoms mentioned above, there are a number of apparently culture-specific somatic symptoms presented in African cultures. Ebigbo (1982: 31–32) lists typical somatic complaints associated with various psychiatric diagnoses in Eastern Nigeria: heat in the body, heat in the head, crawling sensation in the body/head, disturbing and fearful dreams, heaviness of the head causing blurred vision, burning sensation in the body and belly, loss of equilibrium, etc. Similar symptoms have been reported by other researchers in Nigeria (Awaritefe 1988; Makanjuola 1987).

Mumford (1993: 237) asserts that ethnic differences in somatic symptoms are in fact a myth. This myth is based on ethnographic reports and clinical impressions. Indeed, there is a large number of studies which report that non-Western patients with emotional disorders usually present to doctors with somatic symptoms. But Mumford argues that there is a difference between the experience of somatic sensations and the expression of somatic symptoms. Therefore, ethnic differences in symptom presentation are caused by complaint behaviour rather than symptom perception. Given that a number of studies have reported high frequencies of culture-specific somatic symptoms in Nigerian psychiatric patients, Okulate, Olayinka & Jones's (2004) findings seem surprising. They found that somatic symptoms were secondary in Nigerian patients who suffer from depression. Their study sample consisted of 829 Nigerian Army personnel who were asked to anonymously complete the Patient Health Questionnaire. Women were excluded from the sample. The sample was ethnically, culturally and linguistically heterogeneous, because military enlistments reflect the ethnic diversity of Nigeria. In addition to the 13 somatic symptoms included in the Patient Health Questionnaire, the authors added other frequently reported somatic symptoms: heat or 'peppery' sensations in the head or body; heaviness or tension in the head; pain, emptiness or feeling of fluid within the head; and crawling sensations. Using factor analysis, the authors were able to determine symptoms of 'core depressive syndrome'. Most frequently reported symptoms in the core depressive syndrome were loss of interest or pleasure; feeling tired or having little energy; feeling bad about self, as if a failure; and trouble falling asleep or staying asleep, or oversleeping (Okulate et al. 2004: 422–424). Hands/body shaky was the only somatic

symptom that qualified for the list. Therefore, depressive feeling, loss of interest and loss of pleasure are far better predictors of depression than are the somatic symptoms enquired about. This finding is in line with the view expressed in other studies that depression can only be diagnosed with certainty if specific core symptoms are enquired about. Interestingly, in an international study sponsored by the WHO, Ibadan, in Nigeria, was the only centre out of 15 where somatization was found *not* to be significantly associated with depression (Okulate et al. 2004: 422–424). However, although somatic symptoms were not frequently associated with depression, they loaded more heavily on the other factors, which were labelled ‘head somatization’, ‘body somatization’, ‘brain-fag syndrome’, and ‘somatic anxiety’. The finding that there are few somatic symptoms among the core depressive symptoms is questionable, because the study sample was exclusively male. There is a greater tendency for women to use somatic language to express psychological distress compared with men (see e.g. Ebigbo 1986).

Based on the Self-Report Questionnaire (Harding et al. 1980), a psychiatric case-finding questionnaire, which was designed for use in developing countries, Patel et al. (1997) developed an indigenous measure of common mental disorders (CMD)¹ in Shona language. The Shona Symptom Questionnaire is an attempt to combine etic and emic approaches. The Preliminary Shona Symptom Questionnaire was developed in co-operation with primary care providers (nurses, traditional healers, village community workers and relatives). The preliminary questionnaire contained 60 items, including a number of somatic items. A total of 302 subjects participated in the study. The final version of Shona Symptom Questionnaire contains 14 items, half of which are emic items. Of the 14 items, only two are somatic (fatigue and stomach ache). This, according to Patel et al. (1997: 473), is in conflict with the findings of other studies, which suggest that common mental disorders in sub-Saharan Africa are characterized by somatic symptoms. Presenting somatization could also in some cases be explained by co-morbidity with physical illness. As Patel (1996: 742) notes, the exclusion of physical illness is an essential step in the assessment of patients with suspected mental illness. But a physical examination has rarely been done in studies undertaken in Africa. In a WHO primary care study, some patients who received a diagnosis of mental disorder presented with fever and cough. The investigators presented no data on the co-morbidity of physical disorders such as tuberculosis, but instead stated that “it seems that many patients assume that a physical symptom is almost a requirement in order to be seen at a health facility” (quoted in Patel 1996: 742).

¹ Common mental disorders are neurotic disorders presenting with anxiety and depressive symptoms. They are among the most common and disabling diseases worldwide. CMD are recognized as distress states in African countries, but they are rarely thought of as mental disorders (Patel 1996: 742–743).

CULTURE AND HELP-SEEKING BEHAVIOUR

It is a recognized fact that women suffer from psychiatric disorders more often than men. And yet in a Nigerian study, there was a 2:1 male-female ratio in psychiatric patients. A history of mental illness seriously impairs the chances of a single woman of attracting a husband. In Nigeria, somatization represents a defence mechanism whereby psychological distress is channelled into somatic complaints. Only when the stress increases to an unbearable extent would Nigerian women become acutely psychotic and need to be admitted to psychiatric hospital. Married women can better afford to seek help for psychological problems, and are therefore overrepresented in psychiatric care facilities (Ebigbo 1986). Similarly, Makanjuola and Olaiya (1987) argue that due to rigid cultural beliefs, misconceptions, strong stigma and taboos attached to mental disorders and psychiatric institutions in Nigeria, the majority of psychiatric patients would normally rather not consult psychiatrists. When they do seek help, they may present purely somatic symptoms, and mood disturbance may appear to be totally absent. And yet they respond well to antidepressants. The authors refer to these cases as masked depression.² A Zimbabwean study illuminates a myriad of reasons why depressed women would not discuss their emotional problems with primary care nurses. They said they did not talk to nurses about their problems, because they were not asked to; the nurses were busy or uninterested; the nurses could gossip and reveal secrets; Shona women are not supposed to discuss family problems with strangers, and because they thought the psychiatric nurse at the clinic was for "mad people". However, they did seek help from primary care clinics for their somatic symptoms (Broadhead & Abas 1996).

Phobic states have been rarely diagnosed in Africa. In a Nigerian epidemiological study of 1963, phobic symptoms were markedly absent. Morakinyo (1985) suggests that there are several cultural factors as to why in most cases of phobic neurosis patients present only somatic symptoms. The average Yoruba person strongly believes that there are people who appear harmless, but who may be potentially dangerous. In such a socio-cultural environment, it is common for a person to have fears of becoming the victim of witchcraft or sorcery. However, the Yoruba are reluctant to talk about witchcraft. Public accusations of witchcraft and sorcery are frowned upon. Adults, especially men, are not expected to readily admit to fear. These factors prevent the patient from verbalizing his fear.

² Kleinman (1988: 25) criticizes the use of the term 'masked depression', because it implies that underneath the social and cultural factors that shape the expression of the disease, there is a "real" biological disease.

Morakinyo studied the occurrence of phobic states in patients who had been referred to a mental health consultation clinic in Ile Ife. His sample consisted of fifty patients. During the first interview, the patients complained about bodily symptoms and sleep disturbance. Only in two cases was it possible to establish diagnosis and understand the underlying psychodynamics at first consultation. If after two or three consultations the diagnostic category had not been established and the patient appeared to have difficulty in discussing his problems, a drug-assisted interview was used. Morakinyo notes that fear of sorcery and witchcraft is an important psycho pathogenic factor, but finding out about these fears is difficult in most cases.

Among the Akan in Ghana, people suffering from mental distress seem to emphasize the cause of the problem, not the consequence. It is thought that once the underlying problem is solved, depressed mood or anxiety will disappear. As in most African cultures (see Patel 1995), depression and anxiety in Ghana are not seen as illnesses but rather as natural corollaries of stressful life situations. Jahoda (1961) studied traditional healing in Ghana in the 1960s. He categorized the reasons for visiting a healer as follows:

- A. Gynaecological and venereal disease
- B. Other physical
- C. Mental (acute behaviour disturbances attributable to organic or functional psychosis)
- D. Job, love and marriage
- E. Protection and ritual

The third category includes only serious mental illnesses characterized by abnormal behaviour. Patients falling into the fourth category, 'Job, love and marriage', are likely to also suffer from psychological distress. But instead of seeking relief for the symptoms of distress, they seek to resolve the situation causing the problem. It is also possible that some patients in the fifth category, 'Protection and ritual', suffer from anxiety or phobic states, but by drinking protective medicine they believe they are safe from witchcraft, sorcery and other dangerous forces. It appears that mental illnesses are not stigmatized to the same extent as in Nigeria, and I believe the main reason why Ghanaians seldom present psychological symptoms to a general practitioner is that they do not perceive such symptoms as pathological. Mental problems are seen as the speciality of religious and traditional healers. The Akan may seek biomedical care for the physical discomfort caused by the condition, but they probably would not present psychological symptoms unless the health staff directly enquired about them.

The emphasis placed on a cause of disturbance in Ghana is in stark contrast to the way Tahitians deal with sadness and depression. There are words for severe grief and lamentation, but there are no exact terms for the concepts of sadness,

longing and loneliness. People referred to a condition that in Western cultures would be recognized as depression simply as “feeling troubled”, as “not feeling a sense of inner push”, as “feeling heavy”, as “feeling fatigued”, and a number of other terms all referring to a generally troubled or subdued bodily state. These terms are all non-specific and carry no implications of what causes them. Levy calls these underschematized emotional domains ‘hypocognized’ as opposed to other emotion terms such as anger that are ‘hypercognized’ in Tahiti. Troubled feelings that persist too long after the death of a loved one or some other loss are often interpreted as illness or as the effects of a spirit. In many cases, the connection between feeling troubled, and what, from an etic perspective, seems to be the eliciting event, is not recognized. A young man whose girlfriend has just left him, taking their baby with her to a distant island, may diagnose himself as physically ill due to some extraneous cause. If troubled feelings persist, he may consult a spirit doctor who will help him identify and treat the spirit that has possessed him. There is often much collaboration by the community in reinforcing dissociation of certain kinds of causes from the man’s feeling. There are two kinds of knowledge: the covert knowledge, which recognizes certain events as loss and produces a feeling, and overt knowledge, which is associated with a culturally patterned evaluation of, and response to, the feeling (Levy 1984: 218–220).

EXPRESSION OF EMOTIONS

The way emotions are expressed differs across cultures. In many Western societies it is thought that grief caused by the loss of a loved one should be talked about as a way of healing. But there are a number of anthropological studies on different ways to cope with grief. Schepers-Hughes (1992: 270–271) describes how poor women in northeastern Brazil deal with child death. Once a young mother came to her carrying a very sick and wasted baby. Schepers-Hughes rushed the baby to the local hospital, where he died soon after. She wept bitterly all the way home as she was carrying the tiny body. But much to her surprise, the young mother took the news placidly, almost indifferently. Noting her tear-stained face, the mother turned to note to a neighbour standing nearby: “Poor thing! Funny, isn’t she?” What was funny to the Brazilian mother was the inappropriate display of grief and concern over a matter of so little consequence. The mother had not even expected the child to live. This kind of reaction to child death led Schepers-Hughes (1992: 359–364) to formulate a theory on maternal love. She suggests that mother love does not develop in impoverished circumstances where child mortality rate is high. Mothers distance themselves from the sickly children in order to better cope with the almost inevitable death.

Einarsdóttir studied child death and mourning among the Papel in Guinea-Bissau. Although every third child in Guinea-Bissau dies before the age of five years, Papel mothers do expect every child to survive. The death of a child is always a big tragedy for the parents. Mothers openly weep when they have lost a child, but later, they strive to forget the children they have lost (Einarsdóttir 2000: 153). While the Akan and the Papel share many customs and beliefs (e.g. giving children horrible names so that they would be too embarrassed to die and return to the other world, the belief that dead children are reborn, and the old practice of carrying the corpse to find out the cause of death), Akan women are not supposed to mourn when they lose a child. This is not due to maternal indifference, but to a belief that if the mother cries, gods will see that the child who died was very precious to the mother. Gods would then also take any future children of the woman. These beliefs have been integrated into the Christian way of life. A friend of mine, Amma (pseudonym), lost her only child, a four year old boy to typhoid fever. Since children are not considered complete human beings, they are not accorded a proper funeral. The body was taken from the hospital to the cemetery and buried the same day. Amma was totally devastated. The father of the boy lived in Italy, so he was not there to support his wife. For the following weeks, anytime I saw Amma, she was accompanied by her relatives. I was told a bereaved mother is never left alone, because she might try to harm herself. Amma always seemed sad and tearful, but she was constantly told not to cry. Her friends were citing passages from the Bible to console her. The boy had died on a Monday, and the following Sunday, Amma and all her relatives wore white dresses (the colour of joy) and went to church to give thanks to God. In other words, feelings of grief and depression are experienced by Akan mothers after child death, but they are supposed to be hidden.

In some cases emotions are expressed through non-verbal means. Smørholm studied the suffering of AIDS orphans in a poor township in Lusaka. After losing a parent, the children are not allowed to attend the funeral, and their guardians try to make them forget the deceased parent as soon as possible. Love and care are expressed through giving food to children and bathing them. When children were asked to draw a picture of a woman who has treated them well, they usually drew her cooking and themselves seated at a table waiting for the food. Because direct expression of grief, longing and discontent was discouraged or socially unacceptable, children often expressed their feelings through songs, role plays and stories. None of the orphans interviewed for the study complained about the way they were treated by their grandparents, whereas their mother's brother's wife was often described as someone who will mistreat orphans. These tensions are caused by the matrilineal system where a wife has to compete with her husband's sisters'

children for financial resources. These relationships are described in two songs often sang by children:

My grandmother loves me. My grandmother loves me. She cooks for me day and night;
she cooks for me day and night. Tea with sweet potatoes. Nsima with rape.

My mother's brother's wife, she denies me sweet potato, sweet potato bread. She
denies me sweet potato bread. (Smørholm 2005)

As shown above, emotions are not always verbalized, and in some situations they are suppressed altogether. Therefore, it is likely that individuals suffering from psychological distress caused by bereavement or some other stressful life event may well seek medical care for somatic symptoms when other channels of expressing distress are closed. Their somatic symptoms may well be real bodily sensations caused by intense grieving.

EMOTION TALK

In many African languages bodily metaphors are used when talking about emotions. Many non-Western languages do not have a word for depression, which has led some researchers to ask whether a particular experience is available to those who do not have the words to define it (Leff 1973: 300). According to Leff, in a number of African languages a single word stands for both being angry and being sad. Leff studied the linguistic differentiation of emotional states in conjunction with the translation of the Present State Examination (PSE) into Chinese, Czech, Danish, Hindi, Russian, Spanish and Yoruba. PSE aims to cover a full range of mental symptoms, but Leff focused on the sections on Anxiety, Depression and Irritability. Based on an evolutionary scheme of language development, Leff predicted that developed countries would show a greater differentiation of emotional states than developing countries. The countries in which symptoms of depression, anxiety and irritability had the highest correlation were Nigeria and Taiwan. Leff argues that these findings are further confirmed by the difficulties experienced when translating the PSE into Yoruba. The Yoruba words used for depression and anxiety are literally translated as 'the heart goes weak' and 'the heart is not at rest'. According to Leff (1973: 304), "it is evident that they refer to the somatic accompaniments rather than the emotional experiences themselves." Elsewhere, Leff has used the term 'primitive language' when referring to languages spoken in developing countries, and suggests speakers of primitive languages are not able to differentiate between emotions in the same way as speakers of Western languages (cited in Beeman 1985). Morice's study of the lexical categories of the Australian Pintupi Aborigines discredits Leff's argument. Not only do the preliterate Pintupi, who until recently were

nomadic hunter gatherers, have concepts of fear, anxiety, depression and grief, but their emotion lexicon is remarkably complex. They differentiate between 'fear at night', 'fear of specific objects' and 'general states of fear'. For instance, *nginyiwarrarringu* refers to a sudden feeling of fear causing the person to stand up to see what is causing it. *Ngulunyngulunypa* refers to extreme fear which implies watchfulness and some degree of immobilization: the fear of being killed. And *nyirrkinyirrkina* refers to being always watchful and alert, such as always looking out for snakes (Morice 1978: 89–92.) Although fear seems to be a hypercognized emotion due to the environmental threats experienced by the Pintupi, Morice's study nevertheless proves that speakers of non-Western languages do not have any difficulty in differentiating between emotions. Emotion concepts used in PSE or other psychiatric interview schedules may not be meaningful in all cultures, but that does not mean people in those cultures cannot differentiate emotions. Indeed, translation of psychiatric research instruments into African languages has proved difficult, because some of the emotion concepts either do not exist or are interpreted differently. Kortmann studied the content validity of the Self-Report Questionnaire (SRQ) in Ethiopia. The 24 items were carefully translated into Amharic. Ethiopian respondents were asked to comment on their Yes/No replies. Item 9 "*Do you feel unhappy?*" prompted a spontaneous comment from many respondents: "No, because nobody has died." The concept of unhappiness in Ethiopia is usually associated with the feelings of mourning. Item 10 "*Do you cry more than usual?*" was interpreted by many respondents as asking whether they had recently attended more funerals than normal. In Ethiopia, people are expected to attend funerals of everyone they have known, and they are supposed to cry there, whether or not they actually liked the deceased. In all, Kortmann reports that 40% of the affirmative answers were invalid either due to misinterpretation of the questions or trying to impress the doctor by giving more yes-answers than would be expected given the condition of the respondent (Kortmann 1990: 386).

Wierzbicka (1999: 273) notes that in many emotion studies there is a tendency to treat English emotion concepts as conceptual primitives and universals. Therefore, psychiatrists expect that once carefully translated, their research instruments can evaluate the mental state of people in all cultures. However, bodily metaphors and 'abstract' English emotion terms are equally valid expressions of emotional states. Beeman (1985: 220–221) dismisses Leff's evolutionary scheme and argues that metaphor is the primary method of expressing emotion in all but the most clinical settings. The body is ultimately the prime referent for all metaphor, and, furthermore, most 'abstract expressions' for emotional states derive from words that indicate physical functions of the body. A number of scholars have suggested that the apparent presenting somatization in

non-Western societies may be partly explained by the use of somatic metaphors which have been misinterpreted as somatic complaints (Bebbington 1993: 147; Mumford 1993: 232; Patel 1996: 742), but to my knowledge there are no empirical studies of African languages to support this argument. Although anthropological research on emotions is being conducted in all geographic areas, a disproportionate number of studies have been done in the Pacific. This reflects the traditional psychocultural emphases of Oceanic ethnography (Lutz and White 1986: 406).

AKAN SOMATIC METAPHORS

The Akan language is very rich in somatic metaphors. Most terms referring to emotions and character traits have a somatic referent. The word denoting body, *ho* (*nam*), can be found in basic questions such as *wo ho te sen?* 'how are you?' (lit. how is your body?) Nevertheless, the Akan do differentiate between concepts of body and soul. They believe that a human being is constituted of three elements: the body (*honam*), the life-soul (*kra*) and the personality-soul (*sunsum*) (Meyerowitz 1951: 24). In the following, I give a list of bodily metaphors classified by the locus.³

koma – heart

asem no ama me koma pa – this matter has made me happy (this matter has given me a good heart)

nya koma – to exercise patience (to get heart)

oyare koma – he is passionate, given to anger (his heart is sick)

n'akoma ye mmere – he is kind (his heart is soft)

n'akoma nye – he gets angry easily (his heart is not good)

n'akoma ha no – he is easily provoked (his heart troubles him)

ne koma atɔ ne yam – he is happy/at ease/cheerful (his heart has fallen into his stomach)

ebo – chest

ne bo atɔ ne yam – he is contented (his chest has fallen into his stomach)

ne bo da ne yam – he is confident, of good cheer (his chest sleeps in his stomach)

ne bo afu – he is angry (his chest has expanded)

ne bo adwo – he is contented (his chest has cooled)

³ Mr Justin Frempong first drew my attention to Akan bodily metaphors during the Ali Akan I course in Berlin in 1999. The metaphors on the list are derived from various sources: Christaller 1931; a vocabulary by Mr Frempong and my own enquiries during fieldwork in Ghana. Mr Joseph Amoah provided help with the orthography and translation.

ne bo hyehye no – he has a bad conscience (his chest burns him)

ne bo nyε – he is much given to anger (his chest is not good)

ne bo atu – he is in despair (his chest is uprooted)

ne bo awu – (1) he is not given to anger; (2) he is disheartened/apathetic (his chest has died)

ne bo yε duru – he is brave (his chest is heavy)

ne bo yε den – he is brave (his chest is hard)

ne bo nyε den – he is fearful (his chest is not hard)

ɔto ne bo ase – he has patience (he slows down his chest)

ɔnto ne bo ase – he is impatient (he does not slow down his chest)

ɔnya abotare – he is patient (he gets his chest together)

ho – body

ne ho adwiri no – he is greatly amazed (his body has broken down)

ne ho yε fe – she is beautiful (her body is beautiful)

ne ho yε tantan – he is ugly (his body is ugly)

koko – chest

ne koko yε duru – he is brave (his chest is heavy)

etiri – head

ne tiri mu yε den – he is wicked (the inside of his head is hard)

ne tiri mu yε sum – he is wicked (the inside of his head is dark)

ani – eye

n'ani agye – he is happy (his eyes have received)

n'ani nnye – he is unhappy, depressed (his eyes have not received)

n'ani abere – (1) he is in passion/rage/angry; (2) he is grieved, sorrowful (his eyes are reddened)

n'ani so biri no – he is giddy (his eyes are turning)

n'ani abu – (1) he is inactive, lazy, dull; (2) he is tired of waiting (his eyes are broken)

n'ani so da hɔ – he is modest, cool, considerate, wise (his eyes are clear)

n'ani da me so – he relies on me (his eyes sleep on me)

n'ani da ne ho so – he is self-conscious, acts deliberately (his eyes are sleeping beside him)

aso – ear

n'aso yε den – he is disobedient (his ear is hard)

n'aso yε mmere – he is obedient (his ear is soft)

n'aso nni agua – he is forgetful (his ear has no seat)

n'aso adwo/n'aso mu dwo no – he has peace/rest (his ear is cooled)

oyi n'aso – he is careless (he withdraws his ear)

n'agya asem da n'aso mu – he is mindful of his father's words (his father's words sleep in his ear)

n'agya asem da ne so – he is responsible for his father (his father's matters sleep on him)

yam – stomach

ne yam ye – he is kind (his stomach is good)

ne yam ye nwono – he is stingy (his stomach is bitter)

ne yam hyehye no – he is anxious (his stomach burns him)

nsa – hand

ne nsa mu ye – he is generous (his hands are good)

ne nsa mu go – he is generous (his hand is relaxed)

ne nsa ha no – he is a thief (his hand troubles him)

In some languages, emotions are seen as located in a particular organ or part of the body. For instance, the Chewong of Malaysia express emotional and mental states through the medium of the liver. They may say 'my liver is good' (I am feeling fine) or 'my liver was tiny' (I was very ashamed). For Tahitians, intestines are the seat of the emotions (Helaas 1986: 244–245). But the Akan refer to a number of different body parts/organs when talking about emotions and character traits. There is a clear logic behind some of the expressions, e.g. 'his hand troubles him' and 'his ear is hard', but in other cases the meaning of the expression is not so obvious. Some metaphors refer to a somatic sensation, e.g. 'his stomach burns him' and 'his chest has expanded'. Helaas (1986: 245) claims that when organs/body parts provide the loci, emotions are thought of as organic in nature. But I suggest this is not necessarily the case in Akan. When I was enquiring about emotion terminology, I tried to elicit also a literal translation of the expression. But some of my informants had difficulty translating somatic metaphors literally, and they kept pointing out that the literal translation is not the real meaning. When they say that somebody's chest has expanded, they talk about anger, not chests. According to Bebbington (1993: 147), most emotion expressions in English are based on somatic metaphors that are more or less dead. 'Depression' and 'anxiety' originally connoted a physical sense of pressure, and modern expressions such as 'I was gutted' carry unpleasant physical images that are virtually subliminal. Bebbington notes that it would be very easy to interpret similar expressions in an unfamiliar language as truly somatic.

CONCLUSION

Emotional distress is expressed in widely varying ways in different cultures and by different social classes within the same culture. There are a number of factors such as the fear of being stigmatized, and ideas about the cause and appropriate treatment of psychological problems that influence help-seeking behaviour. Patients who, by Western criteria, would be diagnosed as mentally ill may present only bodily complaints to a health care worker, but it does not mean they do not have emotional symptoms. Indeed, most patients in cross-cultural studies readily admit that they suffer from depressive mood and other mental symptoms once they are directly asked. The way people present their symptoms is shaped by culturally-sanctioned illness behaviour. Cultural concepts of health and disease influence the interpretation of distress, and language shapes the verbal expression of distress (Mumford 1993: 239). I have shown that Akan language contains a large number of bodily metaphors of emotions and character traits. But these metaphors have become abstract in the sense that many Akans find it difficult to translate them literally. It is entirely possible that a Western researcher with limited knowledge of Akan language could interpret these idioms as somatic complaints. While there is no specific word for depression in Akan, the closest expression being *m'ani nnye* (I am unhappy), it does not mean that Akans do not experience depressive mood or that they cannot describe it. Cross-cultural studies of psychiatric epidemiology should focus on the local language and idioms of distress. Mumford (1993: 233) uses Urdu idioms as an example to show how important issues of language and idiom are in cross-cultural research. The Urdu phrase *dil main dard* (pain in the heart) refers to a somatic sensation, whereas *mera dil dukhta hai* (my heart aches) is a somatic metaphor. A mistake was made when a south Asian patient complaining of *mera dil dukhta hai* was referred to a cardiologist.

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