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ILLNESS, SELF, DISCOURSE AND SOCIETY STUDY OF MUTUAL INTERDEPENDENCY IN THE CONTEXT OF MINANGKABAU CULTURE

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Abstract:
The topic of this article is connected with my field work in Indonesia within the context of Medical Anthropology. The aim of this article is to illustrate dialectical connection between concept of "self" and particular medical discourse and its treatment, while it reflects the importance of socio-cultural context which determine both this relation on its own and the form and content of the subjects of this relation. In addition it analyzes changes within one`s self which is influenced by assigned disease from one of the medical discourses which are present in the area of West Sumatra (western medicine, local ethno-medicine or Islamic way of treatment called ruqyah). The socio-cultural context does not play important role just in the process of construction of self and various discourses; hence in the end of this article I analyze the reaction of Minangkabau society when diagnose of mental disorder or spirit possession is given to an individual, to illustrate the further influence on the self of health seeker.

Key words: Self, Discourse, Disease, Illness

1. Dialectic Relation between Self and Discourses, Diagnosis and the Treatment

In the context of social constructivism it is important to emphasize that for experiencing of illness - among other factors - the particular way in which individual's self is grasped within the wider environment, both social and cultural, is crucial. In addition it is necessary to reflect its determination by a medical or religious discourse. Hence, this article I am going to open with the reflection of the concept of self as such. Self is the source of identity and its content correlates with social roles. It is a construct that is based on symbolic interactionism. Mead conceptualized it as a result of coherent interaction between "I" and "other." "I" interacts with "others" so it reflexively shapes/creates "me", which is understood as objectified "I". Self is then the result of interaction between "I" and "me" (Mead 1967).

During the internalization of a generally constituted self, the primary and secondary socialization play an important role. Therefore, the process of construction and the final form of the concept self needs to be related to the socio-cultural context, which is set in a historical framework. In anthropological and sociological theories, there are - midst others concepts - identified socio-centric and ego-centric self. In the case of socio-centric self, the boundaries between the individual and society that surrounds it are not fixed and coherent. For example some anthropologists revealed the cultural interpretation of an individual as compressed individual, who is de facto composed of several selves that reflect social relations, rights and social roles that can be found in particular culture (Scheper-Hughes and Lock 1987). In contrast, egocentric self is sharply delineated from the social surrounding. Such self is therefore understood as a closed, but still not isolated.

I am aware that the concepts of ego-centric and socio-centric self in its pure form do not appear in any socio-cultural space. Regarding this theoretical diametric contrast of the concepts of socio- and ego-centric self, I completely agree with Hollan (1992) who mentions that the sharp bipolar definition of so defined concepts of self are exaggerated. At the level of subjective feelings and experiences it is not possible to categorize and simplify in such way. Hence, we have to admit that it is more a theoretical tool that can be found in its pure form only and only in an ideal sphere. Ideality of these theoretical types can be illustrated on the boundaries of the individual and his/her self, which are different in various cultures. Consequently these boundaries are not identical and are not universally perceived by individuals within particular cultural contexts. In Western culture, the concept of personal space clearly extends beyond the body which is understood as the physical boundary that should match the border of egocentric self (Kirmayer, 2007). Similarly, the death of one's part of self, which is caused by the death of a beloved person, undermines the concept of egocentric self and its definition. Similarly then in societies where the theorists identified socio-centric self, the feeling of hunger resemble to purely personal experience of enclosed self (Holan 1992). With these concepts to some extent is related the social expectations from an individual. Shweder and Bourne argue that in socio-centrically oriented societies, the individual is suppressed subject to a whole; hence one behaves in the interest of good of the society. In contrast, in the self-centered oriented societies, one is transforming the environment on the basis of his/her ideas and focuses through surrounding society on his/her own goals and well-being (Shweder and Bourne 1984). But once again, it is important to note Holan and his argument that emphasizes the ideal nature even of this distinction (1992).

While analyzing these different constructions of the concept of self, the role of language cannot be ignored. There is an obvious function of language as a medium that facilitates communication itself. But in addition it is a media, which transmit this communication. It transform one`s utterance, based on the existing words, which are symbolic tools, that are available to both the speaker and the addressee (Kirmayer 2007). Already Shweder and Bourne were interested in the question, if there is some variance and differences in the ability to testify about personality and its particular aspects in some socio-cultural environments that are characterized by their specific way of perceiving the concept of self. In their article, they emphasize the critical role of language, which is based on specific grammatical and lexical components which do/do not provide sufficient tools for a particular expression, which is associated with one's self (1984)[1].

[1]Kirmayer further on elaborates other aspects - such as the language of emotion, the very category of diseases and psychological discourse in general - whose specific form is based on cultural concepts of mind, self and person (Kirmayer, 2007: 234).

Apart of this theoretical division of the constructs of self, the discussion about the universality of self introduces the universalistic concept of transcendental "self" in contrast to the culturally relativistic concept of variable self. The concept of the transcendental self is associated with the hypothesis of a universal and common essence. Consequently this hypothesis assumes that all individuals experience psychological illness, in the similar way. On the other hand, the culturally relativistic approach underlines the differences which are affected by different socio-cultural environment (Murray 1993). For example, the understanding of the individual and his/her self in Western culture is very specific and unique compare to other cultures. It is based mainly on the ideas of (1) Plato - thanks to his concepts of transcendental and unchanging forms; (2) Descartes - due to his dualistic division of the body and the mind/soul (which ushered the concept of a rational person who is aware of its own existence); and on the work of (3) Kant, who expanded western philosophy with the concept of transcendental subject and universal category of the mind that grasps and process knowledge (Murray 1993: 1).

With the topic of this article, there is one more important question, which needs to be answered. Whether it can be expected that there is the same or different understanding of disease and diagnoses in the different socio-cultural environment, where individual's self is built on different conceptual basis; and various medical discourses are present. "The heart is a pump and therefore it cannot be the seat of emotions or ancestral spirits." This fictitious quote points out that differences in the perception of specific parts of the human body are associated with different interpretations. Within the conceptual framework of biomedicine there is no room for anger of ancestors and vice versa within the discourse and society with a different perception of the body and its part, in the place which is designated for the survival of the spirit there is no space for aorta perforation.

Therefore, when considering the universality of the medical disease, it is necessary to admit that often automatically accepted theoretical axiom of the versatility of these diseases, which are anchored in the discourse of western medicine, is associated with an expected assumption of the universality of biology. But as Locke shows, this universalism of biology can be questioned, as she highlights the crucial role of "local biology" (Lock in Hinton and Hinton 2002: 160). Hence, through a broader perspective, it is necessary to accept the fact that biology and the ensuing biomedical discourse modifies universality of physicality. On the actual expectations of universality of biology, is in fact evident in varying degrees latent or manifest ethnocentrism and biological reductionism of biomedicine. Indeed, already Good points out the latent ethnocentrism of western medicine. Focusing on the language he argues: "Our understanding of the psychological and cultural dimensions of sickness and illness is limited not only by the lack of empirical knowledge, but also by inadequate medical semantics" (Good 1977:25). In a similar way, it can be concluded about the expected psychological universalism. "Cosmology, cultural context and created images do not only determine different form, but also content of the psychological experience of illness. Hence, it can be illustrated on the narratives of both the patient and the healer" (Lutz in Murray 1993: 7). This article is based on the approach presented by Holan, who emphasizes that one cannot expect a large degree of uniformity in the way people experience illness, and thus the focus should move more on the specifics and differences (Hollan, 2004: 76). Consequently, it is necessary to reflect these differences not only on the macro level - hence on the different cultural frameworks - but as well on the micro level and various subjective testimonies.

Despite the fact, that for the analysis of the individual's narratives I have used during my research the phenomenological approach and therefore I cannot apply on subjective utterances the concepts of ego- and socio-centric self, these concepts still proves to be useful starting point for the following discussion of their role and impact on the nature of different discourses and negotiated diseases. The process of negotiation occurs according to particular categorization which is bounded with methodology of chosen type of treatment. To what extent is understanding of a one's condition - that is within the biomedicine diagnosed as a kind of mental disorder and through the etno-medicine or cosmology of Islam identified as a possession - interconnected with the culturally defined concept of self, can be clearly see on the following paraphrase, that reflect the way of argumentation and interpretation of differently perceived disease. Concretely, I mean specification of the subjective experience, which is not seen by individual as his/her own, but rather is attributed to other external actor. In the context of biomedicine and psychiatry/psychology, when diagnosing a type of schizophrenia or dissociative disorders, expert deals with the split personality. Hence, this is obviously based on the concept of closed egocentric self (Kirmayer, 2007), which is understood as autonomous and integrated. Due to this specific perception of self, any experience of consciousness which is separated is seen as pathological (Seligman and Kirmayer 2008). On the other hand, discourse of Minangkabau's etno-medicine and/or ruqyah which is anchored in Islam, interpret this phenomenon based on self, which is not so strictly enclosed. Therefore, these discourses work with spirit possession, which appears as entering of other self to the body of possessed person. Thus, in one body can be discovered two different selves, or there may be an exchange of two self. In both cases is important to emphasize that these conditions are caused by an external actor, which may take control over the affected individuals and their selves (Seligman and Kirmayer 2008).

Hence, with the previous discussion above, I illustrated the influence of a wider socio-cultural framework and particular discourse and their diagnosis. Thus it is important to note that, for example, testimony of a patient from psychiatric clinic or a psychiatrist or psychologist is derived from one of the symbolic frame of references that is present in western Sumatra among other discourses of different ways of treatment. Therefore it can be concluded that the narration is not simply output "text" from the dialogue; it must rather be understood as a subjective interpretation, which is situated in a social context that shapes it (Kirmayer 2006). Consequently, Kirmayer in his later article points out other very important aspect: "If the concept of persons varies across cultures, the aim and methods of therapy must also" (2007: 233). However, if one applies a method of psychotherapy that is influenced by a perception of self, he/she must then reflect the nosology of applied biomedical discourse and/or local ethno-medicine.

Once the interdependence of discourse, diagnosis and socio-cultural environment has been discussed, in following pages I am going to focus on the various points of view, that reflect and interprets the change of one's self which is being confronted with an health disorder and following treatment chosen from one of the present discourses.

2. The Change of Self of "Sick" Person

The individuals, with whom I conducted interviews during my research within the framework of biomedicine, were located in the premises of the mental hospital - Rumah Sakit Gadut. Hence, the patients were living there, aside from the society. On the other hand in the case of treatment by ruqyah or dukun individuals, who undergone the treatment, could be exposed to public. It reveals an interesting point. In the first case "madness" is by one discourse hidden behind the walls of the asylum, whereas the possessed person and the treatment are demonstrated. The logic of a mental hospital is therefore to hide and treats in enclose clinic, while the important latent element of exorcism is associated with the exhibiting of the phenomenon of possession, which can strengthen religious faith and amplify the fear of external supernatural dangers.

However, in both cases it is important to reflect the fact that the actual assigned diagnosis and treatment, which is in the case of biomedicine associated with the institution of clinic, affects one's self. Given diagnosis is creating a new perspective through which individual looks at him/herself, thus it modifies their selves (Keyes in Witztum and Goodman 1999: 405). In the following pages I am going to discuss the change of the patient's self or the possessed individual from two theoretical positions. It results from theoretical approach of Goffman, who focus on the impact of institutions; and Kapferer, who rather discusses this change from the subjective level[2]. While Goffman's theoretical approach focus on the role of an institutions and external environment, which "kills" patient's self; in the case of Kapferer's attitude, it is the abnormality itself, or self of jinnee that can alter the patient's self or the one of possessed person.

In the case of the first approach what can be interpreted as homogenization of individuals, Goffman calls "the concept of civil death." This is a process when the patient is subject of the constant pressure of a total institution. It is primarily presented by humiliation, degradation and dehonestization of the patient's self. Thus the result of this systematic pressure is "death" of the individual's self (Goffman 1991: 24). Thus the multiplicity of social roles in everyday life is imitated. Consequently, the insolation allows creating of unified "rags" rather than a heterogeneous group of people ... "(Goffman 1991: 25). In addition on this process - of the creation of a patient with minimal individuality - a specific kind of initiation ritual can be seen (van Gennep 1960). This initiation then involves both the body and identity of a person who undergoes the treatment.

The long-term stay in a psychiatric clinic and its environment, consequently leads to re-socialization, which is based on the logic of this specific place. The re-socialization is deteminated by both the structure of the institution; and by the staff and doctors, who are very important actors in this process. All these elements become factors that are putting pressure on the individual to accept the new environment. This specific process of re-socialization is not dependent on the success of treatment. It is more an institutionalized socializing pressure on the patient's own self (Berger and Luckmann: 1967). The patient gradually adapts to his/her new role or is trying to resist and oppose it. The mentioned institutional pressure is totally absorbed by one's self at the moment when all regulations are accepted and mindlessly followed. This then can in extreme create an inmate of a clinic. But in case of the inmate it is necessary to distinguish two dimensions:

1) Re-socialized individual is no longer able to live everyday life back in the society, which based on other rules and has a different structure then total institution.

2) As an inmates can be understood an individual who accepts (not necessarily internalize) environment of the asylum; and in this specific environment he/she wants to stay mainly due to - for him/her - unbearable stigmatization which would be connected with a negative reaction of Minangkabau society.

In the case of possession and the associated treatment any institution that would correspond to the total institution as such cannot be found. But still it must be reflected that the diagnosis is analogy of total institution in a way. It changes an individual's self by prescribing an objective qualities of spirit possession. It has very strong normative aspect. Besides, as I am going to discuss in the following part, individuals face the changing attitude of surrounding social environment, which is connected with increasing disciplinization that consequently leads to a change of the self of possessed individual.

Kapferer (1979) focuses on the change, or better loss of self as well, but his approach is based on a completely different positions. His article is devoted exclusively to the loss of self during spirit possession, but later in this text I apply his approach on the cases of mental disorders. According to him, possessed person loses the complexity of his/herself too, but compare to the previous Goffman's theoretical approach, where the total institution was the active element causing the change; Kapferer describes a process in which it is the demon that is identified as the active element, which brings the change of the possessed individual and his/herself. It is expressed by the mean that the self of possessed person finds itself in the world of demons and is under their control. This happens as one's "I" stops interacting with others and instead of that interacts with the demon; thereby it is changing "me" and soaking deeper into the demon's world. Thus the final form of self, which is immersed in the world of the demon, is created by this affected "I" and "Me". Subsequently, the possessed individual is not only cut off from the rest of the society, but also the variability of his/herself is limited just to a single one - the demonic self (Kapferer 1979). The interpretation in the Minangkabau culture is to some extents different. The perception on the spirit possession of local etno-medicine and/or ruqyah brings idea of the replacement of self or multiplicity of selves. For example I have encountered a woman who was possessed since her childhood by jinnee who felt in love with her. In this case it is very remarkable, that due to this long-term presence of jinnee in her body, the woman did not felt herself once the jinnee was expelled. Even though she could not get pregnant because of his presence, her sense of incompleteness and dissatisfaction eventually led to the point when she asked the jinnee to possess her again. Hence it is obvious that over time there has been a profound interconnection of her and jinnee's selves.

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[2] Interesting aspects of the changes of one's self are analyzed by Foucault (2003). He focuses on the additional means, which are prescribed to the abnormality – such as monstrosity, treat to institutionalized practices etc. In addition, the question of interlacing of psychiatry, psychology and the law is broadly discussed by Foucault in his famous book Abnormal (2003). Midst other he illustrate on the example of French history how psychology became arbiter of (ab) normality and therefore its diagnoses became imported into the discourse of law.

As I prefaced, I assumed that, the Kapferer's analytical approach on the subjective level to the process of loss of one's self complexity can be applied on the change of patient's self who suffers from a mental disorder. If we accept the egocentrically constituted self and diagnosis which are derived from it, hence are connected with an idea of the bifurcation of self, we can illustrate that the interaction between the "I" and the "others" or "I" and "me", is based on "I", which is influenced by the presence of internal mental disorder. The resulting abnormal self is then altered by the particular mental disorder, which conditioned the constitution of patient's self. Thus, diagnosed mental illness interferes with the integrity of the self.

It can be illustrated on the case of Tourette's syndrome. Sacks writes about utterances of a patient that personifies this syndrome in a constantly present "it" that affects the individual's self and is independent of his will. In his book Sacks (1985) describes interesting story of Ray, who surprisingly was afraid to live without his disease. Tourette's syndrome - that according to him made him to be a set of tics, under which Ray himself did not expect his own self – provided him with a different state of consciousness and even existence. Thus during the "successful" treatment, Ray experienced a fear of losing his sense of being, which was biased with the abnormality that was caused by the disease. Ray was afraid of living without his disease. The treatment kept him within socially accepted/acceptable boundaries. He found himself back in line but his beloved musical "talent" that was caused by the Tourette syndrome, gradually disappeared. As a response to this situation, he found his own way out between the state of health and disease. During working days he was undergoing treatment that inhibits his "talent". He called it "Halad state[3]". These days his disease and its symptoms abated, but it as well meant withdrew of his ability of musical improvisation. By his words, he became deaf and without feeling of the music. With the healing the music left. He compensated these successes in treatment, when he became normalized and calm, during the weekend when he discontinued the treatment. Thus he could temporarily enjoy his lost spontaneity, wildness and music talent.

Similar negotiation between "I" and "it (the disease)" can be point out on the example of patient who was diagnosed the Asperger's syndrome - that is one form of autism. This attitude described by a patient forward her diagnosed is discussed by Sacks (1995). He met a woman who became "one" with her syndrome and she said that, despite the fact that there would be a cure for her disease, she would not take it. Her - through medical discourse described - disorder has become a part of herself. She did not want to accept any treatment, due to the existential fear of adverse changes of herself. Her illness has become a part of herself. She presents and experiences her negotiated identity as autistic. She is autist. Performativity of her personality then mirror the social expectations that result from the social representation of the diagnosed disorder.

In addition it is necessary to discuss various kinds of treatment as they reflect the determination by differently perceived concept of self. In the case of traditional medicine, which is discussed by Kapferer, the ritual of exorcism focuses on the possessed person's "I" and re-establishment of interaction with others during performing a comedic theater play (Kapferer 1979). But the exorcism in West Sumatra is in many ways different. It rather focuses on the jinnee's self. The jinnee is expelled from the body of possessed person by reading the Al-Quran (in case of ruqyah). Hence it can be assumed that the complexity of possessed person's self is brought back by reading of the Al-Quran. Voice of ruqyah, which mediates the word of Allah, then serves as a guide for the lost or suppressed self of the possessed person. In contrast, in the context of psychiatry and various dissociative disorders, an important moment for successful treatment is that individual admits or accepts presence of his/her disease. Therefore, it can be assumed that the patient with dissociative disorder may re-join "separated" part only if he/she reflects the presence of mental disorder and accept its impact on his/herself. It means that the awareness of patient and his /her deeds are partly the mean of treatment.

3. The Social Dimension of Abnormality

Already in the introductory section of this paper I quoted Murray (1993) who suggests that the story of illness is influenced by the social environment of the affected individual. Hence, in this section, I am going to focus more on the reaction, which Minangkabau society adopts forwards to a certain assigned diagnosis. It is because this reaction enriches the discursive construct of particular diagnoses with its social dimension. In the Minangkabau society there, can be found diametrically different approaches to the person with assigned diagnosis of mental illness or spirit possession. While negative perception on mental disorder resemble to despised "madness"; phenomenon of spirit possession does not.

Therefore individuals with an assigned diagnosis of mental disorders are in this society strongly stigmatized. The actual stigma is based on stereotyping and is associated with certain expectations connected with its bearer. As Goffman states: "By its definitions, of course, we believe that an individual with a stigma is not quite human (1990: 15). Once an individual is given a particular diagnosis and undergoes the chosen treatment in a mental hospital, after he/she returns back to wider society, his/her self becomes gradually again complex but it gains a new component - an invisible mark of the institutions and diagnosis – the stigma. This additional quality consequently becomes part of one's self. This process might be underlined by, what Bourdieu called the fatal effect of stigmatizing category. Thus, it is the situation when the individual who is dominated by the stigma, sees him/herself through this category and accepts its validity (2002). The mentioned social exclusion and segregation of mental diseases is also apparent in additional aspects such as physical avoidance of psychiatric clinic and "crazy" people (orang gila). It reflects the fear, which comes from expected infectivity of madness[4].

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[3] The name comes from the medicine he took.

[4] This presumption of infectivity of "madness" is strongly anchored in the lay awareness of Minangkabau society. This assumption has similar characteristics as the interpretation of the process how one is getting ill when suffer from bacterial infection in lay discourse in Western society. In the case of both the spirit possession which is caused by a jinnee and the invasion of "germs", these entities are not inherent to the human body, can live within the individual, but not outside society (Helman 1978).

With the allotted stigma might be connected very important additional layer - a sense of shame, which might be felt by both affected individuals and/or their close social surrounding. This feeling of shame – often presented in the family – can be explained on the basis that the visit of a family member and the consultation with any provider of treatment is associated with assumed abnormality of that individual. Thus, the following negotiation of particular diagnoses might be interpreted as a concrete example, which reveals the imperfections of social relationships that surround the affected individual. Hence, this aspect is to some extent connected with mentioned socio-centrically perceived self and its interconnection with social surrounding.

In contrast to the tendency of exclusion and stigmatization of diagnoses of mental disorder that is present in the Minangkabau society, the almost diametrically opposite approach to individuals, who has been given a diagnosis of a spirit possession, can be found. Due to the fact that one of the factors which is assumed to cause a spirit possession is loneliness and/or "empty mind" of the possessed individual, social environment inclines - after a successful exorcism - to reestablish his/her previous social bounds as intensively as possible in sake to minimize the previous solitude. In addition the individual is then accompanied to the places which might be connected with expected threat, or he/she is urged to practice prayers, which provides a protection against the jinnee. This effort to minimize the risk of any further case of possession, once again illustrate a reflection of the social environment, which is aware of the fact that social environment can have an impact on the actual condition of the individual, and therefore in some way may weaken his/her self, which is then enfeebled when confronted with self of jinnee. This social reaction should then be understood as a form of supervision. An individual who suffered from a spirit possession is forced to pray, which supposed to protect and consolidate his/her self, but also the performance of this prayer acknowledges that in the individuals the jinnee does not dwells anymore. Hence the emphasis on prayers is both an attempt to integrate possessed person in wider social networks; and a tool of disiplinization. Thus the cured individual is through various social practices constantly made "visible". He/she becomes a subject of Panopticon and a process of normalization and disciplinization. Consequently this leads to internalization of the social surveillance in the form of micro-discipline (Foucault 1991) which means a further change of one's self.

In the end of this article I would like to mention in minor, one additional aspect, which might enrich the discussion about the mutual dependence of illness, disease, self and society. Due to the negative perception of "madness" - which in everyday Minangkabau language corresponds with any diagnosis of mental disorders – and awareness of this fact, subjective narratives associated with the alleged spirit possession can be seen as a kind of defense against social exclusion, which might follow by the assignment of the diagnosis of mental disorders. Thus, this navigation during the negotiation of disease is directly stated in an utterance of one respondent, who claimed, that she suffered from "the real possession" compare to the other, who – according to her - made it up. Hence it reveals that the phenomenon of spirit possession can be used as a symbolical tool by individuals while they are being confronted with unpleasant situation or as a way of apologizing and justifying of their behavior.

4. Conclusion

With this article I discussed the interlacing of the concept of self, illness and disease, which is understood as a socio-cultural and historical phenomenon (Good 1977); and diagnosis and particular medical/religious discourses, which are perceived as a social constructs (Sudnow 1967). Hence, within a context of Minangkabau culture, I tried to illustrate on concrete example of spirit possession and mental disorders, which are analyzed through various theoretical lenses, that social and cultural context play a crucial role in the dialectical relation between the concepts mentioned above. In addition, in the process of negotiating and assigning the disease, I demonstrate the change of self which is caused by the given diagnosis; by chosen discourse and its specific treatment; and by reaction of surrounding society.

I hope that this analysis of interconnection and mutual influence of illness and one's experience of health disorder based on his/her self – thus analysis of subjective level – and impact of discourse and socio-cultural frame from the general level provides an insight in this complex network of biased relations which are determinated by their components.

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