COPING IN TWO CULTURES: AN ECOLOGICAL STUDY OF MENTALLY ILL PEOPLE AND THEIR FAMILIES IN RURAL SOUTH AFRICA

THESIS

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ABSTRACT

This study explores severe mental illness in a South African rural district, moving, as with a zoom lens, from the macro-perspectives of (i) Xhosa culture, and (ii) biomedicine, to the lived experience of the individual. Its methodology, predominantly qualitative, employed anthropological and psychological procedures. The fieldwork (1988-1989) encompassed a three month stay in the village of Msobomvu. Patients continued to be tracked informally until June, 1995.

The empirical research has three parts. In part one, the person with a mental illness was contextualized within Xhosa cosmology and social attitudes. The cognitive and social ecologies were tapped through the narratives of high school and university students at different stages of a Western-biased education. Social attitudes regarding mental illness, and confidence in treatment by traditional healers and the hospital, were also evaluated. Traditional attitudes and supernatural beliefs of illness causation persisted in spite of Eurocentric education, with a concurrent increase in the acceptance of Western-type causal explanations commensurate with continued education.

Part two considered the the patients in relation to (i) the biomedical framework (the mental and local hospitals), and (ii) their readjustment to the community after hospitalization. Data came from patient charts, interviews

with medical staff, and follow-up visits in the villages. Socio-political and economic issues were salient.

Part three case-studied people identified by the village residents as having a mental illness. Resources for treatment--traditional healers, mobile clinic, and village health workers-- were the focus. The traditional healing system, and biomedicine, were compared for effectiveness, through the course of illness events. While biomedicine was more effective in containing acute psychotic episodes than treatment by the traditional healer, lack of appropriate resources within the biomedical setting had disastrous results for patient compliance and long-term management of the illness, particularly in people with obvious symptoms of bipolar disorder. The mental hospital emerged as an agent of control.

While Xhosa culture provided a more tolerant setting for people with a mental illness, the course of *severe* mental illness was by no means benign, despite research suggesting a more positive outcome for such conditions in the developing world.

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SECTION I

INTRODUCTION AND ORIENTATION

"*Ukushlola, iyashlola*: sometimes when we hear the howl of an owl we say *iyashlola*, it is predicting something bad which is going to happen."
"What do you do when that happens?"
"people will take sticks of fire and throw them at the owl so that the owl will go away... or kill it."
"I told you the story of the owl getting into the house, what would you say?"
"That is bewitchment to us."
"So what would people do?"
"They would protect themselves, go to an *igqirha*. He would say what was going to happen."[1]

[1]A conversation I had with my interpreter.

CHAPTER 1

LISTENING TO THE DRUMS

Same Space Different Worlds

The transformation that occurred for me through the two hour journey from the context of the predominantly white Rhodes University to the erstwhile Ciskei and its many villages can be likened to the Xhosa's immersion in the river of the *thwasa* person (the one who is called by the ancestors to become a healer), where a different world is confronted.

I entered and left this world many times, and the more I became immersed, the wider the spaces separating these two worlds appeared. The geographical location of Alice, the Amatola basin, and Msobomvu, which I used to know as the farm of Gwali below the Hogsback range, when I lived there between 1969 and 1972, were all familiar and very much part of my life, but I had come back not to listen from the distance to the drumming, but to enter now and try and understand its meaning. Vera Buhrmann, at the 5th National South African Congress of Psychiatry (1987), started her presentation with the following words:

> My question to us is, those of us in the healing profession, do we hear the drums? Do we hear our black colleagues from Africa, hear our black patients, and do we really understand what they are trying to communicate to us?

Although in the early 1970's I had the desire to understand

this other world, sharing a geographical space does not mean sharing the same world, particularly in South Africa, where socio-political barriers have reinforced the walls around cultures. The dead owl in the water-tank was at that time an ominous reminder of a starker world. The barn-owl which I had admired for its natural beauty, was for the people with whom I shared a geographical space, a sign of bewitchment.

Living at that time in the Amatola Basin opened a door and provided a glimpse into a world with little predictability. My family and I were at the mercy of nature to provide enough rain for personal needs but not so much as to cut us off from the town nearby. There were times when the white, ghost-like faces of the boys from the circumcision school jumped out of the bushes, and then there were always the barn-owls, hooting and hunting.

While we crossed the same river as our Xhosa neighbours and listened to the same flock of ibis calling across the veld, there were still fundamental differences between our worlds: when our infant daughter was struck by some mysterious fever we climbed into our car and drove the 800 miles to Johannesburg where we had pre-arranged an appointment with a paediatrician. When the going got rough we would flee from this Third World to the safety and amenities of the white First World. We drew our drinking water from our catchment tank, and our black neighbours fetched it in buckets from the

polluted river.[2]

The differences in experiencing became clear to me when I had a *sangoma* (a diviner in Zulu) throw the bones for me at the first "witchdoctors'" conference in Johannesburg some years after returning from the Ciskei to live in the big city. Through the eyes of the *sangoma*, my life story took on an African form. My concerns with self-actualization became those of bread and travel, my curiosity about what it would be like to have sons and not only daughters became the shame of lacking a boy-child, and my existential anxieties became the fear of sickness of the stomach.

It is, therefore, experience which informs cosmology and in turn cosmologies which shape experience. The contrasting cosmologies of Western and indigenous cultures recur as abiding themes in this thesis.

Defining Terms and my Frame of Reference

The overall aim of this thesis is to explore severe mental illness in a society caught between two cultures, one whose illness concepts are framed in the terms of a non-intentional, mechanistic model, while those of the other, by contrast, have

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[2]I want to dissociate myself from any interpretation of terms like "First World," "Third World," "developed" and "developing" worlds as suggesting that these different "worlds", which exist side by side and intermingle in the South African context, can be seen as separate. Boonzaaier & Sharp (1988) point out how much the underdevelopment of the "black" areas was orchestrated by the dominant and industrialized white sector.

human intention and the participation of the supernatural as an integral part of the culture's explanatory cosmology.

Few black rural communities in South Africa have remained untouched by the dispersing impact of migrant labour, relocations, and general political upheaval. These processes have tampered with their natural roots, throwing them into the maelstrom of different influences. This raises the question as to what they have become, and for those who are troubled with disease, what interventions, Western, indigenous, or hybrid, are proper to their needs. There is no room here for Western romanticism when probing the ecology of mental illness in the harsh reality of the black person's world. It has been my commitment, in entering this world, to put aside preconceptions as to the value, positive or negative, of Western or indigenous resources available to those identified by the community as having a mental "illness" that sets them apart.

My goal has been, therefore, to understand how the community, the family, and the sufferer him/herself, perceive and explain what ails them, and what needs to be done. I have attempted to appraise the resources available and how these resources are made use of by those relevant persons in the ecological context of the patient.

The research is rooted in my long-standing interest in schizophrenia as seen in my Master's dissertation (Cumes,

1978), a seven year involvement with a residence for people with mental illness (1981 to 1988), and finally, an investigation of the treatment of mental illness in the community, which took me to three continents (Cumes & Cumes, 1986; 1987a; 1987b).

The title of this thesis focuses on how the person with severe mental illness and his/her family managed life given the resources available in the context of rural existence, in what was formerly the Ciskei, where context is the key word.

The expression "severely mentally ill" was chosen with some reservation, since there are certain problems inherent in it, one being the concept of illness. For example, certain forms of psychotic behaviour according to the traditional Xhosa view are seen as indicating a special calling (*ukuthwasa*), rather than as evidence of illness. There are considerable problems diagnostically, because there are radical differences between Western psychiatric practice and the indigenous conceptual framework through which mental illness is explained. A narrow focus on schizophrenia per se has been avoided since there is no simple diagnostic equivalent, despite its primacy in the literature of psychosis, worldwide.

In the clinical literature there has been debate around the terminology used in relation to mental illness. The expression "chronic mental illness" has been criticized for its pejorative connotations (Harding, Brooks, Ashikaga, Strauss, &

Breier, 1987); it was felt that this term pre-judged the outcome for the patient and that incurability was not the inevitable course of the condition. The phrase "severely mentally ill" is the descriptive concept that distinguishes longer-term mental illness from brief acute episodes. The latter are often linked in the African context to specific factors such as nutrition or substance abuse (Allwood, 1986).

Western treatment approaches have in the past taken on a dichotomized form, falling either into a romanticized view of schizophrenia, usually adhered to by the novice graduate, or the establishment's medical model. The day-to-day living with people who have a severe mental illness in the psychiatric residence highlighted for me the need for a realistic and appropriate approach to severe mental illness, correcting the often destructive impact that psychological theorizing has had on the patient and his/her family. This has been particularly notable in the history of theory and research related to schizophrenia, as seen in a number of terms, ie: the "schizophrenogenic mother" (coined by Fromm-Reichmann, 1952), and the "double-bind" (Bateson,, Jackson, Haley, & Weakland, 1956). These terms implied that the family drives the person to schizophrenia (McFarlane, 1983). With Laing's publications the schizophrenic was trumpeted as the hero and martyr of the 1960's and 1970's, and the patient was perceived as having a clearer vision of reality in an insane society (Laing & Esterson, 1970). Psychologists were at odds with the psychiatrists and geneticists of the time, who were doggedly

medicating patients and searching for biochemical causes (Torrey, 1983).

Thus over 30 years after the depopulation policy of the mental hospitals in the United States, the thrust in the Western world towards severe mental illness is on the treatment within the community and the strengthening of community resources (Segal & Aviram, 1978). South Africa is lagging behind as concerned professionals reported at the 5th National Congress of Psychiatry in 1987[3].

On 17th October, 1987, a public meeting for relatives and friends of people suffering from schizophrenia was held in downtown Johannesburg with the aim of launching support groups. While there was a fair attendance of whites, very few blacks came. This raises the question of the community's perception of what was being offered, and to whom it was offered.The term "schizophrenia" belongs clearly to Western psychiatry and is not universally accepted by the black community, even in the city. The problem is not always helped

[3]Haysom, Strous & Vogelman (1992) express concern about patients' rights in relation to involuntary confinement and treatment, whereas in the US at this stage the pendulum has swung in the opposite direction, where thinking practitioners and the public question whether the supposed serving of the patients' rights is to their detriment. These authors rely on research done in the 70's, which they consider as recent information, but fail to mention more contemporary findings (Rose, 1988; Torrey, 1995). Their position needs to be understood in the light of the quality of care and monitoring (or rather lack thereof) which bio-medicine provides for patients with mental illness in the black population.

by expanding the number of black professionals,[4] since they often appear to have bought into the Western system. The situation is no longer one when, as documented by Laubscher (1937), black communities tended to hide their psychotic members in case mental health professionals might take them away to the hospital and thereby interfere in the hallowed customs deemed necessary to rescue the individual from insanity. There is still the concern, however, that although the mental hospital is seen as necessary to control the patient, the real problem, insofar as it relates to supernatural causal assumptions, is not addressed. In fact, the patient's well-being may be further compromised because the hospital, unlike the traditional healer, is seen by the patient and family as unable to protect the person from malignant forces. Besides having done much damage, the ethnocentrism prevalent in biomedicine has prevented the establishment of appropriate and cost-effective care.

The Contaminated Water-well

Certain branches of psychology in southern Africa, particularly of Jungian (Buhrmann, 1984) and phenomenological (Schweitzer, 1977; Thorpe, 1982) orientations, have broached the issue of cultural differences between Western and

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[4]Swartz (1991) describes the complexities of the black clinician (usually a psychiatric nurse) in relation to bio-medical discourse. Traditional medicine has at times been associated with the stigma of backwardness, and black hospital staff are often resistant to cultural interpretations, since this has been fraught with political overtones.

indigenous concepts of mental health. However there is a tendency to romanticize the traditional system, forgetting about the socio-political and economic backdrop to people's lives. We are invited to share the ritual, the healing images of Africa, while forgetting the contaminated water-well.

Statistics on infant mortality rates (Omond, 1985), amongst others, tell us how little black society can take for granted regarding the control its members have over their life circumstances. There have been attempts at integrating traditional healing and Western medicine and providing a cooperative community health service (Oberholzer, 1985), but by and large the chasm remains (Thorpe, 1982). The question of the professionalization of African medicine is a complex one, and hides "assumptions which have to be addressed" (Kottler, 1988).

It is here that psychology has something to learn from anthropology. While psychology became obsessed with being scientific, anthropology has remained close to its subject matter. Lamb, in his forward to Estroff's book, *Making it crazy: An ethnography of psychotic clients in an American community*, says:

> What is the everyday world of the psychiatric patient really like? If we try to understand it within the context of our own experiences and our own frame of reference we can easily misconstrue and misinterpret most of what we see. But living with clients in their world, as Estroff did, gives us a whole new perspective. Further she tried to approach her task without preconceived theories, letting the patients determine what was and is important to learn and understand (Lamb, 1981, p.IX).

Since this thesis is concerned with a holistic point of view, the methods chosen are more closely aligned to anthropology than to the conventional methods of experimental psychology. The importance of a relationship between psychological and anthropological research has been recognized at Rhodes University and cooperative venture was started with the aim of doing community research. This recognition came at the time from a phenomenological orientation, which is concerned with the individual's primary lived experience of, and situatedness, in the world, as its starting point (Kruger, 1988, p. 2).

Anthropology has at its disposal, with its carefully documented descriptive methodology utilized in ethnography, a variety of flexible research techniques including participant observation, interviews concerning life histories, charting kinship, as well as more formalized questionnaires (Crane & Angrosino, 1974). Anthropology is probably the discipline related to psychology most expert at systematic field work of a more qualitative kind. Werner and Schoepfle (1987) describe ethnography as the necessary prerequisite to any subsequent investigation, similar to charting a map. It attempts to give the insider's point of view of a culture. The ethnographer relies primarily on observation (participant observation) and conversation (interview). The ethnographer needs, while understanding the *face value* meaning of words and texts, to go beyond it to a deeper understanding of the speaker. Systematic field work of this kind is eminently suited to going back to

basic description since its flexibility makes it adaptable to unforeseen situations.

While psychology, psychiatry and anthropology (and this includes their various sub-disciplines), address the experience, the causation and classification of mental illness in their own specific ways, their individual focus needs to be considered through the grand strokes of their historical allegiances. While psychology was caught up with aspiring to the status of a science, and psychiatry with its competitive relationship to general biomedicine, anthropology seemed less encumbered by Western ethnocentrism, at least in so far as its methodology was concerned. When, however, it came to subject matter in the study of cultures that seemed psychological in nature, psychological anthropology imported established psychological theories and concepts. It is only with the re-emergence of cultural psychology that a true inter-disciplinary approach has emerged, though it seems to me in my reading that it speaks more through the voices of anthropologists than psychologists. Richard Shweder is one of its most prolific and thought-provoking exponents who challenges Western thought, and psychology specifically, to take careful stock of its privileged perspective and its preoccupation with distilling abstract universal principles, like the medieval alchemist extracting gold (Shweder, 1990; Stigler, Shweder & Herdt, 1990; Shweder & Sullivan, 1993). Cultural psychology is the study of "intentional persons" in "intentional worlds," also described as "psyche and culture

making each other up." It has the flavour of a *teleology* which used to be frowned upon in my under-graduate years when we were training rats in mazes.

Mental health too cannot be conceptualized in the abstract, separated from the context in which the individual exists. There is no mental illness that is culture free. I subscribe as a working definition[5] to Romanucci-Ross, Moerman & Tangredi's (1991) notion of culture as "...the system of meaning--belief, knowledge, and action--by which people organize their lives" (p. X). These authors continue to say that such organization structures the diseases to which people are subject. They note that diseases are never experienced directly; people experience the *dis-ease*[6] in a form offered to them in accordance with their culture's constructs. The issue of illness experience and the *underlying* disease, particularly as it pertains to mental illness, presents a philosophical stumbling block for those who try to avoid the dualism and reductionism of biomedicine (see Shweder's critique of Kleinman in Shweder, 1991).

We are positioned in an era when we cannot escape self-conscious reflexivity when crossing cultural and ethnic

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[5]I speak of a working definition only, because I believe that Culture is more than Romanucci-Ross implies. This definition was chosen in that it is pragmatic and eschews the theoretical polemics.

[6]The term *disease* has been broken down into the hyphenated *dis-ease* to emphasize, as do Romanucci-Ross et al., 1991, the subjective experience of the sufferer.

boundaries, particularly those involving the developing and developed world. A history of arrogance and exploitation in the name of knowledge and progress has finally caught up with us. We can no longer muck around blissfully in exotic places without conflicted conscience, as anthropologists, according to Shweder, loved to do. Disciplines prefaced by "critical" as in critical anthropology, or critical medical psychiatry are the order of the day, challenging the motives and relevance of researchers and their projects. Strong doubts have been voiced as to the appropriateness of concepts originating in an individualistic, competitive Western world in helping to shape the future of developing societies. Similarly a purely Western academic training is no longer seen as a suitable training for the social scientists of the developing world (Sampson, 1987; Moghaddam & Taylor, 1986; Nsamenang, 1993). The social science disciplines have often failed to meet the needs of the developing world, having been in service to the powerful industrialized nations. Theory and research cannot be independent of the macro-forces of economics and politics. Nowhere has this been illustrated as dramatically as in the history and recent events of South Africa (Boonzaier & Sharp, 1988; Nicholas & Cooper, 1990; Nell, 1994).

The mental health services in South Africa have in the past received a great deal of international criticism largely due to the inequalities perpetuated in the name of apartheid (Jablensky, 1977; Domisse, 1987; Swartz, 1991). The problem is complicated by the fact that we have a First World system with

all that it entails regarding set standards and rules, which may work reasonably well for a white middle class, but breaks down in Third World situations, where it lacks the creative compromises which are sometimes reached in developing nations less encumbered by Western constraints[7].

An Ecological Perspective

An ecological perspective is central to this study. "Ecology" is defined in Webster's dictionary (1989) as the "totality or pattern of relations between organisms and their environments" (p. 395). This concept, derived from biology, was taken up by a number of psychologists as early as in the 1940's (Lewin, 1951). It had its antecedents in the history of thought going back as far as the conflict between Aristotelean and Galilean notions of causality, the former being a linear cause-and-effect model, and the latter dependent on the interaction of an object and its surroundings (Marsella, 1984). While the interactional position attracted a great deal of interest, it ran into difficulties as it could not be tested with standard empirical procedures. These concepts regained momentum in the 1970's with the publication of Barker's *Ecological Psychology* in 1968, and Bronfenbrenner's ecological approach to human development (Bronfenbrenner, 1979). There was the conviction that this new awareness and concern with natural and

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[7]This is not meant to minimize the inequalities in the distribution of resources between these two different worlds, which maintained the status quo, and the division along racial lines.

meaningful environments could be reconciled largely with the rigours of quantitative, empirical research. Not everyone seems to agree with this, however, and some researchers feel that qualitative methods, such as ethnography, are more appropriate when attempting to capture multiple realities, than are quantitative methods. It has been noted that there is an inability to distinguish cause from effect, as all entities are in a state of mutual simultaneous formation (Anglin, 1988).

In the therapeutic arena the ecological approach found a following amongst theorists and therapists associated with the field of family systems and family therapy (see, for example, Hoffman, 1981, Ch. 14), with Bateson an influential voice. Auerswald was initially an active contributor to the development of the ecological perspective, insisting that health care should be based on the total field of the problem. This goes beyond an interdisciplinary approach by taking a holistic systems view of the issue (Auerswald, 1968). The emphasis on contexts and the meaning these have for the person are amongst the crucial elements of an ecological approach.

While all this may not seem that unusual or novel from the perspective of anthropological discourse, in the arena of general psychology this approach was not considered mainstream. A contextualized person could not be squeezed into a laboratory.

The term "ecology" in this thesis refers to the total field of the person with mental illness. This is the theoretical position which informs the research, but it should be noted that one can never fully describe the field. Economic and medical resources, attitudes prevailing in the community about mental illness, the physical environment of the patient, food, formal and informal social exchanges in the community, power relations and hierarchies, relations between the community and treatment sources, both Western and indigenous, family relationships, patterns of mobility, and above all, the cultural beliefs that impacted on the patients--these were the concrete manifestations of the ecology studied here.

CHAPTER 2

AN ECOLOGICAL RESEARCH DESIGN

An Integrative Methodology

The research can be conceptualized as multiple images taken through the zoom lens of a camera, starting with a wide-angle view of a larger region into which patients were discharged from Tower Hospital, and narrowing to a close-up of a specific village called Msobomvu. The final frame consists of the life experience of a single individual, an ex-patient of Tower Hospital living in this village.

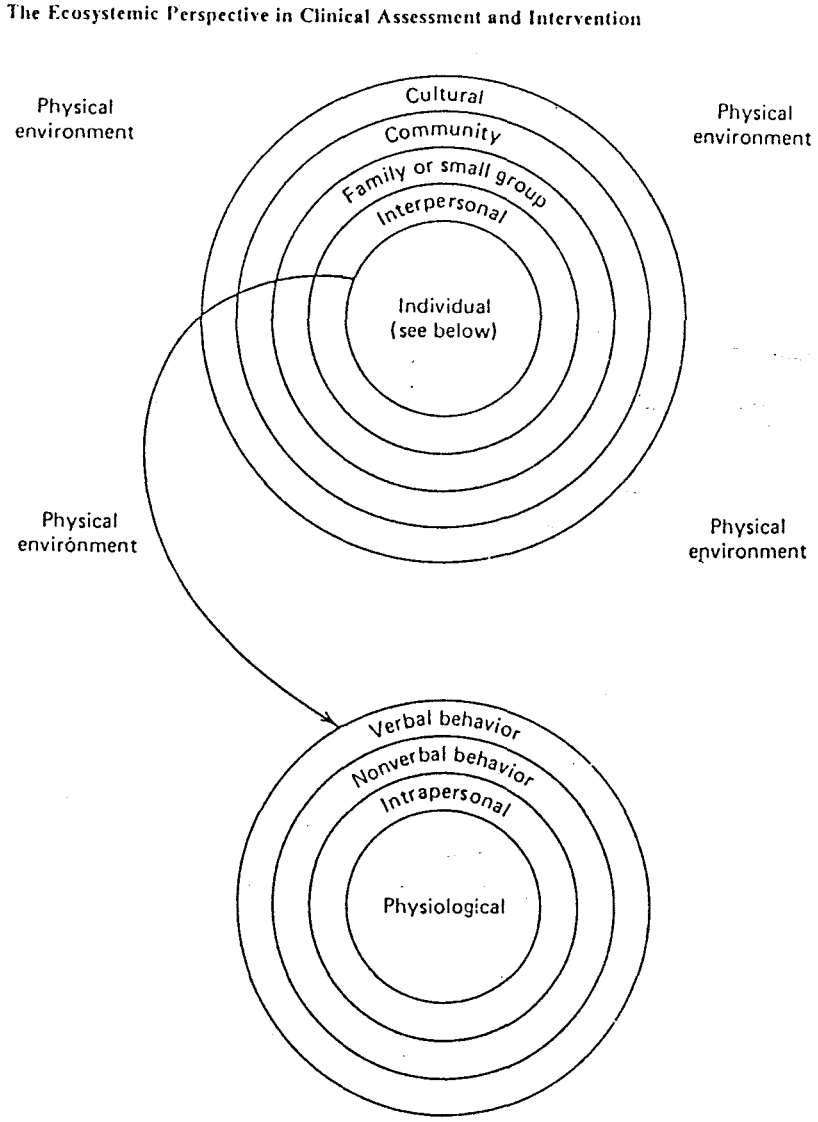
Conceptually my framework rests on a schema of the human ecosystem developed by authors such as Bronfenbrenner (1977) and Barker (1968), amongst others, and depicted by Janoski (1984) in its simplest form as a series of concentric circles, each representing parts of the total system, separated by semi-permeable boundaries characteristic of living systems (see Figure 1a). Interaction and exchange can therefore occur at all levels.

This view allows for the gamut of influences from the microevents of neurotransmitter functioning of the individual patient's brain, to the macroforces of the socio-political situation which are involved in directing the individual life history. This commitment to holism accords well with an

anthropological approach to fieldwork (Fetterman, 1989), but also finds a place for what psychiatry and neurology have learned about the human brain with their more recent technological advances. Anthropological and ecological approaches in psychology tended to look for explanations at the individual and social/cultural levels, particularly with critical anthropology's issue with the hegemony of biomedicine. This has led at times to accounts of schizophrenia, considered unhelpful to the patient and humiliating for his/her parents; Bateson amongst others are now on the list of the "ten worst" readings for severe mental illness (Torrey, 1983). An ecosystemic and holistic approach needs to consider therefore, both macro- and micro-events.

This commitment to holism and an ecological framework in this research is demonstrated by a contextualization of my observations within the larger perspectives of the political and social structures of the times. Emic descriptions of individual life experiences in relation to mental illness, as well as etic data figuring demographic information, are presented. In this way I made use of multiple perspectives, and multiple methods. I wore different hats at different times, in my role as ethnographer, participant observer, and researcher concerned with pragmatic realities. Triangulation--obtaining confirming or disconfirming reports from different sources on the same issues--was a method of verifying my observations, and was built into the research design through the shifting focus from more distant to close-up views of

mental illness. With the larger group of patients, data was dealt with from predominantly an outsider's perspective, in the form of statistics. The close-up view consisted of an ethnographic account of individual lived experience.



The Human Ecosystem.
(*a*) Ecosystemic view: A human life—Extra-individual factors.
(*b*) Ecosystemic view: A human life—Intra-individual factors.

Figure 1a. The Human Ecosystem

(From Janoski, 1984, p. 44).

Figure 1b represents the systems and settings operating in the Victoria East Magisterial District, in relation to the patient with a mental illness.

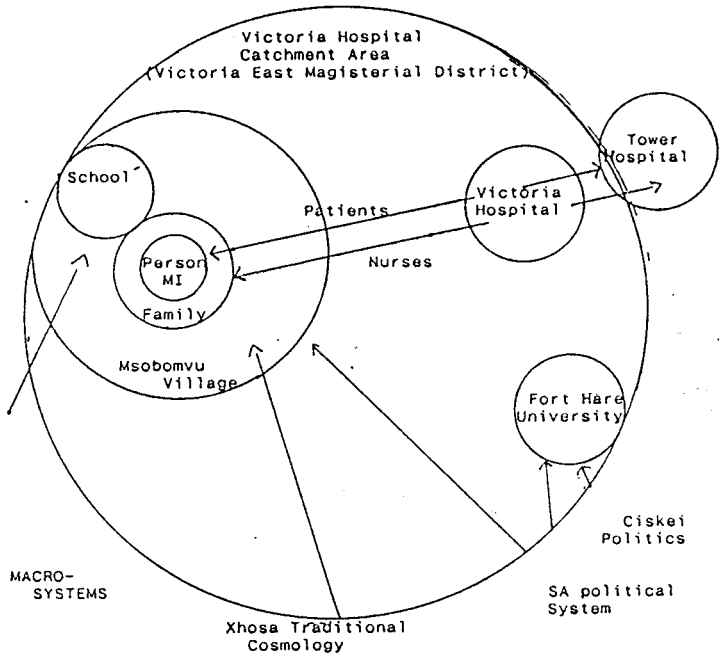


Figure 1b. Settings and Systems

The macrosystem, comprising the political forces and the cultural beliefs, are shown diagrammatically by arrows to affect the various microsystems such as school, family, university and hospital. Patients and nurses move between systems, particularly the hospital and the village.

The patient in the village can be involved in a number of *settings* such as the home, the clinic (either the mobile clinic, or the local hospital where medication can be

obtained), church, or occasionally a work place. At a more abstract level, Bronfenbrenner (1977) views the *macrosystem* as visible in the overarching patterns of the culture or subculture, of which the political structures, the mass media, and the system of biomedical services are concrete manifestations. The difficulty in dealing with patterns at this more abstract level is that they are often implicit. This level is explored in this study through student essays in relation to mental illness. The way the students, as representatives of their culture, think about illness in both Xhosa and Western concepts, is thus revealed in text.

The framework within psychology which was influential comes primarily from systems thinking and the clinical applied field rather than from psychoanalytic theory. This fits well with the experience-near thinking in anthropology, particularly with cultural psychology[8] with its clear position on the inseparability of person and context. I have one reservation here, in that I feel that cultural anthropology seems to underplay biology as being a significant part of the person, particularly in the mental illness experience. Just as the practical issues of survival and availability of resources are part and parcel of the context, so are neuro-transmitter functions part and parcel of the person.

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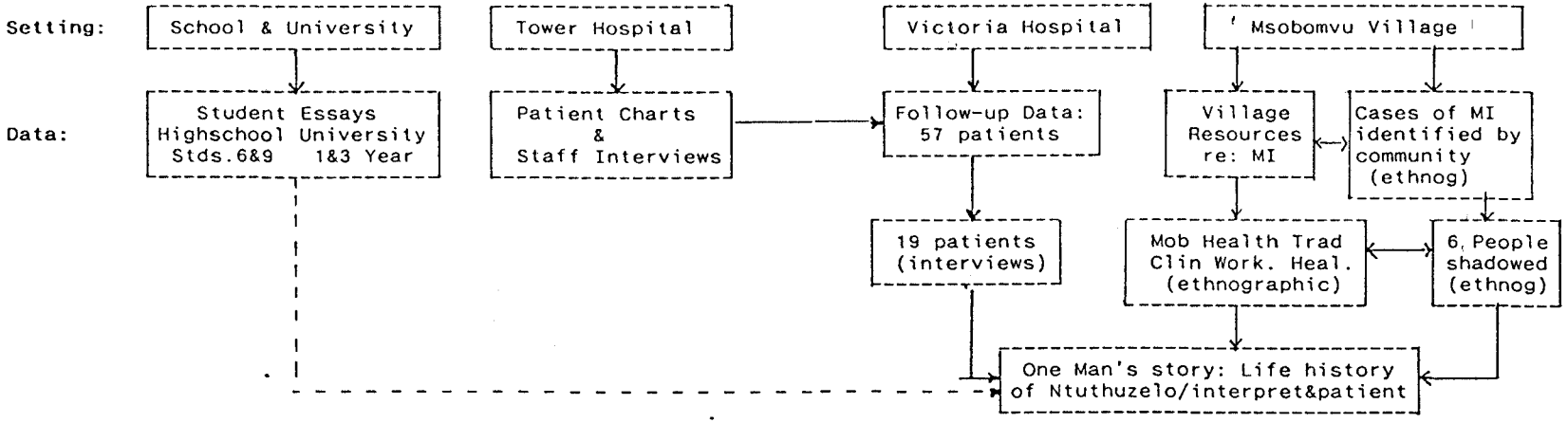
[8]Cultural psychology is really more anthropological in its affiliations and should have been named, perhaps, *anthropological* psychology, since the name psychological anthropology has already been claimed.



Data Type:

Comparison of Trad. & West. Orientation by education

Causes of MI: Trad/Socio-Polit/ W.psychol/W.organic

Attitudes to trad. Healer and Hospital

Recurring Themes (quant. & qualit.)

Social Attitudes to MI (qualit.)

& education

Demographic Data:

Patient Age

Admission Patterns

Reason for Admission

Pat. Characteristics

Work

Power & Control, an analysis: interaction Hosp/Patient/Community Characteristics (qual)

Tracking Hospit. Discharges, Data:

Mobility of patients

Relapse & Readmiss.

Ment. Health System

19 patients & fam interview data:

Socio-ec. status

Attitude:Hosp.Heal.

Causes of illness

Use of Healer

Precipitant Hospit.

Drug/alcoh.use

Social adjustment

Age at breakdown

Living in the Village: Ethnog.

Rural Resources

Mobile clinic: service descript.

V.H.W. caseload (quant. & qual.)

Matrix: Trad. Healers & ethn.

Matrix: 14 People MI

Passing Muster Stigma & Hospital. (quant & qualit.)

Chronicity & stigma quan/qual

Outcome

Efficacy: Treatment

Ethn.data of 6 w.MI

Ethnographic data on one man's life: contextualized in rural SA & Xhosa cosmology regarding education/ tradit.healing/biomedicine & severe mental illness.

Figure 2: Cross-site Analysis: An ermergent methodology.

Figure 2. provides an overview of the different entry points into the world of the person with a severe mental illness, sometimes through interviews with the patients, other times through more casual observations, sometimes from the perspective of the hospital as found in the files, and other times from the more personal discussions with my interpreter, during the days and weeks of working on the translations of the tape-recorded interviews and student essays.

Figure 2 is read from left to right. "Settings" constitutes the top category, showing the four main settings studied--school and university, Tower Hospital, the Victoria Hospital (catchment area), and the village of Msobomvu. Data and data type for each setting is located in the column below. Where qualitative, this is stated in Figure 2, otherwise the data were quantitative.

The narratives which came from the school and university settings are discussed in Chapter 8. Content analyses of essays provided quantitative and qualitative data which led to the conclusions drawn regarding beliefs about causation of illness, and social attitudes prevalent in Xhosa society.

The Tower Hospital setting provided charts on patients discharged into the Victoria East district, and demographic data, related to mental illness. Both charts and staff interviews, with additional information related to hospital care, led to an exposition on the hospital as an agent of

control. This is reported in Chapter 9.

The Victoria Hospital (Victoria East) catchment area forms the basis for Chapter 10. Patients discharged from Tower Hospital into that area were tracked, and demographic data relating to their readjustment in the community were obtained. The rest of the chapter reports on the information obtained from interviews with 19 of these patients. While much of this part consists of quantitative material, descriptions and individual experiences are interwoven.

The close-up view of mental illness comes to life in Chapters 11, 12, and 13, with a focus on ethnography. The presentation of life in the village makes clear my involvement as participant and observer. In this sense I am not an "objective" observer; my subjectivity is part of the research.

Rural resources available for the person with mental illness consisted of the mobile clinic, the village health worker, and the traditional healer. Ethnographic and some quantitative data were included. The 14 people who were identified by the community as having a mental illness, their use of resources, and their search for a cure, were unravelled in Chapters 12 and 13. Chapter 13 ends with the life history of one person, who was one of the original 57 patients located in the Tower Hospital records, and later interviewed as part of the follow-up.

Political and Geographic Context of the Research

The study took place in the rural communities of the Victoria East district in the Ciskei in 1988/9[9]. It is therefore historically placed before the official end of apartheid rule. Victoria East together with the relatively small magisterial district of Seymour made up one of the five planning regions of the historical Ciskei. It is a rural area with pockets of semi-urbanization. The main town is Alice, where the local hospital for the region, the Victoria hospital and the university of Fort Hare are located.

The former Ciskei, a wedge of some 8,000 square kilometers of land of the Eastern Cape was pieced together by removals and resettlement of 350,000 Xhosa-speaking blacks from South Africa, to become an independent homeland, described by official documents as a Republic of South Africa self-governing state. At the time South Africa, under the domination of the Nationalist government, defined homelands as technically autonomous, although in actuality the homeland governments worked in close association with the Pretoria government and were largely subservient to that government.

The Ciskei's independence in 1981 did little to alter that and meant in practice that the people were stripped of their South African citizenship.

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[9]Follow-up data has been included up to June, 1995.

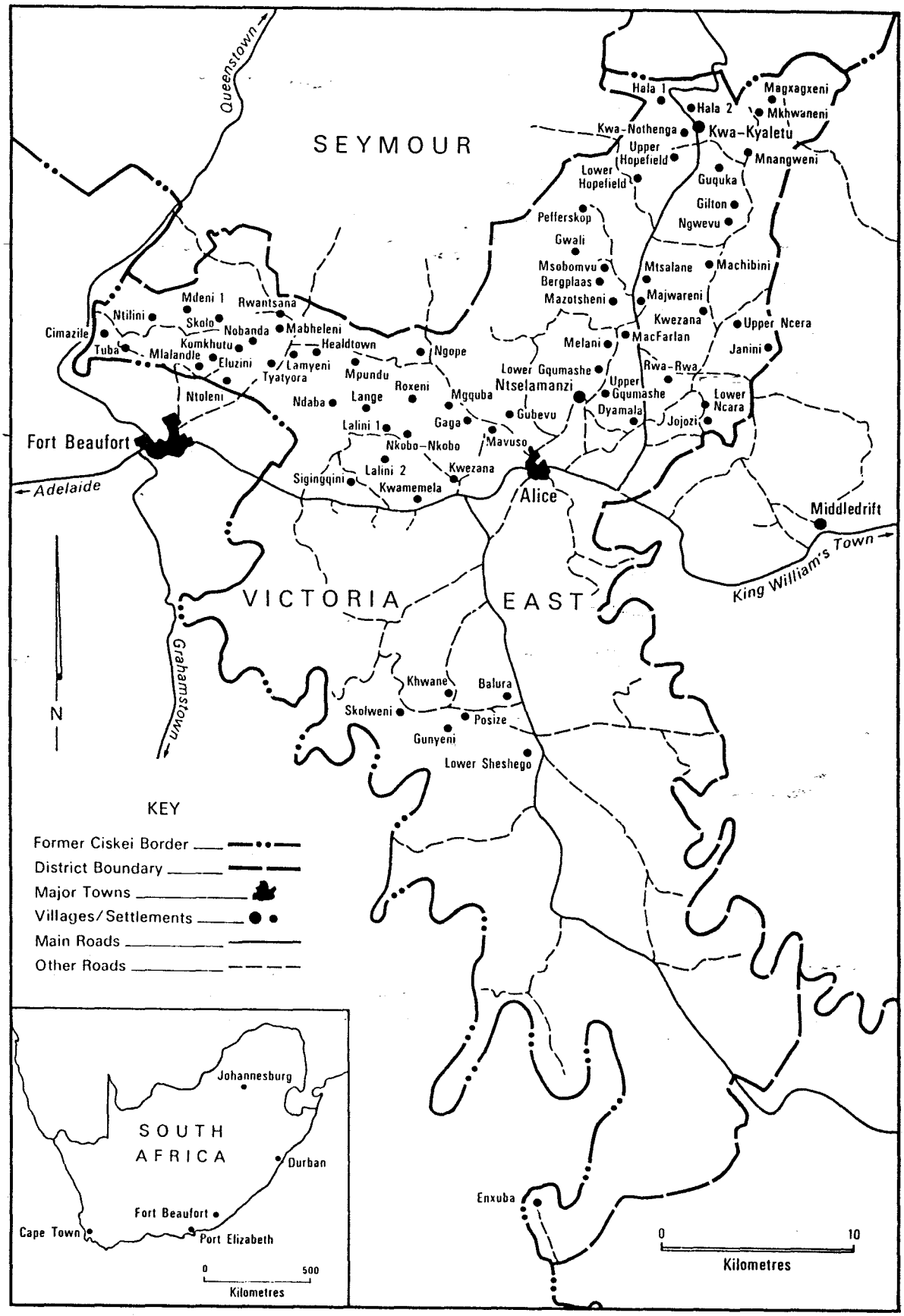

Figure 3. Victoria East District

The independent homelands were strategically significant in that they provided socio-political control, and were a repository for the poor and unskilled. This gave an opportunity for the South African Government to divest itself of the responsibility for problems in that area, as well as creating a more exploitable labour-force for unpopular work back in the Republic (Turshen, 1986). While South Africa's statistics for health looked as if things were improving, this was not the picture reported from the former Ciskei. The social disorganization created by relocations increased the number of broken families, which had already been a problem due to the migrant labour system.

While government statistics, particularly in the Ciskei, are known to be far from reliable, their estimate that only 50.8% of the population (aged 15-64) was potentially economically active, is probably not an over-estimation. This highlights the huge dependency burden in these communities (Ciskei Government, 1984). Of the remaining 49.2%, only some 20%, according to Government statistics, were working, and these apparently also included those who were temporarily out of work, or looking for work. The work situation for the Victoria East magisterial district (inclusive of Seymour) looked even worse, compared to more urban settings. Here only 14.6% of the total population was said to be economically active, compared to 27% in urban areas.

Contrary to expectations there was relatively little

subsistence agriculture. The socio-political conditions, in interaction with a culture whose tribal laws maintain male authority, have not supported the traditions of collaboration on which such farming communities depend (Yawitch, 1983). Some of the socio-political factors related to migrant labour, which resulted in high concentrations of old people and children in the rural areas and the absence of adult males, together with relocations, overcrowding, and poor quality of land strained by over-grazing and soil erosion. Women who have been treated as minors both traditionally and by apartheid laws, were often left to fend for their families, so that they turned to working in the informal sector or on white farms. To this socio-political ecology we need to add the stress of recurring droughts. Turshen (1986) points out that during these drought years of the early 1980's, there were no reports on deaths directly linked to the drought in the Ciskei, compared to such by Mozambique estimates. Instead, there seemed to be a consistently high mortality rate, since subsistence farming did not constitute a protective factor[10].

Ciskei people, besides depending on remittances from migrant workers and commuters to the nearby cities such as East London and Port Elizabeth, relied on pensions as one of their more predictable sources of income. 3,668 individuals in the Victoria East magisterial district were receiving old-age pensions (5.4%), and some disability grants (412 or 0.6%)

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[10]According to the Financial Mail 2 March, 1984, only 8% of inhabitants of the Ciskei were estimated to be subsistence farmers.

(Ciskei Government, 1984). This underscores the importance of old-age pensions in putting food on the table for many families. The disability grants for people with mental illness were insignificant in their number, considering that this category included other disabilities, such as physical disabilities, as well.

The village of Msobomvu is of relatively recent origin, having evolved from a few huts in the 1970's as a result of the formation of the Ciskei and the influx, in consequence, of people to that area. This community consisted of people of the same language group who were, however, lacking the strong historical links of a traditional village. They were in part farm labourers with their families, who were left when their white employers, the farmers, moved away after the area was proclaimed part of the Ciskei. They lost their income, however little it was, and often lost their home. They have since gathered into larger settlements according to their tribal loyalties. They follow the basic ancestral beliefs of the Xhosa (Schweitzer, 1977) as well as claiming membership to the many different Christian churches represented in the area.

This village was, therefore, not chosen for this study by chance; it represented and typified the upheaval in many similar communities in South Africa, where continuity in relation to domicile and land could not be taken for granted. As in other communities, many of the young adults in this one, particularly the men, were away as migrant workers during most

of the year. There were few commuters since the village was too far away from the South African border. The remaining residents of the village were largely pensioners, school children, and some of the young, unemployed adults who had not managed to successfully enter the arenas of work beyond the village. This village had retained its rural flavor and also the problems of similar communities in transition, where roots are far shallower than those of communities that have been established for generations. These considerations emphasize that rural culture in South Africa cannot be conceptualized without a consideration of the socio-political context.

At the time of this research this village, like most other Ciskei villages, was administered through the Tribal Authority system. The Tribal Authorities were the local administrative units of the government and consisted of chiefs, salaried headmen and their councillors, as well as sub-headmen with their councils. The duties of the Tribal Authority included the control of land and agricultural co-operatives, and the preservation of law and order, including the power to settle minor disputes. As Manona (1995) pointed out, the Tribal Authority system was developed in South Africa at a time when chiefs had lost significance and power, and in many parts of Africa the shift to elected authorities had occurred. The executive power of the Tribal Authority was very limited and it was really under direct control of the central government, its major function being to raise funds.

Manona describes the conservative nature of this political structure, in that members were always male, usually uneducated and elderly. They were not representative of the people. With the military coup in 1990 which toppled Lennox Sebe (who was then president of the Ciskei), the Tribal Authority system collapsed. The headmen were dismissed, including the headman of Msobomvu. Manona describes the political upheavals surrounding those times. In Msobomvu the youth cross-questioned the headman as to the funds which had been collected, and it took many hours to convince them that he had no personal benefit from them. (He was an instrument of the Ciskei government, known for its corruption). The new political leader had reinstated the headmen. Mr. C. at Msobomvu had refused the position since he saw clearly that the village did not want a headman. Another man accepted since the salary was increased substantially. The new headman was approached by the youth demanding his resignation, but he apparently refused and took out a gun. The youth killed him, and many of the houses of the councillors were ransacked and burnt. This all happened in 1993. Manona describes similar events in the Keiskammahoek area. Msobomvu is now administered by a Residents' Association.

On my visit in Msobomvu in June 1995, I was told that chief Maqoma had been reinstated but was not living in Msobomvu, and that chiefs no longer had any say. Manona describes, however, ongoing tensions between CONTRALESCA, the Congress of Traditional Leaders of South Africa, and the new community

structures affiliated to the South African Civic Organisation (SANCO), issues involving the role of chiefs in the new South Africa.[11]

The mental hospital (Tower Hospital) was located outside the Ciskei border in the town of Fort Beaufort and administered by a mix of black and white staff. The nurses, both male and female, were all black, while the doctors (many part-time) were predominantly white. At the time of the study, the head psychiatrist, Dr. Anderson, recently deceased, and who had been there for many years, had not been replaced[12]. There was a clear sense of a cultural divide between doctors and patients. The nursing staff fell into an intermediate position: while sharing the patients' culture, they seemed to identify, at least overtly, with the hospital structure and its power-based hierarchy.

Victoria Hospital was the local hospital serving the Victoria East area. Its history goes back to the mission days, but like most hospitals and schools established by the missions in South Africa, it was taken over by the state. Community Services was run by a matronly head nurse, a male nurse, and a

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[11]Manona (1995) describes in greater detail the power dynamics of the Tribal Authority System, which lacked both legitimacy and executive control. (Unpublished manuscript presented in the ISER Seminar Series, Rhodes University, March 1995).

[12]There has been a shortage of psychiatrists in South Africa, particularly in the rural areas. Even Fort England in the small town of Grahamstown has had difficulties in obtaining and retaining psychiatrists. In June, 1995 the situation was no better.

young psychiatric nurse who had joined this department two months before. They were responsible for psychiatric patients admitted to the medical wards. If the situation involved psychotic behaviour, which it usually did, the nurses would have the patient admitted to Tower hospital the next day. This would require the patient being taken to the district surgeon, and the magistrate--since these were usually involuntary admissions--after which he or she, and often a family member, would be transported to Tower Hospital.

Garnering the Data

With this approach in mind, authority was obtained at Tower Hospital, which was the mental hospital for a large part of the black Eastern Cape population, to scrutinize the admission and discharge records of all patients for the preceding year. This was done in order to identify the patients who would comprise the group followed into the community. The names of patients discharged from the hospital into the Victoria East magisterial district were obtained. Patients living in the urban area of Alice were excluded, as were patients who were clearly diagnosed as having a *primary* problem of drugs or alcohol, or an identified organic abnormality such as epilepsy. The patients' charts also contained other relevant and accessible information pertaining to their illness and hospitalization, as well as demographic information, and these data were noted.

My credentials as a doctoral student, and my registration as a psychologist with the South African Medical and Dental Council, were considered sufficient for the Health Administration authorities to permit me to do the research, and review the hospital records. This was the only way in which the target population could be identified in the first place. It is worth noting that patients could refuse to make contact with me when approached in the field. Formal, written consent was not required. The individual's rights to privacy in South Africa was not as central an issue as it is in the United States. This fact applied equally to patients in the white sections of state hospitals. I was, in this case, identified with the hospital in that my initial contacts were made through an outreach worker on the hospital staff. From the patient's perspective, concern with privacy was generally not an issue in their awareness. In fact my interpreters often expressed surprise at my hesitancy in asking the more intrusive questions.

At this initial stage of the field work, I began making contact with a wide variety of people who were connected in some way to the treatment of mental illness in this culture. These were people seen as being in some way part of the culture and were potential informants.

With the assistance of the staff from the Victoria Hospital, which was the hospital for the Victoria East magisterial district and handled psychiatric problems largely on an

outpatient basis, I traced the people whose names had been obtained from the mental hospital records. At times this felt like looking for a needle in a haystack, where word of mouth supplied the map, often fragmentary and difficult to follow. In the many distant villages of the Amatola basin, only the goodwill of the inhabitants made their tracing possible. In this way 57 patients were initially located, of which 19 were finally directly interviewed. Details on the selection of these 19 people are provided in Section III.

A review of hospital records a year later provided information of that year's discharges. The full range of diagnoses, not only those pertaining to people with *functional* mental illness, were obtained and documented. This provided data at the same time on the rate of re-hospitalization of those patients identified in the previous year's records.

I then narrowed the focus to one particular community, the village of Msobomvu, as mentioned earlier. Three of the original discharged patients were located there. Following interviews with the police and other authorities, and with the assistance of Chief Burns Ncamashe, under whose authority Msobomvu fell, I was given permission to reside in this village for a period of three months. From this vantage point, and again through word of mouth, the number of persons with mental illness was seen to be in fact more numerous than the original three, based upon the community's identification of these people as having a mental illness (*isigulo sengqondo*).

Considerable time was spent wandering around the village visiting various people. Two interpreters[13] helped me with the different interviews. One of these, having gone through the experience of mental illness himself, and being particularly sensitive to his culture and community, became a major informant. His own story has been included as part of this research. He had been one of the original 19 interviewed.

Life in the village provided ethnographic data on the individuals who were struggling with mental illness from day to day, and on the way others perceived them. Among these others were the traditional healers who play a major part in identifying and defining mental illness in the culturally accepted ways. These healers and their clients were also interviewed. In addition to the healers as treatment resources, bio-medicine entered the village in the form of the Mobile clinic, on a fortnightly basis. I attended this clinic and gathered information on how illness was catalogued and processed, raising questions about the quality of service provided. Village health workers were interviewed, as they too constituted a resource within the village context.

Access to the culture's beliefs about mental illness and its treatment, both traditional and Western, was obtained by means of narratives invited from high school students and Msobombvu,

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[13]While I had made efforts to learn Xhosa, I had not achieved a sufficient working knowledge to be able to handle these complex interviews. My attempts to communicate in Xhosa were, however, appreciated by the local people, and helped to break the ice.

and psychology students at the University of Fort Hare. Selecting students of different ages and different levels of education made it possible to map the impact of Western culture on the perception of mental illness, as it is transformed by the educational process.

Consolidating the Questions

While I began this study with a commitment to allowing the context to speak with its own voice[14], at the urging of my university professors I formulated a number of questions which I hoped would be addressed through my experiences and methods of garnering information. Now with the data in hand, the questions still seem acutely relevant:

> How does the patient, his or her family, and the community, view the problem of mental illness? Do they in fact see a problem?
>
> What resources do the families, with a member who has severe mental illness, have at their disposal? Who or what will they turn to, and in what order--mental hospital, traditional healer,...?

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[14]An approach without presuppositions has been described by Ho (1988, 1994). The researcher begins with only a global notion of the subject matter, trying to avoid any preconceptions and hypotheses, or even questions. The researcher is meant to achieve an intellectual attitude in which he/she attends to the phenomena as they appear.

How does the community respond to the family of a psychotic person, and to the person himself/herself?

How does the family and the individual respond to the community?

Are there benefits/disadvantages to having a mentally ill member in the family?

What has the individual's/family's experience been with the Western and traditional healing systems?

Do belief systems in regard to traditional healing change with Western education?

These questions have been given careful consideration in Section V.

SECTION II

REVIEW OF THE LITERATURE

Chief Maqoma's Song

Siwafumene amathambo kaMaqoma

We found the bones of Maqoma

Siwafumene amathambo kaMaqoma

We found the bones of Maqoma

Siwafumene kulentaba kaNdoda

We found them on the mountain of Kandoda

Siwafumene kulentaba kaNdoda

We found them on the mountain of Kandoda[15]

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[15] This song refers to the controversial reburial of the historical chief Maqoma. Manona (1995) writes of people's sense of oppression in relation to levies exacted from their meagre resources, and states that "the most hated levies were those which connected with the many rallies held at the Ciskei National Shrine (*Ntabakandoda*) and those which were for the now discredited Development Fund" (p. 14).

CHAPTER 3

PSYCHOLOGY AND ANTHROPOLOGY

Whose Turf Is It?

Approaching a subject involving terms such as "coping," "cultures," "mental illness and rural South Africa," leads to questions as to the discipline or disciplines within which this study is embedded. While my personal grounding is within clinical psychology, broadened by some years of reality testing in daily encounters with people suffering from a major mental illness, my search for the relevant literature started me on what seemed to be a path without an end in sight. Every time I thought I would have some sense of a perspective, another hill ahead, like the *koppies*[16] of the South African landscape, would obscure the view.

This chapter considers the disciplines of psychology and anthropology, but could have easily identified others, such as sociology, history, politics and philosophy. Psychiatry is another significant area, and this has been given fuller treatment in Chapter 6. It is difficult to do justice to the all-encompassing nature of the problematics under scrutiny. A brief historical perspective may help to clarify the contributions these disciplines have made in this area, since

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[16]*Koppie* (also *kopje*) is a term referring to the hillocks found throughout the South African countryside.

their relationship to the subject matter is often not as self-evident as one might have expected (Foster, 1978).

Early Exchanges

Psychology and anthropology may seem complementary, with psychology focusing on human behaviour (or even mentation) and anthropology[17] being expert at an understanding of the social field or culture, an essential prerequisite for being human. Instead, one finds that the two disciplines are marked by a lack of exchange and by conceptual estrangement. This has happened in spite of their common roots.

Jahoda (1982), while acknowledging that speculation about man and society goes back as far as recorded history, traces the roots of psychology and anthropology to the 18th century. It was then that the French encyclopaedists and the Scottish moral philosophers concerned themselves with the attempt to establish natural laws of human nature. One of these laws was thought to be the idea of inevitable progress. The philosopher-scientists of the 18th century were interested in other cultures, largely to reflect upon their own, revealing the ascent of civilization. This led them to an involvement with expeditions, bearing some claim to a scientific purpose, military and commercial interests notwithstanding. Degerando, one of the earliest members of the French *Societe des*

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[17]Jahoda (1982) for this purpose does not distinguish between sociology and anthropology in that anthropologists have been greatly influenced by the classical sociological traditions.

Observateurs de l'Homme, was way ahead of his time (as was Montaigne even earlier) in his awareness of what would be considered today as the dangers of ethnocentrism in interpreting the customs of the so-called *savages*, as well as in his suggestion that "facts only acquire meaning when they are treated as part of a system" (Jahoda, 1982).

After this initial burst of empirical interest, most of the 19th century scientist-philosophers that followed were armchair theorists, relying on the reports of missionaries and travellers to provide the data. The mid 19th century was dominated by the view of Social Darwinism which applied natural selection to the contemporary dominance of the European races. While a lot of the extremely racist views came to be rejected by most anthropologists, some form of this remained in the idea of stages of development for different cultures. Ideas such as the "psychic unity,"[18] and the "plasticity of the human response to socio-cultural influences," were prevalent. Psychic unity was seen as the bulwark against racism, implying that since all humanity is basically the same, and environmental conditions are responsible for any inferiority or superiority observed, the goal for the future was to give equal opportunity to all. This argument applied equally to racial as well as gender categories. This was the intellectual context of both John

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[18]Jahoda (1982; 1992) mentions that the German scholar Bastian, together with Waitz, have been credited with originating the notion of the *psychic unity of mankind*. He also points out that a version of this idea can be found in 18th Century writings as well as in the Stoic philosophy of the 3rd Century BC.

Stuart Mill, who envisaged a psychology closely linked to sociology and anthropology, and E. B. Tylor, who has been described as the "father of modern anthropology" (Jahoda, 1982).

Tylor focused on social institutions and their functions within the broader context of cultural evolution--the progressive development from savagery to civilization. There was, according to Tylor, an associated progression in human behaviour and thought, with logical thinking representing a higher form. Thus Tylor inspired Frazer's famous collection of myths and folklore, *The Golden Bough* (1890), which in turn, had a profound impact on Freud's social psychoanalytic theory (eg: his *Totem and Taboo,* 1912).

At the early stages of the emerging disciplines of psychology and anthropology, their boundaries were not clearly demarcated, and many anthropologists are now seen as part of the history of cross-cultural psychology, whereas some psychologists, in turn embraced anthropology. At the turn of the century, Rivers and his student, Radcliffe-Brown, while doing anthropological fieldwork, emphasized psychological methods and explanations. Malinowski, a contemporary of Radcliffe-Brown, was another anthropologist who initially had close links to psychology in that he studied experimental psychology under Wundt, one of the great fathers of this discipline. While Radcliffe-Brown and his British school later repudiated the relevance of psychology to anthropology,

insisting that customs and beliefs need to be understood by the laws of human society rather than mind[19], Malinowski appropriated a wide range of what had been considered the turf of psychology. He felt that it was the anthropologist's business to record more than social structure, behaviour and emotional reactions. His concern was with beliefs, actions and ideas necessary to "grasp the native's point of view "(Malinowski, 1961, p. 61). Magical thought, in Malinowski's terms, was no longer considered an inferior and erroneous form of thought, but had to be understood in terms of *psychological need*.

A renewed interest in psychological processes was cemented through the influence and leadership of Franz Boas on American anthropology at a time when much of British anthropology under the influence of Radcliffe-Brown had turned its back on psychology. This may have been partly due, it has been argued, to the fact that American anthropologists became preoccupied with *culture* as opposed to British anthropologists' concern with *social structure*. A number of factors then led to anthropology splitting into various specialisms, with Boas being the father of psychological anthropology.[20]

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[19]Radcliffe-Brown came under the influence of the sociologist Emile Durkheim, who argued that suicide rates, which varied between different categories of community Protestant, Catholic, urban, rural) had social causes.

[20]What unified these various approaches in anthropology was there commitment to being empiricists. This contrasts with the more recent development of a French rationalist school in the wake of Levi-Strauss, whose prime interest was the structure of ideas people have, particularly as seen in cultural themes and mythology. Common themes are thus seen as reflecting fundamental

The anthropologist Theodore Schwartz complains that while psychoanalysis became the major source to inspire psychological anthropology to broaden anthropology's boundaries, or perhaps better to deepen its search, psychoanalysis did not return the compliment. Psychoanalysis, he feels, took little note of anthropology's knowledge of different cultures (Schwartz, 1992). As has been pointed out, Freud and his early disciples held to many of the 19th century notions, and conceived of the "primitives" as a fairly homogeneous group (Bock, 1980). Psychoanalysis generally did not avail itself of the cultural knowledge acquired by anthropology, in shaping its theory.

The culture and personality studies, as psychological anthropology used to be called in the 1940's and 1950's, applied the theories of psychoanalytic personality theory to the cultural terrain. Freud's theory, developed over his lifetime, was the first fully systematic view of the psychological nature of the person. He posited the instincts as the motive forces which took the form of drives as their psychological representation. His theory encompassed individual processes considered universal across cultures. The view of intrapsychic conflict has been applied by psychoanalysts and psychological anthropologists alike, to the explication of health and illness across cultures, pathology often revealing the Achilles heel of a culture.

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characteristics of the human mind.

As part of his complex theory, Freud believed that each individual passes through a series of dynamic developmental stages that he termed *psychosexual*. Most notable of these, especially in anthropological literature, was the Oedipal stage, the proper resolution of which was presumed essential for the normal development of the individual or society. The validity of some of these ideas, particularly in regard to social groups, has been questioned (Holme, R., 1972). The psychoanalytic claim of the universality of the Oedipus Complex, and counter-claims by anthropologists[21], have coloured much of anthropology's relationship with psychoanalysis.

George Devereux, both psychoanalyst and anthropologist, was one of a number of thinkers who applied psychodynamic principles to the pathological in different cultures. He addressed the issue of the *adjusted* shaman, and culture-bound syndromes. He insisted on a distinction between adjustment and normality, quoting historical occurrences of insane societies, to prove his point. His main thrust was that cultures provide an "ethnic unconscious[22]" to group-members through enculturation, which teaches each generation what impulses to repress, and what are acceptable defense mechanisms. The shaman is therefore ill in a conventional way; he is, as Devereux states, "like everyone else, only more so" (Devereux,

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[21]Malinowski in 1927 argued from the perspective of his ethnographic findings, that since family structures are culture dependent, the Oedipus complex is a peculiarly European phenomenon.

[22]Devereux's ethnic unconscious differs from the Jungian counterpart in that it is not rooted in biology, but in culture.

1980). His cure is in his having followed the call to become a healer. However, according to Devereux, it is not a cure, only a remission, because there cannot in psychoanalytic terms be a cure without insight.

Devereux attributes the shaman's superior adjustment, particularly in cases where the culture is in transition, to the shaman's personality continuing to be organized around obsolete structures, ignoring the broader reality. While he agrees that probably many shamans would most likely be diagnosed as hysterics in Western nomenclature, rather than as schizophrenics, he states that shamanism is culture *dystonic*, and many will reject the call and become psychotic as a result. He sees the origin of true psychosis to be in premature trauma, where the individual has not been able to acquire the ready-made defenses given by an ethnic personality structure. He also considers schizophrenia[23] as a culture-specific syndrome of modern society. While maligning the healer, he acknowledges that the cultural structures as seen in the ethnic psychoses, and the ethnic unconscious, have their purpose. They provide the disturbed individual with a conventionalized vehicle to express their idiosyncratic disorder, which facilitates the mobilization of culturally given defenses, and presumably a degree of social sanction.

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[23]This is one of the many versions of schizophrenia as a culturally constituted illness, which has controversial results in that it inevitably implicates the family in the construction of this illness.

These are interesting thoughts in relation to the nature of shamanism and psychosis, but some of the observations could easily lead to a much more parsimonious explanation. We know that disease is not simple or one-dimensional, but has many factors contributing to it, such as infection, genetics, and environmental influences. A faulty or different processing apparatus in the major mental illnesses would go a long way towards explaining why some of Devereux's potential shamans did not accept the call but instead became psychotic. Explanations factoring in the biological component would not eliminate culture as a major partner in the process. Devereux actually acknowledged this in describing differences between the shaman and recognized psychotics in the hospital, as well as pointing out that *amok* runners run amok for different reasons, delirium being one of them.

The Freudian point of view sees insight as the quintessential prerequisite for cure. This emphasis comes directly from the Western assumption that knowledge conquers all. It has been suggested in the Foucaultian style, that Freud's genius lay not in his discovery of universal psychological laws but in crystallizing the essence of his time and culture, capturing "the emerging themes of modern Western civilization" (Sampson, 1987, p. 91). What more fitting task, Sampson concludes, "than to enlarge this mental organ of control in order to create an ego in charge of its own house so that humanity could be in charge of the world".

Ewing (1992) feels that anthropology has not given psychoanalysis the credit it deserves. She places some of the blame on anthropologists like Turner and Levi-Strauss, for not acknowledging the debt they owed to Freud. Another problem, she asserts, is the misplaced focus on some aspects of the theory. For example, critical attention was given to the *Journal of Psychoanalytic Anthropology* while it existed, which published a quantity of research obsessed with Freud's sexual drive theory in relation to cultural phenomena, rather than looking to the more recent developments in psychoanalysis[24]. Psychoanalysis, she feels, could have been helpful to anthropologists in their fieldwork. There have been problems in this area, particularly as regards the ethnographer-informant relationship. Here psychoanalysts, as experts in the participant-observer relationship (through the psychoanalytic method of doing therapy), had a real contribution to make. According to the psychoanalytic view, the politically correct anthropologist's reflexive and self-critical stance is a form of censorship and therefore a distortion, and no solution at all. It is only through the analysis of transference and counter-transference that true knowledge can be achieved (Ewing, 1992). This is an interesting argument in that it highlights the multifaceted nature of any relationship, and of knowledge, for that matter.

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[24]Psychoanalysis has largely moved away from instinctual theories to more ego-oriented and more culturally sensitive explanations. At the same time it does not represent a monolithic front, and followers often have different and distinct orientations (Bock, 1980; Stein, 1990).

Psychoanalysis, as a therapeutic enterprise, seems to have lost ground internationally, and particularly in the United States, while many of its insights into psychological phenomena have been accepted into Western popular culture. Many of its tenets are out of alignment with the present intellectual climate in America. With the increase of diversity in the American population, and assertive voices which can be heard from many cultures, both within the US and from the developing countries, there is a new discomfort with power relationships. Today there is an awareness of the realities of incest and child abuse, rather than Oedipal fantasies, and most of all an economic climate that stresses cost-effectiveness of treatment.

While psychoanalytic theory will continue to provide us with challenging tools to view human nature, as an over-arching theory it has not been proven. Psychology has tended to grand theory making, whereas anthropology's involvement with theory seems to have been more pragmatic[25], choosing what has been described as middle ground theorizing, generalizations which will order and explain particular relationships. But it is in the nature of grand theory to fail sooner or later (Kuhn, 1962). Much of what is psychological anthropology today makes use of wider influences. Some of psychological anthropology now falls within the bounds of cultural psychology.

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[25]Psychologists have accused anthropologists for relying on common-sense psychology, rather than availing themselves of what psychological research has generated (Jahoda, 1982).

Cultural Psychology: A Critique and New Integration

Cultural psychology, as described by Richard Shweder, is not to be confused with *general* psychology, whose main aim has been to describe the central processing mechanism of mental life, discovering the abstract universal laws of the human psyche, or behaviour. The assumption in general psychology is that if the environment can be controlled so as to rule out contaminating factors, the underlying causal connections could be discovered. The central processing mechanism was thought to be independent of context and content, hence the preoccupation with laboratory studies and the learning of nonsense syllables[26]. Cultural psychology instead, starts with the assumption that the humans are intentional beings living in intentional worlds.

Cross-cultural psychology, in Shweder's view, as a subdiscipline of general psychology, falls prey to the same mistakes. Its aim is to apply some of the regularities observed in the Western context to subjects of other cultures, providing opportunities to replicate studies. Thus Piaget's stages of thinking in the development of children, was applied to very different cultures to see if the same sequence of schemas and concepts would be found and in this way support the universal applicability of his theory. Evidence contradicts this view, suggesting, for example, that Piaget

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[26]It was assumed that in learning nonsense syllables the basic principles of learning, uncontaminated by meaning, would be unveiled.

had underestimated grossly the capacities of young children, and that most cognitive operations are available to children even before they are literate (Kagan, 1984; Shweder, 1982).

The problem, as conceptualized by many psychologists, is that we have difficulties in creating test situations appropriate to the population studied. Shweder's answer would be that content determines process, and many of the psychological universals may not be so universal. The concept of intelligence in the form of the IQ, is one of these universals which has drawn a lot of criticism. The cross-cultural psychologist was caught between two poles in order to explain differences in performance on IQ tests. On the one hand were the views pertaining to an environmental deficit concept, in which certain groups of people are seen as less able because they had inadequate stimulation in early childhood. The other positions viewed intelligence per se as not differing between cultures; we just have not found a way to appropriately measure it.

The latter view generated the literature on culture-free and culture-fair tests. There were, however, other psychologists in the cross-cultural arena who were aware of the problems, pointing out that there are better ways to look at concepts like intelligence, than by modifying material derived from Western culture. Different societies value very different qualities in the person.

Approaches to Traditional and Western Thought

Anthropologists and psychologists alike have concerned themselves with the cross-cultural study of human thought. The distinction has been made between collective representations[27], the systems of ideas as seen in the myths and theories a particular culture expounds, and the cognitive processes of individuals. Whether one can draw specific conclusions about individual thought processes from cultural products such as mythology, or belief systems, has been debated (Levi-Strauss, 1966; Piaget, 1971; Shweder, 1982). Anthropologists have more often focused on these collective representations[28], whereas psychologists have more often made the individual cognitive processes their unit of study. Hallpike (1979) collapsed this distinction between these two aspects of cognition, by applying Piaget's stage-like theory of individual development of thought to rural, traditional cultures, and consequently has been criticized for this (Jahoda, 1982; Shweder, 1982).

19th century Western intellectuals were little troubled by their progressivist and evolutionary theories, which placed so-called primitive societies at lower levels on the evolutionary ladder, whilst proclaiming the superiority of

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[27]The expression "collective representations" was first coined by Durkheim. His interest was in what role they played in the regulation of social systems (Jahoda, 1982).

[28]Anthropologists have described cosmologies of numerous cultures in great detail, suggesting the advantages and the cost of particular beliefs to the society and the individuals in that society (Child and Child, 1993; Hammond-Tooke, 1986, 1989).

Western scientific thought. This has changed; most people involved in the area of cross-cultural studies are committed to egalitarian principles, and are strongly opposed to any interpretation involving superiority of Western thought[29] (Horton, 1982). This is one of the aspects which has made the topic of the rationality of traditional thought a highly polemical one. There is no doubt that the success rate in relation to prediction and control is significantly higher for the Western *hard* sciences compared to the traditional cultures. Horton suggests that a relativistic stance, claiming that African traditional thought is different from Western thought, and not concerned with prediction and control, has been one way of avoiding offensive implications. According to Horton, both Fideist and Symbolist interpretations of African religious thought serve this purpose. However, there are many problems associated with their stance, foremost of all that they "are committing the cardinal interpretive sin of flouting the actor's point of view" (Horton, 1982, p. 209).

Hallpike (1979) developed an essentially Piagetian interpretation of thought, distinguishing between traditional and modern Western cultural representations. His basic hypothesis is that the cognitive development of all individuals follows the stages described by Piaget, starting

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[29]Some psychoanalysts advance more *politically* conservative arguments, suggesting that countertransference distortions are involved in some of these tendencies to idealize non-Western societies and de-value the Western system (Stein, 1990).

from the sensori-motor in infancy, progressing to the pre-operational, then to the concrete operational and formal operational levels. Thus it is his thesis that everyone is endowed with basically the same potential for thought. Differences in the structure of thought are therefore dependent on the demand characteristics of the circumstances and society of the individual.

> In other words, some ways of representing the world are more elemental than others and consequently will occur before advanced representations in the development of every individual. In societies like our own these elementary forms of representation are inadequate for accommodation to the socio-physical environment, and so the individual is forced to reconstruct them at a higher level of mental functioning. But in primitive societies pre-operatory thinking is perfectly adequate for coping with the demands of everyday life and does not conflict with experienced reality so as to require pre-operatory thought to be reconstructed at the level of concrete or formal operations. (Hallpike, 1979, p. 59).

Thus he is opposed to the empiricist view that knowledge is the passive reproduction of associations of remembered sensory impressions, and that language is the basic vehicle of thought and culture. He is also critical of anthropologists who have assumed that traditional and Western thought share the same structure and only differ in content. He argues against the position that culture and therefore the collective representations in a society are independent of the thought processes of the individuals in that society. Rather than the individuals being passive recipients of their culture, they recreate their culture through action.

Piaget's theory is holistic and dialectical in that he sees cognitive growth as occurring through the individual's general attempt to adapt to fluctuations in his/her environment, with thought functioning as a self-regulatory system, aiming to maintain equilibrium. This is achieved through the processes of accommodation and assimilation. The former refers to the necessary development of capabilities in reaching towards the mastery of a specific environmental challenge. The latter is the stable representation of this competence as it is used in various situations (Baldwin, 1967; Hallpike, 1979).

Hallpike therefore implies that African belief systems, like Western scientific thought, are concerned with the empirical realm, the difference between them lying in the cognitive structures achieved by the individuals of these cultural systems. While he takes great pains to correct the impression that he judges what he calls "primitive thought" as inferior to scientific reasoning, and instead claims that it *can* be profound, his thesis has been offensive to many, and received a great deal of criticism.

The problem was that Hallpike based his thesis almost entirely on classical Piagetian theory; failing to take into account the cross-cultural research which demonstrated the task-dependence of these stages. Thus Shweder and Bourne (1982) found that among the Oriyas in India, concrete thinking in the social domain was the order of the day, whereas they were perfectly capable of abstract thought in other domains. The

researchers attributed this finding to the holistic, sociocentric and organic conception of the Indian social order. A second issue which seems to alter individual responses, is the mind-set with which the child, or adult for this matter, approaches the task. It is true, Kagan (1984) maintains, that as children get older, they are better at second-guessing the researcher's hidden intentions, and that the culturally different are more likely to fail in "ecologically unnatural" tasks, but this does not justify the conclusion that the competences of reasoning and thought are lacking. This concurs with cultural psychology, which maintains that the world around us is never just the physical world, but an *intentional* world (Shweder, 1991).

The work of Horton takes a universalist position and emphasizes that African traditional thought is rational and concerned with prediction and control just as much as Western science is (Horton, 1982).[30] He suggests that we all rely, in dealing with everyday events, on a *primary theory* concerned with a push-pull causality, based on some form of genetically programmed structure, and developed in language-based social interactions. Evidence from human biology and the study of psycholinguistics does not support a tabula rasa point of view of the newborn child (Kagan, 1984). However, it is in areas where this primary theory fails, as in situations involving non-observable and hidden events, that cultures are motivated

[30]Horton refers to criticism by the African churches of the Christian missionary message as underplaying the importance of explanation, prediction and control.

to develop a *secondary theory* which would serve to explain and solve those problems which primary theory cannot. This is where, according to Horton, African traditional thought and Western scientific thought moved in different directions. The African thinkers developed predominantly spiritualistic world-views, whilst Western thinkers have become increasingly attracted to a mechanistic world-view. Horton attributes these divergent choices to the African setting having provided greater order and predictability in the area of human interaction, and little control over those events associated with non-human nature. The same was the case for earlier Western societies. With an increase in technological development, societies became destabilized, leading to the association of order and predictability not with the realm of human action, but with the non-human environment.

Horton turns to other contrasting aspects between African and Western societies, to explicate the deeper differences between traditionalism and modernity. He describes African society as traditionalistic and consensual, meaning that knowledge is attributed to the ancients, and that everyone in the community is involved in upholding and reconstructing the same over-arching theory. This means that changes will not occur abruptly, since the ideas adhered to are believed to be true because they have been tested by time. As the theory is experienced as insufficient and there are repeated failures to

predict events which occur, so accommodations will be made.[31]

Western societies, by contrast, are described by the terms "progressivistic" and "competitive," meaning that knowledge as handed down from the older generation is seen as flawed, and rival theorists are competing with each other to prove their own to be the better theory. This approach has been fostered particularly in situations of rapid change, where new solutions have had to be found. Horton believes that these characteristics have done well for the Western world in the area of the physical sciences. They have not done so well in the social sciences, where clear-cut monitoring of empirical efficacy is often not possible. Instead there is a passionate commitment to one's own paradigm as opposed to that of others, involving a great many factors not associated with empirical adequacy. Horton describes cognitive modernism as a kind of Pandora's box. By comparison, traditional theory, while being resistant to sudden change and novelty, remains more closely aligned to everyday experience.

Horton sees both Western scientific thought and African spiritualistic thought as rational theory, improving on the sense of order and stability the societies experience, protecting their members from anxiety. The advent of Christianity in Africa, according to Horton, presented no major threat. Christianity fitted with the spiritualistic

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[31]Horton's (1982) paper provides a more complex and fuller argument which cannot be covered here.

world-view, and key concepts were readily incorporated into the African traditional cosmology. Christianity and African traditional beliefs never came to constitute competing alternatives, although many of the missionaries construed it this way.[32] Horton expects the greater challenge to come from "the bearers of modern Western mechanistic materialism" (p. 213). He cautions however that European history has shown that there can be a long period of transition, where truly conflictual paradigms exist side by side in mainstream culture.

One may need to ask whether that could be happening at present, as one hears repeatedly the phrase of "society in transition"[33] in the African context. While this usually refers to a move away from subsistence farming to wage labour and industrialization, leading to increased urbanization and rural depopulation, enough chaos has been created to disturb the underlying pre-conditions as described by Horton,[34] for a

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[32]Horton (1982) corrects his earlier perspective in describing, like so many others (Hallpike, 1979; Polanyi, 1959), traditional and African theoretical thought as a closed system. Horton emphasizes that on the contrary, African belief systems have always been open to cognitive innovation and borrowed extensively from foreign beliefs. Original *taboo* reactions to novel events by African cultures, rather than preventing change, provide a method of buying time.

[33]Guinness (1992) describes Swazi society in those terms.

[34]Horton (1971) predicts that ultimately religion in Africa will cease to be a system of prediction and control. For the time being scholars emphasize a revitalization of religious thought in Africa, as described by a recent volume dedicated to African traditional religions in contemporary society (Olupona, 1991). Some of the contributors take a dim view of the type o f analyses anthropologists perform on African religion, which they claim is reductionistic, compared to those of the African scholars of

traditionalistic and consensual mode of thought.

The transition from Western "traditionalism" to Western "modernism", according to Horton, can be found in factors such as the switch from the oral to written mode of transmission of ideas, periods of abrupt and prolonged social upheaval, a decline in social stability, and cultural pluralism. Some of these characteristics while at times are said to lead to despair and cognitive stagnation, they may present fertile ground for progressivist thought. The millennial overtones of the Judeo-Christian religious heritage is said to have provided the seeds from which the progressivist faith in Europe developed.

These characteristics seem highly similar to the conditions in southern Africa, and if Horton's interpretations are correct may, despite all signs to the contrary, weaken the hold of traditionalistic knowledge and allow a progressivistic form to emerge. Craig's work on "underprepared" African learners in the South African university context focuses on a conflict between "africanism" and "eurocentricism" of learning histories (Craig, 1991). Her students are said to rely on a commonsense theory of knowledge, usually based on some unquestionable authority and personal experience, where there is one truth to be revealed. In the Arts and Social Science

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religion. The same would of course apply to psychological considerations. Horton's work, surprisingly, got some reasonably positive mention, since his thesis has been that African traditional religion had an intrinsic ability to adapt.

studies which abound with "ill-structured problems," where no single right or wrong answer can be found at the time, but where alternatives need to be considered, the students flounder. Craig (1990; 1991) attributes this to a number of factors in their learning history, some of which are cultural while others relate to South African Bantu education.

Craig found that the underprepared students relied on a commonsense theory of knowledge, where truth is accessed through an unquestionable authority such as God or the university library, or through direct experience. What some black African learners bring to the learning situation, and what the university curriculum demands, are described as conflicting paradigms for action (Craig, 1990). Although the arguments are more complex and detailed, I cannot help but think of Horton's description of cognitive modernism as some kind of Pandora's box. Critics of the social sciences in Africa have said that Western systems of learning and science have dominated and denigrated indigenous knowledge systems (Sinha, 1989; Nsamenang, 1993) and that local research should be mindful of its own heritage of thought. It seems that using general principles to a fault may be peculiar to some Western cultures. Erchak (1992) comments on this in regard to the views of reseachers such as Cole, Rogoff and others: "people in differing cultures, and in differing contexts within a given culture, solve problems by means learned and used for particular situations" (p. 169). The whole area of abstract thought may be one of relevance rather than competence.

CHAPTER 4

TRADITIONAL AND WESTERN COSMOLOGIES

Cosmology and Context

The relationship between cosmologies and the context in which they are found is a complex one, because of the multi-faceted nature of contexts. Thus urbanization does not necessarily mean that tribal people will automatically change to a Western cosmology; many features of their experience, particularly the absence of control over their life circumstances, may well persist in the urban environment, except that the forces may not be those of nature but of a ghetto society. Western traditions are not, in any case, the only way of ordering experience in complex societies; there are many non-Western societies that prove the point (Cohen, 1974).

While the Western cosmology of illness and healing is believed to be firmly rooted in the objective empiricist tradition of science, that of non-Western cultures are often automatically relegated to the realm of superstition and magic. Consequently when treatment of a mental disorder takes place in a skyscraper or in a modern medical centre it must be scientific, whereas should it be located in a mud hut, it is immediately assumed to be magical (Torrey, 1986).

There is a legacy of Western accounts of tribal cultures dating back to the early explorers, the missionaries and the colonialists. These documents, just like the paintings and sketches of those times, often tell more about the culture of the observer than the native people they depicted. The contacts between the Western world and the worlds of traditional societies, however well-intentioned some of them were, often had serious long-term repercussions for the native people and their world views. The newcomers usually came with the arsenal of invaders: they carried with them not only their weapons, their technological superiority and conviction of being right, but also their hidden troubles such as diseases of man and beast. Tribal cosmologies had people ill-prepared for such an onslaught. This is well illustrated by the great Xhosa cattle-killing movement of 1856-1857 (Peires, 1989).

The tragic story illustrates how historical events are shaped by the cosmology of a people together with their total ecology.[35] This tragedy would never have happened had the Xhosas not been under repeated attack by the European settlers, and exposed to new and debilitating diseases through contact with the Europeans. The most significant was the lungsickness epidemic of 1853 which decimated their herds and struck at the core of their culture.

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[35]Ecology here refers to the physical and cultural world of the people, which in this case includes important features such as the socio-political elements including colonialism, Christianization, etc.

Cattle were both a repository of value similar to gold in Western societies (Schneider, 1981), and an intrinsic part of ritual, connecting the living to the ancestors. They were essential to the customs of the home, safeguarding against threats to survival. Peires (1989) quotes Chief Ndumiso Bhotomane, a distinguished oral historian, as saying that when at times cattle die, or when you expect good maize but you don't get it, this is because the homestead is not right.

So when the people had to watch many of their cattle die in this cruel and unexpected way, only to be followed by a failure in the maize crop due to grubs, excessive rain and birds, it must have "seemed as if nature herself was in league with the enemies of the Xhosa" (Peires, 1981, p. 71).

It was against this background that the young girl Nongqawuse's prophecies of the rising of the dead, and the need to cleanse the people of witchcraft and sorcery by killing all cattle, was heard. It was merely the spark to ignite a culture strained to its limits; it made sense both of the traditional world view and the Christian message of salvation and re-birth, and above all it offered hope in a desperate situation.

The events can only be fully understood by examining the political, social and physical ecology of the Xhosa people of those times--events of the conflict situation between Xhosa and settlers, the humiliation of their chiefs, the economic

decline with the loss of land, and then the illness patterns. The dynamics of this situation seems like a puzzle whose key can be found in the meshing of tribal and Christian cosmologies. The end result: some 400,000 cattle were slaughtered and about 50,000 people died due to starvation and displacement. The tribe lost over 600,000 acres of land with these events. Chief Maqoma, one of the bravest and most brilliant Xhosa warriors, died dejected and alone, imprisoned on Robben Island. It is the village of his descendant which became the prime locus of this study.[36]

Disease, Illness and Context

The above narrative illustrates how illness and culture, together with politico-economic forces, shape the history of a people. Nongqawuse's prophecies would, in a modern Western context, be medicalized, though not necessarily with a diagnosis of schizophrenia. Whatever her personal issues were, in that particular historical moment her individual history meshed with the larger meso- and macro-systems, giving meaning to a world that had ceased to make sense to the Xhosa people.

I distinguish, along with Kleinman (1980), Fabrega (1974) and others, between "disease" and "illness," with the former referring to the biological concept in the Western medical

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[36]The current Chief Maqoma had been displaced, since he was in exile due to a rebellion led by him against the Ciskei government. I was recently told that Maqoma was reinstated after the military coup in the Ciskei when Lennox Sebe was ousted.

tradition, and the latter to a culturally constructed event. Kleinman points out that disease and illness are both explanatory concepts, not entities. He defines them in the following way: "Disease refers to a malfunctioning of biological and/or psychological processes, while the term illness refers to the psychosocial experience and meaning of perceived disease" (Kleinman, 1980, p. 72).

He elaborates that illness includes behaviours by the patient and behaviours evoked towards the patient; in fact illness, according to Kleinman, can be seen as part of cure. Disease, therefore, affects individuals, whereas illness usually affects the individual and the social network or even whole communities. Curing the disease does not necessarily heal the illness, and vice versa.

All social groups have to address the problem of disease, and adaptation in different people can be considered in terms of the reciprocal influence of biology and cultural practices (Alland, 1966). Dubos (1980) views the human group as standing in an open relationship with nature, and aligns himself with a quote from an English public health officer which states that

> man and his species are in perpetual struggle--with microbes, with incompatible mothers-in-law, with drunken car-drivers, and with cosmic rays from Outer Space...The 'positiveness' of health does not lie in this state, but in the struggle--the effort to reach a goal which in its perfection is unattainable (Dubos, 1980, p. 349).

What we call disease could therefore be seen as just an arbitrary label for setbacks in the continual struggle between

man and the forces of nature, and questions to be asked about disease have to do with the characteristics of this particular moment in time. Alland (1970) presents the view that culture is an adaptive response to environmental pressures, that man changes his environment through culture, and the changed context will then assert new pressures, requiring new responses.

Healing and Political Power

The way political power tries to modify belief systems and take control of the health care system is well illustrated by Mandelstam's (1991) account of the suppression and systematic discrediting of the Khanty shamans in Siberia by the Soviet Union. Crandon-Malamud (1991), in her research in Bolivia, found that medical dialogue provided a window on the politico-economic relationships between the groups divided by class and ethnicity. The particular belief systems in regard to the causes divides along such political lines. "How people talk about illness is a means by which the symbolic content of ethnic identity is interpreted, and the nature of social relationships is defined" (Crandon-Malamud, 1991, p. 80). Thus medicine is used both as a mechanism to impede change as well as a resource for resistance (Scheeper-Hughes, 1992). Some of the folk-myths directly reflect the underlying political realities, including the exploitation by the sectors of the society that hold the power.

The myth of the *kasiri* is a case in point. Crandon-Malamud tells how the myth undergoes alterations as the political realities change. The *kasiri* was the robed apparition of a Jesuit priest that was said to inflict death on the Aymara and Quechua tribes by stealing the fat from their kidneys. The fat was believed to be used to make the holy oil for the Catholic Church which sanctified the non-Indian population.

During the 1960's when the failure of the revolution was blamed on American imperialism, the story changed: the *kasiri* was now believed to sell the oil to North America to generate electricity. Later on the myth was to undergo further changes in that *kasiri* now became a *skill* (rather than an apparition) which *mesisto's* (people of mixed Spanish and Indian ancestry, and prior to 1952 controlled Indian labour) could learn, using instruments obtained clandestinely from the pharmacies of the city. The fat thus obtained was supposedly sold to factories at huge profits to make perfumed luxury soaps for European and North American markets. A careful analysis shows how the changes in this myth directly reflect the socio-political picture as it relates to the different ethnic groupings in the country. As malnutrition and the mortality rate of the Aymara decreased, the myth reflected this in that the *kasiri* affliction was no longer thought to be fatal.

Not only are the beliefs of causation of illness shaped by socio-political events and the distribution of power, but help-seeking behaviour too is directly related to the same

issues. Kleinman (1980), in his study of the health care system in Taiwan, found that only families from the upper class resorted to Western doctors for treatment at all times, whereas only the lower class families dealt with sickness at home consistently without resorting to the professional help of the Western or Traditional type. Status and power were similarly unequally divided, with Western-style medical practitioners having most power and status, Chinese-style doctors next in line, and folk practitioners lowest on the hierarchy. Western medical practitioners were amongst the wealthiest people in Taiwan.

Differences between Traditional and Western Cosmologies

> The cognitive world of traditional societies tends to be less compartmentalized than that of the modern Western world. One aspect of life is usually inextricably intertwined with many others, not only situationally, but in the thought of those who inhabit technologically less developed societies (Morley, 1978, p. 2).

Traditional healers may perform many functions. They may act as judge, philosopher, seer and priest, besides their role of healer (Wood, 1979). In many traditional societies therefore, they may be just as much at ease with having to solve a case of cattle theft, as with the treatment of a young woman, who is suffering from convulsions. This does not mean that there is no specialization. Distinctions drawn, however, do not follow Western categories, and the healer's perspective remains holistic. The most encompassing view of folk healers would be, as Kleinman (1980) found in Taiwan, that they act as

cultural brokers, interpreting and ordering the world for their clients according to the traditional wisdom, giving meaning to suffering--"the sea of bitterness"--and providing culturally sanctioned ways of diffusing interpersonal and intra-psychic tensions.

Thus we are facing two very different clinical models which approach problems from divergent perspectives, and actually address separate but related issues. Western medicine is obsessed with curing the biological disease, whereas indigenous and folk healers are more concerned with *cultural healing*.

> Cultural healing may occur when healing rites reassert threatened values and arbitrate social tensions. Thus, therapeutic procedures may heal social stress independent of the effects they have on the sick person who provides the occasion for their use (Kleinman, 1980, p. 82).

Western society, as mentioned before, tends to compartmentalize, and therefore distributes these cultural functions to a number of professions. Some, like the paramedical professions, particularly psychology, have remained within the health care field and to some extent connected to medicine. Others have separated altogether as seen by law on the one hand, and religion on the other.

The effective healer in traditional societies welds the "psychic unity" of the culture (Eliade, in Wood, 1979). Numerous accounts of healing ceremonies of pre-industrialized cultures, with very diverse geographical locations, testify to the healing ritual being more than the curing of particular

physical or psychological ailments (Wood, 1979). It includes the nurturing and healing of the whole person and the affirmation of the solidarity of the community. The good-will thus engendered surrounds the sick person with such concern that even should the cure of the disease fail to be totally successful, the sense of relief and hope will go a long way towards the effective treatment of the problem. Compare this to the modern tendency to view the patient as a case of hepatitis, or a case of schizophrenia!

Kleinman (1988) documented client satisfaction in relation to both Western-style treatment, and the various indigenous folk healers in Taiwan. The rating strongly favoured the indigenous folk methods. Some of the reasons given for their dissatisfaction with Western-style doctors sound similar to universal complaints in biomedical practice: the failure to explain, and spend enough time with the patient. The patient's non-compliance thus engendered can have important consequences, as seen, for example, in the misuse of antibiotics.

This does not underplay the significant contribution modern medicine is making and should make, irrespective of the cultural differences of the societies in question. The general acceptance world-wide of modern medicine reflects this (Kleinman, 1980).[37]

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[37]The issues are however, more complex, as seen in the literature in critical medical anthropology, which contextualizes disease and illness in the larger socio-political system (Johnson &

The question, as some medical anthropologists have come to realize, is more one of pluralism, which can be seen in the help-seeking patterns, where certain illnesses are generally taken to a modern hospital, while others are taken to indigenous healers. However, contrary to a common belief, lay people are not the passive recipients of medical care that the professional medical world makes them out to be. In fact, they "activate their health care by deciding when and whom to consult, whether or not to comply, when to switch between treatment alternatives" (Kleinman, 1980, p. 3). It is therefore time to re-evaluate health care systems.

Kleinman (1980) comes to the following dramatic conclusion:

> Either the professions of medicine and psychiatry and public health should recognize these profound limitations and markedly reduce their professional claims, or they must be reshaped to include *health* and *illness* and the everyday context of sickness and care within their boundaries. The latter course means that the biomedical framework must be united with the ethnomedical framework in some overarching integration. That integration, which is not available at present, would reshape the medical model to include social and cultural questions and methods and would radically alter the program of the health sciences and the professions that carry it out. (p. 382)

Sargent, 1990; Lock & Hughes, 1990; Morsy, 1990), and the exploration of biomedicine as a cultural system (Rhodes, 1990).

CHAPTER 5

TRADITIONAL WAYS OF THINKING ABOUT HEALTH AND ILL-HEALTH IN AFRICA

Africa: Multiple Cultures, Multiple Influences

African traditional cosmology is on the whole very pragmatic, and, with some exceptions, not too much concerned with a Supreme Being. This is largely because in small-scale societies the emphasis is on the local group: the family, the descent group and the chiefdom (Hammond-Tooke, 1989). The ancestors, therefore, play a significant part, whereas *God*, while His existence is acknowledged, is not much focused on.[38]

Even in pre-colonial days African tribes were exposed to multiple influences through inter-tribal exchanges, migrations, and wars. These societies were constantly in flux and receptive to incorporating the deities of their vanquishers (Child & Child, 1993). Where African societies had extensive contact through trade with the wider world, the concept of a sovereign God emerged. In present-day Africa this has been attained through the adoption of the Christian or Islamic God. Where Africans have turned to Christianity or Islam, they have not necessarily dispensed with their traditional cosmology. This sometimes results in a syncretic

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[38]It should be noted that Africa does not have a monopoly on this type of thinking. Consider the role of the saints in Latin American and Mediterranean Catholicism.

version, commonly found amongst many sects. Healing plays a central role in many of the churches, in southern Africa particularly in the Zionist sect (Hammond-Tooke, 1989; Thorpe, 1982). This has created another kind of folk-healer, the *prophet*. With some of the Christian denominations, members are expected to relinquish their traditional rituals, and the prophets can therefore sometimes become a more acceptable alternative to the traditional healer.

Given the influence of other cultures on Africa, it is not surprising that the peoples of this continent are often found to hold contrasting beliefs. The world-view of individuals is usually made up of a range of theories applying to different life events, so that "the human mind is quite capable of holding conflictual beliefs at one and the same time" (Hammond-Tooke, 1989, p. 38).

Such conflicting beliefs are usually situation-specific, and therefore contradictions often go undetected (Conco, 1979; Hammond-Tooke, 1989). While this phenomenon is universal, it is more common in times of transition, as seen in South Africa and to a lesser extent on the rest of the continent of Africa, where there is an increasing shift towards urbanization.

Living with the influence of a modern, industrialized, Western culture is becoming more common in African societies, particularly with the increasing dissemination of Western education, and with post-colonial nations attempting to

modernize. Whether this needs to present a problem for the individual is questionable. There is some evidence that consumers of Western and traditional health care experience these services as complementary (Ademuwagun, 1979a). The problem may be more in the minds of those representing *Western* medicine.

Supernatural and Empirical Explanations

Ademuwagun (1979b) found in his research in Nigeria that education had no significant impact on the pattern of utilization of health services in regard to traditional and Western medical treatment.

> There has been a tendency in the past to take for granted that education in general, and scientific training in particular, can wipe out traditional beliefs widely held in African cultures. With the growth of Western-type education in Africa it was generally assumed that as people began to distinguish between "true knowledge" and "superstitious beliefs," scientific investigation would supersede the worship of gods of rain and harvest, that the aetiology of disease would be traced to viruses and microbes rather than witchcraft, juju and evil spirits (Elliot, 1984, p. 109).

The proponents of this ethnocentric viewpoint must have, together with Elliot, been very disappointed to find that African cosmology is a lot harder to displace than was thought by the representatives of rival cosmologies.

Elliot found that medical students at Medunsa, (a historically black South African medical school), in spite of their scientific training, had no difficulties in reconciling their

understanding of causation of disease by germs with their overall conviction that "nothing happens by chance" and that the real cause behind illness may be bewitchment.

Elliot (1984) stressed the contradictory nature of medical science and African cosmology, and believed that the black medical practitioners may have difficulties functioning in an optimal way in their role as doctors. At the same time he also asserted that such person-centered cultural beliefs interfere with progress and the development of technological societies. As has stated above, it is not unique to Africa that discrepant belief-systems do exist side by side.

Non-Western societies have no difficulty in acknowledging *non-supernatural* causes. These would generally assume the status of *immediate* causes, something which is often readily observed. Supernatural causation falls into the category of *ultimate* causes, and it answers the questions of *why*: "why me?..."why now?" These are the kind of questions one of Elliot's students refers to when he says:

> Africans are not shallow-minded...They want to know the cause of everything especially when dealing with diseases and also concerning bad luck... (and that is why) few Africans are frustrated (Elliot, 1984, p. 111).

These questions are not foreign to Western medical doctors when confronting patients and their families who have to deal with incurable illnesses, particularly where the patient is a child, as in childhood leukaemia (Comaroff, 1979). It is just here that the Western medical model has no answer.

Consider, by contrast, the explanation a Ugandan mother whose child had just died, offered to an anthropologist, Elenore Bowen. "She has just died. Children often die. It is their nature." The belief that some of these tribes have about the "spirit children" who never stay long in the world but come again and again, is just one of those explanations which attempt to deal with the human condition (Wood, 1989, p. 294).

Watson (1982), in telling the life story of Adrian Boshier, a white man who became thoroughly enculturated as a traditional healer, drew on the diary and notes of this enigmatic man. He reached some conclusions as to the function the supernatural has in Africa:

> A belief in magic makes it easier to account for misfortune, and the existence of appropriate ritual permits people to take action of some sort in face of uncertainty and insecurity. All this helps to make the occult at least partly manageable. Having identified the source of trouble and having given it a human face, one fights it with magic of one's own, or employs a magician to do so (p. 150-151).

Traditional Perceptions of Illness and the Supernatural

Vera Buhrmann has been recognized for her contributions to create a better understanding of traditional cosmologies and the indigenous healers on the part of professionals in South Africa, including medical doctors, psychiatrists and psychologists. While her own research focused on Xhosa healing practices (Buhrmann, 1978; 1981; 1983; 1987), her involvement in psychiatric case conferences in Cape Town at the hospital

exposed her to a wide variety of issues. She has, therefore, taken a closer look at the difficulties in the diagnosis of mental illness in black patients, where psychosis may be erroneously perceived because of misinterpretations of culture-specific behaviour. She has published widely and prolifically within southern Africa. While her own orientation is Jungian and phenomenological, she has shown an ability to transcend some of the romanticism characteristic of this orientation, and approaches the more perplexing problems of the interface of culture and mental illness in a pragmatic and honest way (personal communication, 1988).

Buhrmann (1981) stressed that in Black society, the ancestors are part of the community of the living, present as the *living dead* (p. 17). Dreams, visions, hallucinations and rituals are all ways of being in communication with the ancestors. As Ngubane (1988) elaborated in saying that an understanding of African concepts of illness requires an appreciation of the importance of the concept of being *in balance* with your environment.

In African societies people believe that all living things in the environment are interrelated--human beings, trees, plant life, animals, birds. Buhrmann (1978) speaks about this interrelatedness in terms of a holistic view of the person where the individual is not separate from the environment, family, clan or ancestors; nor is there a division into psyche and soma. This, she feels, makes for a "natural cosmic

relatedness," and ego boundaries which are less rigid, and where external and internal realities are not sharply separated (Buhrmann, 1978; Schoeman, 1985). This would, obviously, have significant implications for the *self* and human subjectivity, particularly as regards illnesses, such as schizophrenia (Fabrega, 1989).

Causal Agents in African and Particularly Xhosa Cosmology

In traditional cosmologies in South Africa, the main causal agents of misfortune and illness, in brief, fall into three main categories: the ancestors, the witches or sorcerers, and pollution (Hammond-Tooke, 1986).

The ancestors, unlike witches and sorcerers, are benign in intent, but then can still cause harm in that they may fail to protect their descendants, or even punish them if they should neglect the customs of the home. The ancestral spirits, therefore, represent powerful forces of social control. Hadebe (1986) reports on witnessing several incidents where families of the deceased in Zulu culture went to extreme effort and expense to "bring the body home" so that it could be buried in the appropriate way, even if that meant taking the matter to the Supreme Court. I also experienced, with relatives of a deceased staff member at a residential facility in Johannesburg,[39] the distress which could be engendered in the

[39]I was involved as manager in the supervision of the black staff at Walberton Manor, referred to in the Introduction, at the time of this incident.

family if funds were insufficient to carry out the expensive ritual slaughter of an ox, which is associated with sending the spirit of the departed away and later bringing him home again. A major ritual of this kind is usually reserved for the head of the household, while there seems to be a general but amorphous belief of the continuing existence of everyone after death in the form of ancestral spirits (Hammond-Tóóke, 1986).

Witches and sorcerers, together with their familiars, are the embodiment of evil, and they can cause misfortune as well as illness or even death. The sorcerer is believed to achieve his or her aim by the use of medicines, which is an acquired skill. The witch, usually but not necessarily a woman, is believed to be born as a witch, and to cause harm in supernatural ways. Soul (1974) cites the concepts connected to the belief in witchcraft in the Xhosa culture. The invisible agents which are the witches' helpers include amongst others the *impundulu* which is the lightening bird, and the *uTikoloshe*, the short hairy fellow who is highly mischievous and is probably the best known mythical creature in African folklore, his fame going well beyond the Xhosa and Zulu cultures (Hammond-Tooke, 1974). Both characters are thought to have sexual relations with the witch who keeps them, and in this way may represent compensatory forces in a strongly patriarchal and patrilineal society. Soul (1974) also mentions evil omens which are connected to the supernatural and to bewitchment. He mentions *Isikova* the owl, amongst other birds.

Ordinary people too are seen as having access to witchcraft and sorcery simply by going to the herbalist and buying strong medicines which can then be used to destroy their enemy. *Amafufunyane*, often referred to in the literature by the singular *ifufunyane* and described as a spirit possession, is one of the many conditions culturally attributed to sorcery (Edwards, Cheetham, Majozi, & Lasich, 1985). Amongst the rural Ciskei Xhosa, this seems to be the most prevalent condition of bewitchment in the recent years. It is often at the heart of bewitchment accusations. Symptoms are said to range from hysteria to excitable, out-of-control behaviour which may include running amok, weeping, tearing off clothes, aggressiveness and self-injurious acts. Most of the literature commenting on this condition refer to Zulu culture. Apparently it reached epidemic proportions in the 1920's and 1930's (Watts, 1980). Some have attributed this illness to acculturative stresses (Lee, 1969).

Solving problems by magic, particularly by witchcraft, is not acceptable in traditional African societies. Instead there are formal procedures. Particularly when there is the threat of divorce, the families involved will try and do everything to settle the dispute. One of the exceptions is the use of love-magic amongst the Nguni tribes (Hammond-Tooke, 1974). There is, however, an emphasis on protective magic, so that the herbalist and the diviner are consulted for numerous potential threats.

Witchcraft has to be seen in the light of the moral and social prescriptions of harmonious living together. The good person, "is he who is generous--with his time, his concern and his worldly goods" (Hammond-Tooke, 1974, p. 361). Reciprocity in assisting one another is taught early in life, and is reinforced by the proximity of living arrangements, and people's interdependence. Other qualities are the observance of custom, loyalty to kinsmen and chief, respect for elders, and being clean of witchcraft.

But the strict code of ethics regulating kinship and neighbourly interactions are also at the heart of witchcraft accusations. Hammond-Tooke quotes statistics that only 30% of witchcraft accusations are against strangers; in the Keiskammahoek area 82% were related either by blood or by marriage (1974, p. 358). These accusations can be considered as markers of societal tensions, and can easily be seen as projections (Hammond-Tooke, 1986). The unacceptable impulses of envy and hate towards people whom society dictates should be loved, are thus externalized.

The presence of tensions in the culture has been noted by Guinness (1992), in his research on mental illness in Swaziland.

This stress has been described as the "brain fag syndrome"[40] (Guinness, 1992). Guinness speaks of the fear of envy and bewitchment as an intense cultural response to education, as well as the significance of education in its economic implications. Social factors, like migrant labour, which seems to lead to an unstable parental union and an increase of illegitimate children elsewhere, predispose to greater anxiety, spreading the scarce resources even thinner (Guinness, 1992).

The literature suggests a link between the intensification of witchcraft accusations, and societies in transition (Macfarlane & Thomas as quoted by Levine, 1973; Guinness, 1992). But as Guinness has pointed out, bewitchment beliefs can also help maintain homeostasis within a social group where resources are limited, by discouraging the advancement of the individual. Thus in African peasant society great success would easily be attributed to empowerment by sorcery or witchcraft, or achievement per se may expose the individual to intensified threat by envious others. *Muti* (medicine) with magical powers to achieve particular goals can in fact be procured through herbalists or various other sources, but is often considered dangerous. It is an arena which has led to the distortion of culture as evidenced in the so-called *muti murders* (Guinness, 1992).

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[40]The "brain fag syndrome" is a prevalent form of somatized anxiety and depression first described by Prince (1962) in Nigeria.

This accords with a general tendency in African cosmology to externalize problems, whether they are the causes of illness or personal failure. Guinness (1992) speaks of the brain fag syndrome being a form of *masked* depression, because the depression is not articulated in the Western way, where the problem is often experienced in intrapsychically (eg, as guilt). Externalization, together with the sense that everything has its cure, protects the individual from the desperation and guilt which so often plague the Western individual (Hammond-Tooke, 1986).

Traditional beliefs contain all the answers for the problems life can present, and they also give instruction on what to do about them. However "there is a great social price to pay" (Hammond-Tooke, 1986, p. 12). Witchcraft explanations are essentially paranoid reactions, where blame is put onto others, and which can result in splitting communities through anger and fear.

The third category refers to pollution beliefs. People can become polluted because they are seen as being in a dangerous state, as in the case of women who are menstruating, who are pregnant, who have recently given birth or been widowed, or who are ritually impure. The Xhosa term usually used in this context is *umlaza* (Soul, 1974). Among the Sotho pollution is linked to heat, and both treatment and protection are conceived of as cooling and often involve the use of water, particularly sea water. With the Nguni group, to which both

the Xhosa and the Zulu belong, pollution is linked to darkness and dirt, and treatment is in terms of cleansing (washing and purging). These differences in the belief systems can possibly be explained by regional ecological features relating to rainfall as well as social structures (Hammond-Tooke, 1989).

The Call to Healing

The condition of *intwaso*, the call to become a traditional healer, known as an *igqira* in Xhosa tradition, and a *sangoma* in the Zulu, has received a great deal of attention from anthropologists and psychologists alike (Buhrmann, 1984; Hammond-Tooke, 1989; Hirst, 1993; Kruger, 1974; O'Connell, 1980; Schweitzer, 1977).

The onset of symptoms which mark this call to the profession are often vague (Hammond-Tooke, 1989). Individuals usually describe a variety of symptoms which could be anything from stomach-ache, pains in the back, shoulder, neck or joints, to *umbilini* or nervousness, which Hirst (1993) describes as anxiety or fear. Periods of unconsciousness and withdrawn behaviour are also considered symptoms. Powerful dreams, usually relating to the ancestors and traditional images, seem to act as a guide in the initial call and during the apprenticeship, once the call has been accepted.

While *intwaso* appears as an illness for which the cure is found in the training to become a traditional healer,

conceptually it is not seen as an illness, or the cause of mental illness; only the *refusal* to follow the ancestral call will result in serious illness. Both Hammond-Tooke (1989) and O'Connell (1982) describe the ambivalence which often characterizes the feelings with which the *intwaso* diagnosis is received. It is considered both a burden (*inkathazo*) and a gift. It is a burden in that it places numerous restrictions on the individual, as well as requiring some financial sacrifices by the family; and it is a gift in that it provides new opportunities and roles in life.

Intwaso seems to offer an acceptable solution to an unbearable situation. O'Connell (1982) says that "it is invariably sent to an individual who experiences insurmountable personal problems" (p. 22). His study suggests that *intwaso* is an adaptive response to acute stress generated by conflict between the individual's performance and cultural role expectations. For women the area of role-stress seemed to be in the domestic sphere, whereas the area of stress for men was in the extra-domestic sphere. As O'Connell points out, in spite of strong Western influences, there has been a significant increase of *intwaso* in the Transkei, particularly in areas where the problems of migration, land-shortage and poverty are more severe. He therefore sees a relationship between *intwaso* and the stress associated with contact with white South Africa for the Transkei Xhosa.

It has been noted that women outnumber men significantly when it comes to the profession of the traditional healer (Hirst, 1993). According to early accounts this was not the case in the past, and in fact there were references then to a time when this was exclusively a male domain. O'Connell (1980) sees *thwasa* in women as a response to the patriarchal restraints, particularly in regard to married women who lose all freedom, and often enter a life of drudgery in the household of their in-laws upon marriage. By becoming diviners, women change their social status and *socially* become men, and in this way escape the usual restrictions placed upon them.

O'Connell (1980) suggests that *intwaso* may well be, as Buhrmann (1984) claims, a creative illness, in that it provides an alternative life situation for women who find they cannot fit into the mold of their culture. In this way the forces which could potentially rock the patriarchal foundations of this society are contained.

O'Connell (1980) also addresses the question of why the patriarchal society would allow the present-day increase of women diviners, women who, in other words, take over the leadership of the religious and healing aspects of the society. He maintains that diviners have become marginalized, and that the real power has been taken over by the Christian sects. Men in the Nguni cultures now seek leadership in the Christian churches. It is the *marginalized* women, and men for that matter, who become diviners.

A Society in Transition

South Africa is undergoing major political and social changes, which must impact on the cosmologies of its cultures in fundamental ways. Questions which concern the traditional healer are related to the high profile black youth has assumed through political activity. This is a new development in a traditional culture[41] where power and authority are controlled by the elders of the community. Yet according to reports in the Weekly Mail (Dec 11-17, 1992), the *sangoma* was resorted to for protection by youths on both sides of the conflict between ANC and *Inkatha* supporters, as they went into battle.[42]

There was talk about the necessity of including the chiefs in the future political configuration, in spite of the assumption at that time that they represent structures which are at odds with some of the political expectations of the black politicized public (Weekly Mail, July 2-8, 1993). The same newspaper reported the joint venture of a black *sangoma* and a white artist, in producing *sangoma* totem poles as protective devices against attack on households and farms, which were available for purchase by white farmers and black businessmen alike. Thus the flourishing security business had taken on syncretic dimensions.

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[41]The culture being *traditional* as opposed to *transitional* is relative, and an argument could be made for its having been transitional since the "Great Xhosa Cattle-Killing Movement".

[42]Currently the South African Government is an ANC one, while the Zulu-based Inkatha, led by Dr. M. Buthelezi, is in opposition, and fighting between their supporters continues.

We see in this that even if the traditional healer is being marginalized, this does not mean that the traditional belief system is being rejected. Conco (1979) notes that even the Blacks who are sophisticated and emancipated, and who may generally choose Western medicine and have little faith in traditional medicine, still do not reject "the whole spectrum of traditional beliefs..." (p. 69).

What impact these changes are having is perhaps difficult to anticipate, but then Southern African cultures, and the Xhosa-speaking people in particular, have endured major challenges to their cultural continuity since the European settlers first arrived in what is today the Eastern Cape. Since the fieldwork for this thesis was done, the larger political system in South Africa has officially changed to a democratic one. How this will affect the Xhosa cosmology in the years to come, is something I do not feel in a position to answer. It is, however, important to anticipate possible changes in the role of the traditional healer within the health system.

Research suggests that subtle changes in traditional practices occur because of necessity. Choices in health care in a rural Xhosa community were shown to be dictated by economic factors. Divination (diagnosis) was dispensed with in favour of the cheaper treatments, such as home remedies. Traditional diviners were also consulted largely for treatment (C.Simon, personal communication, November, 1990, Rhodes University).

Simon concluded that this was a strategy which allowed maximum flexibility in coping with a situation of scarce resources. He determined that people make choices based on sound, empirical logic, rather than, as had been assumed, any rigid dictatorial notions of causality.

The literature reflects a process of continuing change in the traditional societies of Africa; modernization and Westernization are part of this process. It is worth noting that the terms "traditional" and "Western" are loaded in the context of South Africa's socio-political history, in that they have been used to justify the plethora of inequalities in the apartheid system. The same arguments, in which "traditional" are seen as meaning "superstitious", "unchanging", and "backward", where these terms are used pejoratively, have also been proffered to account for differences between developed and the developing countries in the wider context of international politics (Boonzaier & Sharp, 1988). The reasons for the continuity of traditional approaches to illness and its healing are many, not the least of which is the scarcity of quality Western medicine available to the rural Xhosa.

In summary, the literature reflects the significance of cosmology in the finely interwoven fabric of society. Contrary to expectation, traditional cosmology, where the terms "traditional" and "Western" are relative, has been fairly resistant to Westernization. Xhosa society, like many other

African societies, has been assaulted and changed since the arrival of the white colonizers and missionaries. While many traditions and the spiritualistic world-view have survived, they have adapted, often in subtle ways. Basic traditional concepts in relation to illness, which are still alive today, were described in this chapter; some of the more complex distinctions have been lost or modified. Those writing in this area have been criticized for rendering a static picture of a traditional world, often based on limited observation (Boonzaier & Sharp, 1988). The notion of the "traditional" seems to have a nostalgic appeal for researchers, as well as providing a potential source for exploitation for all sides in the political struggle. What has been pointed out is that so-called traditional beliefs and customs are often dynamic responses to changed circumstances (Boonzaier & Sharp, 1988). Traditional healers will address the problems people have which cannot be cured by modern medicine, since these relate to the larger social and econonomic context.

CHAPTER 6

WESTERN PSYCHIATRY IN AFRICA: PAST AND PRESENT

Phambana

Doctor, I am taking Mellaril tablets one in the morning one at night. I started taking them on the 24th July 1984 at Tower hospital up to now. They are good for me. They make me sleep well and they quiet my nerves a little bit. My complaints are: Dizziness now and then. Poor eyesight. A stomach that is always aching after meals and after taking laxatives. I am too nervous. I have no courage--always afraid. Having feeling on side where liver is. My breathing is not normal rather slow. My pulse is not normal-- rather slow. My movements are slow. My arms and legs are heavy and inert. Pains where funny bone is on both shoulders. Aching back. There is something wrong with my liver and portal vein because I eat now and the--I get hungry quickly. I can't do manual work-- get tired quickly. Sometimes too much saliva in my mouth. Whole of my back has periodic pains. Too much wax in my ears. My feet and legs become painful after walking long distances not even that long distance. I started using Mental Illness tablets in 1967 December at Komani Hospital in Queenstown. after that I have never been mad. All joints of my Limbs are weak--sometimes too loose sometimes too tight. After long periods I experience to strangulation. Nenmogastric pain after taking laxatives. I am afraid of heights. I find it difficult to climb up a road because of my legs and feet. Too forgetful sometimes. Can't read aloud for more than 1/3 an hour--my brain gets too tired. My muscles shake after doing manual work. I can't listen to a match on the radio for more than 1/2 hour I get tired. My stomach has too much acids. Can't write fast. Cars or motor vehicles driven fast shake my nerves. My power of prehension is poor which means I can't understand anything new I am taught now. The only things I know well are those things I was taught before I got mad-- that is why people when

> they hear me speak English they say there is nothing wrong with me. When I am angry all my muscles start shaking. Frequent nose bleeding. Swollen eye lids next to my eyelashes. The muscles of my body have a tendency of shaking after doing manual work. Always feeling dull. My jaws become stiff and painful sometimes when eating.

This letter was found in the file of a psychiatric patient at the local hospital. His case history was brief. He was working many years ago for a construction company well known by its billboards on the side of the roads in the Eastern Cape with the ironic name of Savage and Lovemore. He became ill with chest pains and left. At home later he became ill again with the same symptoms. After that he did not remember what happened except that he quarrelled with his grandfather over a radio and assaulted him with a stone. He was then told that he was mad. He was hospitalized a number of times and was given a diagnosis of schizophrenia.

While we cannot know for certain what was going on in this man's life and his illness, he describes his suffering in sufficient detail to let us have some rather good hunches. His brief case history suggests some kind of psychotic break during which he assaulted his grandfather. There is no reference to anything which would suggest what the exact symptoms were, except for *violent behaviour* towards a member of his family which presumably got him hospitalized. It seems that this act got him the label of being *mad (phambana)*. There is no reference to any causes, whether medical in the Western sense or cultural in the traditional way.

We cannot, therefore, be sure that he was correctly diagnosed as schizophrenic even in the psychiatric sense. The only evidence we have is the fact that his action was judged as *mad* by the community and the admitting psychiatrist, not simply as an aggressive act. He must have been experienced as being out of control enough to justify hospitalization, which is often the last resort. This letter allows us to explicate some of the Western psychiatric concepts relevant to psychosis, in contrast to the subjective experience of the Xhosa patient. We see no evidence of *hallucinations* or *delusions*, the many so-called *positive* symptoms of psychosis and particularly schizophrenia. Instead, we are given a glimpse into a man's experience of "having lost his health." His tale makes nonsense of a dualistic divide of body and mind, his suffering is real and encompasses all aspects of functioning in the real world.

Our understanding of his particular complaints may raise questions as to whether he is experiencing the so-called *negative* symptoms of schizophrenia, the *lack of drive, psychomotor retardation, difficulties in thinking and learning,* or whether he is experiencing a *post-psychotic depression* which may include "*lack of initiative, poverty of speech, hypersomnia, social withdrawal, lack of interest and pleasure, fatigue and neurasthenic complaints, impaired concentration, guilt and hopelessness, and an akinetic syndrome of retarded speech and motor behavior*"[43] (Sommers 1985,

[43]Emphasis added.

p. 369). He may in fact be describing *side effects* from the *neuroleptic* medication. Sommers (1995) writes about the difficulty of distinguishing between various *extrapyramidal symptoms* associated with neuroleptic treatment and *negative symptoms*, particularly akinesia. She says that this can include "lack of *emotional reactivity, social ineptness, lack of goal-directedness, lack of or retarded spontaneous speech, sluggishness, diminished social and vocational initiative, few gestures, and decreased physical movement*" (Sommers 1985, pp. 369-370). Perhaps a primary question should relate to this man's context addressing issues of whether he is getting adequate food, or whether he has to "walk too far." His letter reflects great sophistication and education, but he tells us that he feels that he cannot function the way he used to.

The *phambana* account shows us the way Western psychiatry translates subjective experience into its disease concepts. Foucault in the 1950's and 60's, gives us a phenomenological account of madness, pointing out that madness as disease is of somewhat *recent* origin and that "only with the arrival of the calm, objective, scientific gaze of modern medicine that what had previously been regarded as supernatural perversion was seen as a deterioration of nature" (Foucault, 1987, p. 64). While there is no doubt about the accuracy of the phenomenological analyses of the experience of psychosis, what are we to make of the cultural interpretations of these phenomena, since the last fifteen years have presented us with powerful evidence for the biological nature of schizophrenia?

Differential diagnosis as well as treatment in the history of Western psychiatry has gone through many phases. Keefe and Harvey (1994) give an up-to-date account of the best that modern psychiatry has to offer to those suffering from a severe mental illness, specifically with regard to schizophrenia. They point out that it was not that long ago--before 1952, when chlorpromazine was discovered--that to be mentally ill often meant in the Western world a lifetime confinement in a huge mental hospital. Biological treatment was generally of a fairly crude form including fever therapy, insulin coma treatment and lobotomies. While this point of view of the history of psychiatry seems to be the one authorized by the medical establishment, a wider reading and closer look at the small strokes of history, leaving aside the wider sweep, reveals a more complex picture.

While the history of mental illness is often portrayed as the practices of the past being ineffective and inhumane in the light of today's knowledge, this was not uniformly the case. There is more the sense that we are going around in circles, or perhaps in spirals, where many issues and situations are being revisited, albeit in a slightly different form. Humanitarian concern has not been invented by this century and Western biomedical practice.

The underlying issue over the centuries was often one of economics and revolved around who was responsible for the care of the mentally ill. The same issues have remained with us. As Warner (1985) eloquently points out, statistics derived from British mental hospitals, as well as a few examples in the United States, show that the discharge rate was already increasing steadily after 1948, prior to the introduction of chlorpromazine.

Efforts to rehabilitate the disabled, including the mentally disabled, also seem to be closely related to labour-dynamics rather than pure humanitarian concerns. Warner makes a strong case for political and economic factors having dominated and still dominating to this day the treatment of the severely mentally ill, thereby affecting their recovery. These issues have received increased attention with international research, such as that which has been conducted by the World Health Organization, seeming to suggest that prognosis for mental illness, particularly schizophrenia, is better in the developing than the developed countries (Sartorius, Jablensky, & Shapiro, 1977; Sartorius, Jablensky, Ernberg, Leff, Korten & Gulninat, 1987; Jablensky, Sartorius, Ernberg, Anker, Korten, Cooper, Day, & Bertelson, 1992).

This brief history of Western psychiatry is not meant to give a comprehensive overview; the aim is only to demonstrate the complex interaction of many different facets, including political, economic, and humanitarian, as well as progress in

the understanding of brain functions and drug research. If we want to get a better picture of the patient with a severe mental illness in the former Ciskei who, though admitted to a mental hospital in the Western tradition, yet adhered to a culture that defined mental illness predominantly in traditional super-natural ways, we have to consider many factors. This includes the state of psychiatry as defined by the First World nations who are on the cutting edge of Western medicine, and past and present medical practices in Africa.

Biomedical Practices in Africa

The history of colonial medical discourse in Africa, while resembling biomedicine in the land of the colonizers, predominantly England, had a direction of its own. As Vaughan says:

> Biomedicine, when it "landed" in Africa, confronted a wide range of different healing practices, more or less systematized, and often existing side by side. In some parts of Africa, and under certain circumstances, one or other system might have become formalized and closely aligned to political authority--but in general there was little professionalization of the task of healing. Though some of the more politically powerful of these systems were dealt a severe blow by the incursions and prohibitions of early colonialism, in general, according to this literature, African healing systems showed themselves to be remarkably resilient and adaptive. Far from being destroyed by the joint assault of colonialism and biomedicine, they tended rather to absorb and internalize, to "indigenize", those elements of biomedical practice which seemed most effective and most impressive--the most obvious being the injection (Vaughan, 1991, p. 24).

This does not mean that colonial authority did not try to demean and inhibit African traditions of healing, but

ultimately lack of resources as well as active resistance by those colonized, presented innumerable obstacles to successful control. Vaughan maps the painful history of medical discourse, showing that in the area of psychiatry it was not the *mad man* who became the other and was thus objectified as it happened in Europe and the United States, but that *the African* in general was pathologized. Difference was inextricably tied to inferiority and connected initially to the concept of biology and race, and later to culture.

Appiah (1992) writes about the problem of the African identity and maintains that authors and intellectuals who have come out of Africa have struggled and mostly failed in escaping an identity as seen by outsiders, allowing themselves to be defined by the gaze of the white man, even when they have reacted against this. Frantz Fanon, who was practicing as a psychiatrist and at the same time was a colonial subject, has written extensively on the subject of the *African identity.* He speaks about the white man projecting all that is bad on to the black person and making him into the other (Vaughan, 1991).

Biomedicine too contributed to the sense that blacks existed in relation to the white colonizers, in that the fascination with *tropical diseases* and the focus on the control of epidemics was really more a concern with protecting the European settlers, than with improving the health of the local population. This gap was filled by the missionary doctors who

took on more urgent problems the indigenous people were experiencing. The missionaries did then provide a much needed service, but this came at a price. While secular medicine created the image of Africa as a repository of disease, missionary medicine thought about Africa's pathology in terms of evil and sin. Biomedicine thus played a crucial part in objectifying the *African* and at the same time shaping African subjectivity. Concrete examples of this were references to the African as equivalent to a lobotomized European, and the belief that child-care typical of Europe in the 1940's with discipline and feeding schedules, would lay the foundations of a more balanced African personality and "could solve the major social and political problems of Africa" (Ritchie as reported by Vaughan 1991, p. 117).

If the treatment or control of epidemics belonged to secular biomedicine, and mission medicine attempted to save the child and cleanse the leper, the mentally ill fell largely under the jurisdiction of the colonial courts. Vaughan (1991) describes how in Nyasaland by the First World War, with a Witchcraft Ordinance and a Lunacy Ordinance on the statute books, the task was to distinguish not only between the bad and the mad, but also distinguish them from the person who was bewitched. Since insanity was upheld as real in the courts, but witchcraft was not, and a belief in the latter normal for an African, the courts had difficulty in deciding on whether a crime was motivated by abnormal paranoid delusions or normal witchcraft beliefs. Though the institutionalization of the

insane had begun in South Africa in the mid-nineteenth century, there was never the equivalent of the European "great confinement" in the psychiatric history of Africa. For the most part, Vaughan reports, "colonial officials were inclined to the view that African communities could care for their own 'lunatics'" (Vaughan, 1991, p. 107). Colonial authorities did not need to scapegoat the mad person, a view held by Thomas Szasz in relation to Western society (Szasz, 1970), since the colonized African could fill that role.

There were a great many inconsistencies in colonial thinking, as seen in the deep-rooted belief that colonialism was a civilizing mission, which hardly fitted the prevailing theory that the central cause of insanity was *acculturation* brought about by education. As Vaughan points out biomedical discourse tells us a great deal more about colonial categories than about mental illness. Colonial thinking distinguishes, for example, between two types of delusions, a *European* and a *Native* type. The so-called European type generally focused on content deemed irrational in that it often assumed power positions felt to be inappropriate for an African; for example "thinks himself wealthy", or "a commander of a great army." The Native type category seems to imply that these delusions come more naturally out of the African psyche, for example, "the belief that he is a lion and wants to kill people and eat them."

Shelley and Watson, amongst other psychiatrists of that time,

attributed the apparent rising incidence of insanity to the loss of tribal innocence, largely caused by education and Christianity. There was a real fear, according to Vaughan, in the colonies during the 1930's, that the disintegration of traditional structures would lead to loss of control. This stimulated a great deal of research and the proposed solution was that of indirect rule, in that the tribal identities were to be maintained, and only those customs dropped that were unacceptable to colonial powers.

One of the most popular and influential psychiatrists of the 1930's to 1950's was J.C. Carothers, who maintained that the incidence of mental illness amongst traditional Africans was very low, and in fact depression was virtually nonexistent. He attributed mental illness to *deculturation*. Since he had no data for the untouched traditional African, he used statistics of American blacks as providing the evidence he was looking for, associating what he thought of as an extreme position along the continuum of deculturation with a high incidence of schizophrenia (Vaughan, 1991). Depression, Laubscher claimed, only occurred where there was enough personal integration to make for a sense of responsibility and guilt, all of which he saw as absent in African culture.

These theories did not go unchallenged. There was criticism both of the so-called myth of the excellent mental health of the rural black population as well that of the "carefree African." One argument suggested that rural mental illness was

often hidden by good care, while delusions in the more educated, urban blacks were more noticeable to the authorities. Another argument, supported by Margaret Field, a psychologist turned anthropologist, suggested that while it was true that literate people showed more mental illness than illiterates, this was not due to deculturation or culture conflict but the demands which were placed upon these individuals. As for depression, she asserted that this was widespread, particularly amongst women, but that this found expression often through the idiom of witchcraft (Vaughan, 1991). However, as Vaughan asserts, it took the post-Independence period for African psychiatrists to develop more fully the argument that the increase in mental disorders may be produced not so much by Westernization, nor by urbanization, but by economic insecurities and the social consequences thereof.

I remember reading in the Washington Post, 1988, an article by Blaine Harden on modernity in Ghana, telling of the conflicting demands on a Ghanaian university lecturer, particularly his obligations to his extended family. Harden reports, "the extended family is a day care, social security and welfare system. It babysits the children of working parents and keeps the elderly from feeling useless. It feeds the unemployed and gives refuge to the disabled and mentally ill" (Harden, 1988, p. 6). The stresses fall upon those who have had the education, and have some earnings. There is a sense that there is never enough.

Treatment of People with Mental Illness in Southern Africa

While Africa, as was mentioned earlier, never experienced the great confinement of the mentally ill, it did have its share of mental hospitals. The complaint, however, has been insufficient beds and poor quality services rather than that large numbers of people were confined against their will. Laubscher (1937) gives hospital statistics in the Transkei, quoting female admissions as 419, males as 670, over a period of ten years. He specified a discharge and therefore *recovery* or *remissive* rate of 36.6% and 33.5% respectively. There is no talk of overcrowding or waiting lists. He also states that "schizophrenics are rarely if ever re-admitted to the hospital" (Laubscher, 1937, p. 255). Compare this to figures by the World Health Organization for 1975-76: 12,089 beds were available for African mental patients in the Republic of South Africa, with an excess of 3,396 Black patients at one point, while at the same time there were 830 vacant beds in psychiatric hospitals for Whites (Jablensky, 1977). World Health also reports on the Smith Mitchell scandal. The Government had since 1964 contracted the Smith Mitchell company to provide custodial care for over 10,000 Black mental patients for profit. The outcome was a warehousing of patients described as a "version of the Dickensian workhouse" (Jablensky, 1977, p. 20). Staffing was inadequate, and personnel insufficiently trained; the discharge rate of patients each year did not exceed 12% of the admission rate. The conditions were felt to represent human rights violations,

particularly in the light of the discrepancy in the quality of psychiatric care for Whites as compared to other racial groups. Later inspections fared little better, since improvements were felt to be largely cosmetic, while a major overhaul of the system was needed (Domisse, 1987).

The problems which were and still are besetting the mental health arena, are firmly rooted in the South African health services in general, and South African society in particular. The Gluckman Commission, while appointed in 1942 by the Government, was ahead of its time in recognizing the relationship between disease and the prevailing social conditions, arguing that a National Health Service was needed, providing free medical attention to all (De Beer, 1984). Suffice it to say the plans were never implemented; the findings were buried with those of other candid commissions in the history of apartheid.

While the Western World became disenchanted with mental health care's focus on large mental hospitals from the late 1950's, these concerns had little relevance in southern Africa; mental hospital facilities were few given the size of the black population, and deinstitutionalization was a consideration. A survey at Ingutsheni Hospital in Matabeleland prior to the metamorphosis of Rhodesia to Zimbabwe, and the end of colonial rule (1969-1971), illustrates this point. Figures in the survey hardly correspond to the trends in America and Britain at those times. Buchan (1976) cautions about transplanting

medical care developed in more sophisticated Western countries to Africa, and that follow-through clinics were the best that community psychiatry could do at this point. These clinics were meant to prevent patients from defaulting on their medication and thus avoiding relapse.

Buchan seemed to be well aware of the variability in diagnostic trends as reflected in the following passage:

> Manic depressive psychosis was rarely diagnosed, but this may reflect a difference in diagnostic practice; the acute hypomanic episodes not infrequently encountered in African patients (Carothers) are usually diagnosed as schizophrenic in our own practice, but may well be labelled manic-depressive elsewhere (Buchan, 1976, p. 30).

A more enterprising community-psychiatry approach adapted to the needs of an African context, pioneered by the World Health Organization, is the Primary Health Care (PHC) approach described by Guinness, a British psychiatrist working for the Swaziland Government Health Services between 1982 and 1987. Part of his duty was the clinical supervision of a 200-bed mental hospital, staffed by one psychiatric nurse, six general nurses and 30 untrained orderlies. The hospital had been established only 15 years prior and provided very basic custodial care, including some fluphenazine to reduce chronicity. It served for patients with florid psychoses and according to Guinness was feared by the local population. Alternative care for the severely mentally ill was in the form of the traditional healer. Before the establishment of the mental hospital the town jail had been the custodian.

Guinness (1992) gives us an outline of the way the PHC model makes maximum use of resources by operating through a hierarchical infrastructure in which tasks are delegated where-ever possible to lower, less expensive and less trained members down, to the village health workers. It involves successive levels of responsibility and supervision and facilitates community-based rehabilitation. Emphasis was placed on a mobile community clinic and case finding. Training was task-oriented.

His description of the difficulties he encountered in his clinical practice sheds light, or rather *gives the necessary questioning stance, to the seemingly neat and authoritative studies comprising research in the developing world.* Hence I shall quote Guinness in some detail.

> Initial difficulties included adaptation to a very different style of practice--heavy clinical workloads,lack of facilities (laboratory and EEG), the need to work through interpreters, unfamiliarity with cultural norms and beliefs, and the baffling clinical profile. Hospital practice consisted almost entirely of florid psychosis, criteria for admission being violent and unmanageable behaviour at home (Guinness, 1992, p. 5).

He describes the complexity of decision making and diagnosis in the context of scarce resources and traditional culture:

> ...the clouding of consciousness of organic confusion had to be distinguished from the trance-like dissociated consciousness of the transient reactive psychoses. Accurate history taking was the only means of distinguishing epilepsy, particularly temporal lobe epilepsy, from hysterical equivalents (Guinness, p. 5).

At times problems like the need for an interpreter were turned to his advantage. This gave him an opportunity to train community psychiatric nurses and gain good cultural insights. But again, he emphasizes that there are no easy answers:

> Paranoid ideas had to be weighed against the widespread beliefs in bewitchment...usually signalled dysphoric mood rather than psychosis. Delusions of control had to be set against beliefs in spirit possession (Guinness, 1992, p. 5).

Guinness raises the question whether this "bewildering plethora of psychosis" is possibly the situation which confronted the 19th century psychiatrist. He compares many of the features of the African population--beset by a high level of physical morbidity and poverty, and lack of education faced with rapid social change--to Europe during the Industrial Revolution. Guinness takes a close look at Swaziland as a society in transition currently poised at a point of an early stage of urbanization. The need for cash income is seen as a key factor in this social transition. Cultural structures and customs which previously were conducive to adaptation for the individual and the group, have become problematic and lead to increased stress. Mental illness both in the form of "brain fag" and psychotic breaks seemed to focus around themes of competition in education and the work place.

Taking a historical perspective of severe mental illness faces us with the interdependence of the individual's physiological propensity to mental illness and the socio-economic and cultural context. It would seem then, that the variations in

symptomatology between current concepts of schizophrenia and those of the past, may partially relate to actual changes in the way this illness, or these illnesses, express themselves. The literature on the subject of European reactive psychosis or hysterical psychoses in the 19th century seems reminiscent of the contemporary African situation (Guinness, 1992).

This is particularly striking in Meynert's (1881) separating aetiology into psychogenic, nutritional, and epileptic, on the one hand, and intoxication and infection on the other. Guinness reports that these are exactly the kinds of issues which psychiatry in many areas of Africa has to be concerned with. The end result, as can be seen in a florid psychosis, may, according to Guinness, then have precursors in central nervous system damage due to obstetric problems, infections, and malnutrition, as well as genetic predispositions plus the stresses accumulating from the total input of psychosocial life (Guinness, 1992). His research raises important questions regarding diagnosis and prognosis of known categories of mental illness, particularly schizophrenia. Some of these issues will be discussed later.

In summary, the history of Western biomedical and psychiatric involvement in Africa and southern Africa in particular, reveals the extent to which it was marked by ethnocentrism and by a racist and judgmental attitude towards the indigenous population. This history also shows an insensitivity to subjective experience and to the traditional belief systems.

As in other parts of the world, it was driven by economics in general, and in particular by the economic and ruling interests of the colonisers. The challenge today, in the light of significant economic needs in southern Africa, is to adapt Western psychiatric treatment of mental illness to the complexities of the many bio-physical and cultural variants that shape the illness patterns as they present themselves in the indigenous southern African context.

CHAPTER 7

MAJOR MENTAL DISORDER: CURRENT STATUS OF KNOWLEDGE

Psychiatric Epidemiology

According to the Director of the World Health Organization (WHO), the prevalence of severe mental disorders which includes schizophrenia, the affective disorders, and chronic brain syndromes, is estimated conservatively at 1% (45 million people) in the world. As for schizophrenia alone, the WHO arrives at an annual incidence figure of approximately 0.1 per thousand (in a population spanning the ages of 15 to 54 years), and a prevalence figure of 2 to 4 per thousand (World Health Organization, 1993).

According to the same sources, there seems to be no differences between developing and developed countries in these statistics, while the prevalence of epilepsy ranges from 3 to 5 per thousand in the industrialized world as opposed to 15 to 50 per thousand in some areas of the developing world (World Health Organization, 1993). Improved life conditions and obstetric care in developed countries are seen as responsible in the prevention of epilepsy.

Figures always seem to carry such authority, and demographic studies convince with the weight of statistics. Warner (1985) illustrates how easily confusion can result from careless

comparisons of epidemiological figures. It can lead to such obvious contradictions as seen in Julian Leff, a British social psychiatrist, arguing that prevalence rates of schizophrenia and manic depressive illness vary little around the globe, whereas Fuller Torrey contends that mental illness is rare in less developed countries (Warner, 1985). Only close scrutiny of the data on which these statements are based can explain how two prominent researchers can arrive at such incompatible conclusions.

The epidemiology of psychiatric disorders, particularly cross culturally, is fraught with difficulties. Firstly there is a problem with the standardization of epidemiological concepts in this area (Westermeyer, 1989). Prevalence may refer to point prevalence, period prevalence or lifetime prevalence, each of which can significantly alter findings since different time frames are involved. Lifetime risk, which refers to the likelihood of developing the disorder, is always an estimate with figures being extrapolated from other data. Issues which affect such statistics and may lead to erroneous comparisons may also relate to population characteristics, such as a predominance of the young as found in many developing countries, or a higher survival rate of the mentally ill as found in many industrialized countries. Some of these pitfalls are avoided by specifying an age as in the WHO studies (15-54 for the incidence of schizophrenia) (Sartorius, de Girolamo, Andrews, German & Eisenberg, 1993). Other population characteristics often debated have been related to socio-

economic status and in- or out-migration.

Comparability is impaired by a multitude of issues affecting data collection, beside the basic features of random population sampling. Societal and cultural factors influence both help-seeking behaviour and experience of mental illness (Kleinman, 1980). Scandinavian countries have been favourites in the research on mental illness since folk registers make for easy tracking, and it was found that nearly all psychotic patients availed themselves of psychiatric facilities in Norway. By comparison, in a survey in Laos, it was found that only 27% had been seen by a psychiatrist (Westermeyer, 1983). Brenner found a historically stable link between increased mental hospital admission rates and economic down-turns in the United States. He concludes that the reasons can be found both in increases of psychiatric symptoms, and increases in intolerance of mental illness (Brenner, 1973).

Westermeyer points out that data collection in psychiatry relies heavily on the following factors:

> (1) importance of self-reported symptoms; (2) specific enquiry into certain psychiatric symptoms not apt to be reported spontaneously; (3) examination of the clinical course over months or years; (4) discomfort and/or disability associated with the disorder; and
> (5) response or lack of response to various treatments (Westermeyer, 1989, p. 10-11).

He indicates that psychiatric data collecting is both time-consuming and expensive, since there are no simple physiological or even neurophysiological tests. This leads us

directly to the issue of diagnosis and comparability.

Diagnostic Issues

To receive a diagnosis of schizophrenia, a person has usually shown some primary symptoms such as delusions, hallucinations, incoherent speech, diminished expression and experience of emotions, lack of motivation, social withdrawal, and disorganized and sometimes catatonic behaviour (Keeve & Harvey, 1992). To receive a diagnosis of manic-depressive, or bipolar psychosis, a person must have experienced mood symptoms, either manic, depressive, or both, which are causing clinically significant distress or disruption in important areas of functioning. Additionally the diagnosis requires that these episodes are not better explained in terms of other disorders, such as schizoaffective disorder.

Torrey (1988) points out that typical manic-depressive psychosis usually presents no great difficulties in distinguishing it from schizophrenia, since schizophrenia is a disorder of thought, while bipolar illness is a disorder of mood. However, it is not *always* that clear, since people with manic, or hypomanic episodes may have schizophrenic-like delusions or hallucinations in which they may believe that they have special powers, or they may become chaotic because their thoughts and speech are either excessively speeded up or slowed down.

While hallucinations are considered one of the defining characteristics of schizophrenia, there is really no single symptom that is exclusive to this illness (Torrey, 1988). The problem has been not so much *what* symptoms were to be found, but *which* are to be emphasized and which are most pathognomonic.

Some of the more popular methods of diagnosis have been the Schneiderian first rank symptoms (Schneider, 1959), and the CATEGO system, in addition to the International Classification of Diseases (ICD-9/10), the current North American classification system, and the Diagnostic and Statistical Manual of Mental Disorders (DSM-III/IV).

Schneiderian first rank symptoms have achieved a following in psychiatric circles because of the clear-cut way they are defined rather than any particular theoretical appeal they might have (Farmer, McGuffin & Bebbington, 1988). The United States had previously used a very broad definition and was looking for greater reliability of criteria, to which the Schneiderian first rank symptoms provided the answer. The CATEGO system is a computer program which processes data from a symptom check list. This list includes both the present state examination (PSE) and Schneiderian FRS. It applies a series of algorithms, based on a hierarchical ordering of symptoms. The ICD and DSM systems have been attempts to use operational criteria. DSM-IV specifies two or more symptoms, social/occupational dysfunction, duration (at least 6 months),

the exclusion of schizoaffective and mood disorder, as well as the exclusion of substance/general medical conditions. It also spells out the relationship between a schizophrenic diagnosis and a pervasive developmental disorder. It thus offers a *smorgasbord* solution. What it does not do is provide definitions of specific symptoms (Farmer et al., 1988).

Kraepelin in 1904 complained that no two psychiatrists could communicate, since everyone made different observations (Westermeyer, 1989). To this day some of these problems persist. Studies like the US/UK Diagnostic Project (Cooper, Kendell, Gurland, Sharpe, Copeland, & Simon, 1972), international research by the World Health Organization, and greater sophistication of classificatory indices as reflected by the work with DSM III, IV, as well as ICD 9 and 10, have improved inter-rater reliability. DSM-IV makes an attempt to align itself more closely with the coming ICD-10, although some significant differences remain. As recently as 1992, authors stated in the *Schizophrenia Bulletin* that "there is little agreement about what constitute the essential features of schizophrenia" (Murray, O'Callaghan, Castle, & Lewis, 1992, p. 319). The emphasis here is on schizophrenia largely because, of the severe mental illnesses, it is the one that held centre stage, and is often taken as synonymous with the term *psychosis* (Torrey, 1988).

Psychosis, however, as referring to a loss of contact with reality, may be due to a number of illness patterns. This

study has focused on the so-called *functional psychoses*, excluding those with known organic aetiology. The other main contender beside schizophrenia is affective disorder, particularly manic-depressive psychosis.

While I tried to adhere to an all-encompassing category of *persons with severe mental illness*, eschewing the thorny issues of differential diagnosis, schizophrenia as a label could not be ignored. In this research, virtually all patients derived from the mental hospital files carried a diagnosis of schizophrenia, much to my surprise. Keefe and Harvey (1994) give risk estimates of 1% for bipolar illness, and Torrey (1988) states that manic-depressive psychosis is about one-third as prevalent as schizophrenia. Even if there are questions as to comparability in many epidemiological studies, one would still expect some sizable representation of bipolar diagnoses in a mental hospital population.

It has been pointed out that in the absence of definitive laboratory tests which can pinpoint the presence of schizophrenia, we are only left with symptoms (Torrey, 1988). At best we can resort to laboratory tests to show the presence of other disorders (in cases of toxic or other gross organic factors) (Keefe & Harvey, 1992). This, as most authors would agree, is the crux of the polemic in the diagnosis of schizophrenia. For all we know "schizophrenia is more than one disease entity" (Torrey, 1988, p. 73).

The debate has been about what the essential symptoms of schizophrenia are, and, in defining it, how inclusive or exclusive this syndrome was to be. Subtyping of schizophrenia constitutes a major part of this argument, which goes back historically to Emil Kraepelin's *dementia praecox* in the late 19th century, and to Bleuler, who changed the name to *schizophrenia* in 1911. The subtyping is seen as more questionable today, in that this tends to shift within individual cases (Torrey, 1988) and more significantly across cultures and historical times (Guinness, 1992; Keefe & Harvey, 1992). Thus catatonia with its bizarre posturing, absence of movement and total muteness, which was the stereotypical image of the schizophrenic patient before the 1950's, is rarely seen today in the developed world. Keefe and Harvey attribute this to the effectiveness of medication. They suggest that these symptoms were in fact attempts to deal with extreme over-stimulation. Schizoaffective disorder has continued to occupy a significant position, in that it is intermediate between schizophrenia and bipolar illness. It used to be considered a subtype of schizophrenia but more recently has been classified independently.

The more current emphasis on a division of symptoms into *positive* and *negative* ones, has its origin in the writings of 19th century authors. They looked at neurological symptoms in terms of loss of function compared to excessive function. In the area of schizophrenia, positive symptoms refer to hallucinations and delusions, whereas negative symptoms

include flatness of affect, social withdrawal, and poverty of thought, among others. While some researchers have treated these as if they represented a dichotomy or even subtypes with a different aetiology (Crow, 1980), others conceive positive and negative symptoms as atoms in the nucleus of schizophrenia (Farmer, et al., 1988).

Differential diagnosis has presented some difficulty particularly in relation to bipolar illness, out of which the schizoaffective disorder was born (Torrey, 1988). Whether this is a real solution is doubtful, considering the literature on questionable diagnoses. In fact, Kraepelin, close to a century ago, believed that schizophrenia and manic-depressive psychosis were two ends of the same spectrum. While a great many issues surrounding the relationship of schizophrenia to bipolar and schizoaffective disorder have not been resolved, a "correct diagnosis" is often crucial in relation to treatment.

An over-diagnosis of schizophrenia and under-diagnosis of manic-depressive illness has been reported in the United States. The ratio reported was 8:1 in favour of schizophrenia for newly admitted patients, whereas the English and Scandinavian literature reports a 1:1 ratio (Keisling, 1981; Pope & Lipinski, 1978). Studies show that while there was a general tendency to over-diagnose schizophrenia, mis-diagnosis affected predominantly blacks and Hispanics (Keisling, 1981; Mukherjee, Shukla, Woodle, Rosen & Olarte, 1983). When admissions were monitored carefully for a study period, the

ratio of schizophrenics to manic-depressives were 1:1 (Keisling, 1981). From a cross-cultural perspective, Buchan reports from an African context:

> Manic depressive psychosis was rarely diagnosed, but this may reflect a difference in diagnostic practice; the acute hypomanic episodes not frequently encountered in African patients (Carothers) are usually diagnosed as schizophrenic in our own practice, but may well be labelled manic-depressive elsewhere (Buchan, 1976, p. 30).

But most convincing of all are the studies by Guinness (1992) in Swaziland, in presenting the pitfalls of diagnosis in the developing world. He describes a high preponderance of transient psychoses which present with active auditory and visual hallucinations as brief reactive psychoses. A high percentage were found to reveal a depression, sometimes only once the psychosis had resolved. Relapses did occur if the patient was discharged into the same stressful situation. Some patients required neuroleptics over several months to stabilize. There were, however, some who later relapsed with a full blown schizophrenia. Guinness sees the brief reactive psychosis as occupying an intermediate position between the neuroses and the psychoses. He speaks of the difficulties in demarcating this as a specific syndrome, and suggests that it can coexist and distort other syndromes.

It was the transient psychoses without depression which were most at risk to develop into unequivocal schizophrenia. Guinness presents a continuum model of a range of schizophrenic-type functional psychotic disorders, on which

"the genetic vulnerability to major psychosis, and any acquired occult cerebral damage (more likely in an impoverished Third World environment) together with the balance of psychosocial life-experience, would determine the individual's place" (Guinness, 1992, p. 66). He also points out that Western classificatory systems have been biased towards post-industrial psychiatric profiles, which favour treating the atypical reactive psychoses as schizophrenia.

Theories of Causation

While we have looked at how schizophrenia is defined by symptoms, and touched on the enduring debates on where the boundaries between the different disorders are to be drawn, the simple question "what is schizophrenia?" has not been raised. The so-called functional psychoses, particularly schizophrenia, have intrigued and challenged society in that they defied normal logic and understanding in the absence of clear organic abnormality (brain tumour, infections, brain damage, and so on).

There were many attempts to make sense of the experience of schizophrenia. Laing, for example, was not alone in elevating the schizophrenic to the position of a seer and critic of an alienating society (Laing, 1961). There are also family therapists such as Whitaker, who gave meaning to the schizophrenic's strange behaviour as acts of self-sacrifice to save his family (Napier & Whitaker, 1978). By contrast, much

recent thinking is in alignment with Jaspers' conclusions, which he derived from a phenomenological approach, that there is something qualitatively different in schizophrenic phenomena which is quintessentially non-understandable (Jaspers, 1963).

The literature of the past is replete with arguments around the nature-nurture issue, going back as far as the previous century, when it was recognized that studying identical twins could help to resolve the dilemma by providing a built-in control. The research on the genetics of schizophrenia began in ernest with Kallman's studies of mental hospital records, with a particular emphasis on concordance rates for identical versus fraternal twins. Variations of the theme were twins reared by biological versus adoptive parents, and twins reared together as opposed those reared apart. Twin studies, particularly in relation to schizophrenia, were being done in the U.S., in England and in the Scandinavian countries (Gottesman & Shields, 1976; Pollin & Stabenau, 1968; Onstad, Skre, Edwardson, Torgensen & Kringlen, 1991).

Twin studies certainly established that genetics plays a part in the causation of schizophrenia since identical twins are three to five times more likely to both develop schizophrenia than are fraternal twins (40% concordance rate). However concordance rates of some other central nervous system disorders are even higher. Thus the pairwise concordance rate for bipolar disorder is twice that for schizophrenia (Torrey,

1992). These findings do not suggest a simple genetic solution.

Twin studies of the past assumed that identical twins were identical at birth, in that they shared the same genes and the same uterine environment. It was therefore assumed that any differences would be due to environmental influences after birth.

Recent studies have modified this position, in that it has been shown that factors such as chromosome or gene changes, differences in blood supply and oxygen, exposure to infectious agents, as well as drugs and chemicals, can make for differences in utero. Identical twins may have different birth weights, for example; there have even been cases where only one identical twin was infected with the HIV virus at birth (Torrey, 1994). The latest, perhaps, in sophisticated twin research in this area, is a six year study of schizophrenia and bipolar disorder in 66 pairs of identical twins, reported on by Torrey (1994). The most up-to-date neuroscientific technology and laboratory analyses, as well as diagnostics, were used in this research.

While retrospective information as to developmental histories were obtained, wherever possible objective confirmation was sought out. While the results from this study found that individuals who have developed schizophrenia had, as a group, more genetic, perinatal and childhood problems (referrals to

psychological, neurological testing, and special education), there were too many exceptions to make possible the prediction of individual cases. As to structural changes of the brain, MRI evaluations revealed that there were indeed statistically significant subtle changes for the affected twins as a group, but these again were not predictive for the individual. Both discordant and concordant twins had more neurological impairment than normal controls, which suggests that genetic or other factors had impacted on both twins to some extent. Positron emission tomography revealed reduced cerebral blood flow to the frontal lobes, and viral research some changes in the immune system, in a percentage of affected twins, but again no magic revelation occurred (Torrey, 1994). Bipolar twins shared many of the same features, though had some differences in relation to specific structural changes, as well as more frequent family histories of severe mental illness.

Brain research has come a long way since the 1970's when the main information on changes in the brain had to be gained from autopsies. Now the new sophisticated technology can reveal minor changes even in deep structures of the brain, as well as capturing images of the brain in action, as seen in blood flow studies. Blood flow is measured since it indicates where oxygen is being supplied for the production of neurotransmitters. A specialized form of positron emission tomography can reveal the activity of the transmitter *dopamine*, which has been thought to be important in

schizophrenia. The most recent technological advance which promises new insights, is the fast MRI which can measure brain activity in one-second periods.

In spite of all the technological breakthroughs, there is very little that is known definitively about schizophrenia and the other "functional" mental illnesses. What is clear is that schizophrenia, and the same is true for manic depressive illness, *is* a disease[44] of the brain. It is also clear that a genetic predisposition plays some part. The exact nature of transmission however, is not known. It seems unlikely that the mode of inheritance is similar to that of Huntington's disease, where a single dominant gene is faulty, unless this gene is heterogeneous in its expression in different individuals. This could be conceived as the subtle variations which are described in the schizophrenic spectrum disorders or even as some neurological abnormality found in some of the relatives of schizophrenics (Keefe & Harvey, 1994). But whether the model of inheritance is one, or a combination of genes, dominant or recessive, the bigger question remaining pertains to what it is that is inherited.

The diathesis-stress model of the 1960's and 1970's (Meehl, 1962; Mednick & Schulsinger, 1975) has changed over time, in that at present stress is conceived predominantly in

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[44]An alternative has been suggested, conceptualizing schizophrenia, amongst some other mental disorders, as a *difference* in brain functioning, "as boundaries of the variation which is intrinsic to *homo sapiens*" rather than as a *disease* as such (Liddle, Carpenter & Crow, 1994, p. 725).

biological terms. The assumption is that stress, rather than suggesting an unfavourable home environment for the young child, may include exposure to unusual intrauterine environments or actual birth injuries. Severe influenza epidemics have been found to be followed by an increase in schizophrenia some twenty or thirty years later. Stress, conceived of in interpersonal terms, has been associated, however, with relapse (Leff and Vaughn, 1981; Falloon & McGill, 1985).

A similar theory is articulated by Guinness in his work in southern Africa, in which he aligned himself with the work of Ciompi and German, who conceptualize schizophrenia not as a disease entity, but as "a critical overtaxing of a vulnerable hierarchy of integrated systems for processing complex affective and cognitive information" (Guinness, 1992, p. 36). This vulnerability is said to develop out of complex interactions of the biological substrate (impacted on by both genetic and acquired cerebral factors) with the totality of life experience. It appears as a modified diathesis/stress model, which provides a working hypothesis for the connection between reactive psychosis and schizophrenia, related to an ecological environment of rapid social transition. Guinness' position does not imply that these syndromes are specific to Africa (indeed he compared them to those common during the industrial revolution in Europe), but that they are peculiar to specific conditions, and therefore less frequent in the

developed world.[45]

Neurodevelopmental models of schizophrenia suggest that both genetic factors and insults to the brain prenatally or at birth, which can be heterogeneous, can lead to the final common pathway with respect to the malfunction of neurocircuitry, as seen in schizophrenia. Research seems to suggest that infants who as young adults became schizophrenic showed certain sensorimotor abnormalities. It is theorized that early in life there is a growth spurt in the area of sensorimotor neural connections. Myelination of cortical association areas and certain limbic pathways continues, and peaks into early adulthood, whereas the metabolic activation of the motor cortex is low at this stage. These peaks are associated with densities of dopamine receptors in those specific areas. Thus abnormalities in movement in the first two years of life may relate to the same underlying problem as that of thought disorder in the adult schizophrenic patient (Walker, 1994). Another version of the neurodevelopmental model proposes a link between hormonal maturation, late puberty for schizophrenics and excessive pruning of synaptic connections. It suggests that early puberty, and insufficient pruning, is linked to bipolar illness (Saugstad, 1989).

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[45]At the same time he feels that there is a need to make careful distinctions and identify, for instance, the underlying depression obscured by the florid symptoms of a reactive psychosis, and not just treat the individual as schizophrenic. A distinction between the mania of a bipolar illness and schizophrenia would similarly be important for the treatment with lithium. He also emphasizes the need to focus on the individual in his social milieu, and acknowledges the role of the traditional healer (Guinness, 1992).

Most theories of functional mental illness involve neurotransmitters, the substances which allow messages to be relayed from one neuron to another. The process can be inhibited or facilitated in many different ways. The most common concepts here are receptor antagonists, those which block transmission, and receptor agonists, substances other than the neurotransmitter itself, which stimulate the receptor. When chlorpromazine was first introduced in the treatment of psychosis, it was thought to be effective because of its sedative properties. It was later discovered that it was, in fact, a receptor antagonist for dopamine. This, together with the finding that amphetamines, which are known to increase dopamine activity, induce a schizophrenic like psychosis in non-schizophrenic individuals, or exacerbate symptoms in schizophrenics who are actively psychotic, led to the dopamine hypothesis.

The hypothesis in its original form was simply that there was too much dopamine transmission in schizophrenia (Stahl & Wets, 1988). This had to be modified later when it was discovered that both under and overactivity of dopamine could be involved, and that in fact, there were different dopamine receptors. These are divided into two groups, referred to as D1 and D2 receptors. Normal activity of D1 receptors, of which there are more in the lower brain areas, inhibit the functions of the D2 receptors which are more prolific in the cerebral cortex.

Not all schizophrenics have been responsive to the standard neuroleptic medications, and with the advent of new medications, such as clozapine, there are indications that other receptors and transmitters are involved. As research has increased in sophistication, so has the awareness of the complexity of brain functions: it would seem that the problems in neurotransmission may have more to do with a state of equilibrium than specific issues of over or under-production (Stahl & Wets, 1988; Keefe & Harvey, 1994).

Treatment, Social Issues and Social Rehabilitation

Previous treatments for functional mental illness in Western psychiatry included psychosurgery, electroconvulsive therapy, immersion in hot or cold baths, various forms of psychotherapy, and so on. At this point, with the realization that "functional" no longer means non-organic, current somatic treatments are predominantly based on neuroleptic medication. Psychotherapy is no longer conceived of as effecting a cure in regard to the major psychoses, while it can be used as an adjunct in helping individuals deal with problems in living (Coursey, 1989; Katz, 1989). Here we need to differentiate between *treatment* and *rehabilitation*, two concepts the World Health Organization has been concerned with.

According to WHO estimates, up to two-fifths of disability worldwide is of psychiatric origin (Burti & Yastrebov, 1993).

While treatment focuses on the reduction of symptoms, rehabilitation concerns itself with the individual's functioning in society. Severe mental illness has been associated with major problems of the individual interfacing with society, issues relating to violence, stigma and unemployment.

Violence and Stigma

Societal factors play an important role in the kind of care the severely mentally ill receive, as seen in statistics suggesting that men are more likely to receive psychiatric care because their symptoms are experienced as threatening, and that unmarried, black or unskilled patients had a greater chance of being treated with neuroleptics (Killian & Killian, 1990). Stigma is reported as a major issue for psychiatric patients and their families (Wahl & Harman, 1989; Torrey, 1994). Research has found that spouses were reluctant to define their partner as mentally ill, and that families delay seeking help for a child, fearing stigmatization (Clausen, 1980).

Advocacy groups, and empowerment approaches, have tried to influence the media and combat stigma in mental illness in the U.S. Comparisons of psychiatric patients and other community residents, however, have shown that the psychiatric patients were two to three times more likely to have exhibited violent behaviour (Torrey, 1994). A survey of the National Alliance for the Mentally Ill reported that one-third of the families

had experienced assaultive and destructive behaviour by their mentally ill relative (Torrey, 1994). Violent behaviour is usually related to problems with medication compliance, which has legal implications (involuntary as opposed to voluntary medicating). The issue here, as has been pointed out many times, is that "the sad irony of schizophrenia lies in the brain's inability to understand its own disease" (Rose, 1988, p. 1).

The World Health Organization also reports a higher incidence of acts or threats of violence to others, or to property, as motivating psychiatric referral in developing (27%) as opposed to developed countries (11%) (Jablensky, Sartorius, Ernberg, Anker, Korten, Day, & Bertelsen, 1992). Research indicates that the issue of violence and mental illness in the developed compared to developing countries may only differ in degree, not in kind (Lefley, 1987a; Perlick, Stastny, Mattis, & Teresi, 1992; Torrey, 1994).

In the Western world this issue is central to what is referred to as the "family burden." In a New York study, self-neglect and violence ranked consistently as the most problematic aspects for families taking care of a psychotic relative (Perlick, et al., 1992). Other studies have reported that families could tolerate psychotic symptoms for a long time and only a behavioral crisis would lead to their resorting to hospitalization (Sampson, Messinger, & Towne, 1962; Teresi, Holmes, Bergman, King, & Bentov, 1989). Lefley (1984) mentions

that 75% of her sample of families with a psychotic member made regular emergency calls to the psychiatrist or primary therapist, 73% needing to hospitalize him/her during the year (38% involuntary, court-ordered commitment), and 51% calling the police at least once during that year. In a survey of members of the National Alliance for the Mentally Ill (NAMI), 30% of families with a person with serious mental illness reported that their relative was assaultive or destructive at home (Torrey, 1994).

The issue of violence has resulted in considerable labelling of the person with mental illness. Illness talk, or self-labelling, never happens in a vacuum, and is shown to be clearly influenced by many factors (Estroff, 1991). Even though in the larger context of societal violence the mentally ill represent only a very small portion, the problem remains: as long as violent behaviour is associated with mental illness it will be difficult to eradicate stigma (Torrey, 1994). It needs pointing out that while hostility and aggression are problems associated with psychosis, the severely mentally ill more often are the *recipients* of hostility and violence (Torrey, 1994).

Fink and Tasman (1992), in their historical analysis, trace stigma in relation to mental illness back to Greece from the fifth century B.C., suggesting that the perceptions of mental illness have not changed much through the centuries. Stigma in the cross-cultural context is a more complex issue. Research,

including the studies on schizophrenia by the World Health Organization, paints a picture of greater tolerance in family members towards difficult behaviour of their mentally ill relatives (Lefley, 1987).

Employment

Efforts at rehabilitation in regard to the severely mentally ill have made use of community approaches such as case management, outreach, as well as drop-in centres, clubs, therapeutic group-homes, half-way houses, social skills training, and so on. Some projects, such as Fountain House in New York City, have addressed both issues of living arrangements and work. Entry level jobs are shared or partnered by staff, to ensure a smooth relationship between employer and employee, in spite of inconsistent work records typical of people with serious mental illness (Caton, 1984; Kanter, 1989).

The work history of the seriously mentally ill has been considered in the West a significant measure of the individual's ability to function, as well as being linked to prognosis. Warner (1985) examines mental illness in relation to labour issues and the economy, maintaining that better outcome throughout history was related to labour dynamics.

There seems to be consensus that unemployment is the hallmark of schizophrenia in the developed world, and that the patient's capacity for productive activity is compromised.

This presents major issues for persons with severe mental illness. Reviews of studies have revealed that 20% to 30% of patients in the community were able to work competitively, with more recent studies suggesting lower rates (10%-15%) (Attkisson, 1992). These researchers have pointed out the variability of findings, depending on issues relating to community type and kind of work.

Vocational rehabilitation has been attempted in various ways--in the hospital, in sheltered workshops, and through job clubs. More recently it has been concluded that hospital vocational programs tend to increase institutional dependency and bear little relationship to vocational success after the patients are discharged (Bond & Boyer, 1988). Some studies have suggested that work itself is more effective than most programs in developing self-esteem, competence and vocational skills (Conte, 1983).

There is data that suggests that this might account in part for a more benign course of schizophrenia in developing countries. Warner (1985) offers unemployment rates as predictive measures of prognosis in a given society. Pre-industrialized societies may provide non-wage labour where individuals disabled by mental illness can be meaningfully occupied in a minimum stress situation. However, he also notes that in developing countries there may be an elevated risk for schizophrenia as a consequence of migrant labour practices.

In summary, the evidence indicates that capacity to work is negatively impacted by mental illness, and that while employment may constitutes a stressor, it can also serve as a constructive rehabilitative intervention.

Contemporary Medications

Medication is still the mainstay of psychiatry in the management of severe mental illness. While the introduction of chlorpromazine in 1954 was the first major landmark in the somatic treatment of psychosis, the introduction of lithium in the United States in the 1970's became the next great breakthrough[44].

Chlorpromazine and its variations have their impact primarily on the dopamine transmitter system, while having also some degree of sedation. It would seem that the potency of the medication is in direct proportion to its risk of the side effects encountered. Side effects such as tremor, restlessness, stiffness, slowness, diminished spontaneity, and slurring of speech, are fairly common. While there are a number of uncommon and more serious side effects, the most feared occurrence is that of tardive dyskinesia. This consists of twitching or jerky involuntary movements of the tongue, mouth, even arms, legs, and occasionally the whole body. These

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[44]Lithium has since 1977 been on the list of essential medications for mental illness brought out by the World Health Organization (Sartorius, de Girolamo, Andrews, German, & Eisenberg, 1993).

are both very uncomfortable and unsightly, as well as at times reaching a dangerous level: worst of all they are often irreversible. It is not clear what percentage is definitely drug-induced, and how much may be due to the disease itself (Torrey, 1983). Anti-cholinergic are commonly used to reduce the side effects. Measures such as drug holidays have not been found to be effective (Harvey, 1994).

Lithium has revolutionized the treatment of bipolar psychosis, but is also sometimes effective in schizophrenia, particularly where there is an affective component, and in schizoaffective psychosis. It is a relatively inexpensive drug, but made more cumbersome and costly because patients need to have their blood levels checked regularly. Lithium toxicity can be life-threatening (Torrey, 1983). Valproate, a newcomer to the field of bipolar treatment, is being increasingly recognized as an effective mood stabilizer and, because it has a wider therapeutic range than lithium, requires less medical monitoring. Its use was generally for epilepsy but has been prescribed since the late 1980's in the United States, and occasionally in Europe a little earlier, for the treatment of psychiatric disorders (Fawcett, 1989; McElroy, Peck, Pope & Hudson, 1991).

While other innovations such as injectable, long-acting forms of anti-psychotic were of major significance, particularly in relation to issues of drug-compliance, the most significant recent milestone was the introduction of clozapine. This is

called an atypical neuroleptic, in that it seems to act on dopamine and serotonin receptors; it does not cause extrapyramidal side effects (tardive dyskinesia). Most important of all it has shown itself effective with a percentage of schizophrenic patients who previously were not responding to other medications. It took very long to be approved in the United States, because in rare cases clozapine can cause agranulocytosis, which is the suppression of bone marrow, a condition that can be fatal (Keefe & Harvey, 1994).

Most texts support with authority the advantages of treatment with various forms of drug therapy, indicating that our present knowledge is progressing by leaps and bounds, promising new and better drugs to deal with specific issues (positive versus negative symptoms), targeting specific symptoms. The clinical reality, however, does not always fit this picture. It has been pointed out there are also the misdiagnoses, the drug refusers, those who cannot tolerate the medications because of serious side effects, and perhaps less so at this stage, those who will relapse in spite of drug therapy (Warner, 1985).

Above all, Warner suggests that with some people with schizophrenia (the good-prognosis schizophrenics) medication may not be necessary, and possibly harmful in the long run. He cites research indicating that the long term outcome of first-break acute schizophrenia treated drug-free in Soteria House, a home for up to six patients staffed by non-professional,

compared favourably with the traditional hospital admission. He further cites support from studies indicating that while neuroleptics are superior to placebos in preventing relapse, drug withdrawal also increases the risk for relapse. This may sometimes be attributable to a drug-induced super-sensitivity of dopamine receptors (Warner, 1985). The argument is that neuroleptics present a risk of worsening the underlying neurochemical defect, a solemn warning against routine administration of neuroleptics!

Outcome

A poor prognosis, that is, a deterioration of functioning, was part of the diagnosis of schizophrenia in the past, compared to a return to the previous level of functioning in bipolar psychosis. Thus, if the patient recovered, it could not have been schizophrenia. At present, the diagnostic criteria stipulate that some symptoms have to be present for at least six months. Currently the view of recovery is more optimistic, since research at the Vermont State hospital, amongst other research, suggests that even after a long chronic schizophrenic illness, significant improvement can occur in later life (Harding, Brooks, Ashikaga, Strauss & Breier, 1987). The contemporary position is that "while a full remission of symptoms and a complete return to the same quality of life as before the onset of the illness is possible, it is less likely than a lifelong course of symptoms" (Keefe & Harvey, 1994, p. 55).

The main source for the more positive view of the course of schizophrenia comes from cross-cultural research. The percentage of complete recovery in the developing countries is quoted to be 40% as opposed to 25% in the U.S. (Torrey, 1988). The International Pilot Study of Schizophrenia, initiated by the World Health Organization in 1966, attempted to find a common language in describing and comparing the major mental disorders in different parts of the world (World Health Organization, 1973). The findings of this research, and subsequent studies, provided strong support that the course of a *broad* diagnostic group of schizophrenia is similar in different countries, but that the course of the illness is more benign in the developing countries (Jablensky, Satorius, Ernberg, Anker, Korten, Cooper, Day & Bertelsen, 1992). The results could not all be explained by a higher rate of more acute onset schizophrenia. The latter involved first contact mentally ill, which raises questions of interpretation of symptoms and their cultural context, as illustrated by the studies in Swaziland (Guinness, 1992). There is at least one field study of untreated mental illness (in Laos) which did not support a more favourable outcome than in Western countries (Westermeyer, 1989). Criticism of cross-cultural research raises questions about comparability, in spite of the obvious sophistication of present methodology (Cohen, 1992; Warner, 1992).

These questions relate to issues of translatability of meaning with patient interviews, as well as the possibility that

similar symptomatology may have different biological bases. It would seem, however, that certain cultural factors in developing countries may provide the basis for better prospects for recovery. It has been suggested that indigenous illness concepts may lead to more tolerance and be beneficial within the expressed emotion model (Leff & Vaughn, 1985). Authors dealing with this subject suggest an absence of stigmatization or labelling as being a significant factor (Lefley, 1990a). However, one wonders if there is not some slight degree of romanticizing of traditional cultures at play in the way the data is being interpreted. But even if the better prognosis for developing countries is only fractionally so, it still presents us with the irony that poverty and lack of resources could provide a more benign context than the industrialized societies of the developed countries with their arsenal of the latest in neuroleptics, brain imaging methods, and other technologies.

Factors Affecting Outcome

Relapse

Despite the more optimistic outcome research cited above, the usual course for people with severe mental illness is one involving remissions and relapses, rather than steady improvement. The literature on relapse in schizophrenic populations in the U.S. and Britain reports a range of relapse rates. Researchers have pointed out that the concept of relapse is somewhat ambiguous, since it has lacked a clear,

consistent definition (Falloon, 1984). Another problem is that some schizophrenics may fail to reach a clinically stable pattern of remission (Ciompi, 1980). Often relapse has been equated with re-hospitalization, but as Wing (1968) points out, this is a social intervention which, while it may relate to the exacerbation of symptoms, is predominantly associated with disruptive behaviour. There is generally a greater tolerance for withdrawn behaviour. These arguments, while they derive from a Western context, seem very appropriate to the population in my study, as shown in Chapter 9.

Expressed Emotion

Some other issues relating to relapse/re-hospitalization rates, concern the context of patients, and particularly the family environment in which they find themselves. This can be illustrated by the expressed emotion (EE) research, which has taken great pains to compare relapse rates for patients living in high and low EE families.

Research on expressed emotion (EE), initiated by Brown and others in England in the 1960's, caught on in the U.S. It highlighted the effects of emotional reactivity and the critical attitude of the family on the schizophrenic patient (Brown, Monk, Carstairs & Wing, 1962; Brown, Birley & Wing, 1972; Vaughn, Snyder, Freeman, Jones, Falloon & Lieberman, 1982; Miklowitz, Goldstein, and Falloon, 1983). Standardized family interviews showed that ratings of high EE was associated with relapse of the schizophrenic relative. The

studies explored the relationship between this measure and various other aspects, such as physiological components, medication, and attempts to change family interaction.

One study compared a relapse rate of 48% in high EE with 6% in low EE families over one year. Over two years the cumulative rates were 62% and 15% respectively (Leff & Vaughn, 1981). There were significant drug interaction effects, which were, however, complex and difficult to interpret. The role of neuroleptic drugs in the maintenance of schizophrenic patients, while being criticized by some as to the risk for long-term side-effects, has been generally supported by research (Serban, 1980). Placebos, compared with neuroleptic treatment, have given relapse rates as high as 72% compared to 16% on medication (Prien, Levine, & Switalski, 1971).

Research looking at other cultures, as seen, for example, in Mexican-American families in Los Angeles, or in the families in Chandigarh, Northern India, had difficulties finding the Western, high EE profile. While this led to the question as to whether the concept applied cross-culturally, it was also suggested that it could relate to the lower incidence of hospitalization in those cultures (Lefley, 1987b; Day, 1982). There has been some criticism of the conclusions reached by the EE researchers in that high EE may relate to subtle characteristics inherent in the patient or an expression of the family's inability to cope with the mentally ill person, rather than to consistent family styles (Falloon & McGill,

1985). In spite of criticism, the EE concept has been beneficial in that it focused on interventions aimed at enhancing problem-solving skills in the families who carry the burden of having to cope with a person with severe mental illness (Falloon, 1985).

Substance Abuse

Substance use among the mentally ill in the U.S. is well documented, with up to 60% of schizophrenic patients being said to use or abuse illicit drugs, including alcohol (Dixon, Haas, Weiden, Sweeney, & Frances, 1990; Drake, Osher, Noordsy, Hurlbut, Teague, & Beauclett, 1990). We are also reminded that these patients live in a society that is using and abusing drugs (Warner, Taylor, Wright, Sloat, Springett, Arnold, & Weinberg, 1994). There is less consensus as to the effect of drug abuse in relation to mental illness.

There is no clear evidence of drugs having caused schizophrenia. It is difficult to distinguish the effects from self-medication in early stages of mental illness, though most would agree that drugs may be implicated in triggering the onset of the illness in individuals who have the predisposition. Much of the literature comes down heavily on the maladaptiveness of drug usage amongst the mentally ill, with reports on their exacerbating psychotic symptoms, affecting medication compliance, and increasing re-hospitalization rates (reviewed by Dixon et al., 1990; Keefe & Harvey, 1994).

Results reported by various studies are not always consistent, and it has been pointed out that substance use is more readily labelled abuse when it pertains to the mentally ill population (Warner et al., 1994). The same authors found in *their* sample that heavy substance use was *not* associated with medication non-compliance, increased psychopathology, or more frequent hospitalizations. In fact, subjects who preferred cannabis had *fewer* hospitalizations than those who preferred other substances or were non-users. Some patients reported that cannabis has a calming effect (beneficial in relation to depression, anxiety, insomnia, and physical discomfort), while it did not help with symptoms of paranoia and hallucinations. Alcohol and hallucinogens were reported to have only modest beneficial impact on symptoms. One interesting observation was that subjects who had little structure and activity in their lives were more likely to use cannabis as a way to deal with boredom. There were limitations to this study as it relied heavily on self-report.

Medication noncompliance *was* associated with alcohol abuse and higher levels of psychopathology (Warner et al. 1994). A host of studies reports the use of alcohol with schizophrenics to be associated with poor outcome (including delusions and hallucinations), depression, assaultiveness and social instability (Drake et al., 1990).

The question has been raised as to why mentally ill people would resort to drugs. There have been different answers

given. These include statements that they are used "for the same reason everyone else uses" (because they are available, socializing effects and peer pressures) to specific answers which indicate that drugs give the patient an explanation for his/her psychotic experiences. Other reasons given are that they counter depression, improve functioning, and counter side-effects of psychiatric medication (Torrey, 1983; Dixon et al., 1990). Insofar as this is true, some drug preferences have a biochemical logic.

These comments apply significantly to southern Africa and in particular, to the area in which my research took place. The former Ciskei, as with much of South Africa, is heavily penetrated by bottle-stores, the black liquor trade being a cornerstone of South African retail capitalism. This trade is progressively displacing the more benign sorghum beer. In addition, the territory is adjacent to the Transkei, an important and historic dagga-growing[45] area. The wide use of substances often confounds the clinical picture. Guinness (1992) dealt with this problem by excluding many patients where there was any suspicion of alcohol or dagga being contributory.

Summary and Conclusions

In this chapter I have reviewed the state of the art that biomedicine has to offer, as regards the theory, diagnosis,

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[45]*Dagga* is the South African term for cannabis.

aetiology, and treatment of major mental disorders, with particular emphasis on medications. Western treatment, despite its heavy biological emphasis, also includes forms of rehabilitation of the person with mental illness by advocating community approaches that incorporate support in the social, occupational, and recreational areas. High interpersonal stress in the family context (EE) has been associated with relapse.

Issues of stigma, violence and unemployment continue to be major obstacles to the person's optimal integration in society. Despite a long history of negative opinions as to the prognosis for recovery of people with severe mental illness, and particularly schizophrenia, recent studies are more optimistic. Multi-national research has surprised contemporary biomedicine by suggesting that the prognosis in *developing* countries appears to be better than in the *developed* countries. This is particularly interesting in that the former countries do not have full access to state of the art psychiatry, as reviewed in this chapter. There are, however, serious questions as to the comparability of mental illness profiles. The existence of schizophrenic-like symptoms in developing countries is not in question; what is at issue is whether they represent the equivalent to our syndromes of brain pathology. The clinical presentation of people with mental illness and their prognosis is further compounded by substance abuse. Again this brings into focus the fact that the expression of mental illness appears to be mediated by

factors in the ecological context and culture of the person. This is an emergent theme in this thesis.

SECTION III

EMPIRICAL RESEARCH

Mental illness is just like other illnesses you may come across, but the difference is this illness can change a person's conduct. People losing their homes, their jobs and some other rights...When a person has this disease the people judge him in a different way; some are afraid of him and some consider him to be useless and all this can affect him.

(A quote from an essay by a std 9 pupil)

CHAPTER 8

ESSAYS OF SCHOOL CHILDREN AND UNIVERSITY STUDENTS AS WINDOWS INTO THE COSMOLOGY OF MENTAL ILLNESS AND HEALING IN XHOSA CULTURE

Introduction

One of the research strategies I have implemented to access the cosmology of mental illness and healing in the populations studied, makes use of student essays as a way of getting access to the implicitly held beliefs about mental illness in Xhosa culture. I felt that essays by Xhosa students with different levels of education would reveal the relative impact of Western biomedical concepts as acquired through the educational process, as opposed to the influence of traditional beliefs, on their understanding of mental illness.

Choice of the Sample

By selecting students at the beginning and end of high school, as well as at the beginning and end of their university psychology undergraduate courses, I am sampling across varied degrees of Western biomedical knowledge, and in this way tapping into levels of acculturation into Western thought in interaction with the indigenous perspective.

All standard 6 (8th year) and standard 9 (11th year) pupils of the high school were involved. These two classes were chosen to represent both the start of high school with the expectation of more naive, grass-roots perceptions, and the end of high school[46], with, as stated above, the expectation of their representing a greater level of exposure to Western ideas. Since schooling was not taken for granted, nor free at the high school level at that time, students were often older compared to their Western counterparts. Both age and sex of the authors of these essays were obtained. Since they were written in Xhosa, it took many hours over many weeks for my interpreter and me to complete the translation of these narratives. That process in itself became a valuable experience, and provided an informal way of engaging in a rich and varied communication on Xhosa culture with my interpreter.

To minimize external influences, the essays were written in the course of the usual class situation, at the request of the regular teacher/lecturer, and students were asked not to identify their essays by name. The university students wrote their essays in English, the usual teaching mode at their university, and the high school students wrote theirs in Xhosa, since Xhosa is more dominant at the school level, and some students experienced great difficulties in communicating in English. The official languages of the former Ciskei were Xhosa and English. The rural population, particularly the

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[46]Matriculants were writing examinations and not available for this study.

older generation, spoke only Xhosa. There were some who spoke Afrikaans because of a work history on the farms.

The high school was situated in the village of Msobomvu. The University of Fort Hare, some 10 miles away in the town of Alice, was at that time the only university in the former Ciskei, though the Transkei, which was a separate unit politically, provided, with its university, an alternative for Xhosa-speaking students.[47] Fort Hare has a long and proud history. Originally founded by the missionaries, it has produced many notable graduates.[48] According to 1983 figures, 84.3% of Ciskeian university students were attending Fort Hare (Directorate of Planning, Ciskei Government, 1985). The students are from urban and rural backgrounds. Over 50% of the population lived in a rural setting. One may debate the definition of what is urban, since some settlements designated as small urban locations have little to distinguish them from rural ones. Fort Hare is, however, located in the area under study, that is the magisterial district of Alice, otherwise known as Victoria East, or the Amatola basin. The high school was rural and within the geographical area studied.

The discrepant numbers between both Std. 6 and St. 9 students (63 versus 36), and 1st year psychology and 3rd year psychology students (73 versus 27), reflects the ever

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[47]The Ciskei and Transkei as political entities no longer exist.

[48]For instance, Mandela, Tambo, Nyerere, Mugabe, Biko, and others.

increasing competition and numerical attrition as students progress. According to the 1984 statistics, of the 75 schools of the Victoria East/ Seymour district, only 17 are secondary schools. The population was close to 27,000 people, excluding Seymour, which means that the number is hopelessly understated considering that the figures are out of date (Ciskei Development Information, 1984).[49]

The university professor and school principal were asked to request of the students as part of the class assignment that they write on their own ideas of mental illness, the causes, the role of the traditional healer and the hospital, and to comment on *amafufunyane* and *ukuthwasa* (traditional Xhosa concepts). Those concepts were specifically mentioned to give the message to the students that traditional ideas were acceptable as part of their essays. Students were asked to submit their responses without including their names on the papers. No mention was made to the students of the fact that these responses were part of a specific research project.

Traditional and Western Orientations

All essays were rated either (1) "YES," (2) "YES?," or (3) "NO," on the dimension of "traditional" and "Western" orientations, depending on whether the overall characteristics were congruent or incongruent with traditional/Western type

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[49]The accuracy of the official Government statistics has been questioned.

thinking. *YES?* was reserved for responses which seemed ambivalent or doubtful. If the content did not reflect details relating to traditional Xhosa culture, the essay was rated as *NO* for the traditional category. The same procedure applied to the rating of Western orientation. Many essays therefore received a traditional *YES* and a Western *YES* rating, if the content referred to traditional beliefs such as witchcraft as causative of mental illness on the one hand, and psychological or organic causes on the other. Acceptance or rejection of traditional or Western treatment did not necessarily affect these ratings, since students could show themselves as comfortably aligned with a traditional world-view, while expressing criticism of the traditional healer. As Hallpike (1979) emphasizes, giving the example of the Azande, criticism of the "witchdoctor" is not repressed, but contrary to one's expectation that this would undermine the traditional belief system, it can serve to consolidate these beliefs by explaining failures in the treatments.

Table 1 gives the data for the four groups of students (standard 6, standard 9, 1st year university, and 3rd year university).

Table 1. Traditional and Western Orientations in High School and University Students.[50]

Level of Education	No	Yes?	Yes	No. Students
Traditional				
Std. 6	6 (9.2%)	2 (3.1%)	57 (87.7%)	65
Std. 9	2 (5.9%)	3 (8.8%)	29 (85.3%)	34
1st Year	18 (24.7%)	10 (13.7%)	45 (61.6%)	73
3rd Year	3 (11.1%)	5 (18.5%)	19 (70.4%)	27
Western				
Std. 6	32 (49.2%)	19 (27.7%)	14 (21.5%)	65
Std. 9	1 (2.9%)	7 (20.7%)	26 (76.5%)	34
1st Year	2 (2.7%)	0 (0)	71 (97.3%)	73
3rd Year	0 (0)	0 (0)	27 (100%)	27

These data are represented graphically in Figure 4.

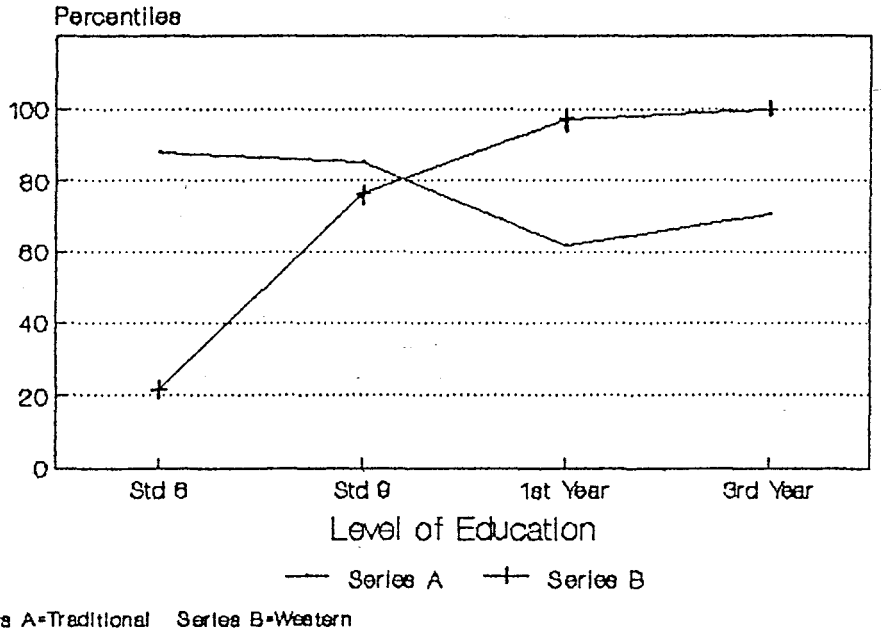

Figure 4. Comparison of Traditional and Western Orientations at Different Levels of Education.

[50]When equal numbers were required for statistical analysis, random numbers were used to select representative samples. When high school students' responses were divided into male and female groups, no significant differences were found.

Figure 4 shows the steep increase of Western orientation with higher levels of Western-type education, but an insignificant drop in Traditional orientation. Chi square analysis indicated that the students *YES* for a Traditional classification was not significant, but the groups differed significantly for the Western *YES* rating (chi square = 19.85, df = 3, $p < .001$).

When high school students were compared to university students, again significance was achieved for Western orientation (chi square = 11.54, df=1, $p < .001$). Of interest too is that the biggest increase seems to occur between standard 6 and standard 9 high school students.

The details become more apparent with a closer look at the content of the narratives, particularly when the various causes of mental illness which were identified by the students are considered.

Perceived Traditional and Western Causes of Mental Illness in Relation to Education

Table 2 gives the data on the students' beliefs as to the causation of mental illness, indicating whether they attribute them to these origins: Traditional, Socio-political, Western-psychological, and Western-organic.

Table 2. Causes of Mental Illness Identified by Students

High School Students					
Causes	Std. 6	%	Std. 9	%	Total%
Traditional	45	69.2	31	91.2	76.8
Socio-political	0	0	5	14.7	5.1
W-psychological	11	16.9	22	64.7	33.4
W-organic	11	16.9	24	70.6	35.4
Total number of students	65		34		

University Students					
Causes	1st Year	%	3rd Year	%	Total%
Traditional	51	69.9	24	88.9	75
Socio-political	28	38.4	9	33.3	37
W-psychological	64	87.7	22	81.5	86
W-organic	57	78.1	25	92.6	82
Total number of students	73		27		

Figure 5 presents these data graphically:

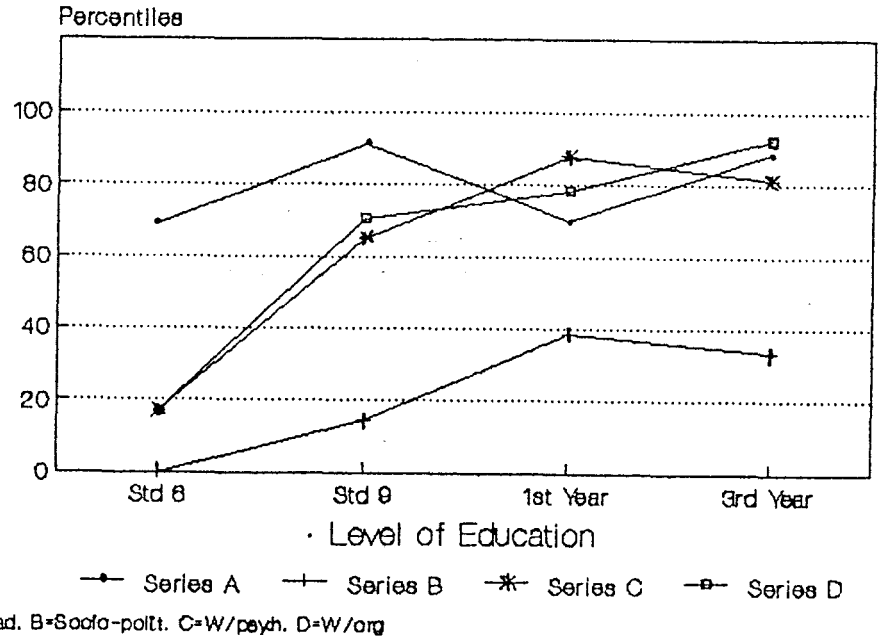

Figure 5. Causes of Mental Illness: Beliefs and Level of Education

This graph clearly illustrates that early high school students (standard 6) think of causation in traditional terms, with little thought to socio-political issues in relation to mental illness. Nor do they show much consideration of other categories--that is, the Western ideas of psychological and organic causation. With increasing levels of education, standard 9 students, and university 1st and 3rd year level students, with their exposure to psychology, show a steady increase in all categories, except for the Traditional which hovers consistently at a high level. In fact, the data seem to indicate a *drop* in 1st year students in their expression of traditional causes of mental illness and a subsequent rise for 3rd year students. While the results in relation to Western causation for high school versus university students are significant at $p < .001$, comparisons for Traditional and Socio-political trends in relation to education do not in themselves reach significance.

Because of their extensive exposure to Western knowledge of psychological and organic factors in relation to mental illness, 3rd year psychology students were not expected to be so committed to a traditional world-view. The drop in traditional type data with 1st year university students can be interpreted as relating to an initial sense of confusion, their being overwhelmed with Western psychological teachings, and their feeling pressured to put traditional ideas aside. By 3rd year, students may have re-established an equilibrium, having become more critical of Western teaching and choosing a

commitment to a Xhosa or "Black" identity. This is supported to some extent by the greater frequency of negative or absent responses among 1st years in relation to the traditional healer, and concepts like *amafufunyane*. Consider the following examples from the students' narratives:

> Traditional doctor: They will suspect the evil spirits which cause the illness in a particular case, and in some they help a lot but in other people they use wild plant and they cause various diseases like TB, cancer, etc.
>
> I know nothing about it.
>
> The traditional healer...This is the most primitive way of thinking that sick people can be cured. This is actually far from reality. Sometimes patients through their belief find themselves cured. They get cured because of their psychological belief.
>
> The traditional healers...They have got nothing to do with this illness because they haven't got the certificate to treat this illness. They do not know how the mind functions.

3rd year students discuss the traditional healer in less negative ways, often referring to "our culture", or "we believe". Consider a 3rd year student's reference to witchcraft:

> In our culture it is believed that a person may be bewitched by another. It is believed that through use of certain "herbs" you may be able to make another person ill mentally.

And another:

> Another traditional view of mental disturbance is that of bewitchment. They believe that you must not look at the illness in the modern way only but also in a traditional way.

As discussed earlier, traditional cultures do not seem to have

a problem with holding conflicting beliefs, and there seems to be a tendency to apply each to particular situations (Hammond-Tooke, 1989). Many students make the distinction of *ukufa kwesi Xhosa*, being sick the Xhosa way, as opposed to *other* illnesses where Western medicine and technology are welcome.

One of the 3rd year students presents the two views in a very articulate and systematic way:

> ...there are two basic viewpoints that one can look at when one talks about the causes of mental illness. The one is just the more traditional point of view that one has become mentally ill because of witchcraft performed by another individual, in other words, the other person has got hold of, for example, an object close to the owner person, i.e., a favourite piece of clothing or even his own lock of hair. With the use of those objects, the witchcrafter has set out to cast a spell, so to speak, on that individual making him/her therefore go mad or mental. The other viewpoint, i.e., the more Westernized viewpoint, has evolved more out of the evolving time and the improvement of the medical field. Causes of mental illness here are thought to be found in the individual, i.e., probably due to some sort of chemical imbalance, or due to genetic causes. Accidents, of course, can induce mental illness, i.e., damage can occur to the brain. But all in all, causes are thought to be more physiologically internal, rather than external....The witchdoctor plays an important role in that through our occasional referral to them, we are in fact keeping in touch with our own traditional roots.

He concludes by referring to the positive use of modern technology and the hospital, particularly in regard to x-rays and scans, but suggests that the traditional healer and his plants are important, especially in situations where modern medicine does not work.

Contrary to 1st year students who express more difficulties in

being open about what they think, often rehashing directly what they have probably just learnt in their courses (evidenced by repetitiveness of the same answers), many 3rd year students are comfortable with the two world-views standing side by side.

Different Categories of Beliefs

The different categories of traditional beliefs are presented in the form of a comparison in quantifiable terms. This is followed by a number of sub-sections describing the themes as they have crystallized from the students' narratives.

Table 3. Traditional Causes of Mental Illness as Identified by Students.

High School Students					
Causes	**Std. 6**	**%**	**Std. 9**	**%**	**Total%**
Bewitchment	50	76.9	20	58	70.7
Calling to become a healer (*ukuthwasa*)	32	49.2	11	32.4	43.4
Neglect of Customs	13	20	4	11.8	17.2
Other (curses, *amakosi* incorrect use of herbs)	2	3.1	2	5.9	4
No response	11	16.9	3	8.8	14.1
Total no. of students	65		34		

University Students					
Causes	**1st year**	**%**	**3rd Year**	**%**	**Total%**
Bewitchment	45	61.6	23	85.2	68
Calling to become a healer (ukuthwasa)	18	24.7	18	66.7	36
Neglect of customs	5	6.8	3	11.1	8
No response	20	27.4	1	3.7	21
Total no. of students	73		27		

Table 3 illustrates how students' traditional beliefs of causation of mental illness break down into 3 basic groups: bewitchment beliefs, *thwasa* (beliefs suggesting a calling to become a traditional healer), and the neglect of customs.

Bewitchment beliefs of causation are by far the largest group, with customs being the smallest. The relative contribution each level of education makes to these categories conforms to the previous pattern.

Bewitchment Themes

Bewitchment is usually mentioned in connection with jealousy. The story goes as follows: someone is doing well in the community in that the person is improving the lot of his/her family, and in particular is achieving academically. This evokes jealousy with individuals who are not achieving, and when a critical situation such as a final examination occurs, something happens. The protagonist's pen mysteriously disappears and reappears, after which it has a mind of its own and goes out of control, refusing to obey the hand of its owner. The end result is the collapse of the protagonist, with an individual who roams the countryside, picking up papers, wearing rags and being withdrawn or assaultive in behaviour. The protagonist is taken to the *iggirha* (the healer), the mental hospital or both, often to no avail.

This is a common story, variations of which appeared time and again in the students' essays. The protagonist is usually brilliant and successful, the one bewitching him/her is usually a friend or neighbour, and the end result mostly tragic.

A second bewitchment theme which seems related is the *amafufunyane* concept, *amafufunyane* being the creatures or grave-ants which are sent again by a jealous neighbour or friend to possess an individual. They are usually said to have been purchased from Durban or Natal and consist of a powder which can be blown into the wind and thus magically sent to the victim. Few students knew how the powder and the ants are related or get mixed. Sometimes it is said that the powder turns into ants inside the victim's stomach. The protagonist either ingests the powder without knowing it or hears a knock on the door at night and when the person says "come in!", they answer "we are already in," thus having entered the person's stomach. These ants then control the person, making him/her do things dangerous to herself and others: they command and the person will have to obey, even if it means walking great distances, or committing suicide. If the victim does not eat and thus fails to provide food for the creatures, they will eat his/her liver...so the story goes. The person will usually be taken to an *igqirha*, who will try and drive these creatures out. This is not an easy matter, because they know many tricks. The *igqirha's* aim is to make these creatures talk, so that they will tell who sent them and why, which is a

necessary step in chasing them out. They will engage in a battle of wills with the *igqirha*, by trying to face downward avoiding to talk, or even hiding in a toe. This is usually given as a reason for the failure of treatment. Enemas, emetics, beating and other methods may have to be applied. Even getting the creatures drunk with gin is quoted as a technique, for only when they are drunk will they tell the truth. Once driven out they are said to return to the person who sent them.

The stories have their variants, in that sometimes the ants are red but more often black, sometimes small but usually large; occasionally they are not referred to as ants at all but as little men, insects or demons. But the main theme is consistent, the victim is not responsible for his/her actions, and is controlled by these creatures. While the victim's lips are moving, the voices are those of the inhabitants, who can be of a different gender from that of the protagonist. The *amafufunyane* are usually said to speak Zulu, while some students maintain that they can speak any language, but not English or Afrikaans.

While these bewitchments are said to cause mental illness, the narrators sometimes insisted on distinguishing between say, *amafufunyane* and mental illness, just as they often distinguished between *ukuthwasa*, the call to become a healer, with mental illness. It is only when the bewitchment is not dealt with, or the call is not heeded, that a true mental

illness eventuates. Thus it would seem that mental illness stands for the abnormal, whereas bewitchment, and especially *ukuthwasa,* is in the realm of the normal, something which is only temporarily perverted and which needs to be put right according to traditional ways. Many narratives were not clear on this issue, and my interpreter, a man very close to his culture, often shook his head, saying that they were wrong.

The prevalence of envy in relation to bewitchment as seen in the student essays, is a pervasive theme in Xhosa culture. I was told by the headman of Msobomvu that, were one to move with one's possessions and livestock to a new village to settle, it would not be wise to take everything there at once. Cattle should be moved one by one, little by little, otherwise you would find your cattle mysteriously dying, bewitched by envious people. You should not seem too wealthy too quickly! As a somewhat embittered narrative of one of the university student's portrayed it: "You decided to go to university and you end up being mad". No wonder then that students would often speak about individuals who had been "too brilliant," or "studying too hard without giving the brain a rest," and that "mental illness is caused by being too educated."

The *Intwaso* Theme

Students' *thwasa* beliefs are perhaps at the core of the culture, in that they are strongly regulated by cultural expectations. It is of interest that a high percentage (66.7%) of third year university students referred to *intwaso* in

relation to mental illness, which fits with a general picture of third year university students showing an increased commitment to their cultural identity. While the orthodox traditional belief is that only the unresolved *intwaso* will lead to real mental illness, the students did not convey this with any clarity. This raises the question as to who in fact gets diagnosed in this way. Does this include individuals who would be considered to have severe mental illness by Western standards? *Ukuthwasa* is a highly culture-specific procedure and, contrary to some reports (Warner, 1985), which see a psychotic disposition as a significant trait of the traditional healer, the steps required from the initial call through the training demand that the individual be finely attuned to the cultural norms, an extremely difficult task for anyone in a psychotic state. Many who *thwasa* do not complete their training; this fact is recognized in the essays.

The *intwaso* theme goes as follows: the protagonist isolates him/herself[51] or is drawn to traditional song and dance, so much so that people may consider the person crazy. S/he will have series of dreams in which her ancestors will speak to the person, giving him/her instructions to admit to the illness, and go to a particular *igqirha*. Usually it will take some time before the protagonist agrees, because s/he has to accept a totally new approach to life, and altered circumstances. S/he is said to become more ill, and only after s/he agrees and

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[51]Although I have referred to men and women in relation to *ukuthwasa*, *intwaso* affects, predominantly, women in Xhosa society at this time.

goes to an *igqirha* will the symptoms go away. S/he then goes through a number of rituals, including the slaughtering of a white goat, before s/he will qualify as an *igqirha* in his/her own right. Most stories talk about those who thwasa through the river, who then become the most powerful *amagqirha*. The protagonist disappears, and is said to have sunk into the river,[52] where the ancestors take care of him/her and teach him/her. The family is advised not to cry, because if they do s/he will never come back and they will find that s/he has drowned.

This theme is significant in that it suggests that *amagqirha* who inspire most respect in the culture, have not undergone the usual apprenticeship; instead, they emerge as fully fledged diviners after a period of having disappeared and said to have been submerged in the river. Contrary to the apprenticeship, which is a somewhat public event in that the novice is known to be in training with a recognized *igqirha*, often together with others who are also in training, those who *thwasa* through the river go through a private event, for which it would seem there is very little public evidence. The training therefore is assumed to be supernatural. This suggests that ultimately the culture gives greater credibility to the supernatural than to traditional knowledge passed on from full *amagqirha* to their apprentices. This could make room for the existence of different kinds of *amagqirha* and explain

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[52]Hirst (1993) remarks that going under the river is a widely used metaphor representing the arduous process of becoming a diviner.

some of the contradictions in the study of the personality of the traditional healer.

The Theme of Customs

The category of *customs* was cited more frequently by the standard 6 students, possibly because of their greater grass-roots connection to traditional life in the village. The failure to carry out the customs of the home, or to carry them out correctly, is seen as an explanation for mental illness as well as other misfortunes. One particular ritual which is singled out is the one accompanying the death of an important family member, such as the head of the house, which needs the ritual slaughter of an ox, an expensive business. But then some students agree that there are compromises, a goat may be slaughtered provisionally, to give the ancestors the message that the correct ritual was not omitted for reasons of neglect or disrespect.

Western Psychological Causes

Table 4 highlights the changes that occur with education in the students' perception of the causes of mental illness.

Table 4. Western Psychological Causes of Mental Illness as Identified by High School and University Students.

Causes	Std. 6	%	Std. 9	%	1st.Yr	%	3rd.Yr	%
Frustration					22	30.1	9	33.3
Stress/Study Anxiety	10	15.4	17	50	29	39.7	6	22.2
Internal/Guilt Conflt/Depres.			2	5.9	24	32	2	7.4
Externl/Contxtl. Depriv. of needs			4	11.7	21	28.7	1	3.7
Fam. Prob./Child Rearing/Abuse	1	1.5	5	14.7	21	28.7	1	3.7
Social/Cultural Issues					5	6.8	6	22.2
Loss/Sad Past Experiences					26	35.6	5	18.5
No response	54	83.1	12	35.3	8	11.1	5	18.5
Total Number Students	65		34		73		27	

When it comes to Western psychological causes, standard 6 students had a very limited recognition of such causation. They isolated only issues which could be subsumed under the categories of family problems and stress. This we can assume tells us something about what they experienced as powerful influences in their lives regarding sickness and health; psychological issues can therefore hardly compare with traditional causes, with, for example, the influences of bewitchment.

Standard 9 students had a broader psychological perspective, acknowledging some further categories. A high percentage of students at this level still did not register any Western psychological causes of mental illness. This changed with the university students who, particularly at the 1st year level,

almost all included psychological categories. Differences amongst 1st and 3rd year psychology students may reflect predominantly the teaching curriculum; this is supported by a certain degree of uniformity and repetitiveness of student responses within each year. Chi-square analyses for each of the 8 categories on Table 4 in relation to high school versus university students, reached significance at the $p < .01$ or $p < .001$, except for stress/study/anxiety, where the chi square score was not significant.

The category of "stress/study/anxiety" is obviously of some personal relevance to all students. It fits closely Guinness' portrayal of the symptomatology of Swazi students, where there is a predominance of somatized anxiety in the highly competitive and stressful arena of education. In fact, it largely refers to the same issues dealt with under the rubric of bewitchment, since students most vulnerable to symptoms seem to express their stress in their escalating fear of becoming the victim of the envy by others, this resulting in bewitchment (Guinness, 1992).

"Frustration" as a grouping of responses only emerged at the university level, usually referring to the frustration of not achieving one's goals. Again, one needs to consider the excessive expectations and financial investment in education in the former Ciskei, and in Africa more generally, which has found its expression in the "brain fag" syndrome. Academic achievement is obtained at tremendous cost to the individual

and his/her family. While financial issues usually play a considerable role, as seen in the last minute scramble by students to obtain the means to pay their outstanding fees prior to examinations, students often had to endure a lot of hardships, in order to stay at school or university; failure rate was high and many students carried the additional burden of representing their family's hopes for a better life.

How much the Western categories of causation were integrated in the students' world-view is difficult to determine accurately, in that the students, particularly at the university level, were used to proving to their lecturers what material they had absorbed. Individual responses varied and some statements certainly came across as material regurgitated from class, whereas others were convincing as personal statements in that a point of view was argued, or elaborated with anecdotes. However, the most convincing narratives with a great amount of detail came from standard 6 and 9, the lower levels of education in these samples.

Some further evidence is found in the discrepancies between 1st year and 3rd year psychology students' responses. If we take a category, for example of "internal" causes, which refers to intrapsychic issues, such as guilt, internal conflicts, and depression amongst others, one would assume once students had come to articulate these as problems, they would then constitute a stable aspect of their perception of the world. Thus, 3rd year students would be expected to make

use of this category at least as much as 1st year students. If, however, the category emerged purely as a result of *temporary* influences, such as just having heard a lecture on psychoanalysis, then it would not be surprising if, a few years later, the material has faded, and intrapsychic issues had ceased to be a feature in the students' conceptual repertoire.

As previously noted, intrapsychic or "internal" explanations were not found in recognizable form in the Xhosa world, largely because the culture has traditionally placed responsibility for action outside the individual, whereas Western culture has looked for the causes within the person.

While categories of psychological causation persisted to the higher educational levels, there was not much consistency from 1st year to 3rd year, except in the areas of frustration and stress/study/anxiety. The number of students who did not make any reference to psychological causes declined, however, with level of education, as can be seen from Table 4.

Western Organic Causes

Table 5 displays the students' response frequencies for the causation of mental illness by Western organic causes.

Table 5. Western Organic Causes of Mental Illness as Identified by High School and University Students.

Causes	Std.6	%	Std.9	%	1st.Yr	%	3rd.Yr	%
Drugs	4	6.2	19	55.9	31	42.5	12	44.4
Genetics (born wrong)			2	5.9	11	15.1	13	48.2
Trauma (accident)	4	6.2	7	20.6	9	12.3	14	51.9
Alcohol	3	4.6	7	20.6	14	19.2	7	25.9
Prenatal (Brain not workg)			2	5.9	5	6.8	8	29.6
biochemical	2	3.1	6	17.6	5	6.8	1	3.8
Malnutrition					9	12.3	3	11.1
No response	54	83.1	9	26.5	16	21.9	2	7.4
No. students	65		34		73		27	

For statistical reasons, chi square analyses were applied to the comparison between high school and university students only. All the main groups were statistically significant at $p < .05$. "Genetics", which contains all reference to the inheritance of mental illness, including statements such as "born wrong", only truly emerged as a category at the university level, whereas the effects of drugs, alcohol and trauma come into play at the lower high school level. "No response", in other words the absence of any mention of organic causes of mental illness, decreased with education, standard 6 having a "no response" rate of 83.3%, whereas 3rd year university students had one of 7.4%. This difference is statistically significant when high school students are compared with university students (chi square = 26.45, $df = 1$, $p < .001$).

Socio-political Causes

Table 6 represents the findings on the students' perception of socio-political factors in the causation of mental illness.

Table 6. Socio-political Causes of Mental Illness Identified by 1st Year and 3rd Year Psychology Students.[53]

Causes	1st Year	%	3rd Year	%	Total%
Poverty	20	27.4	2	7.4	22
Unemployment and lack of housing	6	8.2			6
Racial discrim./ racist laws	11	15.1	3	11	14
No response	45	61.6	18	66.7	58
No. of students	73		27		

Only 33.3% of 3rd year, 38.4% of 1st year and 14.7% of standard 9 students mentioned such factors in regard to mental illness. Thus we are looking at a relatively small number of student responses. Those who did respond mentioned poverty, unemployment (which includes lack of housing), and the third category, which contains a number of political issues (racial discrimination, lack of freedom or rights, Group Areas Act, State of Emergency and political harassment). It was surprising to have such a high "no response" rate in this arena, since at least the Fort Hare students, like university students more generally, tended to be politicized.

[53]High school students were excluded because of the low percentage of responses. Only five Std. 9 students (14.7%) made any mention of socio-political issues.

The context of their writing these narratives, as the main explanation was mitigated by the fact that nobody was identified by name. It is unlikely therefore that the students' anxiety of political reprisal was the prime influence. The professor requesting this student project, was trusted by the students.

Therefore the reason is more likely to relate to a response set rather than the students feeling constrained in expressing what they thought. The alternative assumption is that these students, even 3rd year psychology students, generally did not think of the causation of mental illness in socio-political terms. Mental illness was still closely linked to traditional concepts, although it had expanded to include some Western psychological and biological categories. Asking for causes easily elicits the question of *why*, a spiritual question, whereas the *how* of the illness is by-passed.

Attitudes to the Traditional Healer and the Hospital

Table 7 gives a picture of the students' attitudes towards the traditional healer, and the mental hospital. Both positive (+) and negative (-) attitudes are represented.

Table 7. High School and University Students' Attitudes Towards the Traditional Healer and the Hospital.

Attitudes	Std.6	%	Std.9	%	1st Yr	%	3rd Yr	%
Healer +	42	64.6	21	61.8	38	52.1	16	59.3
Healer -	3	4.6	6	17.6	9	12.3	2	7.4
Hospital +	33	51.6	22	64.7	54	74	11	40.7
Hospital -	11	17.2	3	8.8	5	6.8	2	7.4
No. students	65		34		73		27	

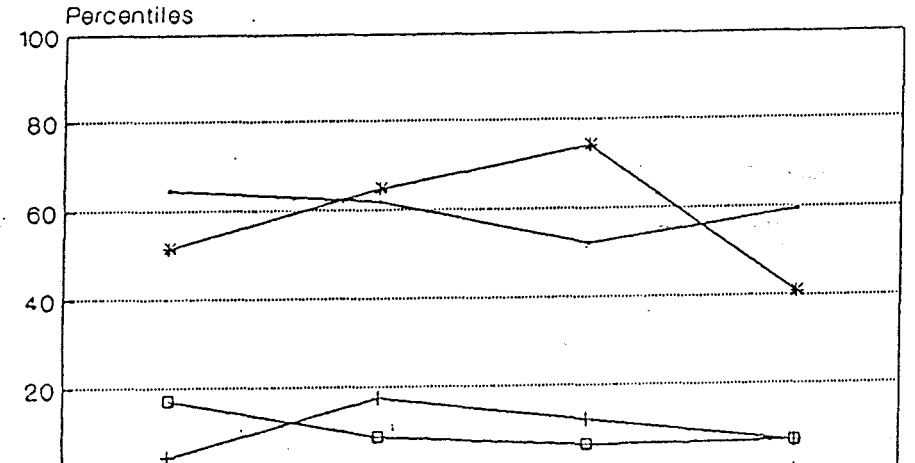


Figure 6. Attitudes to healer and hospital:

Figure 6 gives a graphic presentation of the trend in attitudes in relation to education. Analyses were, for statistical reasons only, obtained for high school versus university students. Results were not significant for the attitudes towards the healer or the hospital.

Figure 6 shows that more students express a positive than

negative attitude towards the traditional healer; the percentage never exceeded 65%. This certainly does not reflect a vote of full confidence. The same can be said for the hospital, the exception being the positive ratings by 1st year students (74% rated the hospital predominantly positive). These responses should not, however, be considered as equivalent to traditional and Western attitudes. As has been argued before, traditional societies generally seem to tolerate criticism of their healers, as this does not represent a threat to the belief system; instead individual healers may be rejected as being "only after the money" or "not knowing what they are doing", which can therefore explain known incidents of failed treatment. Medical treatment in traditional Xhosa culture, as in many such cultures, faces the problem that every illness is expected to have a cure. This means that given a reasonable period of time, the treatment will be evaluated as either a successful cure or a failure. The word *ukunyanga* actually means to heal, treat and cure, reflecting the culture's lack of distinction between these different concepts.

This attitude can present problems for the traditional patient in regard to Western health care, where medication is often taken for maintenance purposes. If patients experience improvement they will believe that they are cured and will therefore stop taking the medicine. Should symptoms return at this point the patients will probably conclude that the treatment has failed. On the other hand if they do not

experience substantial improvement in the first place, the treatment will be evaluated as having failed, and they will stop medication anyhow. Western doctors in turn then conclude that the patient is non-compliant.

While attitudes to the healer do not necessarily correspond to the general orientation, or the predominant belief in traditional versus Western causes of mental illness, it is interesting that 1st year university students expressed both more negative attitudes towards traditional values, and more positive attitudes towards the hospital (74%). This changed for 3rd year students, who showed some increase in traditional thinking and a considerable drop in enthusiasm for hospital treatment (40.7%).

Negative evaluations of the hospital included comments such as "not cured", "pills cause palpitations", "don't cure, just calm", and "person may be stolen by the witches". Negative evaluations of the healer include statements like, "he just causes quarrels", "does not cure", "he will only beat you", "you waste vast sums of money", "will only tell you that this person is bewitched by a neighbour", "sometimes does not see the *umhlola* (cause)" and "he will give him herbs to drink which will make him worse".

Positive statements about the hospital are often general, as in these comments of a 3rd year student:

> Hospitals help the mentally ill in trying to restore to them their healthy minds. Psychiatrists and clinical psychologists play a major role. Drugs are used when necessary. Various methods are used in trying to heal these people.

Or:

> Sometimes they are given drugs, or placed on the shock counter...so that they can return to their minds. People are taught how to behave because other illnesses arise from those faulty learnings.

Students also expressed ideas about the hospital as a place which will provide care for people with mental illness as well as handing out items such as soap, which poor patients cannot afford to buy.

Positive statements about the traditional healer often emphasize that the *igqirha* is needed for the culture-bound syndromes. However not all students limit the role of the *igqirha* in this way, as can be seen by the following:

> Yes I can say that *amagqirha* do have help for a person that is mentally ill, because they cure him by giving him traditional medicines. A person who is mentally ill who is being treated by an *igqirha* does not become fat and swollen, he becomes like other people.

Or:

> the *igqirha* can cure the mentally ill person, because he gives him bitter medicines.

A preference for the *igqirha* is also expressed in that he is seen as having supernatural powers, and therefore is able to provide protection for his patients from witches. He inspires confidence in that he has visions, whereas Western doctors "do not always see clearly."

Many students saw a role for both the hospital and the traditional healer, as seen in these comments by a standard 9 pupil:

> To take the person to the hospital is good but on the other hand is not good. It is good when the illness is caused by drugs or when he is worried in his heart; doctors can help. But if it is caused by *intwaso* he will never be helped in a hospital. He should go to the *amagqirha*. To conclude the hospital and the *igqirha* have a part to play in treating these illnesses.

Recurring Themes in Student Narratives

Table 8 sets out concepts that recurred many times in the student essays. While, this does not represent an exhaustive list of possibilities, and some important concepts may have been omitted, it will provide a brief summary of words representing different worlds.

Table 8. Recurring themes[54] in the Narratives of High School and University Psychology Students.

Theme/Concept	Std.6	%	Std.9	%	1st Yr	%	3r Yr	%
a Witches	26	40	10	29	25	34.2	10	37
b Ants/rhorho	13	20	6	17.6	11	15.1	6	22.2
c Jealousy/envy	9	13.8	5	14.7	6	8.2	3	11.1
d Hlope/white	9	13.8	1	2.9	0	0	6	22.2
e River	9	13.8	1	2.9	11	15.1	3	11.1
f Amakosi	5	7.7	0	0	3	4.1	1	3.7
g Spirits	2	3.1	3	8.8	14	19.2	13	48.1
h Demons	2	3.1	1	2.9	3	4.1	5	18.5
i Hallucinations	0	0	0	0	8	11	8	29.6
j Retardation	0	0	1	2.9	8	11	8	29.6
k Schizophrenia	0	0	0	0	5	6.8	1	3.7
l X-rays/inject.	3	4.6	4	11.8	3	4.1	2	7.4
m Study	2	3.1	2	5.9	5	6.8	3	11.1
n Frustrat. goals	0	0	0	0	3	4.1	6	22.2
o Brain	3	4.6	18	52.9	11	15.1	10	37
p Car accidents	1	1.5	2	5.9	5	6.8	4	14.8
No. of students	65		34		73		27	

The first seven terms (a - f) come out of the Xhosa traditional world, where the person is concerned about witches and bewitchment, which can take on the shape of grave-ants or *rhorho*. All this is motivated by the envy of neighbours or friends. The ancestors may call you to become an *igqirha*, in which case you need to wear white beads, and perhaps even meet the *abantu abamhlophe* (white people who are ancestral spirits), when you sink into the river.

The next two concepts (g & h), while belonging to the traditional world, are more specifically connected to the *spiritual churches* such as the Zionists. The prophet or *umthandazeli* is not said to get rid of *amafufunyane* or grave-

[54]Based on the frequency of the words used in the essays. These are culturally significant words and are seen as representing themes.

ants, but demons (*demoni*), and he is concerned with spirits.

The concepts (i - l) relate to Xhosa perception of the Western medical world with its specialist terminology--hallucinations, retardation and schizophrenia, as well as with its technological symbols, x-rays and injections. The students had difficulties with the concept of retardation, since Xhosa culture does not seem to distinguish between retardation, mental illness and forgetfulness as seen in the expression *ngqondo emfutshane*, which means mind shortage. Many students, even 3rd year psychology students, were confusing *retardation* and *mental illness*. This could not be explained by their having misunderstood the topic of the essays, since the terms were used interchangeably.

The concepts (m - p) are more closely related to the empirical knowledge of the students and problems they are most likely to encounter in everyday life.

Reading Between the Lines

The quest here really concerns tracing the *thoughts* behind the narratives, in the attempt to understand the cognitive context of the persons with severe mental illness who return to the hills east of the Hogsback mountains. While we can easily describe what their mud hut might look like, or the food they might eat when returning after some weeks or months from *Tower*, the mental hospital, it is a great deal more difficult

to grasp the thoughts they may have about themselves and their illness, and the reactions of the community to which they are returning.

In Chapter 4 the debate about the nature of African traditional thinking as compared to present Western thinking was considered, including such issues as the rationality of traditional thinking, when seen in its own context (Horton, 1982), and the assumption that different people's thinking corresponds to different Piagetian developmental stages (Hallpike, 1979). Regarding the latter, we need to note research which has shown how sensitive these Piagetian levels are to the specific task being completed (Shweder, 1982), this showing that the structure of thought is not independent of content.

The question one must ask is how these ideas apply to Xhosa society as we see it today. One can hardly take Xhosa society as representing "primitive" society in the generally accepted sense. Nor is Xhosa society illiterate in that while many of the older generation of the rural population cannot read or write, most of the young have had some schooling. The students whose narratives are being perused have reached at least high school, and half of them were attending university. While a large percentage of Xhosa speakers are rural, many are inevitably caught up in the effects of industrialization and urbanization, in that the migrant labour system has penetrated into the most remote spots of the country. And yet the

belief-system seems to persist.

In order to address the question it may be helpful to examine the narratives in a more qualitative way.

The author therefore scrutinized the essays in regard to a number of characteristics: (1) objective presentation with some evidence of being able to take different viewpoints and develop a logical argument, (2) categorical as opposed to non-categorical statements, (3) concrete and specific content, and (4) confusion.

(1) Objective Presentation: None of the students developed a *consistent* argument about their position in relation to Western and traditional thought, acknowledging clearly an understanding of the conflicting premises of the two cultures. This requires one stepping out of one's own shoes and looking at issues from alternative perspectives. The closest essays to achieve this position were those of a few 3rd year university students.

Some examples of this kind of cognitive sophistication are the following statements from 3rd year students:

> Medicine--attributes the *Amafufunyane* to hallucinations.
> Witchdoctors--attribute the *Amafufunyane* to evil spirits/demons which they claim are sent to the person who has them by his/her enemy.
> Question: If these *Mafufunyanes* aren't put into somebody, then how do they enter his body?
> How do we account for the different languages?
> How do we account for the fact that they will know members of one's family, together with their problems?

> It is difficult to see the role of traditional doctors because what I had often found is that people, even if they don't say it out, go to them having a target in their mind. I believe that traditional doctors because they know this fact try to get a way through the person's mind--they are always vague in putting a matter; for instance, they will say to Xhosa infertile woman "MaDlamine, you know her in the family is responsible". They say this because they know it is one of the commonest names among the Xhosas.
>
> The traditional healer: To reassure one in (times of) trouble since he is aware of one's ideas and beliefs has a psychological effect. They help one talk out one's problems as they usually guess which problems are needing a response. Most people feel they get relief after this, even if they have not taken treatment internally. To strike one's belief in diagnosis is one way of solving the patient's problem.

The number of students questioning cultural ideas, or who present at least some of their narratives in an objective way, is less in the high school group (7.7% Std. 6; 5.9% Std. 9). Some of this difference may simply be due to the fact that university students learn the jargon of objectivity. Even taking this into account, high school students showed a qualitative difference in their arguments. Consider an excerpt from a standard 6 essay:

> *Amafufunyane* don't exist because sometimes people say a certain person is possessed by them, whereas that is a lie. Sometimes he doesn't want to go to school because he's interested in pleasures.

(2) Categorical statements typically make definite authoritative pronouncements such as "mental illness is...," "once a person suffers pain for long time ...he becomes affected, and this is because...," "the traditional healer cures those who believe...," "mental illness is a bad

illness...," "mental illness is caused by bewitchment...". Non-categorical statements tend to be open- ended and suggestive rather than offering dogmatic answers. Characteristic expressions can be seen in the following:

> mental illness is caused by many things, it can be caused by thinking (too much), be(ing) bewitched by people and rituals...

and

> mental illness is sometimes caused by *amafufunyane*. They may cause him to be mentally ill.

Categorical presentations are seen to be congruent with pre-operational thought, whereas open-ended statements fit later cognitive structures. In each case there were changes with education: the big shift in non-categorical statements seemed to occur between standard 6 essays and the rest of the students, with the former having only a small percentage of essays with a predominantly non-categorical quality. As far as a categorical presentation was concerned the difference between the different groups was not striking, but high school students generally came across as more categorical.

(3) Concrete and Specific Content: This is a highly significant category, which distinguishes clearly between high school students and university students. University student mostly wrote about mental illness in general terms, whereas high school students, particularly the standard 6 pupils, were more specific, often telling stories referring to someone they knew, or a situation they had heard of. This can be seen in the following examples:

> Here in the village there was a boy who used to fight. When there was a party people were worried that he would stab someone ...Today he is picking up dirty things and burning them. He wakes up early in the morning to wash his body in the river and at sunset he does the same, even today he's still mad" (A standard 6 student).
>
> Some cry bitterly, some may run without reason, another one is laughing all the time...They are sometimes sent to the shops and sometimes they are sent to fetch water with a leaking bucket. And if he sees that the bucket is leaking and he will tell them, they will know that he is well..." (A standard 9 student).
>
> A mentally disturbed person does things which are undesirable. He or she can walk through the streets naked. One who is mentally ill tends to be aggressive. He is wild. One who is mentally ill there are things which he or she cannot be allowed to do, such as driving a car, even if he or she has got a driver's license which he or she obtained before he or she fell ill" (A 1st year university student).
>
> Another contribution to mental retardation is religion. We usually hear about religious fanatics. Take for example, Christianity. Some of these people would like to be very, very holy, but this is not possible in the world we live in because it's full of temptations. So they start claiming that they are holy when they really aren't. Supposing a person who claimed to be a virgin, falls pregnant. This hits her so hard because she never realized that what she does in the dark night (would) come out in the open. The effect again is usually to go crazy" (A 3rd year university student).

Compare these concrete and specific statements, to a more abstract and general one by a 3rd year student:

> Views on mental illness depend largely on the cultural views held in that society. Mental illness is viewed basically as caused by "bad spirits" which are put in one's body so that they can make him maladjusted...

What distinguishes these narratives is not so much the content but the style of these statements, reflecting a different way of expressing ideas. This is not to say that the more abstract

essays were necessarily the better ones; in fact, many of the high school students wrote more interesting and creative narratives, whereas the university students produced a great deal of stereotyped material.

(4) Confusion: Many essays contained some elements of confusion and inconsistency, both in content and structure. The most blatant example of confusion was that of the concepts of mental illness and mental retardation, which was particularly marked at the 3rd year level. As was previously explained, this may relate to a large extent to the Xhosa concept not making a distinction between the two. There were a few students who drew some distinctions, although the details still showed some confusion. Consider this text:

> Before discussing the reasons why people suffer from mental illness I would like first to differentiate between the two concepts, ie, a) mental illness and b) mental retardation. Mental illness occurs when "normal" mental function of a person is impaired--whereas in mental retardation the normal mental function has never been attained--and recovery is impossible; mental retardation is something that one is born with.

A great deal of contradiction and inconsistency could be found in these narratives both in content and style of presentation, so that sometimes it was difficult to determine whether they were presented objectively or not, or whether they were categorical or not.

From the essays it could be argued that the students showed some difficulty with more abstract thought, which would be supportive of Hallpike's (1979) thesis that thought in a

traditional society is organized at a level lower than that of formal operations. This would be congruent with the difficulties many students experienced with the subjects of science and mathematics. However, at the same time it is certainly not enough to prove that this pervades all aspects of Xhosa society. What must be remembered is that these students are being evaluated here from a Western point of view. Horton (1982) notes that traditionalist cultures tend to produce and sustain a single overaching theoretical framework, rather than a multiplicity of such frameworks. The illness concept in Xhosa culture falls within the supernatural, and tends to be incorporated within this over-arching framework, and this makes it difficult for these students to compare and contrast different perspectives.

These same students are quite capable of complex and abstract thinking *within that traditional framework.* This is supported by the fact that students who are known to be highly "politicized", at least at the university level, did not apply socio-political conceptions to the issue of illness causation. Many students managed to present traditional and Western views of mental illness side by side, without feeling the need to defend and argue, or even acknowledge the fundamental contradictory nature of the two cultural perspectives.

Stigma and The Tale Told

While so far the qualitative analysis has focused on the teller of the tale and how he/she perceives mental illness, we now need to consider the tale and the people who are at its center. It is interesting that we hear much more about people with mental illness, or the victims of the African illness (*ɔintwaso*, *amafufunyane*), from the high school pupils, than from the university students. When it comes to describing symptoms and actual tales about what "mental illness" looks like in the villages, it is the high school students who provide us with details and who share with us their own feelings and attitudes as well as reflecting those of the community.

The essays were scrutinized for comments on people with mental illness, describing negative judgments about them, and statements about the writer's personal negative feelings or those of the community, towards people with mental illness. The clearest evidence of stigma was seen in the students' descriptions of ill-treatment of individuals with mental illness by the community. Percentages of students referring to or showing evidence of stigma in their essays were as follows: standard 6: 40%; standard 9: 67.6%; 1st year university students: 4.1%; and 3rd year university students: 0%. The 3rd year students focused on issues of causation, and made value-laden statements in relation to these, but kept references to people with mental illness very general. There were no

consistent distinctions drawn between the various diagnoses in terms of causation and particular stigmatizing symptoms or community attitudes, with the exception of *intwaso*, which was often described in less malignant ways.

It is accepted, however, that if the *intwaso* is not dealt with, the individual can become mentally ill like the others. People with mental illness are described as being vagrant and dirty, different from every one else. They are usually seen as assaultive and dangerous. Consider the following comments:

> A person who will be walking up and down the streets who doesn't know what he wants... makes him useless" (Std. 6).
>
> He becomes a filthy ragged thing who eats dirty things. Some beat people in the streets--you may take him to a mental hospital, he may be treated and given pills. Some may be fat because of the treatment. You may think that he is well and it starts again with what he had been doing (Std. 9).
>
> A mentally ill person is recognized by his doing strange things... another symptom of mental illness is that he is talking to himself. He wants to assault people without reason.
>
> A mentally ill person hasn't got a good outlook, he becomes scared and some like to assault people, some burn up their clothes, they can damage their homes.

Then there are personal statements of the way the students feel about people with mental illness and their behaviour. It would seem there is a strong element of fear in relation to the unpredictable nature of the ill person, as he/she is perceived:

> He talks to himself, assaulting people, he may do things which cause people to feel uncomfortable about him. His family may decide to take steps about him (Std. 6).

the better someone may be doing in life, the greater the risk for a bewitchment.

> Some people play with the lunatic, they make him an amusement. Some love him and give him everything. I take him as my own brother and sister because that may happen even to me (Std. 6).

> You'll see the children in the streets making amusement of them. They tease them so that time may pass pleasantly because no-one (of their home) takes care of them.

> I become worried when I meet a person who is mentally ill--Some like to ask for food in homes and the person will give him old food and he's going to eat because he doesn't know. I become moved if I see a person who is mentally ill in the street, when people mock him and he keeps quiet. Others will call him some silly name...

> The most painful and terrible one is mental illness, it causes the person to be an amusement, especially if that patient is not his relative, they don't take the person as one who is created. They misuse him; they take him to their fields to plough, picking up papers in spite of the sun--things which you cannot demand of a person when he is not ill (Std. 9).

There are definite beliefs about how people with mental illness should be treated. The emphasis seems to be on accommodating, and especially not provoking the person. This relates to the concern that the individual may become violent, and, with some students, there is a strong sense of wanting to be therapeutic in relation to the person with mental illness, and hoping to achieve this by being supportive, even if this means giving in to the person's whims.

> I pity a person with this illness because people of this world will do nothing for him. I treat him like other people so that he may feel comfortable and my friend will be happy until he goes away from me.

> Bad things is done to mental patients--to ignore and despise them or to always talk about their illness, while they should be treated the same as other people until they forget they are ill.

> A mentally ill person should be obeyed so that the illness may not go further.
>
> Another thing is that you should not scold him--The person can't do anything right. I take a mentally ill person as he is. I talk to him, I answer what he asks. Every time I try by all means not to make him cross, because when he's cross it will be difficult to stop him (Std. 9).

Other advice for ways of handling people with mental illness is more rejecting, emphasizing that they are not to be trusted. Out of this attitude recommendations of hospitalization emerge. These reflect an awareness of the burden to the family and community that mental illness represents.

> It is difficult to keep this kind of people at home and that is why the people send them to the hospital with such an illness.
>
> You mustn't have a mentally ill person with the children because he may kill them. You must not scold a mentally ill person because he's going to assault you. He may also pour hot water on himself because he is unconscious... (Std. 9).

The theme of the person being unconscious, a term equivalent to being "out of touch with reality", is fairly common, implying that the person with mental illness is not responsible for his/her actions. This fits well with bewitchment, because there too something is done to the individual; he/she is the victim.

If we are to take these comments as true indications of the community's attitudes, they would hardly conjure up a society which happily integrates its people with mental illness, or always provides an optimal context for their recovery. The

comments suggest some dissonance with studies supporting the view that patients with mental illness have a better prognosis in Third World countries (Lefley, 1990a; b; Torrey & Torrey, 1974; Sartorius, Jablensky, Ernberg, Leff, Korten & Gulbinat, 1987). This reveals the problems with the First world/Third world dichotomy, especially in a South African context (Boonzaier & Sharp, 1988).

The most pertinent summary of the potentially damaging consequences of mental illness (cited at the opening of this section), was the following, by a standard 9 pupil:

> Mental illness is just like other illnesses you may come across, but the difference is this illness can change a person's conduct. People losing their homes, their jobs and some other rights...When a person has this disease the people judge him in a different way; some are afraid of him and some consider him to be useless and all this can affect him.

This poignant statement indicates an understanding of the fact that mental illness affects the person's behaviour, has a significant impact on the circumstances of the sufferer, influences the way others perceive him/her, and, finally, damages the sufferer's self-esteem. This description, while coming from the Xhosa perspective, could have been given anywhere in the Western world.

Summary and Conclusions

When looking at mental illness in rural Xhosa culture, there is the need to get into the heads of individuals who comprise that culture, before we even approach the sufferers themselves. As we have learnt from the literature, human disease expresses itself in diverse ways, and is given multiple meanings in different societies. We never encounter the pathology in the form of viruses or malfunctioning synapses directly, unless we are in the laboratory, bent over slides of tissue or focusing on computer tomography. We usually meet individuals and come face to face with their *dis-ease*, their way of being within their physical and cultural environment. The perceptions of their society are paramount in affecting the way they perceive their own state of being, and what they can expect from the people around them, which in turn will modify their own state.

Xhosa high school and university students have with their essays given us a glimpse of "mental illness" as it is encoded in the thoughts of individuals by their culture. With a Western-type education a second culture is introduced, which at a fundamental level stands in conflict with the old traditional one. The narratives show how this newer culture with its language of naturalistic and technological concepts, flourishes with increasing education. The narratives also show that this does not displace the old culture, which remains for most people a fundamental base of experience.

The student narratives present us with a view of mental illness that focuses on two distinguishable aspects: (1) the root of the problem (causation), and (2) the result (conduct). The interplay of these two aspects with the traditional treatment by the healer, the *ighirha*, and the Western treatment by the hospital, determine ultimately how the sufferer is perceived and perhaps treated. It seems that most students agree that being *ukuthwasa* does not label the individual as mentally ill; only when the state persists, in other words when it is not resolved in a culturally appropriate manner, does it turn to mental illness.

There is a similar view about *amafufunyane*, except that here the distinction is vague as to when it would be seen as mental illness as opposed to a temporary state of possession which the person can be rescued from. Ultimately most matters of illness or misfortune are seen as having a supernatural basis. This is not always articulated, particularly at the higher levels of education.

People with mental illness are usually exonerated from blame for their disruptive actions by the culture. When, however, traditional methods and Western treatment have been exhausted to no avail, the individual is labelled mentally ill and negatively valued. At this point the original diagnosis as *thwasa*, *amafufunyane*, or various other diagnoses, including Western causes, seem to make little difference in that the disruptive behaviour becomes the paramount problem.

CHAPTER 9

PATIENTS AND THE HOSPITAL

Introduction

This chapter is divided into two parts. The first of these, "Patient Profiles," focuses on information contained in patient files kept at the mental hospital. It presents an objective description of patients discharged from the mental hospital, comprising diagnosis, number of admissions, reason for admissions, and other such data. The second part, "The Legacy of Control," takes a closer look at the mental hospital charts and attempts to extract the essence of what hospitalization in the rural Ciskei/Eastern Cape was about, by offering an ethnographic analysis of the documentation in the hospital charts. This is amplified by information from interviews with nurses, medical personnel, and the patients themselves.

Victoria East Mental Health System

Tower Hospital, usually just known as *Tower* is, as mentioned earlier, located some 18 kilometers from Alice, the hub of the Victoria East magisterial district. This mental hospital is located outside the boundaries of the Victoria East district, and was at the time of this research separated from this catchment area politically and administratively. The hospital

and the local town, Fort Beaufort, were part of South Africa, whereas Victoria East was classified as Ciskei.

This had certain implications for the patients. One of these involved major administrative problems around admissions and referrals, since these procedures have to follow specific routes. It has sometimes resulted in a patient who lived relatively close to the hospital having to first travel to Alice to obtain papers and be seen by the district surgeon.

Tower, however, still remained *the* mental hospital for this area. Others, such as Fort England in Grahamstown, and Komani in Queenstown, were much further away (100+ km). Patients declared criminally insane, the *State President's patients*, generally did not remain at Tower. These patients usually passed through the prison system into Komani hospital. There was also a local hospital in Alice, the Victoria hospital, which admitted mental patients occasionally, but usually treated persons with mental illness on an outpatient basis.

The Victoria East district encompassed one of the more rural regions of the Ciskei, in that it did not contain any large urban settlement. Estimated population figures, according to the 1984 census, were 12,712 small urban, and 60,576 rural, as opposed to 330,000 large urban, 51,944 small urban, and 530,217 rural for the whole Ciskei (Directorate of Planning,Ciskei Government, 1985).

Patient Profiles

While 1988 generated 68 entries of patients discharged into the Victoria East magisterial district with a diagnosis of functional psychosis, mostly schizophrenic, only 63 were actual cases; the others were repeats. All diagnostic groups were included for 1989 in order to establish the distribution of various diagnoses. The results can be seen in Figure 7.

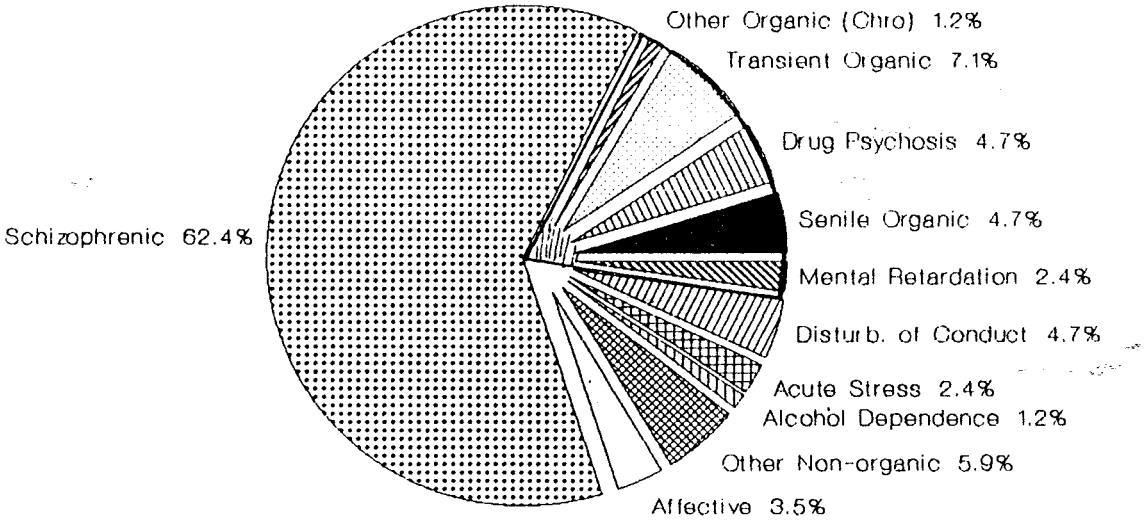


Figure 7. Diagnostic Proportions: 1989, at Time of Discharge.

A closer look at the distribution of organic as opposed to the functional disorders, particularly schizophrenia and manic-depressive (affective) psychosis, raises serious questions, particularly in the light of what we know about developing countries and the dominance of transient psychoses or brief reactive psychoses. Guinness's (1992) breakdown of diagnoses has been included for comparison (Figure 8).

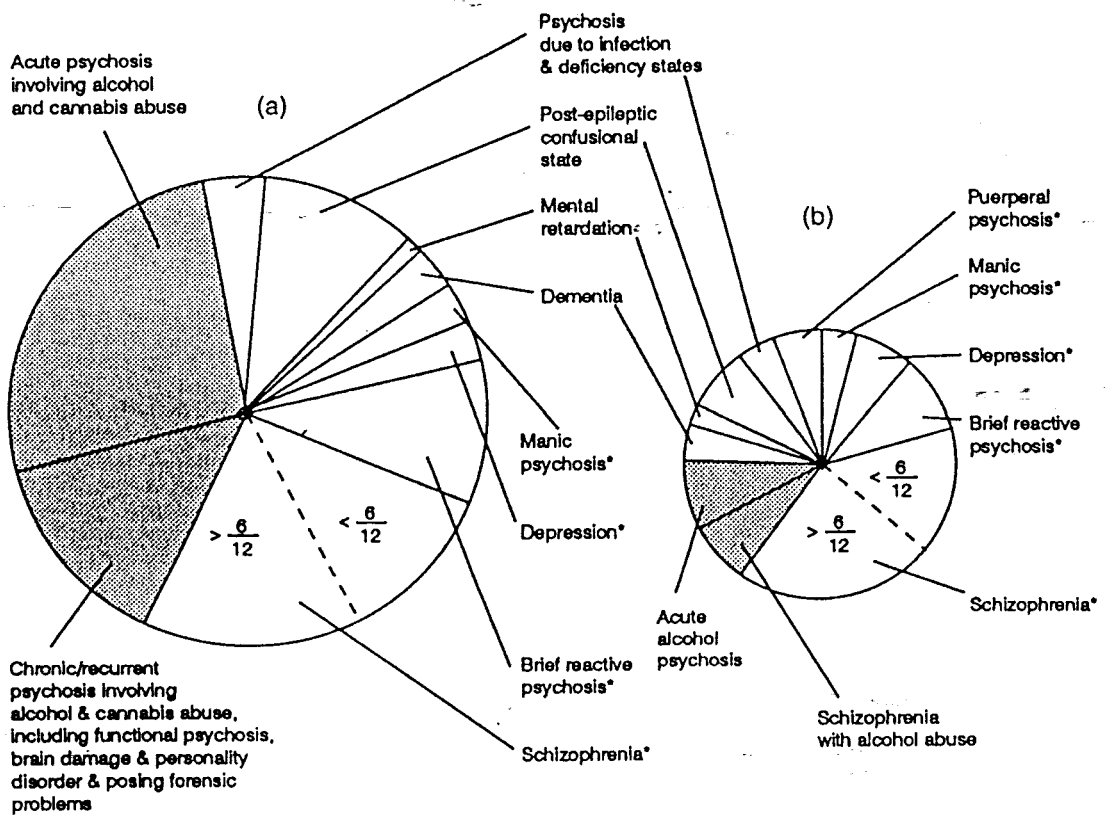


Fig. 1 Diagnostic proportions of annual hospital admissions for (a) males ($n = 440$) and (b) females ($n = 185$). ▨ denotes alcohol-related, * = study sample.

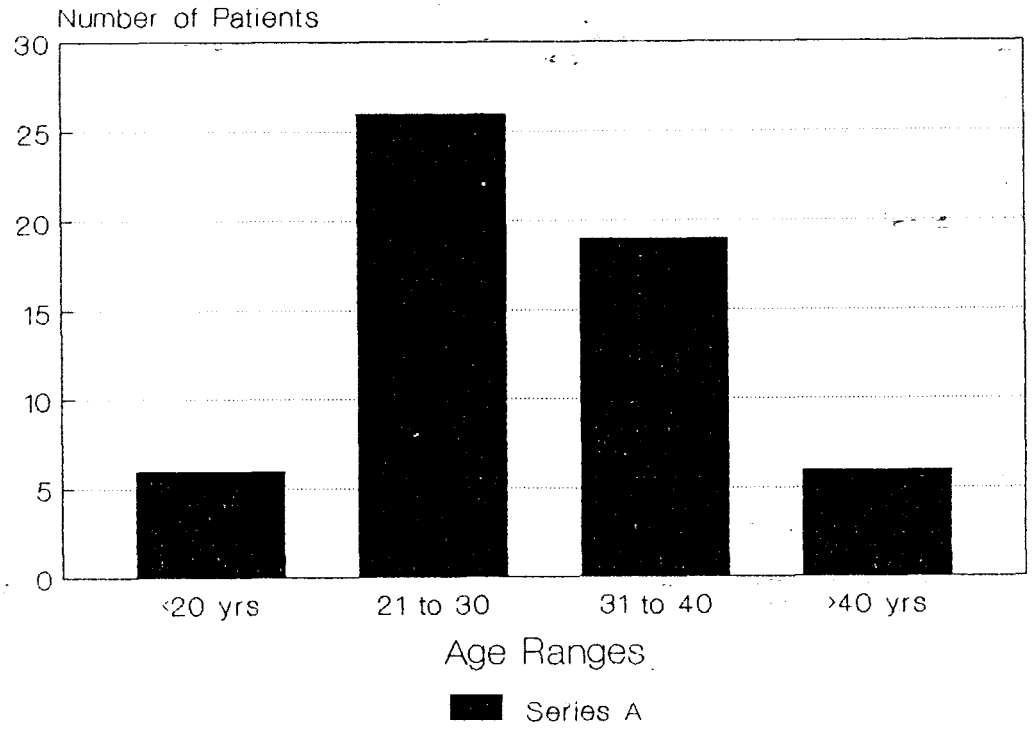
Figure 8: Guinness's Diagnostic Groups at Time of Discharge (Guiness, 1992, p. 26)

While this study started with 68 entries, when readmissions and missing files were excluded, 57 cases were left. The hospital charts were analyzed for the following features: age, admission patterns, reasons for admission, symptoms and organic factors, educational status and occupational history.

Age Distribution

Figure 9 presents the age distribution of the hospitalized patients with severe mental illness who had originated from the Victoria East magisterial district and were now discharged

back into their communities. With the exception of two patients they all had a diagnosis of schizophrenia.



Males: 43 Females: 14

(Discharged 1988. Males:43; Females:14)

The median age for this group was 30 years which would fit well with Warner's hypothesis that schizophrenic breaks bear a relationship to labour market stresses (Warner, 1985). Early adulthood is the period in life when individuals in these communities were expected to find employment and if necessary leave home, entering the migrant labour system.

A comparison with U.S. hospitalizations reveals a higher and earlier peak in my sample, in the 25-34 age group for

hospitalizations.[56] One can only conjecture that this could relate to the greater degree of violence as a reason for admission, more typical of younger males with acute symptomatology; it may also reflect an earlier morbidity, which is typical of poverty-stricken rural conditions. The predominance of males over females, a ratio of 43 to 14 in my data, is not atypical for developing countries, while the incidence of schizophrenia is thought to be equal for males and females in the West[57] (Warner, 1985).

Admission Patterns

Figure 10 gives a breakdown of the 57 patients in terms of first admissions, re-admissions (two hospitalizations) or multiple admissions.

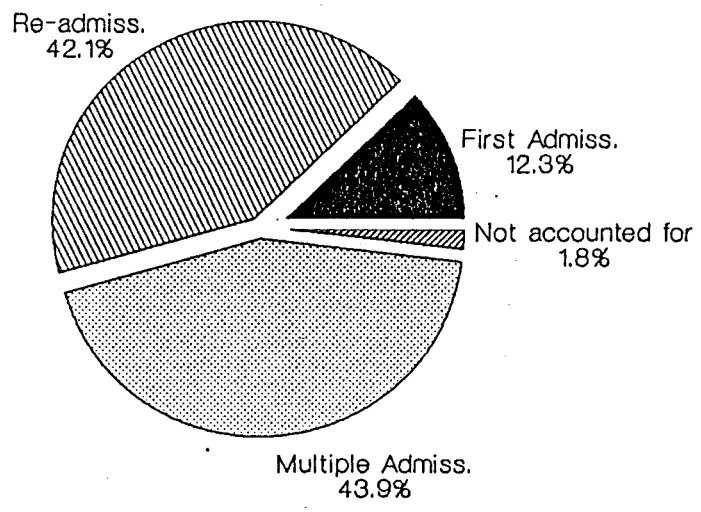


Figure 10. Hospital Admission Patterns

(Total N: 57; Males: 43; Females: 14)

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[56]Regrettably, I have been unable to trace this reference. The information was available at Tower Hospital in photocopied form.

[57]Warner suggests that females with a schizophrenic illness may go undetected in developing countries as they are less exposed to wage labour demands in early adulthood.

Readmission refers to 2 admissions; multiple is more than 2.

The high percentage of readmissions seems at odds with the general picture of better outcome for the developing world. However it would go along with the sense that hospitalizations are reserved for the more disturbed, seriously mentally ill individuals in these communities, and may represent therefore, a bias towards chronicity.

The alternative view is that outcome for schizophrenia may not be as benign, in this part of the world at least, as the international studies of the World Health Organization suggest (Jablensky, Sartorius, Ernberg, Anker, Korten, Cooper, Day, & Bertelsen, 1992). Could we be looking at a society in transition from agrarian culture to an industrialized one, where the old traditions are at odds with the new demands, as Guinness (1992) describes Swazi society to be? The Ciskei experienced great instability in its political history. While the outlying rural areas were more removed from the political issues which city schools and university students were embroiled in, yet these issues filtered through in various ways.[58] The implementation of different kinds of taxes, for example, were experienced as a heavy burden by the impoverished villages.

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[58]The only street name in Ntselamanzi, a location close to Alice, was *Freedom* street, scrawled on a make-shift wooden board. It had been done by some youths, and a nurse said that she was surprised it had not been removed as yet by government people.

Length of Hospital Stay

Length of hospital stay for the 57 patients in this study was calculated as the median number of days of stay. This median was 46 days. The mean and standard deviation were calculated, omitting one long-term hospitalization of five and a half years. The mean was 55.41 days, the standard deviation being 38.56. In an interview, the head administrative officer at Tower hospital mentioned that the average length of stay for an acute psychosis is about 47 days. This is a little shorter than the 1971 US figure for the median hospital stay for schizophrenia (60.4 days), excluding the criminally insane.[59]

Reason for Admission

Figure 11 dramatically illustrates the high preponderance of violence as the prime reason for hospitalization. It has been pointed out that there are differences in tolerance of pathological behaviour between families and/or differences in perceived burden (Perlick, Stastny, Mattis, & Teresi, 1992). While hospital charts at Tower included comments on presentation and physical hygiene, these were in the nurses' notes, not a reason for admission. Admissions were generally involuntary, though sometimes the patient was tricked to come in rather than forced. For a patient to come and admit himself was rare, and in this sample stood out, acquiring (probably

[59]More recent statistics from the U.S. (Center for Mental Health Services and National Institute of Mental Health, 1992) are difficult to compare, since the structure of services has changed, emphasizing short-stay hospital and community residential facilities, while cutting down on long stays at State hospitals.

largely for that reason) a different diagnosis.

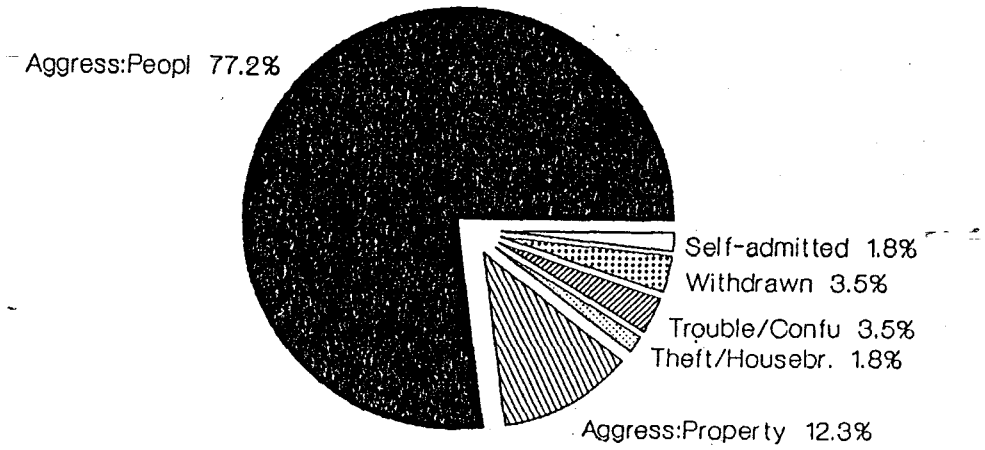
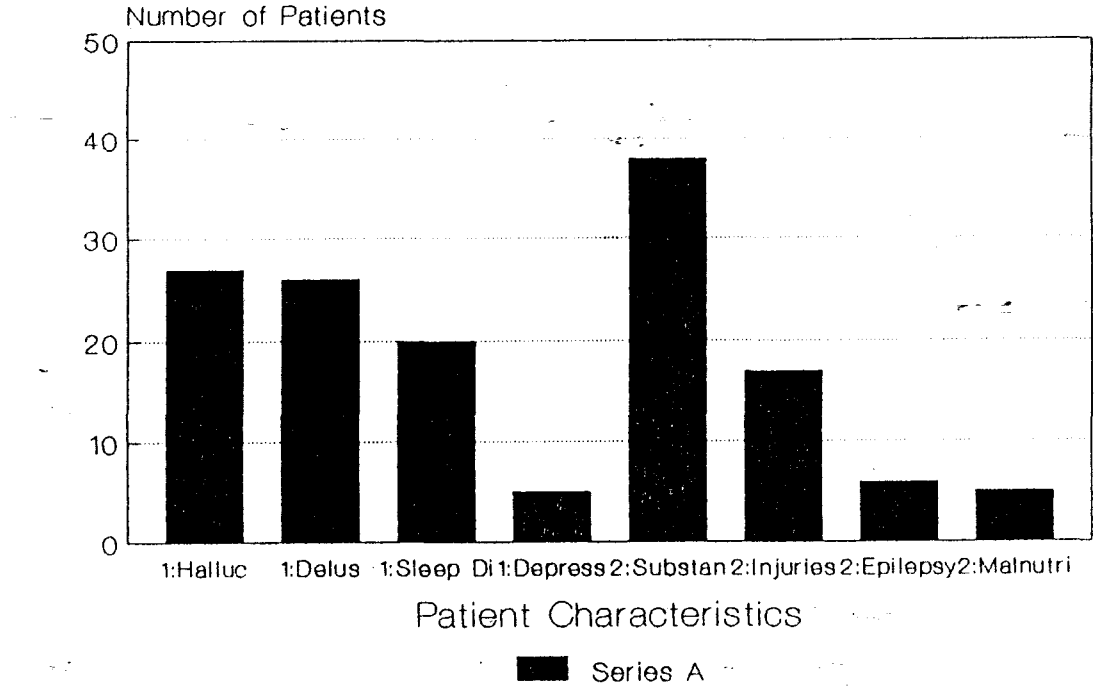


Figure 11. Reasons for Admission to the Hospital
(Total N: 57; Males :43; Females: 14)

One gets the impression that the communities and families saw to the hospitalization of their psychotic members when they wanted these individuals to be controlled, to be stopped from causing damage. Whatever way they had conceptualized the problem before did not matter. Some of the patients whose admission to the mental hospital was unrelated to violence (there were five of these cases), had, on previous occasions been assaultive. The families may have been sensitized by their relative's previous behaviour.

Symptoms and Soma

Figure 12 presents patient characteristics in terms of (1) symptoms, and (2) organic factors.



1=Symptoms; 2=Somatic Issues

Figure 12. Patient Characteristics: Symptoms and Soma (Total N: 57; Males: 43; Females: 14)

Twenty-seven made reference to hallucinations, 19 of which noted the hearing of voices. The latter presents some difficulties as "hearing voices" is culturally acceptable. In the Western context, audible thoughts, as in voices, are defying the acceptable self-structures in relation to the inside/outside boundary (Fabrega, 1989). The Xhosa traditional culture does not have this division, and it would not be surprising to hear the voices of the ancestors. Guinness (1992), however, insists that the non-psychotic will experience these voices in dreams, *not* voices in the waking state. Patients, according to the psychiatric records, seemed to readily "admit to hearing voices," and at the same time

deny hallucinations or mental illness. The former is acceptable, the latter are not.

Twenty-six out of the 57 patients were referred to as having delusions. But once again there are difficulties in distinguishing a schizophrenic type of delusion from the culturally acceptable beliefs in witchcraft. In twelve charts the delusions made specific reference to witchcraft. In some of the records, the delusions were elaborated on as "believes neighbours are bewitching him," or "accuses neighbours of witchcraft." These particular statements could just as easily apply to anyone considered perfectly normal and healthy in the community. The author had conversations around these beliefs with the local school teachers, and these statements could have come out of their mouths.

Twenty of the charts referred to a sleep disturbance, 19 of which were in terms of an inability to sleep and described a manic quality, and one in terms of sleeping too much, this seeming to go with a depression. The agitated hyper-excitable behaviour is typical, as we have seen from Guinness' (1992) descriptions, of brief reactive psychoses in Swaziland. It can also reflect the manic characteristics of the bipolar patient.

There seemed to be some degree of changing diagnoses as seen in the records of patients, particularly between drug/substance related diagnoses and schizophrenia, as well as affective psychoses and schizophrenia. Depression was

mentioned in five cases. When this is viewed in conjunction with hypomanic behaviour and grandiosity, one again must consider a possible bipolar condition. Only a single patient out of 57 was diagnosed with an affective psychosis (he previously had a schizophrenic label). This again highlights the apparent under-diagnosis of bipolar disorders. The unavailability of lithium, the drug of choice for bipolar conditions as a stabilizer, eliminated the need to differentiate between schizophrenic psychoses and the mania of the affective disorder, since the same neuroleptic drugs would be used.[60] This issue will be addressed again in the section on the legacy of control.

As to the organic factors involved, 38 of the 57 patient charts referred to dagga or alcohol consumption, 17 to injuries of some kind, including car accidents and head trauma, 6 queried epileptic seizures, but did neither confirm this or rule it out, and 5 made reference to the patient appearing severely malnourished, which could suggest some form of malnutrition as a contributing factor.

As previously noted, the so called functional psychoses have clear indicators of subtle organic, cerebral pathology. The figures above suggest that in this patient population other more obvious organic factors were implicated. The most

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[60]While lithium itself is cheap, its administration involves the close monitoring of blood levels because its therapeutic range, between effectiveness and toxicity, is narrow. By contrast, a newer drug, valproate, has wider applicability and requires less rigorous monitoring.

prevalent of all related to the use of substances. To what degree the use of substances constitute abuse was difficult to assess, since it was complicated by the culturally acceptable use of *umgqombothi*[61] and dagga.

The issue of substance abuse is thus more complex than it is often reported to be, and needs to be evaluated in context. In the present sample alcohol may well have been a contributing factor in assaultiveness, as indicated by references to being drunk at admission in a minority of cases.

Work

In the present study 3 people out of 57 (5%) were said to be working at the time of my follow-up (one of which was re-hospitalized thereafter), 4 (7%) were doing odd jobs, 22 (39%) were unemployed (some of these had been unemployed for some years since their initial breakdown), 5 (9%) were scholars, and 8 (14%) had never been employed.

In the light of demographic data on the serious unemployment problem in the Ciskei, it was not surprising to see such poor results of employment rehabilitation for previously hospitalized patients. Compared to the old-age pensions the disability grants (DG) for the mentally ill, considering that this category included also other disabilities, were insignificant in their number. In this study 9 patients (16%)

[61]I was told by a nursing sister that *umgqombothi* is high in calories and is not too intoxicating.

mentioned the DG, including one individual whose grant had been discontinued, and one who had applied and was waiting to receive it.

While the DG could hardly be seen as playing a significant economic role, since so few individuals received it, it still figured heavily in the patient's talk. Nursing staff from the South African based mental hospitals commented on disability grants as something many apply for, and that schizophrenics may have a chance of getting, but not so depressives, since they could recover and work again.

Patients often did not understand the procedures that access these pensions. For example, they had to be reviewed, and therefore patients often unknowingly let their grants lapse (Segar, 1994). The situation may not have been as destructive as it has been reported in relation to epilepsy, where patients chose to continue having seizures by mismanaging their medication to still qualify for the grant. Not many patients with mental illness qualified for a DG because, having fewer obvious physical symptoms to show, they had a more difficult time proving that they a were unfit to work. Psychiatric nurses used the patient's dependence on the DG to urge compliance with the medication. When people managed to secure a DG it helped ease their life situation, and provided some status (Segar, 1994).

In the Ciskei there was relatively little consistent subsistence farming. Villages, and homesteads within individual villages, varied considerably in their involvement in agriculture and even in cultivating a small garden. People complained that they did not have the money to buy seeds, or that there was a lack of a consistent water supply. Few of the discharged patients were actively participating in growing vegetables.

The picture which we see in relation to employment and economics, for this patient population, does suggest higher risk factors. Employment was an area of anxiety and constant concern. In an interview, a psychiatric nurse commented that the patients *only* worry about jobs. Education, too, represented a focal point for stress. It was seen as a way to better jobs, and families often invested more money in it than they could afford. When psychosis occurred in relation to the stress of study and examinations, or the anxiety of finding the means with which to pay school fees, the individuals seemed to continue to define themselves in relation to their studies, hoping to go back to school and pass examinations. Some of these dynamics seem similar to those described by Guinness (1992) in Swaziland.

The Legacy of Control

When Guinness accepted his post in Swaziland as psychiatrist to the Government Health Services, he accepted the responsibility for a population of patients who, only fifteen years prior, were "moved out of the town gaol" (Guinness, 1992, p. 4). This *legacy of control* has been popularized and dramatized, and sometimes distorted in the media and novels of the developed world (Gabbard & Gabbard, 1992).

Foucault (1987) has sensitized us to the power dynamics related to illness and control. Table 9 represents the way hospitalization-care in this context was organized, both by internal, hospital-related factors and by external ones concerning the community and the patient, to function predominantly as a means of control.

The process involves the mental hospital and its procedures as well as the preliminary actions by the community--the patient is brought in accompanied by someone, such as a nurse, relatives and/or the police). Often, the relatives' opinion, or the voice of the community, is represented in what is referred to as "documentation". While the cells in Table 9 are marked by arrows showing the direction of effect, the flow of influence can also be vertical, or extend to other columns. Suffice it say that only the main impact is noted. The text below explains the intent of the table, with headings representing each cell.

Table 9. The Mental Hospital as an Instrument of Control.

Societal Contributions ----> 1	Hospital as an Agent of Control 2	Hospital-related <---Contributions 3
a. Assaultive ---> behaviour of patient	a. Court-room lingo deny/admit	a. Lack of prof. resources (no res. <---psychiatrist)
b. Community demand for control ---->	b. Use of neuroleptics	b. Lack of lab.& <--EEG facilities
c. Cultural attitudes to ----> authority	c. Focus on compliance	c. Hierarchical & status issues with <--- nursing staff
d. Cultural beliefs and social -----> stressors	d. Focus on psychotic symptoms not stressors	d. Cultural mis-match & language <--- issues
e. Florid cultural expression of distress ----->	e. Over-diagnosing schizophrenia	e. Lack of lithium carbonate in <---- treatment

Column 2 represents the way the mental hospital functioned. On the left (Column 1) are the domains which impact on the hospital's control issues, but are external to the institution and largely societal. On the right (Column 3) are domains which are intrinsic to the hospital, and which also affected the way the mental hospital was carrying out this function.

The theme of the mental hospital as an instrument of control is not meant to be levelled as a criticism of Tower Hospital. There were, however, shortcomings, as anyone from the hospital administration would have acknowledged, in that the hospital had to accommodate a large number of patients and was not as well equipped as many hospitals of the developed world. Yet within the context of Africa it probably did not compare badly. However, in the South African situation, there was better care for white patients. The issues which are raised here may to some extent apply to mental hospitals of the developed world too.

The hospital was said to have 600 beds and at the time of the research had 604 patients. The hospital administrator stated that usually there were fewer patients. The hospital population consisted mainly of florid psychotic patients, many of whom were diagnosed schizophrenic.

1.a. Assaultive Behaviour of Patient

The referral reason, regardless of diagnosis, was predominantly aggressive behaviour in the community, serious enough to be experienced as a threat. Many patients, particularly those from the rural areas, had been to the traditional healer, or the faith-healer, at least when the problem first started. There was consensus on the statement that "there is a thin line between sanity and insanity,"[62] and

[62]This was depicted on one of the many posters adorning the walls of the Community Services office at the Victoria Hospital.

families were reluctant to take their psychotic relative to the *emagezeni* (the lunatic asylum). When the problem continues or, when the healer sends the person to the mental hospital (there is pressure on healers to do that, and they are afraid of legal problems should someone die on their door-step), hospitalization is resorted to.

The family would contact Victoria Hospital Community Services, and they would refer the patient to the district surgeon, and then take him/her to Fort Beaufort. If the patient was difficult, the psychiatric nurse would take the patient to the magistrate, for an involuntary admission. Urgent cases were often admitted to Victoria Hospital over night, and the individual was sedated, sometimes on an hourly basis until he/she could be taken to Fort Beaufort with the necessary forms.

1.b. Community Demand for Control

When an individual roamed the village and was seen as violent, the people were supposed to call the headman, who then requested the assistance of the police. At Tower Hospital, the patient was taken to the admission ward, asked to strip, examined, and given the standard hospital edition to wear. This procedure, backed up by the demands of relatives, the headman, and possibly the chief, set up the mental hospital to become the agent of control. The patient too, played his/her part in this, through the precipitating act.

1.c. Cultural Attitudes to Authority

The social context, which is imbued by Xhosa traditional culture with an emphasis on respecting authority, played into this singular role of the hospital. The young and unmarried had no voice, and were expected to obey. It is only with increasing age and having a number of children, and perhaps the passing on of their parents, that authority was won. Since the mentally ill often did not seem to acquire these roles, respect would elude them. No wonder then, that one of the patients presented his standard 10 certificate at admission.

Tribal court in the villages saw to it that the rules were obeyed, and stiff fines for stock-theft and illegitimate pregnancies were meted out. The local high school dismissed some students who complained about money and the lack of sports. They had originally come from the city and had not learned the rules of the country. Some of these cultural attitudes emerged from the information which was recorded about individual patients. Thus the individual's membership to a particular church or sect (Church of Zion, Anglican etc.) and whether he attended regularly, was often recorded. This established the individual as a law-abiding citizen. People were distinguished in terms of being an *older* as opposed to a *younger* brother; a mother possibly as an *elderly* mother.

Universally, it is the poor who are more likely to land in the mental hospital. Individuals in positions of authority, like "the absent-minded professor," are less likely to be judged as

odd.[63] A person in this position, even when he (it is more likely to be a male) contravenes more serious rules of conduct, may be seen as *uyathwasa*--in the process of becoming *thwasa*--where *ukuthwasa* is the state of *being thwasa* (the ancestral calling to become a healer).

1.d. Cultural Beliefs and Social Stresses

Cultural beliefs, like those related to bewitchment, play a central role in attitudes to behaviour that is different or psychotic. They shape the demeanor of the family and neighbours towards the ill person, and determine the individual's self-labeling. Derogatory terms like *igeza, phambana, asikho zonke, sail-on,* and so forth are used by people to refer to what they see as *lunatics, crazies,* and *people without a mind.* While these terms were used for people who exhibit bizarre behaviour, the explanation was often one involving "bewitchment due to the envy of others," which made the patient a victim rather than the perpetrator. Thus pity was one of the emotions which mental illness evoked. In fact there were numerous stories in the villages about individuals who were just too clever, or deserving, or otherwise special, which elicited feelings of envy in the community leading to tragedy.

These cultural beliefs may also influence the expression of distress, and make a diagnosis in the Western psychiatric

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[63]A statement made to me by a black professor at Rhodes University in reference to her own culture.

sense more difficult. Many of the patients expressed beliefs of being bewitched or given poison *idliso*--another form of bewitchment/sorcery--by stepmothers, neighbours or fellow students. Paranoid ideas are thus encouraged by cultural attitudes. Blame is projected rather than turned inward.

Feelings were often defined in terms of external circumstances. To my question to a mother "Is your daughter unhappy or sad?," she replied, "She's happy, there's nothing wrong." One woman's breakdown was defined by *nerves*, not supernatural causation, because her husband was drinking all the money away and not providing food for the children. She therefore was seen as having reasons to be upset. Social stressors are thus often defined narrowly and not experienced by the family as precipitants.

Since the mental hospital rarely had a detailed history or the means to obtain more subtle information, the emphasis was on the presenting, or documented symptoms (and their control) which precipitated the hospitalization, at the expense of specific stressors.

1.e. Florid Cultural Expressions of Distress

The community itself was not surprised at *wildness* in behaviour. The culture sanctioned a certain amount of it and explained it, for instance, as *inkenkqe*, one of the signs of being *ukuthwasa*. *Inkenkqe* is the state the person is in when, during a ritual dance, he takes some coal from a fire and puts

it into his mouth, or when he is quarrelsome and wild, or again when he withdraws and wants to be alone. "When the *amagqirha* run around during an *intlombe,* the ritual dance, hitting people with a whip, that's because of *inkenkqe.*" The psychiatric sister too felt that there is nothing wrong with a person being upset and becoming aggressive, that like the mentally retarded person, the individual has no other way of expressing these emotions. She said, "that's why there are more men who go to hospital for violent behaviour, since they are more secretive than women, and don't talk to others."

3.a. Lack of Professional Resources

When it comes to hospital-related features, which impact on the way hospitalizations are defined, the mental hospital should not just be seen as this chemical straitjacket, as it has sometimes been portrayed by social critics. In the first place, people do not feel good being out of control, and, as is often portrayed by the hospital staff, the alternatives are not necessarily benign. The administrator at Tower Hospital elaborated on his position on traditional healers, saying, "They do not have the sedatives. That's where Mrs. S. and I disagree, but then she hasn't seen the injuries we get to see here at times. They will starve them or tie them with ropes, sometimes hit them."

The hospital also provided "three square meals a day" (recognized by the staff as treatment in eliminating malnutrition), five blankets and hospital clothes. There was

sport, church, some attempts at vocational rehabilitation, some TV--all aspects which patients often said they liked. And yet there were the absconders, those who break out, and perceive this place as a jail. As to occupational therapy, staff complained that families did not encourage independence, and all gains made at the hospital are lost.

Tower hospital at the time of this research employed some four to five doctors on a part-time basis. These were often not psychiatrists and tended to be almost always white. The late Dr. Anderson, the psychiatrist who used to be in charge of Tower, and had been for over twenty years, never made the impression of being the most liberal man in his politics, yet patients and nurses alike referred to him with a great deal of respect, implying that he understood the cultural situation. He seemed to have been a father figure. Criticism by doctors was levelled against the situation at Tower as well as Fort England in Grahamstown, for the staff's lack of familiarity with more sophisticated approaches in diagnosis. Psychiatric intervention therefore focused on the basics, specifically the *control* of symptoms as they manifest in unacceptable behaviour.

3.b. Lack of Laboratory and EEG Facilities

Another problem related to limited resources was the lack of laboratory and EEG facilities. This made it difficult to rule out organic factors as precipitants in patients presenting with psychotic profiles. In the patient files mention was made

of the possibility of epileptic fits, head trauma, even a growth on the temporal region of the head. There were also many patients with a suspected history of alcohol and cannabis abuse, not to mention the need to differentiate the acute brain syndromes due to vitamin deficiencies, infections or parasitaemias. Comments made in medical charts in this area were sparse, making the occasional reference to observations, such as "no fits observed." There seemed to be the underlying pragmatic assumption that what was not taken care of by "three square meals a day, will need to be controlled with neuroleptics."

3.c. Hierarchical and Status Issues with Nursing Staff

The hierarchical organization of the nursing profession seems to be ubiquitous. In the hospitals in Southern Africa this feature may have been enhanced by the authority-based structure common to the prevailing culture. Another reason, one may conjecture, could relate to the status of the nursing profession in a context where there is little opportunity to achieve professional advancement. Individuals may have chosen the profession not because they saw themselves as wanting to enter a *helping* profession and providing a service, but because they were ambitious and wanted to get somewhere in life.

The psychiatric nurse attached to Victoria Hospital presented as an educated and forceful young woman. She expressed dissatisfaction with the lack of status she felt psychiatry

had at this hospital. The issues usually revolved around priorities of transport. The question was often who would get transport and for what purpose. She spoke about another hospital which had a full time psychiatrist available.

The nurses descending on the villages for clinic day, tended to keep some distance from the villagers while having their lunch, sitting cooped up in a hot Kombi. In their gleaming white uniforms, they stood out amongst the crowd . Clinic was an efficient business, and God help anyone who lost his/her clinic card. Nurses seemed to be a cut above the rest. They demanded respect: blow the hooter to have gates open. They did not like to get their shoes muddy from rain-washed dirt roads leading to remote homesteads; they wanted to be driven right to the house, however rough the road. Nurses had authority, even the softer, kinder ones. They would admonish the patient, lecture, educate, advise.

A great deal of time and energy was put by nurses into formal events, government celebrations of some kind where the nurses' choir would perform. Special choir garments were ordered. Events required a lot of planning, transport was arranged, and the hospital became quiet and deserted without the confident chatter of the nurses.

Sometimes this research seemed to come to a standstill, because of the many events which competed with it. A word from the head-nurse cleared the way and the research could proceed.

Amongst the nurses both at Victoria Hospital and the mental hospitals, there were some very remarkable, powerful women. There were also indications of conflict, between departments in relation to priority and the sense of being important, as well as implicit conflict between nurses and a local chief in relation to patients.

Chiefs and headmen sometimes had strong opinions on individuals who fell under their jurisdiction. They may have felt at times that the hospital should see to it that the patient gets cured rather than being encouraged to apply for a disability grant. Psychiatric nurses tended to feel that this was interfering in their business, and that it was a judgement for community services to make. The battle got waged through the avenue of bureaucracy, the filling in of forms or the omission to do so.

While this information is predominantly derived from hospital contacts other than with Tower hospital, it reflects issues which the hospitals had in common. Staff transferred from one hospital to another, or got trained in one and then worked at another. Rank played an important part, and nurses who had many years of experience but had not passed the relevant examinations, seemed to receive less respect, and would be very circumspect about making assertions which they felt no authority to express. A male nurse with some fifteen years of experience made no claim to being able to say what diagnosis he would give an individual patient, but deferred to the

judgement of the medical doctor. He could not imagine disagreeing with the doctor's opinion.

3.d. Cultural Mismatch and Language Issues

There were exceptions, and one of these occurred in relation to issues of cultural mismatch between doctors and patients in the mental hospital setting. A nurse was present when I intervened on behalf of the family of an elderly woman who had been admitted to Tower Hospital. The family was desperate, wanting to take their mother home in order to claim her old age pension, which she had to collect personally. Many families depended on the stable albeit small amount of money which they would thus receive every other month.[64] The white doctor said, "This is her pension, she is being fed here in the hospital; this is immoral. The family can't have it both ways." The black nurse was incensed by the doctor and said to me afterwards, "It's because he doesn't understand the way we live, and he's not a psychiatrist, he would then be more flexible, like Dr. Anderson." Here the nurse took a stand different from the doctor, although she did not say so to his face. Ultimately though, she justified her position by referring to his lack in qualification. The event was therefore still contained within an authority based system.

This is the same system that generated information in the chart that stressed categories of rank such as staff nurse,

[64]In 1992 it was placed on a par with white social pensions, and is currently R740 every two months.

professional, senior nurse, and so on, when there seemed little relevance as to what kind of nurse accompanied the patient. This was so noticeable, since most charts were relatively sparse in the amount of information which was conveyed.

The cultural mismatch went beyond the white doctor/black patient situation. The contradiction was between the professional biomedical psychiatric culture, and the traditional-folk culture.

The black hospital staff were initiates of the former, and subscribed to the system, at least within the work context. While they had grown up opening farm gates, they now blew the hooter and expected others to open the gates for them. This does not imply that they did not want to do the best for the patient, only that the individual was defined by the context of the mental hospital.

Individualism was emphasized. The disability grant was spoken of as the *patient's* pension in this context, while the culture in the village emphasized the family, the group, and the sharing of resources. When a nurse at the mental hospital was asked about the staff's views on witchcraft, he made it clear that while there was a division wherein some believed in it and some did not, they would never share this with a patient, since "otherwise we would be harming the doctors work because there is no proof of that--no proof beyond doubt. Even

the patient cannot prove that someone is bewitching him." Black staff insisted that "not anyone should be able to treat these patients, they should be licensed," and that the "more responsible healers refer psychotic patients to the hospital."

The hospital charts framed as delusions themes such as "believes in neighbours bewitching the patient," and "hearing voices in the stomach"--typical of the *amafufunyane* belief, which the culture outside the biomedical context defined as normal. Here again, the focus was on psychotic symptomatology, and control. A nurse at Tower Hospital answered the question as to whether he could tell that patients had amafufunyane, as follows:

> Some of them have got *mafufunyana* but most have not. All those who say when they have, when you follow up the monthly notes of the doctors, they'll say: "no, I don't have *amafufunyane*, I'm better, I want to go home now."

Biomedical culture was therefore practiced not only by the white doctors, but also by the black hospital staff, the very people who personally may still endorse the traditional view. Within the work context they spoke of the need for education in the villages in regard to mental illness, where education meant being inducted into the biomedical culture. Vera Buhrmann said in an interview, "black hospital staff don't want to talk about witchcraft; it makes them seem primitive."[65] A Xhosa psychiatric nurse voiced opinions that sounded as if they came right out of an American civil liberties treatise,

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[65]Personal communications.

"people who are educated know that the psychiatric patients are like other people, they have rights." What distinguished the nurses from the hospital and the *village health workers*[68] was that the former represented Western biomedical culture and power, while the latter shared the culture of their patients and they were powerless.

While the stress was on psychotic symptoms when it came to treatment in the mental hospital, nurses tended to explain these illnesses as having been caused by frustration and social factors. There was little evidence for their conceptualizing schizophrenia as a neurobiological disorder, in terms of neurotransmitters. At the same time, supernatural causes were not excluded. It almost seemed as if there was a continuing debate between the two cultural frameworks. When it came to hospital treatment though, the situation was fairly simple and pragmatic and boiled down to control.

3.e. Lack of Lithium Carbonate in Treatment

Lithium, the treatment of choice in Western psychiatry for bipolar disorders, was not used. Options were limited, and the exclusion of lithium carbonate as a form of treatment had major consequences. The doctors and some of the nurses were aware of the problem. As one of the nurses referred to it:

> There was a patient from Cape Town who was on lithium carbonate--we changed this to haloperidol,

[68]Village health workers had been introduced as a way of extending primary health care, an approach supported internationally by the WHO.

and were not allowed to order it."

A doctor at Tower Hospital justified this:

> It is a very dangerous drug and I wouldn't risk that on such an uneducated population. You need the blood levels ...

As to one of the consequences, the almost total omission of a diagnostic category, that of the bipolar disorder, the same doctor commented:

> You will probably say we under-diagnose these; and I think that's true, because we have limited information --just our own notes--and to diagnose affective disorders we would need a more detailed history. To all intents and purposes we treat them like schizophrenics anyhow.

So the predominant and probably the most urgently needed function of the mental hospital, one which the jail used to serve, was the *containment* and *control of florid psychosis*, as it presents a danger to the community. This process seems to be largely poverty driven but needs to be seen in the larger socio-political context.

2.a. Court-room Lingo: Deny/Admit

The effects are a court-room style initial intake and documentation, expressing itself excessively with the words "*denies* mental illness," "*admits* hearing voices," "*denies* dagga," "*admits* liquor," and so on. Neuroleptics were the predominant treatment, consistent with the inevitable diagnosis of schizophrenia.

2.b. Use of Neuroleptics

When the patient was discharged, there were often problems with follow-up. On one day's rounds to clinics in the Victoria East district, the nurses complained that half the patients were defaulting. Medication was often prepackaged, and uncomfortable symptoms were dismissed as "just, side-effects." The mental hospital charts recorded complaints such as "feels that medication makes him dizzy," "weak," "drowsy," and so on. While the staff in the hospital was aware of this, medication nevertheless seemed very routine (dosage and type), as if everyone was measured with the same yard-stick. Disipil or Akineton--anti-cholinergics--were seldom used for side effects. Whether that was because there was little need for that, or because less attention was being paid to the issue of side effects, was not clear.

With some of the case histories, however brief and tentative, one may be tempted to question whether epilepsy was really ruled out, and that possibly treatment could have been more mindful of organic factors. The emphasis remained throughout on getting the patient's behaviour under control, a pragmatic response to the demands of the community, in the absence of more sophisticated ways of assessing organic and social precipitants.

2.c. Focus on Compliance

The focus in the mental hospital was on compliance, with repeated comments in the charts like "cooperative and calm,"

"is behaved," "resistive to carry out orders given," "polite," "uncooperative--no insight," "shows remorse to defaulting treatment," "continues attitude towards interviewer, cheeky," and so on. This reflected both the cultural attitudes to authority and the power issues within the nursing profession.

2.d. Focus on Psychotic Symptoms, not Stressors

While the nursing staff seemed to think of social stressors causing mental illness, and were somehow still rooted in their culture in regard to supernatural causation, when it came to assessing, and responding to individual patients, the focus became the psychotic symptoms. Social stressors were rarely acknowledged, and cultural beliefs were reframed as delusions. This was heavily influenced by their work situation providing a cultural setting, different from that of their personal one. People in rural Africa, as elsewhere, have forever adapted by resorting to methods that work, in a pragmatic way. According to one informant, a simple test of whether a traditional healer was special and deserving of respect, as opposed to crazy, was whether the treatment he/she provided was successful.

Xhosa people are said to follow tradition. The headmaster of a local high school replied to the skeptical comments of the Sotho guidance teacher who had studied psychology, "You're not Xhosa." A Xhosa person generally took bewitchment very seriously, even if he/she had little confidence in the traditional healers. Western medicine had the status and the

power, and nurses' understanding of a patient's problem and the treatment given, did not necessarily match. Patients were accustomed to not being given explanations at hospitals. The treatment context was fraught with misunderstandings and cultural re-interpretations. Thus the folk explanation for epilepsy was "worms."[67] Patients avowed that this was what the doctor told them. This has been discussed more fully in Chapter 11.

2.e. Overdiagnosing Schizophrenia

The tendency of over-diagnosing schizophrenia could be seen as a pragmatic way of dealing with the lack of lithium as a treatment modality, perhaps a subtle way of avoiding cognitive dissonance. If there are no patients who need this particular medication, known as a powerful way to stabilize bipolar illness, than nobody had to feel as if they were not providing the best that could be done. The community fed this belief by bringing mainly the patients who were out of control and manic. When the patient was depressed and withdrawn, he/she was tolerated by the community. Diagnosis was geared to the treatments available, and the anti-psychotic arsenal was certainly a powerful and effective one.

One may ask what the cost of this pragmatism was to the patient. Were the patients needs really addressed, if social stressors were not considered in the reactive psychoses, nor

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[67]This explanation may *in part* derive from the fact that cysticercosis is endemic and can infect the brain, leading to seizure disorders.

lithium available to even out the excessive mood swings of the bipolar patient? What were the long term effects if the depression, hidden by an acute psychosis, was not treated, and side effects were ignored in the hospital's preoccupation with controlling florid symptoms?

CHAPTER 10

PATHWAYS AFTER THE MENTAL HOSPITAL

Tracking Discharges

This section contains an initial number of entries which were derived from the discharge book at the mental hospital. Each of these is accounted for, and the categories into which these entries fall are discussed.

The research started with a scrutiny of the hospital discharge book, which contained entries of the patients' names, the date they were discharged, as well as some additional information including diagnosis, gender and magisterial district to which they returned. Sixty eight entries (52 males, 16 females) were drawn from these records, representing the complete population of patients discharged into the magisterial district of Alice, excluding all the organic psychoses. The time period sampled extended from the beginning of December 1987 to end of November 1988. Discharge records were further followed up for the subsequent year to the end of November 1989, in order to further establish relapse rates. The fate of the 68 entries is represented in Table 10 below.

Table 10. Follow-up of Patients Discharged from Tower Hospital

Total Discharge entries for 1988	68
Re-admissions	9*
Excluded First Admissions	4
Excluded (Urban)	5
Excluded (Out of Magisterial District)	4
Moved away	12**
At Circumcision School	2
Problem Cases	7***
Not Traceable	6
Patients Interviewed	19

*4 of these were presently still at Tower
**5 to extended family; 3 in search of work.
*** Wandering aimlessly, or assaultive.

Comments on this table follow.

Mobility

These figures reveal a fair amount of mobility. Nineteen percent of the original number of discharged patients had moved during this year. If one adds the four patients whose current address was outside the magisterial district of Victoria East, implying some kind of relocation, the total number of individuals on the move would be 25%. Usually the patients seemed to be moving between different members of the extended family. My understanding is that where there is an extended family which still has some bonds, a mentally ill person, or the burden this creates, could be shared by the larger family system. This may also provide some relief for the patient who is in conflict with particular family members. As to the stress this might create for the patient who needs to adjust to different family situations, I found only a

single patient amongst the relapsers[68] who was known to have moved to the city to live with his brother.

Another reason for leaving home was in search of a job in the big cities. This information was obtained from three of the patients' families. One family specified that they had heard that their relative had found a job, but knew no details. The life of the migrant worker is certainly stressful, and the case histories show that many initial psychotic breaks seem to have happened in work situations in the cities or the mines, precipitating a return home.

A different form of mobility is usually referred to as "wandering about aimlessly," which seems equivalent to what has been referred to as "vagrant" in the literature (Guinness, 1992). Walking for pleasure, such as climbing the mountains beyond the village, was not customary in this part of the world. Going places was expected to have some purpose, usually to visit family. Going into the bush, unless it had to do with searching for lost goats or cattle, would be to collect medicinal herbs by the healer or herbalist, or else a response to the call from the ancestors, or bewitchment, or madness.

Seven patients, or 11% of the original group, could not be interviewed because they were acutely psychotic when contacted.

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[68]The fact that he had moved to a big city added a confounding stress factor.

If we think in terms of relapse, this is a very conservative figure, since those patients who had moved away not only included a few successful ones who mustered the strength to search for a job in the city, but also those who were starting to encounter problems, defaulting on medication, and running away from their own turmoil.

Relapse and Re-admissions

Relapse rates were calculated first over one year (1988), and then continued over a second year (1989). In 1988, 8 patients out of 63 were rehospitalized, and in 1989, 5 more were admitted, three of these more than once. The percentage of readmissions for the first year was therefore 13%, and 21% after the second year.

Eleven percent of the original number of discharged patients we the community were identified as psychotic and thus could not be interviewed; others could not be contacted because they were back in the mental hospital. Thirteen percent were rehospitalized in 1988.[69]

Hospital records were scrutinized the following year to test the hypothesis that the 11% of patients who were symptomatic and at times assaultive in the community (relapsed as seen by symptoms), would soon be rehospitalized. It was interesting that this did not occur; only one patient who had had multiple

[69]This figure excludes any duplications due to multiple admissions.

hospitalizations returned to Tower by the end of 1989.

My intention had been to see how long these so-called problem patients remained within the community, before action was taken. My encounters with these people were usually handled from the safety of the car, and with two cases the information was obtained from a third party. All were referred to, by the nurses and villagers as "wandering around aimlessly." Contact was made through serendipitous scanning of the area, with the help of the local children. The psychiatric nurses were not prepared to get too involved with these "difficult customers," saying that this was the job of the police. However, for the police to take action, either a family member or the head-man would have needed to go to Alice and sign the necessary forms at the magistrate. It would seem that people were reluctant to make this move, and that they waited for a major incident. The other reason they gave was that it does not help; soon the patient is out again and the problem gets repeated. One particular relative of a very disturbed patient we searched for in the streets, expressed a sense of hopelessness about it, as well as fear. She was frightened to take action in case he would find out that she had done this to him.

This raises the question as to what differentiates those patients that "relapsed" in the community but were *not* rehospitalized, from those that were. The re-hospitalizations in this study usually went hand in hand with defaulting medication. But that was not the whole picture.

The problem in any comparison between this study and research in the developed world, is that we have to take into account differences in help-seeking behaviour. Hospitalization in the former Ciskei was not resorted to easily even if the individual was experienced as threatening. The other problem relates to the bigger issue of comparability: at what point is an individual considered as relapsing when the criterion is based on symptomatology?

The number of patients involved, 6 relapsing without hospitalization, 13 readmitted, is too small a sample to be anything but suggestive. Another problem which impeded accurate information related to difficulties in tracing some of the files. Names were spelled differently at times, and occasionally the same patient would go under different names and even different files. The files of all the "problem" patients were available, while only eight of the rehospitalized patients were found. There were no features which stood out dramatically as different between the two groups. They were all discharged with one month supply of medication, sometimes just oral medication (Largactil, Mellaril). At other times they received a monthly injection (Modecate), plus pills. Occasionally they received anti-cholinergics (Disipal).

Alcohol and dagga were implicated in both groups. With the latter there is insufficient information to draw conclusions about the extent to which substance abuse was contributory.

Another difference between the hospitalized and non-readmitted group was age. The median age was 28 years and 36 years, respectively.

Characteristics which may have been significant in preventing rehospitalization in response to psychotic behaviour were: living alone (one patient), a tendency to avoid social contact while vagrant, as well as a tendency to remain in rural areas. Symptomatic patients visiting towns or cities seem more likely to be picked up by the police. Some hospitalizations according to word of mouth and hospital charts had occurred this way. Ironically, the higher functioning individual who was more mobile was at greater risk for rehospitalization. This can be seen by individual case histories. The patient with the highest education, who had dropped out of a law degree, and had been maintaining a job, was detained at the Botswana border and then rehospitalized. This incident seems to have been alcohol related.

The case history of the one individual who was viewed as problematic, but was subsequently rehospitalized a number of times, can shed further light on the issue under discussion, since he and his family were later interviewed. These rural people tended to react by acquiescing to the demands of their psychotic relatives. If the patients were seen as assaultive, the family would try and avoid confrontation and if necessary contact wherever possible. If the crazy (*phambana)* person inflicted real damage, such as burning clothes, the house, or

actually assaulting someone, then action was taken and the individual was hospitalized. Because the families tended to "go with the flow," readmission was usually delayed, when the mentally ill person was resistant. Sometimes, when patients actually asked for hospitalization and acted out in order to achieve it, readmissions were precipitated. In the case mentioned above, the individual was known to threaten to kill someone in order to achieve a long stay in the mental hospital.

Circumcision

A more specific cultural reason for being away was for the young men to be attending circumcision school. Two young men,[70] 18 and 24 years old, could not be reached because of their attendance at circumcision school. Circumcision was still practiced in these communities, and involved a complex period of ritual and challenges. It was seen as the initiation into adult status. This usually occurred in the teens, but could sometimes be delayed when individuals were mentally ill. It could also be seen as a way of treatment if the cause of the illness was perceived as a *neglect of customs*. At times it could be a period of stress, and first psychotic breaks sometimes happened in this context, though not frequently enough to be statistically significant.

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[70]Circumcision being a seasonal event may have determined the timing of their absence.

Urbanization

Exclusion of urban patients was done in terms of urban living circumstances, rather than the fact that a particular settlement was given the legislative status of being a town. The distinction of small-urban versus rural settlements in the Amatola Basin area was not a clear-cut one. Thus while Kyaletu was referred to as a town, it had little to distinguish itself from the near-by Binfils or Msobomvu; in fact it was more remote. What is the distinction here between a semi-urban slum and an impoverished village? There were certainly differences in density of the dwellings, but that seemed to have little to do with their status as towns or villages. The availability of space seemed to relate instead to the size of the settlement and the proximity to Alice, the central town of this area and its hub. Remote villages which were more isolated seemed to have more space at their disposal.

Inter-system Mental Health Issues

Another issue which needs mentioning here, is one related to the use of the services provided, an issue pertaining to the mental health system. The filing system of Tower Hospital yielded an initial figure of 63 discharge entries pertaining chronic mental illness during the year of 1988. The estimated figure over the same period of time for patients received back into Community Services at Victoria Hospital was 19, about one-third of that figure. This number was derived from a scrutiny of files which yielded 38 patients over the last two years. This means that two-thirds of patients discharged from

Tower Hospital did not find their way to the follow-up treatment offered by Victoria Hospital.

What was actually happening? The usual procedure was that a patient discharged from Tower received a pink form containing some basic information about his hospital stay and the treatment received. A copy was sent to the central office of medical services in the Ciskei from where it got redirected to the correct magisterial district and hospital, in this case Victoria Hospital. There were two possibilities as to what may have been going wrong: the documents may have gone astray, or were delayed to such an extent that by the time they arrived the continuity was lost and the patient may indeed have relapsed.

Back Home

In this part of the research I discuss the 19 ex-patients who were successfully traced to their homes, and who were interviewed with their families. While the study started off with 63 patients discharged during a full year (December 1987 to the end of November 1988) into the Victoria East magisterial district, nineteen (14 males, 5 females) were actually interviewed.

The interviews provided a window both into the world of the patients who found themselves back in their community, and a perspective on the patient in relation to the mental health

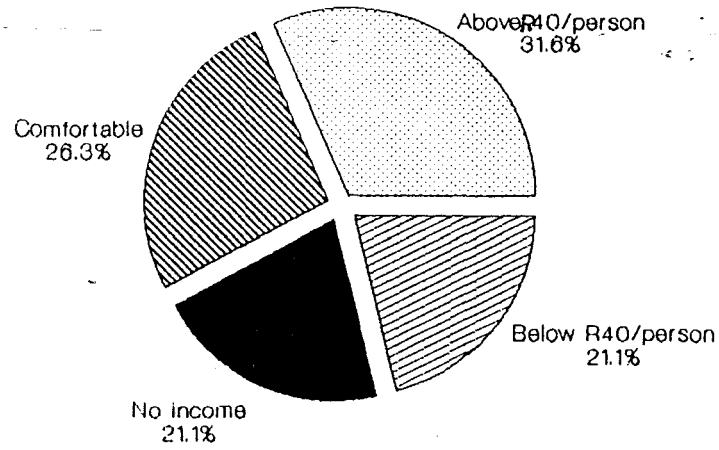
system. The latter was particularly apparent in the authority relationship of the psychiatric nurse to the patient. The nurses differed in their styles of interaction, but all took on an authoritarian approach by giving advice and lecturing the patient. They tended to join with the family in admonishing the patient.

> Nurse: "Who is washing your clothes?"
> Patient: "My mother washes my clothes."
> Nurse: "Why don't you wash your own clothes?"
> Patient: "He - he!"
> Nurse: "That you may have something, you know how to spend your day on, because you know you're not working. Did you ever go around locally, among teachers, people and so on, seeking jobs so as to keep yourself busy and not feel lonely? I mean jobs like gardening and washing of cars, and by so doing giving help to other people!"

Many comments were received pleasantly, although somewhat passively. Occasionally it seemed to create some tension. In one situation the psychiatric nurse became really angry when she experienced a young woman as being "cheeky."

The findings of these interviews are presented in the form of a number of pie-graphs.

Figure 13. Socio-economic Status.



The most important aspect of the patient's return to the village was their re-entry into a situation where s/he often is another mouth to feed, and where there is no guarantee that his/her basic needs will be met.

26.3% of the patients' families did not *feel* financially compromised ("Comfortable"). This does not mean that they owned great wealth, but simply that they had sufficient food and enough money to buy some clothes, and possibly managed to raise money for the education of their children. Those families usually relied on a number of old-age pensions, or a disability grant perhaps, and some family members working. Pensions, while they did not provide a lot of money (R234 in the Ciskei, R300 in South Africa, every other month), were a more reliable avenue of income than other sources, with the exception of professional salaries. The other characteristic of these families was that they had relatively few dependents.

Those with just above R40 a month per person as income had enough to feed themselves. However 21% were below that amount, and their struggle to survive became a constant focus for the family. 21% of the families had virtually no income, and were

dependent on the good-will of neighbours and relatives to survive, often denying themselves a meal in order to give it to the sick person.

These were some questions asked:

> Q:"How many are you here at home?"
> A:"It is his father and I, with five of my children besides him ... he has asked for (a pension)... and is still waiting for a reply."
> Q:"Who is supporting the family?"
> A:"Nobody, not unless somebody gives me five shillings for a bucket of water... I have been looking after him. I was working before, weeding thorny plants. This job got finished. (His younger brother), he is still attending school...I myself did not even eat or get nothing today. For him, to eat, he was helped by this (neighbour) who gave him porridge."

The lack of motivation, and a sense of hopelessness due to their illness, was hard to separate from the despair they felt in this harsh, impoverished world.

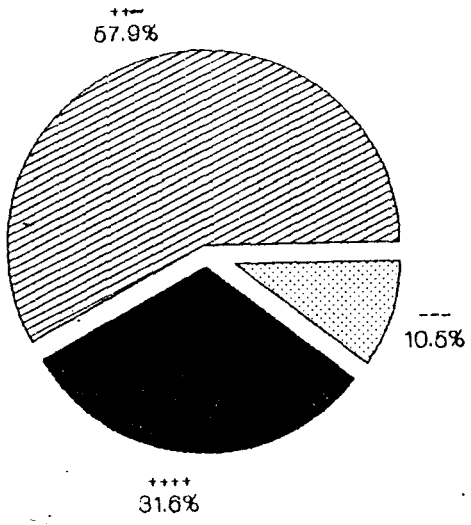
When visiting one young patient's home, the feeling of poverty was oppressive. He seemed passive and depressed. The nurse knew the sisters, who had dropped out of family planning. There was no attempt even at making a garden, in order to grow some vegetables, the one way poor families often provided a little for themselves.

Disability grants (DGs) were not easily approved, and seemed to bear no relationship to need, or severity of mental illness. Young patients had no hope of getting a grant, since there was the belief that they would be able to work as there was nothing wrong with their bodies. Four (21.08%) out of the

19 patients interviewed were receiving DGs: one had his discontinued, two had applied but were not sure of getting one, and another two were expressing the wish for a grant.

One of the problem patients, who was continually threatening the community, said that he would kill someone in order to ensure a permanent home in the mental hospital. His DG was refused, and he and his family had very little to live on. He was the patient with the most admissions, and the thickest file. This young man had about 2 to 3 admissions to Tower a year. The nurses from Community Services avoided him since he was considered dangerous; he regularly "defaulted" medication. This seemed to show the system as failing. One had to be careful though not to look at this in too simplistic a way, as I discovered later. Through my presence, Community Health Services came to focus on him and there were attempts to help him obtain a DG, but the situation collapsed when his aggressive style of interacting got him back into the mental hospital.

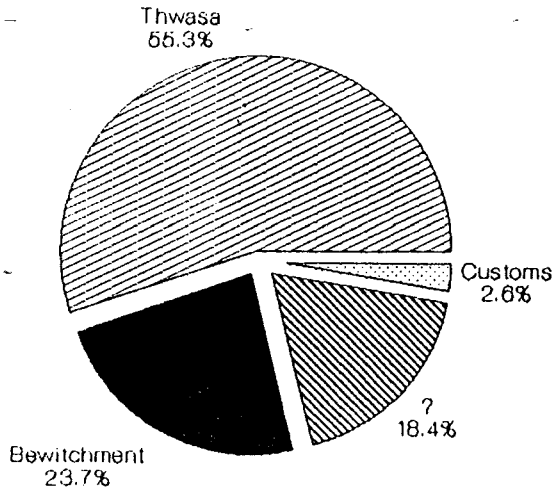
Figure 14. Attitudes Towards Hospital and Medication.



Attitudes of these discharged patients towards the mental hospital varied. Six were positive about their stay, in that they felt it was both helpful and somehow enjoyable; 11 were positive with reservations, and 2 were negative and felt that Tower had not helped them. Two had stopped taking their medication, but these were not the same people who spoke out against the hospital.

Positive comments had to do with the medication helping, as well as patients saying that it was "fun" there, that they slept well on beds, had lunch, and got entertainment, soccer, TV, church, and so on. Negative comments included their saying that the medication made them feel weak, dizzy, drowsy and shaky, and that there were too many mentally ill people. "Positive with reservation" presents a category where individuals enjoyed their stay in hospital, or felt that it was helpful, but had some doubts, such as side effects or other specific issues. While not everyone may have spoken from the heart, enough details were given to provide a fair estimate of acceptance or rejection of their hospital treatment.

Figure 15. Causation of Illness.



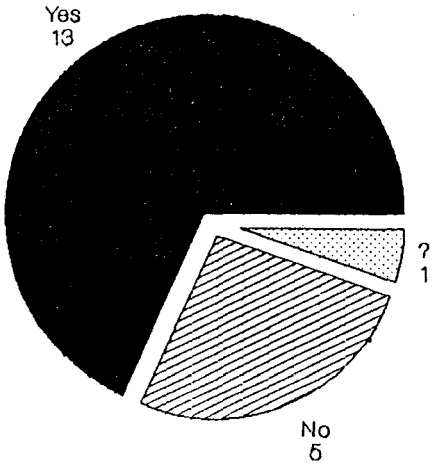
Causation of illness clearly demonstrated the rootedness of these people in their culture. Bewitchment was the single most clearly held belief, which contrasts with the "doubtful" category marked on the pie-graph with a question mark. The latter position was mostly adhered to by families where there was an initial diagnosis of *thwasa* which was later revised to *amafufunyane*, or where a Western belief such as brain-injury competed with traditional beliefs. There was not a single incident of a clearly held belief in a Western cause. In one instance the family was obliged to disregard their traditional orientation since the church they belonged to was rejecting of such beliefs. The pros and cons of different traditional labels (*ukuthwasa* as opposed to *amafunyana* or *idliso*, being the main ones) were often debated, and seemed to have a normalizing function. Contrary to Vera Buhrmann's view[71] that *mafufunyane* finds its equivalent in the psycho-neuroses, as does *ukuthwasa*, whereas the psychoses, particularly schizophrenia, are outside that realm relegated to plain craziness *phambana*, the patients themselves and their families

[71]As discussed with her in a personal interview in 1988.

used these terms rather loosely. Even if they had been ill for years, with many hospitalizations, there was still the thought that maybe, yes, maybe if the *amafufunyane* can be made to talk, then they would be cured. These *rhorho* (bugs) will be told to go back to those who sent them in the first place, and justice will be done.

Alternatively a mother might decide that her mentally ill son may need to have a ceremony done. The goat horns were hanging in preparation on the wall. Rural folk have learned to try many things in their battle for survival. The Christian funeral is just one of those things, the ultimate life insurance; even traditional healers made sure they had one. Fourteen patients had some affiliation to a particular church, or sect, irrespective of their traditional beliefs.

Figure 16. Use of the Traditional Healer.



Thirteen of all patients claimed to have consulted a healer, while 4 stated that they had never been to one. I later discovered that at least one individual had been treated by traditional means, but had denied it at the time, largely because of his church's antagonism to these traditions. He had originally been diagnosed as *ukuthwasa*, and had started on an initiation to

become a healer. He kept his white bead from those times, a symbol of his *thwasa* status, but had stopped wearing it.

Nine of the 13 claimed that the healers' treatment had not helped, and 3 were still getting some form of traditional help. Traditional beliefs in supernatural causation of illness, and mental illness, did not go hand in hand with confidence in the ability of the traditional healer. Comments relating to healers being after the money, charging too much, and being crooks, were not uncommon. People seemed to feel that it was not like the good old days when the healers knew what they were doing, when they were powerful. The alternative, the faith-healers, were rarely referred to by this group.

In an interview a lecturer at Rhodes University, a woman deeply connected to her cultural traditions, commented,

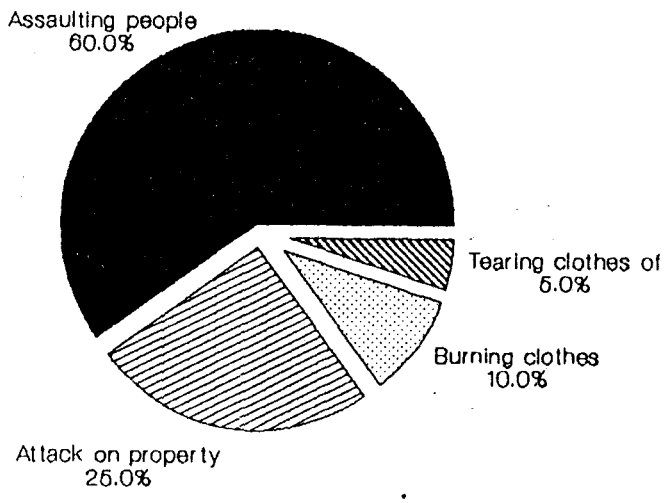
> "..in most situations the whole idea of healing is sort of taken over by Western medicine, but the trouble is when Western medicine is not available, in terms of human life, then the person has nothing.."
> Q: So you think this has had an effect on the rural area too?"
> "Yes, in that people are not confident."

I had told her of a little experience I had had when staying at Bed-and-Breakfast place in the nearby mountains, the Hogsback. There a woman, a white woman, was apologetic for taking longer with breakfast, as her maid had not come in. The story that emerged was as follows: The white woman went to see what had happened to the maid, and found that she had stayed

home because her child was very ill. The child was running a high temperature. She had, however, consulted the local *igqirha* and had been given some medicines. The white employer was horrified, and persuaded the maid to take the child to Victoria Hospital. The white woman drove her maid and the child the forty five minute drive to town. The child got well.

This event left me with uncomfortable questions relating to the power relationship between these two people, and how the event would affect the woman and her child in the long run, the issue of tradition and identity versus modernity, what there is to be gained, and what is lost.

Figure 17. Behaviour Precipitating Hospitalization.



Behaviour precipitating hospitalization focuses on where the community draws the line. At what point would they reject someone who is different? Assault proved to be the predominant category. Twelve patients had been assaulting people, 5 had been damaging property, and 2 were burning clothes. Out

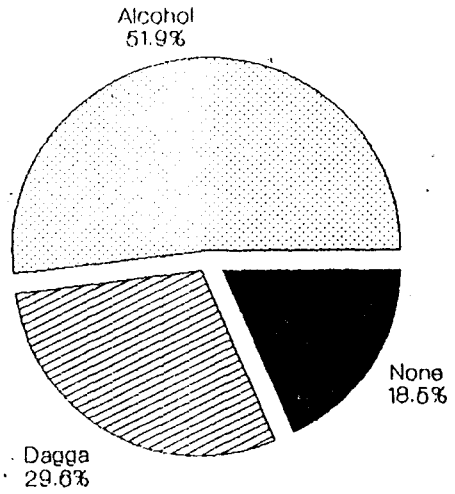
of these one also was reported to have torn her clothes off, and some 5 mentioned an inability to sleep. The behavioural descriptions are those common for the psychotic profile in Africa (Guinness, 1992), and raises questions as to diagnostic issues. There is often the problem of an insufficient case history, together with the lack of laboratory and EEG facilities at mental hospitals, plus all the other issues previously discussed.

Getting a more detailed background about how the problem started with one patient, revealed a significant head trauma at a young age which seemed to have resulted in seizures and vomiting blood at the time, after which he was dismissed from school because he became too difficult. Thus while that may not have been the onset of the psychosis, it could have been a significant factor.

All 19 patients interviewed were given a diagnoses of schizophrenia, but questions remain as to their accuracy. It was said of one young woman that the hospital treatment had helped calm her aggressive behaviour down, but otherwise she had not improved. She had recently, in fact, been put on an anti-depressant medication (Tofranil). The same issue of the diagnosis of bipolar disorders is also being questioned. If patients are being treated for schizophrenia erroneously in this way, mood-swings will not be curtailed, since only the extreme points in mood are being medicated. Would this boost the revolving-door phenomenon in hospital admissions? The

answer may not be that clear-cut, as there are other factors in the ecology of the rural Ciskei masking, or compensating for, such predictions. One of these is the greater tolerance of deviance, so that only extreme, out-of-control behaviour will lead to readmission.

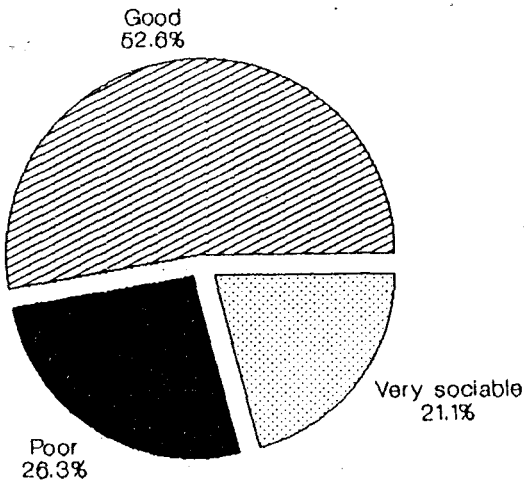
Figure 18. Drug and Alcohol Use.



Another factor confusing the picture, is the high degree of alcohol and cannabis usage. While 14 patients said that they were using alcohol, and 8 dagga and alcohol, we need to consider how this may have affected the illness profile. As discussed earlier, the literature is divided on the impact of drugs, and to a lesser extent on the effects of alcohol on mental illness. While alcohol more often seems to worsen the prognosis, cannabis is sometimes seen as beneficial. Of the individuals interviewed, only one family insisted that the patient got aggressive in reaction to dagga, and two other families said that they were opposed to its use but had no control over the patient's habit. Many felt that alcohol would just make them drowsy.

It was difficult to judge the extent of cannabis and alcohol abuse. Financial issues in themselves may have limited usage. A nursing sister at Fort England made the comment that the problem is that people consume alcohol often on an empty stomach, leading to more severe intoxication. Some of the patients were known to look for drinking parties, and celebrations in the villages, but this would hardly distinguish them from the average resident.

Figure 19. Social Adjustment.

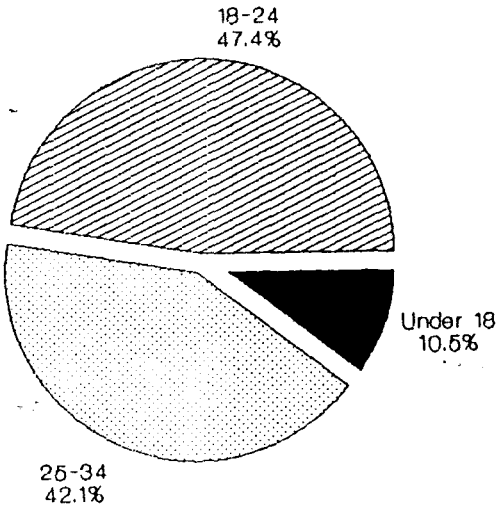


I determined that social adjustment was poor for 5 patients, good for 10, and as sociable for 4.[72] The poorly adjusted were those that were loners, or were seen as socially inappropriate. The ones whose adjustment was judged as good had better inter-personal skills and had some same-sex friends. Those who were rated as sociable were outgoing, and had heterosexual relationships. This would suggest that under 30% of the patients had the more typical presentation of severe mental illness. The question here remains whether this is due to the

[72]The family assisted me in completing a rating.

better prognosis in the developing world, or whether that relates to differential diagnosis.

Figure 20. Age at Breakdown.



Age at break-down, at times relied on estimates, in that it was not always clear when the actual illness started. In one or two cases particularly, there was a definite sense that the person was different even as a child, yet at the same time the problematic florid psychosis seemed to have happened later. The age of highest vulnerability, early adulthood, coincided with Western expectations (Keefe & Harvey, 1994). Alcohol-related psychoses tend to peak later. In this small sample, not one had his/her first break after the age of thirty-five.

Work Efforts

There is a sense that none of the 19 patients were really wage- earners. Some have gone back to the cities between hospitalizations, or a woman tried her luck at being a nanny in Fort Beaufort, but the stories consistently tell of disappointments, of being sent away, or, as the families

sometimes see it, that they cannot understand why their relative just "leaves." There is work in the gardens, sometimes a little farming to do, "but you need fencing to keep the goats out, money for seeds, and the drought can always wipe it all out...more disappointments!"

Some had it better. There were the old age pensions, and even some disability grants, but they depended as much on luck as on the rain. Sometimes one wonders where poverty ends and mental illness begins...

SECTION IV

IN THE VILLAGE

Explanations for the more benign course of illness have usually postulated lower stress and higher social support in developing countries, together with a world view that both expects recovery and frees the patient and family of blame. Opportunities for productive labor, supportive families and extended kinship networks, and externalization of causality have all been considered factors in lowering stress levels and facilitating recovery (Lefley, 1994, p. 188).

CHAPTER 11

THE VILLAGE CONTEXT

Rite of Passage

> Igama lam ngu Heide Cumes, ndivela eRhini, ndingumfundi eRhodes University. Ndilapa ukuza kuhlola impilo jenu...[73]

There was a lot more to say, some of which I managed with my limited knowledge of this complex and beautiful language; the rest Mr. C., the headman, explained. I would come and visit people and wished to learn how people cope with problems, particularly those related to mental illness and *ukuthwasa*, and their experiences related to Tower Hospital and the *amagqirha*. I expressed that I was moved by their welcoming me and that I hoped that people would talk openly with me and let me know when anything I said was upsetting to them. "The Bible said," the headman's wife exclaimed, "God created man and woman, not black man and woman and white man and woman. There is no such distinction in the Bible, therefore it is my belief that you must welcome Mrs. Cumes into this community."

This was my introduction into the village community. The elders were to vote by a show of hands as to whether I was to be granted permission to stay in the village. I had strong backing by having Mr. C.'s and Mrs C's support.

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[73] "My name is H.C., I come from Grahamstown. I am a student at R.U. I am here to understand how people live..."

I had asked who was to attend this meeting and I was told that the committees or their representatives were going to be there, but that everyone was invited. It was also mentioned that the young people usually don't attend these meetings, that they were shy to speak and would go along with the decisions made. People, mostly elderly, had been streaming in slowly. There was singing and dancing. One woman heaved herself across the threshold with difficulty, only to stamp her feet and dance as soon as she was inside the hall. When the meeting was declared open with a prayer, everyone settled down. Only some shuffling of the latecomers and a lot of coughing was to be heard.

After my welcome was dealt with, other issues were focused on. There was the problem of the communal gardens. People were asked to pay 50 cents so that seeds could be bought and a worker hired. The produce would be sold cheaply to the community, and the proceeds were to be used for obligatory expenses such as the Ciskei agricultural show and other Government requests. One old man stood up and declared angrily that he'd rather go to jail than pay that 50 cents. My young companion, who was present in order to help me follow the discussion, found this amusing. She concluded that now everyone was going to pay, since they did not want to go to jail! Indeed everyone started to scratch around in trouser pockets, or handkerchiefs for some coins. The money was dropped in a brown paper bag on the table, and the names of those that paid were duly recorded, by the secretary.

Other issues on the agenda included Ciskei taxes, a case of a woman asking for her own homestead, since her husband had kicked her and her children out of the house. Finally receipts were handed out for the payment of the development and security fund. Without these receipts, I was told, people could not get pensions nor anything else from the Government. People took these receipts very seriously and there seemed to be some problem about two of them missing. When business was concluded, some old men shouted, "sing and dance to show the visitor that you can." I was accepted into the village community as a visitor, and I was protected as a member of the headman's household.

This village acceptance could only be granted after the political protocol had been met. The presence of a visitor to any village had to be reported to the Chief of Police, the Ciskei Security Branch, and the magistrate. There seemed to be tight control over people's movement, and the rural areas granted little anonymity as compared to the big cities. Local power was invested in the chief of that area at that time, a situation which has changed in the new South Africa, and faltered even earlier with Prime Minister Sebe's overthrow.

Msobomvu's position was somewhat unusual in that Chief Maqoma had been in opposition to the then head of government and had attempted a coup. This involved people in the village and some individuals including the headman had been imprisoned while others went into exile. Maqoma's land was given to the chief

of the Amagwalis, placing Msobomvu under the jurisdiction of Chief Ncamashe. According to history these chiefs were natural rivals. Msobomvu now fell under the Amagwali Tribal Authority, instead of the Amajingqi. It was through chief Ncamashe, therefore, that my visit had to be negotiated. He was a powerful man and was able to quell any suspicion as to my person and my intentions. The anomaly consisted in the fact that the chief in power was effective in controlling this village only through the duties of the headman, an extremely upright earthy man and devout Christian, who, in spite of having been associated with Maqoma and also imprisoned, carried out the rules as dictated by authority. It was his belief that this was the right thing to do.[74]

Living in the Village

The Physical Terrain

While Msobomvu is a brief 15-20 minute ride by car or taxi away from Alice, the nearest town center, it is a long, long walk. So life in the village depended a great deal on individual circumstances; the R3 to go to town by taxi could make all the difference. The landscape always looked beautiful to me, with the Hogsback Mountains beyond the hills. The road which winds through a number of villages turns left, declines slightly to cross a stream and then climbs up the hill encircling the village by turning back upon itself on the

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[74]My introduction to the village showed how social status is determined by age, gender, and authority, this creating a difficult position for young people with mental illness.

other side of the *donga*[75] which divides the village, finally taking the motorist to important places like the school, the Red Cross hall and the headman's shop. The ordinary person would use a short-cut across the *donga*, where the odd cow or horse may be grazing. There are streets of a kind, but the clay can be slippery and the pot-holes are enormous, so that taxis limit their drop-off points to a few public places. Often people get off at the lower end, the entrance to the village, since Eastern Cape drizzles can set in for days and weeks turning the world grey and the ground into treacherous terrain. There are times when the streams swell and stop all commuters. People will stand on both sides of the torrent shouting across the rushing water, passing messages. This is how it has been for long time, much of it even before this particular village sprawled over the hills.

The long time residents mapped the village out according to different areas, Riverside, Highway, Nompumelelo (Success), and Thembalethu (Our Hope). The younger generation seemed unaware of this subdivision; they adhered to a more widely accepted map of the village focused on landmarks such as the headman's house, Mr. K. the *iggirha's* rondavel, the school, the shop or the nursing sister's house. These were usually bigger and more imposing structures, which stood out amongst the rest. These often carried the stamp of authority, their owner being a man or woman of some importance. There were also lot numbers but they seemed to mean nothing except to

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[75]Gulch.

statistics and the administration.

It still looked much the same on a visit in 1995. Other things had changed. Even in 1988/9, there were communal taps in the streets, where people could fetch safe water, when previously the children and women had to carry buckets on their heads all the way from the stream a half a mile below the village. This stream could be muddy and drying up, but still provided a source of water for cattle, as well as being used for the ever constant washing of clothes. The taps were one reason why many residents chose Msobomvu.

Choosing to live in Msobomvu

The headman and his family had opened a shop in another village before coming to Msobomvu. There where no taps in that village and the streams were far away. Still, they stayed since there were fields to plow and gardens to grow vegetables in. Mrs. C. said, however, that she saw that people were jealous and then in 1978 burnt their shop and Mr. C. was assaulted. Mrs. C. and her husband had got caught up in party politics involving a Mfengu/Xhosa division. Most Mfengu tended to support the opposition, while the majority of the Xhosas supported the ruling Ciskei National Independence Party. Mrs. C. and her family made a fresh start in Msobomvu.

They were devoted to their church. To this family Msobomvu was a safe place compared with the locations in the city. It was a place where children still listened to their elders, and the

village provided an opportunity to be self-sufficient. They felt that they could manage, though there were times that money issues became a threat to harmony in the house. They were also both aware of people struggling in the village, in spite of the taps, and in spite of the fields and gardens. Mr. C. described how the village started in 1980 with people coming from all over: Port Elizabeth, Adelaide, Maqoma's Hoek and the farms, as he said, "mainly from the poor side".[76]

Elements of Subsistence

The pensioners remained with the children in the village, while their sons and daughters tried to find work in the towns. He thought that they could earn something around R200 a month, but not all of that would come home to the village, since the person would have to cover expenses in town. Msobomvu itself did not offer any jobs, except for some "piece" jobs, connected to agriculture; but they were seasonal, paid only R69 a month, and were considered more appropriate for women.

Those working on the mines could do better; they would come home over Christmas, a time when money as well as alcohol flowed in the village, creating other kind of problems. The poorer people in the village seemed to feel cheated of their

[76]This village fits more closely the betterment scheme than the forced removal type of resettlement, in that people came voluntarily through their connection to chief Maqoma. However, many of the residents had been forcibly displaced from farms or other areas during the re-allocations of land and the establishment of the Ciskei.

dreams; they felt that whatever money they brought had gone, and there were no jobs or opportunities. Of the 600 homes in Msobomvu, less than half made use of farming opportunities.[77] Only those that could manage, farmed. There was a tractor, but it had to be paid for in advance, and the lucky ones would get it the following year, but even then could still miss the best part of the season. People often answered questions relating to farming with "no money for seeds", or "no tractor" and "no rain", or "too much rain", besides being too old and too sick to work on the land.

The headman's position on this was a little different. He shook his head and said,

> Our people here they don't understand and so they suffer, they don't want to try anything. The Government wants people to form groups, so that they can get loaned money from the banks. They must have security, so that's why they must be in groups. Like, look what you can get out of one pig. You can buy a pig and get food on credit. When the pigs are big you can sell them. In six months they are big enough. Out of four pigs you sell one to pay the Government, the others are profit. But they don't do this. The Government wants to see if you can save money, R5 a month, so that they can see you are planning something. If you get pension, you get R200, and you use it all up today, tomorrow you have nothing left.

Mr. C. believed in development.

He expressed frustration about what he saw as mismanagement of resources. He told the story of a man who was buying food for his mother's funeral on credit, counting on the community's

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[77]Rudimentary Ciskei Government statistics, based on the 1984 census, shows Msobomvu with 530 structures and a derived population of 1,590.

contributions to pay for it. Mr. C. had warned him not to rely on the community, and it happened as he predicted, the man could not repay his debt. He also pointed out that pensions were really there to feed one mouth, not a whole family. But in Msobomvu survival seemed to depend on pensions. Old age pensions in the former Ciskei were R234 every other month.

Pensions paid out in the Republic of South Africa were R300. These were changing to R150 every month, which promised hardship, since people often travelled far to collect them in person. The pensioners were loathe to risk making changes in order to save themselves the expense and endurance of the long taxi rides every other month, since this money was their life-line, and a precarious one to boot. Mr. C. concluded, "Pensioners cannot make homes today, the money is very little." Mr. C. had been poor himself; he was a self-made man.

While most of the money in the village went to food, so that pay-day was for many the only meat day, life was divided into feast and famine, with scarcity outweighing celebrations. It was ironic that in this context there were always obligatory celebrations organized by the state. To the nurses at Victoria Hospital these were opportunities to wear their new choir outfits, a day off from work, and, it would seem, a moment to feel important. To the village these often meant more taxes to pay. So most of the money went on food and the Government taxes. Mr. C. explained,

> R10 is Ciskei development tax, R10 Government Security fund and R5 membership card, that is for a woman. For a man it's R10 more for the Government Security Fund.

He added that there was still the money for the celebrations. When asked what these taxes were for, he scratched his head saying, "It's not easy to explain because we must say as the Government says it", but brought it down to pensions, bursaries and defense. Defense apparently became the issue, when their was some trouble between the Ciskei and the Transkei, and the Government felt that they did not have their own military might.

Housing

Another reason for coming to Msobomvu was affordable housing. Discussions dwelt on the high rent in the cities and scarcity of dwellings. There were the hard-luck stories of women whose husbands had died, and who had to room with other families, a precarious and uncomfortable arrangement. Houses in Msobomvu usually had no great intrinsic value. Made of sticks, mud, and cow dung with either a thatched, or corrugated iron roof, it took only a few seasons of neglect to turn them back to nature. The timber and iron were considered of value.

I felt this cycle in my own life, as I saw the house which was a home to my young family disappear, so that today all traces are lost and I cannot be sure of the exact spot where it had stood, just below the village of Msobomvu. On my first visit, some six months after our departure, the metal roof was gone,

and the doors were missing. Then, a season later, the walls were crumbling, and it became difficult to point out the kitchen, or the bedroom. It was not long afterwards that all evidence of a garden, a fence, a water tank and even trees had disappeared. Someone found a use for all these things, at least those which nature itself did not wash away.

And yet people could pay from R500 to a few thousand to buy a house; some were just sheds, others were better; they could even have a foundation. The significance of housing is well illustrated by the story of Mary, a high school student, who had been boarding with another family for R45 a month, which bought her a bed and basic food. But, she complained, her clothes were stolen, and her school books torn by the children. When her younger sister came to Msobomvu, the girls, with the help of an uncle, built a house. To many the house may have looked like a patchwork shack, but to the girls it was a home of their own. Mary passed her Standard 10 at the local high school, while many city students, embroiled in the political issues of South Africa, lost their education in the heat of the struggle. She continued her studies at the College of Education, in spite of the usual scramble for school fees--a rural success story.

Entertainment

What was there to do in the village? The answer depended, amongst other things, on the age of the person asked. Some of the young girls could not wait to get away from Msobomvu. If

they had the taxi fare, friends in town, or a boyfriend with money, fun was found in Alice, the next best thing to a city. It offered social events at the local university, beauty contests, musical events, an opportunity for some shopping, and so on. Msobomvu was a place where you would spend your time cooking, cleaning, washing clothes, and attending church. Those who were trying to live off subsistence farming never ran out of things to do. It did not rank high in popularity, though. Older people complained that the younger ones did not help enough. The children had school, church, played games, sometimes flew a home-made kite, and hung out with their peers. Occasionally the children put on shows with the help of teachers trying to raise money for drum-majorette costumes, performing the high-kicking *amakosi* dances. The girls giggled. Some enterprising boys were waiting at the entrance to the village for business. For 50 cents they would transport the heavy bags of mealie meal or samp spilling with their owners from the taxis after a pay-day shopping spree in the town, to people's houses. They took pride in their wagons which they had fashioned from scrap-metal and wood, some of which even sported discarded license plates. The old people attended meetings and liked to dance. Everyone seemed to take pleasure in singing, particularly in church, and everyone seemed to turn up at funerals, probably because of the food. Family rituals, and other traditional events, often attracted those passing by with a promise of *umqombothi*, the home brewed beer and sometimes even something stronger.

Imbeko

Imbeko, that is respect, and adult status in the village, seemed connected to authority. People showed respect in that they obeyed the Government, the chief, the head man and the councillors, whether they liked it or not. Authority filtered down, the headman was vested with the authority of the chief's, and the councillors' in turn were vested with the authority of the headman. Respect seemed to be more than authority, in that Chief Maqoma was respected not only for being historically the chief, but also for being good to people. Councillors were elected. A councillor could not be a young person as he needed to be the head of a family. Whether he was rich or poor did not seem to matter. Women would get respect for being wives of chiefs, headmen or councillors, teachers or just plain old. To have a voice in the village meetings a woman had at least to be the mother of children and no longer beholden to parents. Men had to be perceived as adult, and have at least had a family.

Old age counted for something. There was no such indulgence of children. At my farewell, the old people drank the cold-drinks, because that was what they wanted, and the tea was left for the children. Since more people arrived than expected, the rainbow coloured cake baked by some of the women who helped me prepare for the party, was distributed to the old people. The children had to wait for what was left over.

Respect and adulthood, becoming a person of substance, took time in Msobomvu. But the passage of time, it seemed, was not enough. Marriage, with the demands of *lobola,* the financial settlement with the bride's family, put a heavy burden on most young men. Official marital status, and family, were thus no easy matter either. Achievement through education seemed to be generally an area of stress, as was discussed earlier. This could be seen in the bewitchment stories surrounding scholastic achievement.

The favourite radio-soap at that time told the story of Torka, a young girl, who does well at school. Her best friend's mother was jealous because *her* daughter was failing. She arranges a switch in registration numbers so that our heroine fails. The teacher turns out to be a witch, and continues to persecute Torka, once she leaves school, trying her luck in getting a job. A young man gets hired to follow Torka and frighten her. She instead turns around and confronts him. He realizes his error, and confronts the witch instead. The young man and Torka become lovers and get married. This was the story which unfolded every Tuesday. Everyone crowded around the radio the same day and hour each week; even Mr. C. made sure he did not miss any episodes.

While he was skeptical of traditional things such as the villagers accusing their neighbours of envy and bewitchment, he himself had consulted an *igqirha* when money went missing. He was respectful of Mr. K., a well-known local *igqirha,* but

saw his shortcomings and wondered whether this man's diabetes was not the harvest he was reaping for meddling with the supernatural in an immoral way. There were rules to everything; showing disrespect would anger authority, or the ancestors.

It is my hope that this description of the village conveys something of the socio-political, economic and cultural terrain of the time, on which Msobomvu's mentally ill walked.

Illness in Msobomvu: Rural Resources

Illness Talk

There was no clear division of illness into mental and physical, although people did talk about *ukugula ngenqondo*, illness of the brain or mind. An initial illness event, while possibly described as *igeza* or *phambana*, did not automatically suggest that the individual was suffering from a mental illness and was in fact *ukuphambana*. These issues were not clearly defined in everyday life in the village, but theoretically at least, crazy behaviour could have been a manifestation of *ukuthwasa*, the calling to become a healer; only the future would decide. Real mental illness then, would be the result of neglecting to take care of the ancestral call. The call did not necessarily have to be in the form of crazy behaviour. It could easily take the shape of bodily pain, as long as it was packaged in recognizable symbolic form.

The village health workers distinguished between patients they spoke of has having "high blood", coughs, swollen feet, and not talking, amongst other kind of problems, and those they described as wandering, retarded, epileptic, wild, or paralyzed with unpredictable moods. The second group they thought of as having a mental illness. This list also included *thwasa* and bewitched patients. There was some confusion, typical for the layman, between description of symptoms and diagnosis. Opinions diverged in regard to diagnosis according to the individual's membership in the traditional healing system (*amagqirha*), Western medical system (nurses), or the Church (in cases where the particular Church rejected traditional customs as superstition). Many churches claimed miraculous healing of their own, through the power of prayer or an inspired *umthandazeli*, the faith-healer. Some Christians were conflicted about their feelings about Xhosa traditional beliefs. It was explained in the following way:

> The Church would agree that there is bewitchment, but this bewitchment and the *amagqirha* are of the same government; they have divided themselves to two sides, into this side which says we are going to heal and those who are bewitching. It's occult.

The boundaries were often blurred, particularly since membership was not exclusive, even when beliefs were at odds with such membership. Some *amagqirha* were previously faith-healers. Their switch, while threatening their "walking in the light" in the eyes of others, did not change their bond to their church. Pragmatic concerns, particularly cost of treatment, seemed to figure a great deal in illness talk.

Families readily shopped around, making use of all kinds of treatment available, if they could pay for it.

Patients who could afford the luxury of consulting a private medical doctor in town (Alice), or in a more distant bigger town (King Williamstown), would do so. *Amaggirha,* and faith-healers too, seemed to grow in reputation with geographical distance. Sometimes you were in luck and a travelling healer came to your home bringing with him/her the aura of the mythical Mecca, since travelling incurred cost and danger. There were places known for their strong healers. A close one for Msobomvu was Middledrift. People claimed that they were often guided in their choice by dreams, while some acknowledged that they went by hearsay. There was one *igqirha* whose name was legend; people came from far away and camped out in order to consult with her. Even the nurses and a white dentist waited hours in the hot sun.

The local black doctor in Alice was a well educated man with a Masters in Community Health. He charged R15 per child and R25 per adult, including medicines. He said that this means he sometimes gains and sometimes loses in the deal. He said that there had been a decrease in TB with development in the villages, particularly in regard to clean water supply through taps. He considered the most serious problem to be hypertension, often called the silent killer, since the person could drop dead without much warning. Poor diet, alcohol and obesity were prime causes. Diabetes was another illness he

found to be endemic. Less serious, but anxiety-provoking nonetheless to local folks were, according to the doctor, scabies and pubic lice, referred to as *ukhwekhwe* and pig-lice, respectively. He said that people usually felt with pig-lice that "something terrible had befallen them", they did not connect it to sexual contact. The local healers, he felt, knew that it was easily treatable with paraffin.

Msobomvu residents would report (usually in relation to cases involving out-of-control behaviour) that the *amaggirha* had said that the illness was due to a bewitchment because of envy, that there was one *fufunyane* facing down, which explained the problems in treatment, or due to the neglect of certain rituals (particularly in relation to old people). In cases which seemed identifiable as relating to seizures, two explanations dominated. One was "*idliso*" the explanation said to have been offered by the *igqirha*, the other as "worms", the explanation given by the doctor. People seemed to be open to both: the explanations made sense. The hospital, they claimed, gave no explanations, just treatment.

A mother worried about her young daughter who was given pills at the hospital for her fainting fits, to take the worms away, she believed. She never saw the worms come out, so she stopped the pills, but the fits continued. She suspected that the real reason must be supernatural, *idliso*. The health workers concurred, "fits are always, according to doctors, due to worms". The local doctor in town seemed surprised. While he

knew of some cases of cysticercosis due to eating infected pork (tapeworm), he could only attribute this folk belief to Western medical doctors not doing their job and failing to truly communicate with their patients. More recently I located a doctor who asserted that cysticercosis was endemic in this area, resulting in permanent brain damage in some children and in seizure disorders. Dr. Bax attributed 30%-50% of all seizure disorders to cysticercosis.

A condition occurring in young girls which, by the local *amagqirha*, was identified as a clear case of *amafufunyane*, had according to reports been described by the hospital as the girls having a creature eating the inside of the stomach. The symptoms described involved an eating problem, sometimes pain, and was accompanied by great distress and "unstable mood". They had been given pills by the doctors, but the treatment had not helped. The community, once they felt they could speak freely, discussed the pros and cons of various concepts as fitting the patients they knew, in great detail. There was flexibility in labels, and even after years of mental illness, there was always the chance of a cure if only the *igqirha* or the medicine would just be powerful enough. There were also the fatalistic shrug, the dispirited dismissal and resigned "I cannot say", when years of searching had produced no cure.

Village Resources: The Mobile Clinic

Victoria Hospital in Alice provided clinic days to the outlying villages, and Msobomvu was one of them. Tuesdays,

fortnightly, Western medicine arrived in Msobomvu. It was a day off for the pre-schoolers, since the clinic was held in the Red Cross hall, which doubled for the pre-school. Long before the nurses in their perfect white uniforms arrived, the hall was bulging at its seams with people. Counting was a hopeless task, since the picture was constantly changing. It was easy to miss the babies since they often blended into their mothers' broad backs, wrapped up in *doeks*[78] and blankets, particularly as it was a windy day.

That day my count was 43 adults, mostly women, a number of school girls, and about 15 babies. Some 20 people were waiting outside. The nurses arrived at 12:45 p.m. in their Kombi. They remained in the crowded car to have lunch. They were late, as they had problems with transport. Once clinic started, the chaos was ordered with maximum efficiency: one queue for family planning, thighs exposed ready for the injection, one for immunizations and check-up of babies, one for the anti-natal clinic and the last one for minor ailments which included everyone who did not seem so ill as to be taken to hospital. Patients were sent on to the prescription queue where pre-packaged piles of medication for the common illnesses awaited them near the door. In two hours 81 cases were seen and treated. There were the inevitable obstacles to the smooth functioning of this rural conveyer belt system; an old woman had lost her medical card, and was told off by one of the nurses, and a child had dropped some of the coins he

[78]*Doek*--Scarf wrapped around the head.

was clutching in his hand, the fee being R2.

Medication for known clients with mental illness was also pre-packaged. Patients preferred to go to Victoria Hospital where the chances for a listening ear and some *imbeko* were better. Long-term patients did not have to pay the usual R4 fee for a hospital visit. One big reason for getting treatment at Victoria Hospital was also the elusive pension, the DG. Applications had to be supported by people who knew the system. At times, nurses, were said to use this as a threat in enforcing 'patient compliance'. The mobile clinic was geared to pre-packaged medical care, and nurses did not waste much time in looking at their patients, since complaints were made to fit a small number of treatments. The complexities of anti-psychotics with their many side-effects could hardly be expected to fit this system.

Bridging Two Systems: The Village Health Workers

The village health workers were women who were long-time residents of Msobomvu. They were given some basic health training and a small salary. This initiative was started by the Degem Project, which originated in Israel. As far as I could determine it fell under the Department of Health, training and supervision being the responsibility of the Victoria Hospital. There was little that divided these women from the rest of the villagers, except perhaps that they understood they were expected to refer to the clinic before following their own personal preference for a traditional healer.

They thought of their patients in terms of some broad-based categories, such as "sitting-down people", for those suffering a paralysis; mental illness (also referred to as *ingqondo emfutshane* - being short-minded, which at times could double for forgetfulness); and epilepsy, understood in the traditional causal terms of bewitchment, or in relation to worms. They knew about Western-style medicines for epilepsy, such as Tegretol, but conceptually made sense of this so common illness in folk terms. Another dimension which figured was whether the person looked like someone who was "well cared for". Usually this referred to someone's grooming. They, like the rest of the village, considered patients cured when they went back to work. Improvements in grooming, however, were appreciated as a measure of the person being better, even if the individual continued "talking alone". They often described someone as having appeared well as "he was looking as if he was coming from work and going to church".

They had acquired, presumably from the nurses, the category of "minor ailments", one of the main groupings targeted for treatment by the mobile clinic. It was not unusual to have death occur in relation to a "minor ailment".

Consider the case of Noluthando, a woman in her late twenties, who was paralyzed. The village health worker had visited her on one of her rounds in her area in the village. She reported that the illness happened after the woman was married. Therefore it had to be "something she got from the house she

was married into". The village health worker described her assessment of this situation in the following way:

> They are separated now and the husband doesn't care for her, whereas she was beautiful when he took her as a wife. The first time I visited her I tried to talk to her as she had a fever. Then I became afraid of seeing her. When I came back again she did not talk as before, she ignored me. She is short-minded. Her mother sends money and I found it is difficult for them. When you talk to her a child answers. It is visible that she is not right. There are two children. They look after her. They are between ten and eight years. When I came back a second time, she was dressed like a married woman.
>
> Question: You think they used bewitchment or did she just get ill?
>
> Answer: (Laughs embarrassedly) I think she's bewitched.

The village health workers expressed discomfort with some of their clients who they experienced as deranged, putting home-visits off for a while. They were also reluctant to intervene, avoiding confrontations. This was the way everyone in the village approached mental illness; the idea was to humour the person so as not to provoke angry outbursts, but rather to give in to demands, however annoying and difficult these were. Nurses, by contrast, tended to be more off-hand and challenging of patients, but then they could afford to be, being armed with authority and the injection needle. All the village health workers had was advice.

They took their advice to the homes of their neighbourhood, lending a sympathetic ear, and keeping a brief record of their caseload. They were painfully aware of the problems their patients faced, who often did not have the money to attend the

hospital or clinic, to which they had referred them. Long-term medication programs were a problem, both because of the cultural attitudes to treatment and cure, and in relation to the financial burden. It was rare therefore that children with epilepsy remained on a maintenance dose of Tegretol, since that required regular hospital visits, involving a fee of R4 and the cost of transport.

The three village health workers differed in the number and types of cases they had seen. Table 11 represents the distribution between the workers in the number and type of clients.

Table 11. Caseloads of Village Health Workers.

Client Category	HW1	HW2	HW3
Clients with Mental Illness			
Total No.	4	5	17
Prev. Hospitalized (Tower)	4	2	6
Males	3	4	12
Females	1	1	5
Adults	4	2	13
Children	0	3*	4
Retarded/Epileptic	1	4	9
Thwasa	0	0	2
Amafufunyane/Traditional	3	0	3
Behaviour "wild," "wandering"	0	1	3
Other Illness**			
Total No.	9	14	21
Old Age (pensioners)	2	13	14
Adults	3	1	7
Children	4	0	0
Male	6	1	6
Female	3	13	15

* Two had pig-lice.
** This included "high blood"/diabetes cases.

The health workers were all aware of TB and spoke of 8 individuals on treatment, mentioning some that had recovered and others who were symptomatic but not undergoing treatment. The "mental illness" category included anything where mentation and the emotions were affected. Epilepsy, and the "traditional" explanation illnesses were represented in both the "mental illness" category and the "other illnesses" category.

Nine of the of the 14 people previously hospitalized at Tower who had been picked up by my study were on the case-loads of the village health workers. They were less involved with the problematic teenagers in my study.

These women constituted potentially an important resource, in that they had informal contacts both with patients and with some of the traditional healers. They had easy access and communication with the patients and traditional healers, but were subject to constraints which applied to everyone. These involved the authority relationships relating to gender, age and social status. They were also subject to the divisions and conflicts which sometimes occurred along kinship lines. They had a more difficult position in relation to the health system to which they were connected. It seemed that their voices were not heard: they felt largely ignored by the nurses, and unable to represent their clients' needs. They also felt put upon by their clients, since they could not meet their expectations in terms of financial assistance, transport and other practical

matters. The bridge they tried to forge between the folk understanding of illness in the village and Western medical culture, never quite stretched far enough to connect the two.

The Traditional Healing System as a Resource in Msobomvu

Msobomvu had, at the time of this research, 14 traditional healers, of which 10 considered themselves full *amagqirha*. Table 12 represents a summary of the data extracted from interviews with these healers, and encounters relating to their work.

Four of the healers, while receiving some training, had not as yet come through, and it seemed that not everyone does at the end of it. Mrs. T., a university lecturer and at the same time a person committed to Xhosa tradition, explained the issues involved in the process of *thwasa*.

> *Ukuthwasa* becomes a family action. If as a woman I am *thwasa*, I have to go back to my family, not my in-laws. If there's nobody in my immediate family who has gone through it, you have people go out and look for somebody. If the ceremonies get carried out as they should be, the ancestors are pleased; if something goes wrong there, the person goes mad.

In the village, some of the more pragmatic folks were questioning the state of affairs concerning *ukuthwasa*, saying that things were not like they used to be, and that "many don't come through".

Whether the person had achieved the status of being a full *igqirha* could perhaps be considered the dividing line between a potential patient and an important resource.

Table 12. Descriptive Matrix: Traditional Healers of Msobombvu

Name[79]	Family history	Initial calling	Types of problems treated	Training issues/ place	Treatment issues/ fees	Ethics	Full Igqirha
MaMbam-ba	?	Umbilini headaches crying	P ig-lice, no child-ren, no amafu.	?	People don't want to pay/few clients R10		Yes
MamNtan-de	Sister, son & bro-ther all amagqirha	Umbilini, thin, felt better after she accepted	Only vumisa and customs	Local, R280, not finished	N/A	Doesn't know the rules yet	No - depends on money
Mr. S.	Whole family are healers	Born like that	Thwasa, not amafu, falling sickness, impundulu will treat anything	Learned from father	10 clients a month from Cape Town, PE, etc. R25 vumisa, thwasa costs R800	No special rules. Does not refer to hospital.	Yes, but not formally trained.
Mxolisi (Referred to by Mr. S. as young boy)	Family all amagqirha	Violent, fits, head injury (Tower H)	?	Trained with family locally	Works together with Mr. S.	No special rules	Yes, but born that way
Mr. Qwathie	Father thwasa, ggmother igqirha, aunt igogo	Born that way; dreams. Last 2 years sick a lot (he's 46)	Does not treat	Went to 3 amagqirha but dream told him to go home	N/A	N/A	No - needs bushman to train him
MaRadebe	Last-born son thwasa - she's training him	Problems with eyes, compelled to sing and dance	Stomach ache, head-ache thwasa, not amafu.	Two years, had 7 children, husband supported it	Patients scarce, says she's too old. Cannot beat up herbs. R10 per family	Many rules, "you treat your patient as your own child"	Yes
Sisiwe	Many thwasa in family. One drowned in river	Used to run around	Does not treat	With Mr. K for 2 years but she left. Complains he was Zulu trained. Needs Xhosa training	Expensive part of thwasa rituals are the goats and the gin	Defied Mr. K. Got drunk	No

[79]Names have been changed to maintain confidentiality.

Name[80]	Family history	Initial calling	Types of problems treated	Training issues/ place	Treatment issues/ fees	Ethics	Full Igqirha
Mrs. B.	Sotho family back-ground, but accul-turated	Was wearing old clothes and collecting herbs in childhood	Amafu, phambana, thwasa, cough, stomach, cannot treat AIDS or cancer	Started with a faith healer in PE, then to Natal with Mr. K Husband support-ive, took care of kids	One patient a week/ month. R100 for tx.	Critical of Xhosa amagqirha No rules. Refers nerves and TB to hosptl.	Yes
MamTsha-we	?	Sick with pains and lot of dreams. Lost 3 children	Custom problem; swollen feet, thwasa. Diagnoses amafu but doesn't treat	6mo trg after faith healer training	Building a rondavel to accomm. patients R10 vumisa, R30 admission	Rules. Refers phambana to hospital She worries if patient dies you go to jail	Yes
MamTshon-yane	Cousin thwasa but not trained	Started at school Std 6, 1957, during exams. Crazy, running away, tied with ropes	Isifo sokuwa & ukugula ngenqon-do. Pig-lice, menstrual pains, idliso	In Kirkwood, had 1 child at the time	Used to travel, very busy. Travelled in Transkei. Deposit R50. R250 per family	Rules in relation to tx. No boyfriend during training	Yes
Mr. K.	Whole family	Wandering in the veld. Said to be crazy. Ixhwele first	Thwasa, amafu, all kinds of illnesses	E. London for herbs. Fully trained in Zululand	R180 for thwasa. Concerned with legal issues if patient dies	Strict rules but criticized for not sticking to rules himself	Yes (leading igqirha in Msobom-vu)
MamPinga	Husband divorced her and abandon-ed the family when she accepted the call	Headaches palpitat-ions, wanted to be alone	Does not treat	Trained in Cradock. Igqirha left. Second igqirha not success-ful	N/A	N/A	No
Nothoza-ma	None	1938. Bad dreams, too much breathing	Phambana, amafu., no babies, tries all	PE, then Natal with Mr. K	1 patient per month	Rules. Will refer to hosptl for injections	Yes
MamCethe	?	Umbilini. Second wife in polygy-mous marriage	No thwasa No amafu. Chest problems, tiredness		Too old; few patients	Food taboos. Sexual taboos	Yes

[80]Names have been changed to maintain confidentiality.

An initial diagnosis of *thwasa* was not unusual for patients with mental illness, but coming through was another matter.

The family histories of *amaggirha* and patients with a mental illness seemed linked in that the latter had *amaggirha* and *thwasa* relatives; *intwaso* also seemed to run in families. Perhaps this gift of the ancestors was also a burden. No wonder then that the *intwaso* was often referred to as *le nto*, this thing, particularly by healers not fully qualified, since the word was thought to call the *inkathazo*--the trouble--on to themselves. Only once the final rituals were completed was it clear that the threat of madness was defeated.

Eleven out of 14 healers were women, most of whom only started their training after marriage and children. Families and even husbands often saw fit to go to great length, even borrow money, to encourage completion of this process. One husband, however, divorced his wife, and abandoned her and their six children, because of his wife's decision to accept her *intwaso*. Her home was in the Transkei and she was working "digging up small bushes in the camps of the Whites"; her mother was helping her as much as she could. She finally found an *igqirha* in Cradock. He left before she could complete her training, and she cried a lot. Her next *igqirha* did not work out for her, and she deteriorated. She said that she was supposed to have been taken to the river or the forest, but neither happened. She was having visions and dreams of the things that needed to be done, but seemed to have no idea how

she was going to finish her training. She, like most of the others, felt that the big obstacle to coming through was financial. The fee was not the big problem, but the animals for the rituals, and the gin needed, were seen as very expensive. The sum varied a great deal; there was talk of '*inkomo*'--the cattle prize--which often stood as a symbolic cow rather than a real one, and was said to be anything up to R800.

The young girl, Sisiwe, who had been to Mr. K., a well-respected local *igqirha*, said that it had not worked out for her. After being part of his household for two years, she had dreams telling her that he was the wrong *igqirha* for her since he was Zulu trained, and she needed a Xhosa *igqirha.* So her family paid Mr. K. and she left. According to Mr. K. this girl had shown no respect for the rules, or his person. When she had shown up drunk and insulted him and the others, he gave her a beating. She had since been to a young Xhosa-trained *igqirha,* or so I was told by reliable sources in the village, and she had come back big with child. The problem was, or so the story went, that this *igqirha* was married already.

A third story of "not coming through" was a little different. Mr. Quathie, a man in his 40's, who owned considerable livestock, including a herd of angora goats, and who I often saw riding proudly on a fine horse, had been to three *igqirhas*. Nobody could treat him, he claimed, and an *igqirha* finally said that he needed to be treated by a Bushman,

because his clan came from Abathwa, and were descendants of the Bushmen. His father also told him in a dream not to go and search for more *amagqirha*, but to stay home and look after his livestock. A later dream convinced him that an elephant would come from the river and spurt water over him, but not harm him. This is how he was to become a full *igqirha.*

The ten full *amagqirha* in Msobomvu did not equally represent a resource to Msobomvu's troubled people. Their abilities, specializations, ethical standards and confidence varied a great deal. All were ready to take on a *vumisa* as well as treat the patient. They spoke of "beating up" their own herbs. Mr. C., the headman, was one of the people who regretted the lack of clear division, as in the olden days, into those who *vumisa*, the *igqirha* or the *igogo*--seer, and the *ixhwele*--the herbalist, who treats. Two of the women healers were in their seventies, and felt they were getting too old to treat. For problems related to mental illness, only four unequivocally accepted the more difficult patient described as *phambana*, or those suffering from *amafufunyane*. *Ukuthwasa* was more readily accepted. One *igqirha* diagnosed mental illness and *amafufunyane*, and then referred these patients to the hospital.

Of all the patients who had been identified as having a mental problem in the community, six had had contact with four of the *amagqirha* in Msobomvu, and sometimes with more than one of them. The men seemed more assertive, dismissing the general

claim that there are too many *amagqirha* and not enough paying patients. Some of the women had said in effect that "*thwasa* does not work anymore", meaning they could not make a living from it. The men, however, flatly stated that it depended on how good you were.

Mr. S. was quite cocky about the fact that he never referred to the hospital, and would even treat cancer, (although he had never done so). He and his young partner in the business, Mxolisi, also made clear their claim to being full *amgqirha*, this resting on their being "born that way", rather than on the usual formal training. It did not seem to stop them from being amongst the more popular healers in the village. Two families, however, had reported to me that they had not been satisfied with the treatment their relative received from both Mr. S. and Mr. K. Mrs. B., by contrast, seemed to have had some success with teenage girls suffering from *amafufunyane*. Mamtshawe was treating an older man who had previously been to Tower hospital, in spite of her claim that she did not accept people with mental illness; she attributed his problems to the neglect of customs. There were many contacts with traditional healers, of which a good number had occurred elsewhere, since seemingly the status of the individual was proportional to his/her distance from one's home. Some *amagqirha* made this work for their business by taking to travelling.

There were two schools of thought amongst the traditional healers of Msobomvu, the one described as following Xhosa

tradition, and the other bearing the stamp of their final training in Natal. Mr. K. was the link to Natal. He had a homestead, including a rondavel high on the slopes of the village for his clients. Every child could point out where Mr. K.'s rondavel was. He had a few *thwasa* women in training. Nothozama, a qualified *igqirha* who seemed devoted to Mr. K. and had been taken by him to Natal to complete her training, was rumoured to be one of his girlfriends. She referred to him as "father" and showed deep respect and gratitude to him. Mrs. B. had also been taken by Mr. K. to Natal. Mr. K. and his followers were easily identified by their colourful Zulu beaded headgear, compared to the traditional Xhosa garments which tended to emphasize the colour white, and the use of white beads.

There seemed to be some ambivalence about the introduction of Zulu medicine to Msobomvu. On the one hand, special powers were attributed to such foreign medicines; on the other, it was looked upon as dangerous and demonic. Even the *amafufunyane*, the grave-ants which possessed the sufferer and needed to be tricked into talking, were said to be speaking Zulu.[81] Mr. C., the headman, expressed similar concerns. While he liked and respected Mr. K. he said,

> Mr. K. has gone wrong. He should never have gone to Durban and learned that Zulu stuff. He even told me that you mustn't have women and liquor and now he has girlfriends and drinks too much, and he is starting to suffer because of that. He slaughtered 2

[81]A teacher at the local high school, who had experienced the *amafufunyane* possession in some students, said that it was not real Zulu they spoke, but some sort of gibberish.

> cows on the weekend, and he doesn't let the blood run out. He takes a bucket and opens the stomach and lets the blood run in. He takes that into his hut and it is never seen again. These demons, I believe, they ask for blood.

The contrast made was often in terms of Xhosa medicine being clean, or white medicine, made from herbs which came from the *veld*, as opposed to blood-rituals. The main focus was a treatment referred to as *amakosi* which consisted of a white powder which was thought to come from Natal, and which enabled the individual to see visions and *vumisa* without any training. The difference was that the person using *amakosi* was unconscious during this process. The popular journal, *Imvo*, carried an advertisement for mail-order *amakosi*. This was often a topic of interest. There were dangers associated with *amakosi*, and people felt that if you did not know what you were doing, instead of fighting the *amafufunyane*, they would turn back on the person. There would be no rescue from *amakosi*. The belief was if you were meddling with things brought from elsewhere, and this caused a bewitchment, local healers could not help; the one who gave the powder to you needed to be consulted, and he was often over the hills and far away.

Mrs. B. seemed to be making a name for herself in treating teenage sufferers of *amafufunyane*. She took these girls into her home where they had to wash with herbs, drink, vomit and steam with herbs, whether they liked it or not. When the *amafufunyane* finally confessed where they came from, the healer took the girl to her place in Port Elizabeth, in order

to drive these creatures out far from the girl's home. One girl talked about how she wanted to kill herself, run in front of a car, and even tried at one stage to do so by swallowing Sunlight soap and Omo. She had an eating disorder and problems with her family, her step-mother having come between her and her father. When the *amafufunyane* revealed that it was the step-mother who had sent them, it led to a re-alignment of the family, with the step-mother cast out. The girl expressed great confidence in Mrs. B, even though she had resisted some of the treatment earlier on. She felt good when she came back from Port Elizabeth, "fat and happy".

The effectiveness of the traditional healers will need more in-depth consideration, and this is best examined in the context to of the patients identified by the community. There were the success stories, usually in relation to teen girls, but the healers also had a significant role in the shaping of the person with mental illness, even if there was no miracle cure to report. They participated in the illness definition, the attribution of blame, providing a window of opportunity for the sufferer to conjure up a creative solution.

The healers themselves had found in their role a creative solution. They--the ones who had come through--had to have shown great commitment and perseverance, often with the help of their family. The women particularly had risen from low status positions to new roles, outside the control of their in-laws. MamCethe, the second wife of a polygamous marriage,

comes to mind. Now that she and the first wife were old, their husband long dead, they lived in harmony as friends, but could remember that it was not always like that.

There were signs that not all was well for this brave group on the fringe of the community. There were the complaints that "*thwasa* does not work anymore", and in spite of the men's assertion that there was no problem, the fact that Mr. K. was putting all his efforts into his shop, and the *amaggirhas'* readiness to embrace the new South African Traditional Healers' Council (SATHC), with it's certificate and other paraphernalia, suggested otherwise. At a meeting at Mr. K's rondavel, a myth was born between the prayer to God--the *camagu (*be appeased) response by the group--and a report back letter from representatives of the council. It was said that patients suffering from AIDS and cancer were going to arrive in Msobomvu from Namibia by aeroplane, and Mr. K. would be called upon to organize Msobomvu's resources to deal with this influx. There was talk of housing many people. Payment would be effected by the office, and even police would need to assist with transport. Special herbs would need to be cultivated, possibly at the university farm. The healers of Msobomvu were proud to be chosen, although they were a little in awe of the events to come. Even the old women, who had earlier spoken of being past treating patients, were signing up as members (joining fee was R25), ordering their certificates (R80) and the badge in the shape of the African continent (R12), at considerable expense. They were ready to

meet the challenge. This was to happen as early as January 1990. In February 1992, The Weekly Mail published an expose of the SATHC as having been sponsored by the South African Defense Force, since it wanted to use healers as a "conservative bulwark against 'radicalism' in the black community." Needless to say, the patients from Namibia never arrived.

A few days before I was to leave the area, I paid a visit to Mr. K's store, at the turn off to Msobomvu, a few miles away. I found the building dilapidated and cold; there were gaps where the wood had rotted away. Nothozama greeted me from behind the counter and called my attention to what looked like a heap of clothes bundled up on the in a room adjoining the main shop. It was Mr. K. huddled in pain on the floor. He was stripped of his colourful *igqirha* attire, the dignity of his kraal, and just looked old, poor and sick. He and Nothozama had stayed the night because they had not been able to get back to the village, and in any case, Mr. K. did not like to leave the shop unattended. Mr. K. said, "I'm diabetic, I'll never be cured, I mustn't eat too much, I mustn't eat too little, it's all no good." I later heard that Mr. K. died, there was talk of it having been due to a bewitchment. I could not find his rondavel on my recent visit, nature seeming to have reclaimed it. Mr. S. also died, and his assistant moved away.

And so we see that the mortality of these healers was an ineluctable part of life, as is true for all of us, and that, like their Western counterparts, their human and professional fallibilities were all too evident. While pawns in the larger political system, they were significant players in the illness drama as it unfolded in the village. Their understanding of illness and its treatment, whether of body or mind, created order and meaning out of confusion: they spoke the language of the people and, irrespective of the individual patient's endorsement or rejection of some particular healer, were embedded in their consciousness.

CHAPTER 12

BEING "CRAZY" IN MSOBOMVU

A Young Woman's Story: A Village Perspective

16 January, 1990.

Nonceba has died. She relapsed. She went to Mr. S. for *imvumisa*, who told her that the witches want to see her dead. She is pursued by an *impundulu*. The reason is jealousy because of the house in which she lives. He said that she is also possessed by an *ifufunyane*. A car was hired to take her to the hospital, but she refused and ran away. They took her to Bergplaas to be treated by a spiritual healer. She was to stay there. She became worse and her relatives were going to take her to the hospital but she died outside the premises of the spiritual healer.

Nonceba died the month after I left Msobomvu; she was 24 years old. I remember reading in her hospital file, that she admitted to drinking Crackling, smoking Best Blend (wine and tobacco), and that she left school in Standard 4 because of pubic lice. She had a child after her first breakdown, still in her teens. There was an issue over paternity and Nonceba and her family could not pursue their claim, and demand recompense. Nonceba was secretive about her illness; only her neighbours, the village health workers, and the headman knew, or so she thought. She had tried to go back to work, taking care of children of a family in town. She was found praying excessively and lost her job. She had then pinned all her hopes on her boyfriend, a migrant worker on the mines in Johannesburg, and whose house she was living in. He was to

marry her. She loved listening to music on the radio, and she loved dancing. Her boyfriend died one month later in Johannesburg under mysterious circumstances, I was told.

Nonceba had contact with Tower Hospital some years earlier. She had appealed for help to at least two of the local *amaggirha*, during her illness events, and she had been visited by the village health worker. Mr. K. who had been treating her earlier, failed to keep her safe, and at that time she almost got stabbed by a man she had insulted at Bergplaas. The village health worker felt uncomfortable around Nonceba, since she was related to the man who most likely fathered her child. Tower Hospital had previously contained her, but like most of the local patients she "defaulted" on her medication (Mellaril, 100mg. bd). When I had asked Nonceba's mother whether she thought her daughter was "unhappy, or sad", since she appeared depressed, the answer was "No, there's no reason". Depression, or unhappiness was attributed to external events. Nonceba was one of the twenty people identified by the community as having a mental illness. Her story does not fit with the positive outcome research has painted of mental illness in the developing world.

Illness Events In The Village

Figure 21 summarizes important issues around the 20 individual cases of *ukugula ngenqondo*, being crazy in Msobomvu.

Table 13. Descriptive Matrix: Profile of Individuals Identified by the Community as Having a Mental Problem.

Patient "name"[82]	Illness events/ violence	Fam. history	No. of hospitalizat.	Illness explanations	Finan./ socio-econ. situat.	Work	Social relations	Stigma	Fam. and comm. manag-ement
Mlugisi (M)	Talks to himself /throwing things	Uncle ment. ill	2	Amafu./ thwasa	Applied DG/m. applied pension	Minimal /makes bricks	No girl friend	Phambana/ no fam. trust +	Lets him sleep./ girls scold.
Richard (M)	Wild/ visions /burns clothes	Cousin ment. ill	5	Thwasa /amafu.	Earns a little money	Piece jobs	No girl friend	Cheated out of money +	M. lets him use alc /"pot"
Tomorrow (M)	Stole cows/ talks to himself	Someone white-blooded /thwasa	2	Nerves due to wife	Brother buys groceries	Grows pumpkins etc	Two children/ wife left '73	Comm. blames wife -	Fam. does washing, chickesn etc
Jacob (M)	Beats people/ speaks alone/ or sleeps	Uncle igqirha	2	Rituals bewitch /idliso	Fam. supports him	Dyuamic preacher	No girl friend	"We forget he was ill" -	trick him into hospit-al/ g.m can control him
Lamla (M)	Beats people/ attemp. rape	Brother ment. ill	2 Died '92 - poison beer	Idliso due to envy	Depends on bro. Mother in hospital	Piece jobs in past	No girl friend	Says people look at him odd cousin afraid +	Brother can control him
Thosama (F)	Attack children with axe	Cousin igqirha	3	Nerves/ amafu?	Husb. fails to support	Takes care of sister's child	Married 4 children	People sorry/ blame huaband -	Sister takes child away/ supportive
Phindile (M)	Beats people when he doesn't get what he wants	Aunt ment. ill	15+	Bewitch-ment. Ran away from vumisa	Father pension poor	Not working	No girl friend	Cousins still love him. But he feels looked down upon +	Give in to what he wants. Keep quiet.

[82]Names were changed to maintain confidentiality.

Patient "name"[83]	Illness events/ violence	Fam. history	No. of hospitalizat.	Illness explanations	Finan./ socio-econ. situat.	Work	Social relations	Stigma	Fam. and comm. manag-emet
Simon (M)	Attacks children if provoked	Mother's fam. ment. ill	Many (56-76)	Idliso/ Mr. K says it's thwasa/ ibulawo	Has DG/ Extended fam keeps it	Odd jobs for tobacco	No girl friend	Children tease him/ Story of stale food +	Comm. allows him at rituals and beer drinks
Gladman (M)	Burns clothes /prays excessively	Lots of ment. ill & amagqirha	About 7	thwasa/ bewitch due to envy/ nerves	Worked as my interpreter	Working tries to continue educ.	Girl friend/ problems with lobola	Teens say he's diff. from ment. ill. Has girlfriend ?	Girlfriend supportive & cires for him Fam. supportive
Nonceba (F)	Pray too much/ wild/ insults	M. problems/ uncle in Tower	1 Died late '89 outside faithhealer's hut - bewitchment	Bewitch if ifufu due to envy	Boyfriend sends money M. helps. Poor	Looks after boyfriend's house. Lost jobs.	Boyfirnd, child	Tries to keep ment. ill secret. Some difficculties in com. but people make demands -?	M. denies depres feels no reason for her to be unhappy. Neighbour's critical
Eunice (F)	Confusion. No violence	2 sons ment. ill	1, then she died in 1991? In hosptl.	Rituals. Death seen as natural - old age	OA Pension. Discontinued in hosptl	Used to care for house & garden	Grown up children. Widow	Good hardworking person -	Hosp. would not release her- lost DG
Nora (F)	Excited aggressive, Roams about.	Mother nervous	3	Thwasa	No-one takes responsibility	Never worked Never schooled	Never had a boyfriend	Aunt does not entrust her kids to her. Fam. doesn't want her. M/F div. & remarried +	Fam. moved away. Neighbors took care for a while

[83]Names were changed to maintain confidentiality.

Patient "name"[84]	Illness events/ violence	Fam. history	No. of hospit-alizat.	Illness explanations	Finan./ socio-econ. situat.	Work	Social relations	Stigma	Fam. and comm. manag-ement
Stim (M)	Suspici-ous, talks to himself. Dang-erous with weap-ons	Ment. illness & thwa-sa in fam.	2	Idliso/ thwasa	DG	Gard-ening	No girl friend	Consid-ered pham-bana. Gets some female visi-tors +	Ig-nores prob-lems. Leaves him alone. Does not use his DG
Wel-come (M)	Went "crazy" Drove car into wall on job	Ment. illness and thwasa	1 - long ago	Dagga	De-pends partly on rela-tives. Applied for Old Age pension	Un-employ-ed	No girl-friends acknow ledged	Nothing wrong -	Visits exten-ded family
Non-dumiso (F)	Sleep-less. Quarrel with boss. Sleeps too much	Ment. illness & thwasa	None. Out-patient tx - long-term.	Thwasa nerves due to hus-band's death	DG. since 1974 Owns her house in Mso-bomvu	Lost jobs when she got ill. But main-tains house & grden.	dow-ed; two sons	No prob-lem -	Comp-lains no supp-ort from hus-band's family before death
Nocawe (F)	Ran wild. Visions	Her aunt on father's side was an igqirha	None	Bewitch /to be stolen by witches due to jealou-sy	Hus-band sends R350 a month from JHB	Ran shop. Shop fell apart after illness	Married with 2 child-ren	Sym-pathe-tic -	Neigh-bour took her to igqir-ha nearby
Pumla (F) Teen	Fight-ing with family. Suici-dal. Eating prob-lem	G/moth. igqirha Twin sister had pro-blems	None	Amafu sent by step-mother	Mem-bers of family work-ing	Work-ing as hawker Wants to fin-ish school by corr-espond-ence	18. Has boy-friend	Ckeeky blamed on step-mother -	G.moth supp-ortive Father kicked stepm. out

[84]Names were changed to maintain confidentiality.

Patient "name"[85]	Illness events/ violence	Fam. history	No. of hospit-alizat.	Illness explanations	Finan./ socio-econ. situat.	Work	Social relations	Stigma	Fam. and comm. manag-ement
Sindis-wa (F) Teen	Sto-mach aches. Mind not stable.	No ment illness.	None	Amafu blamed on neigh-bours	Poor family. Girl now work-ing in Cape Town	Work-ing in Cape Town	Had child before she got ill. Teen-age preg-nancy.	Cured Blamed on neigh-bours -	Lived with igqirh. some time. Family kicked neigh-bour's door in
Tabisa (F) Teen	Pain in stomach Very quiet. Cries.	Mother thwasa. Uncles amag-quirha	None. Saw doctors and ama-gquira.	Idliso or amafu	Comfort-able. Father has govt. job	School-ing Std 8	Teen-age preg-nancy at 14 Has boy-friend	Con-cern - Quiet child, good -	Fam. wor-ies. Spend a lot of money search ing for cure.
Nomzi (F) Teen	Sto-mach prob-lem. Goes uncon-schous. Confus ed	Fam thwasa & faith healer	None - has been to Victoria hsptl - outpat-ient	Idliso, ifufuya -na	Lives with aunt who has aa job.	School - Std 6	Boy-friend on Hogs-back	Teacher says she's a weak student Problm. worse when she can't cope -	Accom moda-ting but compl. that she does not take the herbs from igquir. or meds. from doctor.

These individuals were diagnosed by the community, usually by a number of key figures--the headman, the village health workers, the *amaggirha*, teachers, neighbours, and relatives in the village. Fourteen of these people had been hospitalized at Tower at least once. Some of the rehospitalizations included other hospitals further afield. One woman had attended out-patient clinics for years and was taking anti-depressants intermittently. She was one of the few people on a disability

[85]Names were changed to maintain confidentiality.

pension. The other five who were not hospitalized, while most of them had made use of medications, doctors, the clinic and even Victoria Hospital, predominantly relied on traditional healers. Four of these five were in their late teens. This represents therefore a different mix from the usual group, diagnosed as schizophrenic in Tower Hospital.

The illness behaviours which led to their selection, were, except for the teens, typical for people with severe mental illness, in the mental hospital. Behaviour often involved features considered by Western medical practitioners as psychotic, and more than that it included serious acts of violence. There were differences between these people in another way. As I have noted previously, diagnosis in these rural mental hospitals is problematic, and it has been pointed out, even admitted by at least one doctor, that there was a tendency to over-diagnose schizophrenia, omitting bipolar illness as a diagnostic category almost completely. While my research did not attempt to re-diagnose each individual case, focusing instead on severe mental illness in general, it became clear to me while living in the village that some of the former Tower patients showed chronic psychotic features more typical of schizophrenia, while others showed little deterioration in functioning between episodes of flagrant illness. The pattern of the latter often varied between excessive sleeping (depression?) and excitable manic behaviour, frequently accompanied by sleeplessness. The depressive episodes were often not remarked on since the focus

of hospitalization has always been the troublesome behaviour, particularly when it included acts of violence. Suffice it to consider this group as intermittently ill. The teen group varied, including symptom patterns which to Western medical perception appeared to have some physical aspects, including possibly an ulcer, epilepsy, as well as some major family problems, and eating disorders (anorexia nervosa).

Perusal of the illness explanations highlights that traditional explanations were the order of the day. These seemed broad and were modified over time. Explanations related to rituals and customs were more likely to be diagnosed in old age, as well as when illness struck more than one member of the family. The general concept of bewitchment due to envy, usually applied irrespective of specific causes like *amafufunyane* or *idliso*. This illness talk was the common property of the community; the *amagqirha* had a more refined language of the supernatural including a variety of concepts, which constituted the differential diagnoses of the experts. But unlike Western medical practice, traditional illness explanations always seemed to remain accessible to the individual sufferer.

'Nerves' were reserved for situations when the individual sufferer was facing serious problems acknowledged as issues which could cause grief to anyone. It was therefore a consensual category of naturalistic causation. This category, at times, held up even in the face of repeated

hospitalizations. Thus Thozama who had attacked her children with an axe, was seen as suffering from nerves because her husband was not supporting the family, but sinking his wages into alcohol. According to the hospital charts she was suffering of schizophrenia, while her intermittent illness pattern together with an initial referral note were suggestive of a bipolar illness. Tomorrow, whose illness history was one with chronic psychotic symptoms, was also seen as suffering from nerves, the reason being the desertion of his wife 17 years earlier. The fact that his wife left *after* he got ill was disregarded.

Financial concerns were apparent for most of these patients and their families, a problem they shared with the rest of the village. Related to this was the problem of unemployment. Disability pensions were the dream of many, but only two of the 20 were recipients at the time this field-work was being done. While some of these people had been working previously in the nearby town, or even in the cities far away, they could not regain that level of functionality. Some had made efforts which had failed, including their engagement in education. This, however, did not apply to the young girls, who seemed to be able, at least at this stage, to remain at school. Sindiswa even successfully re-entered the job market in the big city. Some low-key productivity as seen in growing vegetables seemed more achievable to these people. One young man under the care of the faith healers had become a dynamic preacher, which led to the village thinking of him as cured. But sadly this is not

where the story ended; he was said to have relapsed later on.

Social relationships provided areas of contrast for people with mental illness in the village. There were some who had families, or at least a boyfriend/girlfriend to speak of, while others never achieved that level of social relating. This aspect seemed both a sign of the person's ability to function as well as fulfilling one of the criteria of adult status in this cultural context.

The degree to which individual patients were stigmatized was assessed by collecting information about the way the community responded to them, in words and action. This information was collected from many different sources in the village, including comments by high school students, as well as the sufferer's own thoughts on this matter. The issue of blame featured in relation to stigma. Blame led to pointing fingers at other people, either directly as in the case of nerves, or indirectly as in bewitchment accusations. Blame was not just a theoretical issue, it was often a precursor to action.

The management of illness events was another issue closely aligned to that of stigma. There seemed to be a general tendency to passively submit to the situation and actively avoid confrontation. This led to be people tricking their relatives into coming to hospital, rather than forcing the issue. The story of patients being told that they were going to visit family and then finding themselves in hospital, was

repeated many times. This explained an occasional problem I had encountered in the follow-up part of this research, where 'relapsing' patients refused to come near the car to be interviewed, since they expected to be tricked. I asked one patient how he felt about having been tricked, and he thought about it and said "there was no other way. It did help".

While these were brief descriptions of the data contained in the descriptive matrix of the Msobomvu patients, more interpretative steps are to follow.

Passing Muster

From the start of my research, evidence seemed to be pointing at stigma being directly related to hospitalization in a mental institution, in this case predominantly Tower Hospital. The comments by the nursing staff both at Tower and at Victoria Hospital are a case in point. As someone said "it is better to go to jail than to Tower".

> There's stigma. Most of us are afraid of a psychiatric patient. A psychiatric patient is a new term; we used to say 'a mad somebody'. the stigma attached is that people say he'll never be right. He will die mad. If you come to a psychiatric hospital and you stay here for one month or three months, when you'll go home to resume your duties, if you are a teacher, go teach, you will see that the parents will say, 'no, my child will never be educated by a mad person. If you are admitted once at the psychiatric hospital, nobody would ever accept you again.

This view had a lot of support from mental patients themselves, although many also claimed that everyone had treated them well. *Passing Muster* became a new way of looking

at the stigma issue, viewing complex interactions which resulted in attitudes of acceptance or rejection in this community.

Table 14. Hospitalization and Stigma.

Hospitalized at Tower	Significant Evidence of Stigma	Significant Social Relationships
Yes 14	7 (2?)	5
No 6	0	6

Table 14 looks at the relationship between variables, and demonstrates that contrary to expectations, significant evidence of stigma could only be found for 7 of the 14 patients hospitalized at Tower. With 2 of the remaining 7, there were some problems in relation to acceptance. The 7 that were not significantly stigmatized all had had long-term hetero-sexual relationships, 3 having been married.

The school girls I asked about different people with mental problems in their community distinguished between Gladman and some of the other people with mental illness, stating, "he is different, he has a *girlfriend*". This perceived difference could relate to the fact that he had a girlfriend, this providing him with status, or that he was functionally different, with his having a girl friend being a consequence of that fact. Either case did not support the view of a blanket stigmatization associated with hospitalization.

Instead it shows that people draw on different experiences when forming opinions.

Non-hospitalized people with mental problems carried no stigma, and all had significant social relationships. Only 5 of the 14 ex-Tower patients had significant social relationships.

Table 15. Chronicity and Stigma

Chronic vs. Intermittent Illness	Significant Evidence of Stigma	Significant Social Relationships
Chronic 9	7	2
Intermittent 11	0 (2?)	9

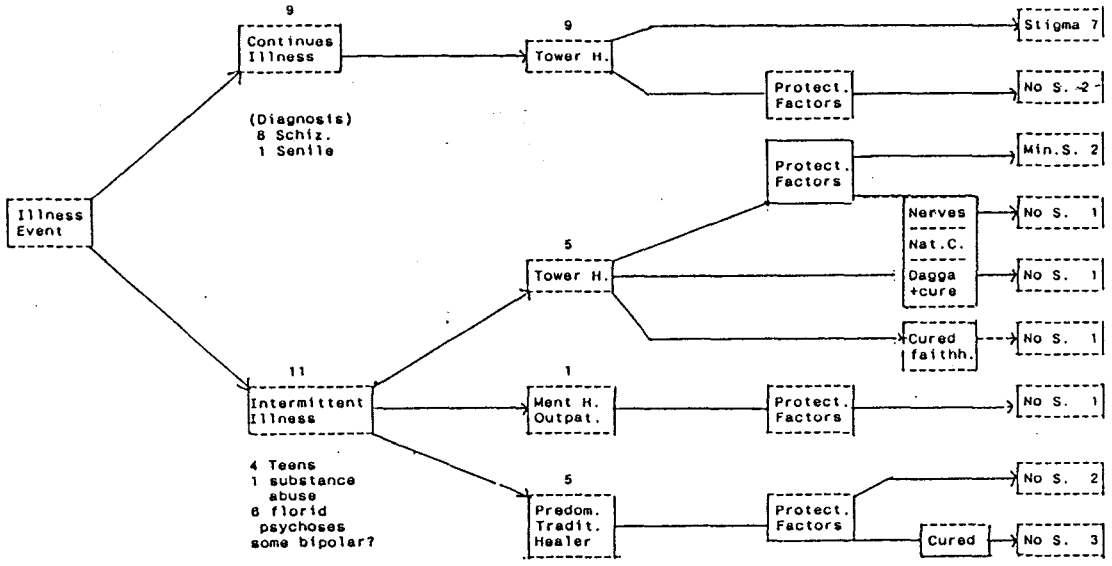

Figure 21. Passing Muster.

This led to a another way of looking at people with mental problems in the village. Dividing the group of people into chronic and intermittent illness events provided another way of linking variables. Focusing on the outliers--the two people in the chronically ill group who were well tolerated and respected in the community--revealed some further interesting insights. One was Eunice who was senile. She had a reputation for hard work and had raised a family. Neglect of customs was seen as the cause, particularly since two of her sons were suffering from a mental illness. When she died a year later, the community attributed her death to natural causes, old age. The other person, referred to previously, was a man in his fifties, whose wife had deserted him following the onset of his illness and hospitalization at Tower. The family had had enough resources to make sporadic use both of traditional healers and private doctors. He retained some psychotic symptoms throughout these years. The community explained his condition as being the result of his lack of a wife. His sister-in-law made a direct connection between onset of illness and the desertion of her brother-in-law by his wife, disregarding temporal sequence.

It would seem therefore that powerful factors can sway the cause of acceptance and rejection in the community. These have been subsumed as 'protective' factors. The common sense expectations were not fulfilled when mapping qualitative causal chains. For example, degree of violence in the illness event was *not* a major influence in community rejection. The

woman who had gone crazy attacking her children with an axe, was referred to very sympathetically, since she had good cause to go *phambana* with worry, as she could not feed her children; her renegade husband was the culprit!

The cardinal protective factor was the social relationship, particularly marriage for the older person. This superseded old age. As the headman's wife explained, to win respect/*imbeko* and participate in the decision making process in the village you have to have proven yourself by having managed the responsibilities of a family. Thus Simon, an older man, consistently psychotic, was not shown the usual respect owed to his age and gender. Even the children were allowed to tease him for a sport. Jacob, who was thought to be cured when he became a dynamic preacher under the care of the faith-healers, was talked about by his family in the following terms, "We even forget he was ever ill". Thus the status of the church had rubbed off onto him for a while, together with the sense of being cured.

Even substance abuse as a causal explanation together with the sense of being cured, counteracted stigma. Passing muster in the community was a flexible accommodation to the way the situation unfolded. Everyone knew all too well that it did not take much to land in jail. There were forces against which people could not win: "The better the man, the greater the risk for a bewitchment!"

The community's approach was therefore a pragmatic one; it evaluated whether the person could be a functional member. If the sufferers were judged to have earned *imbeko* before the disaster befell them, so that they had passed muster already, then Msobomvu residents were prepared to show great tolerance, at least for a while. Blame figured in this equation; if there were strong reasons for tracing the problems to some culprit, it was assumed that there was a sure path to fixing it. Thus bewitchment accusations led to good neighbours becoming enemies, and in the case of Sindiswa, the kicking in of her neighbour's door.

Outcome

One is left with awe at the human ability to persevere and endure when tracing the meandering of Msobomvu patients between the two systems, the Western medical one, represented by the mobile clinic, Victoria Hospital, Tower Hospital, and a number of private doctors, and the traditional healing system represented by local *amaggirha* and those further afield as well as the *umthandanzeli*, or faith-healer (briefly touched on in this research).

In my follow-up enquiry in June, 1995, the progress of the 20 people were tracked. Three had died, one tragically as a result of her mental illness. Eight continued to have relapses, with some resulting in rehospitalizations. Relapses in the village took the form of the person being unresponsive when spoken to, being assaultive, muttering to him/herself,

not making sense, and so on. Two moved out of the area. One has continued in much the same way. Nondumiso, who had been using out-patient treatment and medication over the years, is struggling along, often sleeping the days away. Her disability grant helps her manage. Thosama, whose financial stresses drove her to wielding an axe (during an illness episode) is now on a disability pension.

It was harder to trace the five people, including four teens, who had never been hospitalized. Nocawe's shop has closed down, and she joined her husband in Johannesburg. Her health status seems uncertain, according to reports. The girls' status seems uncertain too. Pumla still struggles with an eating problem but is said to be managing. Tabisa's father was killed in Msobomvu during the turmoil of 1992 before the New South Africa. Her sister is said to have taken her to Johannesburg. It seems none of the five were hospitalized in a mental institution, since no such news reached the village.

The typical pathway between Western and traditional conceptions of illness will further unfold as I review one individual's life below. Following the footsteps of the people with mental illness in the village, it became clear that rehospitalization did not happen inevitably after psychotic behaviour. People were stoic and had a long fuse. Is this different in the Western context? I have seen in United States cities many people with a severe mental illness who roam the streets, poking in trash cans in search of food.

While Simon may have been the epitome of a village lunatic for Msobomvu, a target of the children's boredom, we find comparable figures in Kona Hawaii or New York City. The difference may be in degree, in that the family and the neighbourhood in Msobomvu tolerated the capriciousness of mental illness a lot longer than do people in many other parts of the world. One reason for this may be the glue that binds the extended family, and demands *imbeko* in the form of love for family members. Thus Phindile's cousins and nieces asserted their continuing affection for him, in spite of his fitful anger, his threats to beat them up, his insistence that they should not speak, and his claiming the lion's share of food in a house where scarcity prevailed.

The Efficacy of the Traditional Healer and the Mental Hospital

Mapping the temporal sequence of individual residents revealed a consistent pattern, if one excludes the teenagers, who seemed to constitute a very different group and would not have met any criteria for the diagnosis of a major mental illness in the Western medical framework. With Nocawe the issue of a Western diagnosis was more problematic; her 'psychotic-like' symptoms were too short-lived at the time to constitute a major mental illness, and matched descriptions of transient psychoses discussed by Guinness (1992).

The sequence of events in the life of a person with a serious mental illness was one which started with a dramatic illness event, often with someone getting hurt, or property destroyed.

The family reacted at that point, and took the individual to a traditional healer. Sometimes the first call was to the hospital, particularly if the event involved the criminal system. Tomorrow, who stole some cattle in a delusional state, was a case in point.

When the traditional route was taken, the *igqirha* provided a *vumisa*, which was usually followed with treatment. Sometimes the patient could not be contained. The healers were known to resort to binding the person with ropes, and they had some natural sedatives as part of their repertoire. With the legal implications, including threats of jail if found guilty of wrongful deaths, healers were often reluctant to take on clients where such drastic measures had to be implemented. The nursing staff in the mental hospital were quick to tell stories of patients they had seen, who had been bound with ropes and maltreated by the traditional healers.

In cases of serious mental illness, the end result as reported by clients who had consulted the *amagqirha* was that it did not help, or at best that it seemed to help, the proof being that they were still alive. The visit to the healer would delay the time period the person with a mental illness remained in the community, since the family was waiting to see whether he/she would be cured. As the behaviour of the individual spiralled out of control, a hospitalization became inevitable. The person was either tricked to go to Victoria Hospital under some pretext, or forcibly taken there by the police. At

Victoria the patient would be sedated and escorted to Tower Hospital. With hospital confinement ranging from a few weeks to a few months, the inevitable diagnosis of schizophrenia, and treatment with neuroleptics, the patient would calm down and be released back to his/her community.

The patient would take with him/her a month's supply of medication, and a referral note to the Community Services Department at the local hospital. Patients generally reported feeling better at that stage. They would sometimes continue taking the medications until they were used up, at other times stopping even before this point. Two factors seemed to influence these decisions: one was the cultural concept of treatment in terms of a cure or no cure, and the other was the uncomfortable side-effects neuroleptics tend to have, particularly if they are not carefully adjusted to the individual's response.

Patients would, at least initially, make attempts to go back to work, since that constituted a real measure of a cure in the eyes of the community. These efforts usually failed, since the patient on medication often felt heavily sedated and had problems functioning. If the patient went off the medication, the psychotic symptoms tended to return, exacerbated by stressful situations. Even without returning to work, there was no easy adjustment; being home and doing nothing led to despondency. Patients, particularly young men, found solace in the use of cannabis and alcohol, sometimes in the context of

traditional ritual. Patients practically never remained consistently on medication. They sometimes reported using the treatment on an 'as needed' basis.

At this point the family would see that their relative was not quite right, and consider another consultation with the *igqirha*, or perhaps the faith-healer. The number and kinds of treatments sought, including private doctors, was dependent on the financial resources of the family. Sometimes there was just enough for another *vumisa*, providing a second opinion. Of all the families, Tabisa's made the greatest efforts, and invested a lot of money in the search for a cure for their daughter. The number of traditional treatment events outnumbered the Western medical ones by far. They were able to follow their preferences in that her father was a government employee with a steady income. In addition, since Tabisa's illness did not involve out-of-control behaviour typical of the seriously mentally ill, the mental hospital was not considered. Her symptoms appeared more physical, at most having a psychosomatic component, if viewed from a Western medical perspective.

When patients stopped taking their medication and became psychotic again, this did not inevitably lead to immediate rehospitalizations. Severity of illness had no clear relationship with the number of hospitalizations. Tomorrow, for example, was chronically psychotic, and only had 2 hospitalizations throughout his fifty years. Gladman, who was

24 years old and functioning at a high level between relapses, had about 7 hospitalizations. Hospitalizations seemed to depend on how conspicuous the patient became, the effects of the psychotic behaviour on the community, and serendipity. Gladman, for example, got himself admitted when he paid a visit to the Victoria Hospital in order to report another patient's assaultiveness.

The case histories of the individuals with a serious mental illness in Msobomvu leave no doubt that as far as containment goes, the mental hospital was a most effective agent. At least one of the tragic deaths which occurred in the village could have been prevented by timely hospitalization. The consequences for the families in terms of their having fallen victim to their relative's psychotic behaviour, could have been minimized also.

The traditional healers' role in treating other types of 'mental' problems needs to be distinguished from the treatment of serious mental illness. The outcome of the five cases which did not fit the latter group seemed more positive, even if the long-term outcome could not be established. The *amaggirha* with their knowledge of the individual's world was undoubtedly well positioned to intervene therapeutically, as we saw with some of the teenagers. The local *iggirha* was also experienced as helpful in relation to Tomorrow, even if this did not impact on the actual psychosis. A lot seems to depend on the individual *iggirha*; *amaggirha,* as do psychotherapists, vary in

ability, adherence to ethics and personality. The role of the *amaggirha* could be conceived of as an adjunct to psychopharmacological treatment, in the same way that psychotherapy and psycho-education are adjuncts to the treatment of the seriously mentally ill in the Western medical system.

Treatment by the mental hospital and after-care with medication, while they were effective in containing and controlling psychosis, were far from satisfactory in the long run. The problem was that the focus was on *control* rather than on accurate diagnosis and treatment. This affected particularly those patients who could be considered as suffering from a bipolar disorder. Since the Tower Hospital made no use of mood stabilizers such as lithium or valproic acid, and simply sedated these patients heavily on a permanent basis, their well-being and functionality was adversely affected. It is also easy to understand why these people were resistant to taking their medication, since bipolar patients are known to enjoy some of the early, creative hypo-manic states. Patients with a schizophrenic illness may not have fared so much better, since not enough attention was given to the monitoring of side-effects of these powerful medicines.

The mental hospital therefore, partially due to the lack of resources, did not provide the best Western medicine has to offer to people with a serious mental illness. The end effect was that the symptoms were contained for a period of time and

people were kept alive, only to find themselves trapped between a robot-like existence on medication, or the constant threat of 'running wild' without it. The image I was left with is that of the *izithunzela* or zombies--a kind of living dead who are forced into servitude by the witches. One wonders whether there is any connection to the fear people sometimes expressed, that there was always a great risk of *being stolen* at Tower by the witches.

CHAPTER 13

PERSONAL NARRATIVES

One Day in a Life

Six of the patients previously in Tower Hospital, and considered as having schizophrenia, were shadowed over the period of one day. I am reporting on of three of these people, with a description of the typical activities, and the quality of life, of the mentally ill person in the village.

Two young interpreters, one male and one female, both residents of Msobomvu, were asked to take three people and spend a day with each of them. Their task was to go along with the normal proceedings of the day, following the direction of their hosts. The aim was to achieve an understanding of the way these people lived the everyday of their lives, within the world of the village.

Simon, as noted previously, was the village lunatic. He was an older man, living with his extended family. He looked dirty and unkempt, and was bent over like a tree that had been beaten by the same winds over the years. My young assistant had a hard time finding him, since he was often out and gone from his home by the time the sun rose. There was no love lost between him and the family. The family was not that closely related, in that he lived with his father's brother's wife,

the men being deceased. The family used his disability grant which created an arena of conflict. Anything that was given to the family for Simon never reached him.

Simon spent his days from sunrise to sunset wandering about the village, with a nose for food and *umqombothi* (local sorghum beer). Initially my assistant invited him to her family's house; he seemed easy and friendly, sometimes muttering to himself and saying things nobody could follow. Subsequently I requested that she spend more time with him seeing what *he* wanted to do. On the day my assistant trailed him, he first walked to the shop. Some of the big boys were teasing him saying, "Say you are a fool!" He repeated what they said, and then one of the boys would point to another shouting, "Simon, beat that one!" Simon walked up to him with a stick, and the boys ran away laughing. He finally walked away from the Gqokro's place, talking to himself in a troubled fashion.

He detected some activity and noise, which he took to be a party. It was indeed a party for a boy who had just come out of circumcision school. He seemed unsure whether to go in, and hesitated. He was invited in and was given *umqombothi*. My assistant was unable to stay with him since this was a male domain.

Simon was tolerated by the community and even included in events, particularly rituals, where *umqombothi* flowed freely,

and the atmosphere was congenial. He was also teased and used by the children. The village health workers felt that there was nothing wrong with this, and that it was friendly.

I was subsequently informed that it was just such a 'friendly' encounter which finally led to the need for an intervention, since he had assaulted some boys. He was taken to the hospital. After this he was placed with his sister, who seemed to take better care of him. Most recent reports were that he was looking clean and well, although he continued talking to himself.

Mlungisi was a friend of Ntuthuzelo's, my other helper, and he welcomed his visit. This young man was living with his parents and siblings. His sister had epilepsy. When he arrived, however, Mlungisi was sleeping. When he was woken up he helped sweep water out of the living-room, where the rain had poured in. They had some tea together after which Mlungisi went to sleep again.

In the course of the day, Mlungisi expressed his distress over his parents' lack of trust in him; they would not send him to the shop. This worried him since he felt that he was better, but feared that he could relapse. He also had to report to his parents when he went out, and where he had been. He borrowed nail-clippers from my assistant, and cut his nails. My assistant observed that Mlungisi's bedroom was the best room in the house, having no leaks. They had more tea in the

afternoon and he talked about his hope of going to Johannesburg to work on the mines. He doubted that his parents would let him go. Mlungisi also spoke about his avoiding church and that he believed it was better to worship at home. He wished to buy some bread, and since Ntuthuzelo had some money from me for such eventualities, they went off to the store. They passed a house where there was a ritual going on, and stopped by to eat some meat. At the end of the day, he expressed his wish that Ntuthuzelo stay longer.

The third narrative involves the visit to **Nonceba**, who later died tragically. My assistant went to her house 10:00 a.m., finding a lot of children who had come to play with Nonceba's son. This young woman was living in her boyfriend's house, together with her child. She reported that her boyfriend had been there a week earlier, and that he was to come again in December. Nonceba started cooking lunch at 11:30 a.m., and she was playing music on her cassette recorder. She was telling her visitor that she was going to get married in January. Nonceba maintained that her boyfriend really cared for her child, since he had bought shoes and pants for him. He had also given her R100 for groceries. He subsequently sent her another R80 in a letter. She continued talking about this relationship, feeling good that he was starting to trust her. In the past he had taken the wardrobe key with him, and had on this particular occasion entrusted it to her.

Nonceba asked my assistant if she minded her smoking. Then she

made tea and continued talking, saying that if her boyfriend did not marry her, she would go to Cape Town to look for work. A neighbour's child came to the door and asked for food. Nonceba said that there was none. She complained to my assistant about the neighbours asking for food, and their insults. She said that at one stage she heard them talk about someone smoking, and she realized that they were talking about her.

Her child seemed to cry a lot and she became impatient with him, hitting him. She made tea again around 3:00 p.m., when the children went outside to play. The two young women remained inside listening to music, and dancing.

She spoke a little about her child's father, and that she had not been sure at first who the real father was. She said that she did not want the boy to go to his father's family because she loved the child. She said that her boyfriend took the sizes of her child so that he could buy clothes for him in Johannesburg. She also mentioned that he was going to send more money on the 18th of December.

It was late in the afternoon, and Nonceba started to make supper, peeling potatoes; my assistant helped by cutting the cabbage. The floor was wet, there seemed to be a leak in the roof. Close to 5:00 p.m. a neighbour came by, asking for some mealie meal. Nonceba was being helpful, commenting that this was the only neighbour who in turn helped her...

We see from these narratives that there is a personal isolation within a busy community. Ritual events seem to allow the marginal individual to partake in the social event and a share of the food and drink. This sanctioned social outlet may be confined to men only. Similar observations were made earlier during the initial interviews when I began following up Tower Hospital patients.

The three narratives differ in that Simon, Mlungisi and Nonceba were differently placed in their community in relation to age and gender, which in turn affected their lives and the problems they encountered.

Simon had the status of the village lunatic, which made him an "amusement for the children" and left him open to some mistreatment and exploitation by the adults of Msobomvu. While the story of a day in his life gives a small sample of what happened to him in the course of days, weeks and months, other encounters with him in the village, and commentaries by the residents, amplified this theme.

This status as the village lunatic also opened people's hearts to him: there were many instances where the shop-keeper would sell him tobacco, even if he did not have the right amount of cash. Neighbours would at times acknowledge him with truly benign intent. Simon was conscious of being the butt of people's jokes, and while he had difficulties protecting himself in the social context, he showed sparks of knowledge

beyond that of many of the residents.

Simon was a myth in Msobomvu; there was not a child who did not know how he first got ill due to a bewitchment when writing an examination at school. Simon was described as having been brilliant. He was a living example of how being special or better may actually put you at risk in a world of envy and witches.

Mlungisi, was a young man and therefore restricted and supported by his family context. His mother was anxiously watching his moves and her actions confirmed some of the assumptions in relation to stigma expressed by the Tower Hospital staff. He slept a great deal, was very restless, and had difficulties making an adjustment to being back home. Some of his problems could have been due to side-effects from the medication. He was receiving an injection of Modecate (2cc monthly) as well as Mellaril tablets (100mg. daily). He had dreams of getting away and still making it in the job market. It was also clear that he was fragile and in no condition to take on the world. He responded to his friend's visit, feeling isolated and restricted at home. At the same time his family treated him well, freely provided tea--a luxury--and made few demands. His life was hum-drum and it did not seem surprising when during other encounters with him, he started wondering if he did not need to go back to Tower. He had not connected with the church, one of the options for a social network and entertainment in the village.

Nonceba, as a young woman with a child and a steady relationship with a boyfriend who was a migrant worker, experienced a certain amount of support by having a house to live in and some monetary contributions. She also had contact with her mother, who herself, according to the community, "was not quite right". Her mother had a house full of small children who were malnourished and seemed uncared for. The observations of a day in Nonceba's life revealed again a somewhat isolated and hum-drum existence. Her escape was music and cigarettes, and she seemed to be preoccupied with her boyfriend and plans for the future involving him. She had one neighbour with whom she seemed to have established a mutually supportive relationship. The rest of her neighbours were problematic to her. She seemed to have no connection with the church, and missed therefore one of the major social outlets in the village. She spent her day confined to the four walls of a small hut, avoiding exposure to her neighbours. She was nevertheless responsive to the visit of my assistant, whom she treated as a confidante. Her relationship with her child was also tenuous, and she was using the other children as caretakers.

None of the three people had achieved a life which they experienced as satisfying. Simon, the village lunatic, was in his own way the happiest of the three. While not being unaware of the lack of respect meted out to him in the village, he seemed less concerned with his lack of a positive valued

social position. Mlungisi and Nonceba were more dysphoric, drifting through the day without much purpose. They did not avail themselves to any great measure of the social resources within the community. Alcohol and dagga, to relieve the boredom, was more significant in relation to Richard, another patient. Medication management seemed to be a problem for many, both in relation to defaulting and appropriate dose. The same issues played themselves out with all six of the patients with severe mental illness. The sense of bleakness and isolation stood in sharp contrast to the buoyant, bustling life in many of the social events in the Msobomvu, where chores were often turned into communal events, and hardships into a passionate relationship to the church and to God.

One Man's Story: Ntuthuzelo

Ntuthuzelo[86] was both an articulate informant as well as a patient with a mental illness. My contact with him started during the initial stages of my research in the latter half of 1988, when I tracked ex-Tower patients back to the villages within the year of their being discharged from this mental institution. I remember him as well dressed as if he were on his way 'to church'. He presented himself as a devout Christian of the Baptist faith, and said that he had never consulted the traditional healers.

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[86]Ntuthuzelo gave me permission to use his real names. All others in the text are appropriate substitutes.

One year later, when I was looking for assistants who would help to guide me through the cultural vicissitudes of Msobomvu, and interpret, since my knowledge of Xhosa was limited, Ntuthuzelo was suggested as an appropriate candidate. I must admit that at the time I was hesitant about this choice, since I had envisaged a 'mama', someone who held the village's respect in the palm of her hand: I had been impressed by South Africa's black sisterhood. I was also concerned about how the residents would respond to one of their own who was known to have a mental illness. I compromised and accepted this young man on a part-time basis, splitting the job between him and a young woman who had recently finished high school.

The many hours I spent with him where he helped with careful transcription of interviews, and translation of students' essays, provided a lot of opportunity to become comfortable and develop trust on both sides. He proved himself an excellent communicator of his culture, and a person sensitive to the patients and their families in the community. This story is the result of these encounters, together with his more formal statements on his ideas of mental illness (which he spontaneously offered after reading those of the students), his life story, his family's history, and finally, after my departure, his letters. These kept me in touch both with his life and those of others in Msobomvu.

Ntuthuzelo's Life Story

> My name is Ntuthuzelo, in Xhosa this is Consolation, because I had to be a consolation to my mother when she lost my father. There were other names that were given to me, for instance, Ngqungelukuwela--a person who is striving, and Solomzi--that is the person who takes care of the home. My father said before he died that the child should be called Siphiwo which means Gift. Then when I was able to talk I called myself "Gladman", this was just because I liked the name.

These names located this boy and later young man within the history of his clan, his family and finally the events of his own life. He traces his ancestry back to the famous Xhosa prophet Ntsikana who, according Ntuthuzelo, prophesied the coming of the Bible and money to Africa. "He told his people to take the Bible but not the money." Ntsikana in Xhosa history advocated peace and the submission to God, accepting White civilization, rather than fighting it. Whether Ntuthuzelo was conscious of the School Xhosa/ Red Xhosa divide I do not know, but his life story represents a continuous struggle between his attempt to stay on the side of the Church and master his fate through education, and the pull of his ancestors.[87]

Ntuthuzelo's father died even before his mother could gave birth to him. His mother was telling, with tears in her eyes, how hard it was. "He got cold from his work and he was suffering from TB." He was sent to hospital in Port Elizabeth and died.

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[87]The School Xhosa/Red Xhosa division has a history going back to the 1820's, and represents different ways of resisting and coping with colonialism and white rule--see Mayer, 1980.

Ntuthuzelo's father had been trying to get a house for his family in Port Elizabeth, but died before he had achieved this goal. After his death mother got ill and returned to her father in Riebeek East, where Ntuthuzelo was to stay. She described her problem as due to nerves caused by the death of her husband. She said she was suffering from "sleeplessness, heart attack and high blood". She spoke with bitterness about her husband's family, saying she got "niks" from them.

Ntuthuzelo had to be the *consolation* for his mother. He remembered crying secretly as a child so that he would not worry his mother. He heard people asking: "Whose child is this?" As he got older, Ntuthuzelo decided that it was the love of God that had taken his father, and God's will therefore, and even later when he was dragged to Tower Hospital, that he must be the son of God! As he was his mother's consolation so did God and prayer become his.

While his mother returned to Port Elizabeth having been ill off and on for years, Ntuthuzelo remained in the care of his maternal grandparents in Riebeek East. He was a sickly child, suffering from "worms, coughs and the chest", so that his grandfather had to take him on the back of his bicycle to the hospital many times.

When he was old enough for school, the principal told him at registration to cover his left ear with his right hand, stretching all the way over his head. This was to tell if the

child was ready for school. Ntuthuzelo's hand could not reach, and he had to wait another year. He was vindicated when he finally went to school in 1972 and overtook those who had started earlier. This was the time his second name *Ngqungelukuwela* came into play: he was striving to be the best.

Ntuthuzelo's school years seemed to be the focal point of his life story. They were years of success, interspersed with increasing amounts of adversity. He said of himself that "I happened to be brilliant at school", and this reminded me of the story of Simon, the village lunatic, whom everybody said was brilliant at school too. Ntuthuzelo retained first place until he reached Standard 5. Standard 6 was a year of petty disputes in the school between the ex-principal's wife and the class teacher in regard to the position of principal, so teaching was neglected and Ntuthuzelo was the only one of his class that passed. The next years involved different places and different homes, usually with relatives, in order to continue schooling. At Debenek, where he, his cousin-brother[88] and an uncle were boarding with family from his father's side, in order to be able to go to high school, they were treated harshly. They had to roll a big drum of water from the dam to the house, and were given little food while the rest of the family ate well. Standard 9, in Nyaluza school in Grahamstown, brought illness in the form of stomach ache: the doctor said

[88]The term "cousin-brother" denotes closeness between members of the extended family who are not actually siblings.

that it was gastritis, and Ntuthuzelo was starting to lose grip on his sense of success.

Life had changed in other ways. In 1981 his grandparents were forced to leave Riebeek East, the place Ntuthuzelo considered home, where his grandfather had worked at a White boarding-school.

> They were moved by the Government...They had to go. They obeyed the word of the Government.

Many people were moved, except those that worked for the Whites, on the farms, for example. The family was taken to Alicedale to a location, but there the rents were too high--R38 a month. This finally brought the family to Msobomvu in 1984. Grandfather had plans to farm, and Msobomvu, under Chief Mqoma, promised a new start.

Mother had been staying part of that time in Port Elizabeth, boarding with other people, and paying for Ntuthuzelo's school-fees while struggling with her own illness. She had tried various jobs, but would lose them when "the illness was provoked again". She would fight with her boss. She was told not to stop treatment, but when she felt stiff or would sleep all the time she was tempted to stop taking her medicines. By 1972, she had become "too nervous" to work, and managed to obtain a disability pension.

She had consulted the *amagqirha*. Even recently her mother, Ntuthuzelo's grandmother, had met an *igqirha* on the road from

Mdeni, another village, who made a *vumisa* for her. Her conclusions were:

> They speak differently, some say it's an *idliso* which goes up to the head and others say there are some rituals. But usually they say I'm *thwasa* and need to become qualified.

She said that it felt at times as if something was pulling her brain apart, and sometimes it was like bells ringing. She had felt very sick when she was on four pills a day, and felt better when they reduced it to two.

Ntuthuzelo felt that it was time he honoured his obligations to his mother and brother, and work in order to assist the family. This was the heritage of his third name: Solomzi, the person who takes care of the home. He decided to take Standard 10 by correspondence and enrolled with 'Success'[89]. The jobs he got were temporary and poorly paid; the lecture notes got torn by his aunt's children. He was suffering from palpitations, hearing frightening sounds of birds, even in town. He consulted a faith-healer who could not help him, but he felt better as time passed.

1984 was a significant year, in that besides his family's move to Msobomvu, Ntuthuzelo went to circumcision school and at the end of the year travelled to East London to obtain his father's death certificate from the hospital, and then to Alice and the 'native affairs offices' to investigate his father's benefits. But all his efforts were in vain and

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[89]A correspondence school.

Ntuthuzelo turned again to Port Elizabeth's job market.

He started working for a pittance as a salesman at a furniture store, then changed to a motor-spares department where his prospects were better. His palpitations grew worse, and he resorted to praying in the toilet at work. He lost the job and took a train back to Alicedale where his father's relatives lived. His uncle who was working at the mental institution in Grahamstown at that time took him to Tower Hospital. He remembered little of all this, and spoke of having been unconscious.

When he was released he managed to get a job as a repair and service assistant with the great Binfils Dam construction in the Victoria East district. But Ntuthuzelo said that soon he was relapsing; he stopped sleeping and became very excitable. At work people objected to the din he was creating, as he was singing religious songs. He went to the foreman and explained that he was suffering from nerves and had to stop working. His grandfather took him back to Tower.

He remembered visions from that time. In one he was in court and was given a Bible tract which told the story of a boy who stole some eggs and put them in his pocket. It was night and raining and the nurse whom he was accompanying held the torch for him. The boy avoided the light, afraid that the nurse might see his bulging pockets. He fell, broke the eggs, and ruined his clothes. She said, "If you'd have walked in the

light, you wouldn't have fallen." There were other visions as bright as snow, or pink as the sunrise and purple as the night sky. Out of hospital again, Ntuthuzelo would stop his medication.

At the end of 1986, he went to his paternal grandfather's brother in Peddie. His aunt was an *igqirha.* Ntuthuzelo said,

> She gave me a *vumisa*, saying that I am a *thwasa* person, and that there is a poison in the stomach, which was put there by someone when I was a baby, someone who had died and is a relative of mine.

Ntuthuzelo's aunt's husband was an *ixhwele* and they worked together. Ntuthuzelo's treatment consisted of drinking herbal mixtures, vomiting and washing with herbs. That's where he also learned about *amakosi*, the treatment which came from Zululand and which he felt, may be right for amaZulu but not for amaXhosa. He described how a white or reddish powder was being prepared and swallowed, together with some gin from a beaded calabash. There were other aspects to this ritual involving the slaughtering of a white hen. The blood was mixed with bile and the person would have to drink some of this; take a piece of the raw liver and a tot of gin.

He was being trained as an *igqirha*. But his troubles became worse, and they became afraid of him. He remembered that time as one of whispers and scandals, only his father's uncle standing by him. Ntuthuzelo went back to Tower Hospital in 1987, and has never returned to Peddie. Thwasa is said to be both a *gift* and a *burden*. Ntuthuzelo still kept his white bead from those times, but would not wear it.

He went back to work, this time in Alice, while his family was living in Msobomvu. His job at the bakery involved unusual hours which meant that he had to stay in town, causing additional expense and leaving him little. He said that his position was supervisor, but his salary was not. Ntuthuzelo turned to the Bible again with all his fervour. He was one of the few residents of Msobomvu who had climbed the hills in his frenzied devotion to God, getting his clothes torn and his limbs scratched. Only if cattle was lost would a sane person venture into nature beyond the village boundary. Going places always had a pragmatic purpose. He was taken back to Tower Hospital March 1988.

It was later that year that I met Ntuthuzelo, since he had been one of the patients discharged back into the Victoria East district. He was taking Mellaril, and living in Msobomvu. He became my teacher and assistant, and seemed well-liked in the community. He was a loyal member of the Baptist church. His church was reluctant to consider training him, but he was given responsible tasks in relation to the youth. He had a girlfriend who cried for him, and seemed to be devoted to him. He had hopes and dreams. Ntuthuzelo did not feel comfortable outside his village, and a visit to Tower hospital to see Msobomvu residents created a great deal of strain. A nurse, in typical nurse's fashion, admonished him, telling him never to come back to Tower.

After I left in December 1989, I received sporadic letters keeping me informed of some of the events in his life. Early in 1990, a strong and positive letter spoke of Mandela's release and the happy toyi-toying in Msobomvu. A letter in May spoke of his wish to complete his matric by correspondence. The theme of striving re-emerged as did his commitment to taking Bible courses by correspondence. Late in the year in 1991, he reported that he had been assaulted by Jacob, one of the other patients, the dynamic preacher. He went to discuss this with the psychiatric nurses at Victoria Hospital, and was admitted. He remonstrated in his letter how people do not understand his mission given by God. He wrote,

> I know when you are admitted at a mental hospital it doesn't help to convince the officers that you are not ill, so I just do what is done, as an Englishman says, when you are in Rome do as the Romans do.

Tower Hospital was his university, and this was God's way of training him, rather than letting him waste his time at a seminary. He wrote of having changed his alliance to the Church of Zion, and he had the gift of talking in tongues.

In 1992, Ntuthuzelo wrote more about his religious path. He was considering study in the USA at a Bible school in Kansas. He wanted to enroll for some correspondence courses in practical evangelism, costing R225. His interest seemed to proliferate, encompassing careers of great diversity, and he had also applied for a learner's driving license. A new issue which seemed to trouble him a great deal had to do with his wish to marry his girlfriend. At that time she was almost

finished with her teacher's training, and lobola would amount to a lot of money. He wrote with despair,

> It is difficult to pay lobola here because of lack of employment and disability, but she is the one I love.

He was feeling that the wizards were against him, and said,

> Remember these wizards will do anything to stop my progress, because they envy a progressive person.

His mother lied to him, telling him that she wished to go with him to visit his brother at the hospital and also go to church, when he found himself at the psychiatric department at Victoria Hospital. This time he was taken to Fort England, in Grahamstown.

He was now receiving a disability grant, which helped him feel a little more secure financially, but did nothing towards the actualization of his striving. He was trapped between feeling incapacitated by the effects of the medication--so that if he had plans he would not take his pills--and going crazy. During his hospitalization at Fort England, he made a good friend, who advised him to stay away from dagga. This he felt had helped him to be more stable, but had deprived him of some comfort.

He now divided things into two kinds, those that were Christian on the one hand, and those that were traditional on the other. He felt that it was his traditional way of life that exposed him to alcohol and dagga, while his Christian life was clean. He therefore experienced some distress about his mother's wish to complete her training as an *igqirha*. But

he had not given up his striving.

Ntuthuzelo was torn between the divided heritage of his ancestors, the prophet and the *amaggqirha*, the invitation to strive for better things, and the limitations of his circumstances. His gift was also his burden, a heritage which played itself out in his genealogy. His mother was suffering from a mental problem, or *thwasa*; his mother's brother who lived in a chicken coop on the family plot, was a dangerous and suspicious man with a mental illness; his grandfather's brother had been to Tower, his great-grandfather was an *igqirha*, and finally on his father's side there were many *amaggqirha*. One was even known to produce bank-notes with the help of *amakosi*. Ntuthuzelo, most of all, took his call from the prophet Ntsikane, the most famous of his ancestors.

Ntuthuzelo in his commentary on the causes of mental illness wrote,

> It is caused by the following: poverty, overestimation, overjoy, disappointment, bewitchment, drugs, beliefs, values and *thwasa*.
>
> When money is needed he may have nothing to contribute. He becomes worried and he prays with exaggeration. If his parents are deceased, he has no financial foundation to help him, and he may be lonely. He may be given a special spiritual gift, then he overestimates himself. Some call themselves Jesus. Overestimation in most cases comes from poverty. I knew a girl who was convinced that Chico, the musician was her boyfriend. Some have placed a bet on a certain horse in a race, having hope that it will win. And when it doesn't, they become disappointed and eventually mad.
>
> Sometimes it is caused by bewitchment. Someone may put *idliso* in his stomach--I don't know how-- but when a person becomes a certain age, this smoke goes

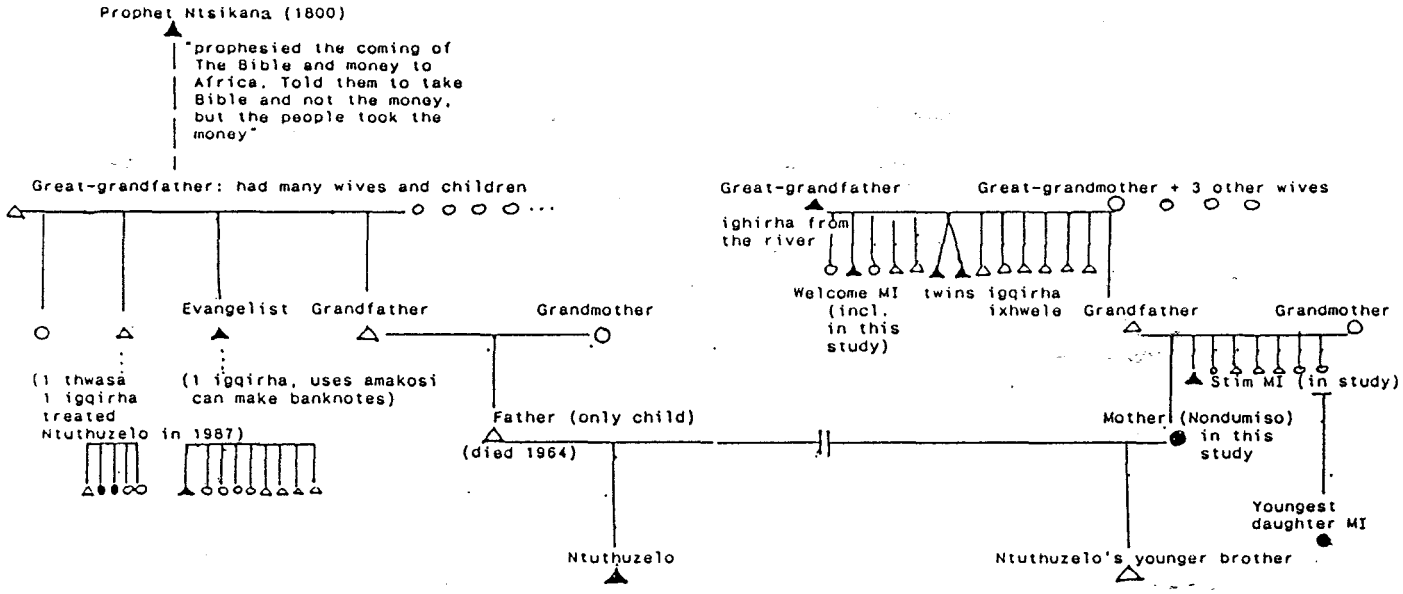
> up to the brain, and he becomes mentally ill. The *igqirha* may take away the soil where a person has been walking. This causes the person to wander all over the country. When *amafufunyane* are put into a person's stomach, he may hear voices and see visions or talk to himself. The voices he hears may be everywhere. This causes him to be worried and afraid.
>
> The *thwasa* person should accept the call and acknowledge the ancestors, if he does not it may ruin his life and he may have the misfortune of becoming mentally ill.

This shortened version of his long exposition on mental illness was written early on in my contact. It advises that the *thwasa* call needs to be accepted. Later on he rejected this position in favour of reinforcing yourself through the power of Jesus. He was torn between the traditional and his Church, between the *amagqirha* and Tower Hospital. Education did not deliver him from poverty! He struggled to live up to all the expectations placed on him at the beginning of his life. His own choice, captured in the name of Gladman, continued to elude him.

The traditional healers did not seem to have been able to stop this spiral into mental illness and numerous hospital stays. The mental hospital while helping him regain control, left him incapacitated, unable to do much besides vegetating. The medication regime left little energy for life itself, for his striving for success, taking care of the home, and being his mother's consolation. His culture warns that great gifts can exact a great price: being better than others can always lead to loss in a world where there is not enough to go around, and envy lurks at every turn. I had doubts about Ntuthuzelo's

hospital diagnosis and I had doubts about the choice of treatment. The big question which I will always ask myself continues to be, how Ntuthuzelo's life would have been if he had been given the best that Western psychiatry has to offer.

Figure 22. Ntuthuzelo's Genogram.



(Gift and Burden: Religious passion, *intwaso* & mental illness) The shaded symbols represent those individuals in Ntuthuzelo's genealogy that were marked as different either in their carrying the gift of *intwaso* in being healers or prophets, or carrying the burden of mental illness.

SECTION V

SUMMARY AND CONCLUSION

..If this is the case prognoses for major mental illnesses in developing countries may no longer be as benign unless compensatory mechanisms are developed. It can only be hoped that any erosion of cultural supports is counterbalanced by greater sophistication and distribution of psychotropic medications and by more effective rehabilitative technologies...Meanwhile, Western nations are beginning to understand the benefits of extended support systems and normalizing productive roles for persons with major mental illnesses (Lefley, 1994, p. 198).

CHAPTER 14

SYNTHESIS

Preamble

The Journey

This research has been, for me, like a journey on foot into the wilderness of the Eastern Cape, where pathways are poorly marked, and where, for long stretches, there is no-one to ask directions. Patches of euphorbia forest create a sense of mystery in an otherwise harsh, stony world. It took time to find my way, and I am left wishing that I could have explored some facets in greater detail, and remained a little longer in that part of the world.

The research was seeded in 1969 when I first began living under the shadow of the Amatola mountains, in the area which was to become Msobomvu, just prior to the formal demarcation of the Ciskei. Its completion now brings to a close a facet of my relationship to Msobomvu, but despite my leaving South Africa to live at the antipodes of the globe, the research has strengthened through understanding and a sense of history, a bond to this part of the Eastern Cape and its people.

Limitations of the Research

In completing this study, I have been fully aware of the limitations in many of the details of my work. In general I am left with some regrets, having chosen to range so broadly over

a terrain that often deserved a more fine-grained analysis, while allowing myself the liberty of elaborating on those aspects informed by my own interests and clinically-based experiences. My knowledge-base in the area of cognitive theorizing as it applies to conceptual thought in present-day Xhosa society, does not do justice to the complexity of the field (as represented in the work of Irvine, 1972; Hallpike, 1979; Horton, 1982; Craig, 1991; Shweder, 1991; Greenfield & Cocking, 1994). Here, as in other parts of this endeavour, I often felt that I blithely went where angels fear to tread.

Overall, the research has been a satisfying experience. I have learned something of the intricacies of anthropological methodology, and the potential for a rapproachment between cultural anthropology and psychology. My choice to work both through the departments of psychology and anthropology was driven by the nature of the research and a strong sense that this was what was needed. Without a formal background in anthropology, this led me into areas often confusing while also rewarding, particularly at this juncture in South Africa's history. This is a complex time to be working in these fields, given that internationally these disciplines are now being challenged by voices from the developing world demanding a self-critical attitude that considers the larger, socio-economic context. While personally gratifying for me, I realize that in traversing two disciplines and pursuing some of their vissicitudes, I covered material in which I was not always thoroughly grounded.

Coming Full Circle: Questions and Answers

I had formulated some questions before starting this research (see Chapter 1). They targeted the issues affecting the experience and context of the lives of people with a severe mental illness. These questions will now be addressed, and contextualized in the discussion which comprises the remainder of this chapter.

How does the patient, his or her family, and the community, view the problem of mental illness? Do they in fact see a problem?

The patient, the family and the community were all keenly aware of how painful a mental illness could be to the sufferer, and how frightening to all. Students expressed an awareness that this could happen to them too, which intensified their empathy as well as their fear. Where they differed from their Western counterparts was in their culturally-based assumption of spiritualistic causation. Herein lies the basis of their *externalization* of cause, in contrast to the Western internalization through biochemical, genetic and psychological explanations. Bewitchment was often ascribed to envy, the sufferer seen as having been too clever, or working too hard. Mental illness therefore served to enforce sociocentric values within the community, while also causing conflict.

In the early stages of mental illness, the problem was at times ascribed to *ukuthwasa,* the call by the ancestors to

become a traditional healer. Here too the individual and the community acknowledged a problem, even if this was not considered an illness as such. The condition was spoken about both as a *gift* and a *burden*.

What resources do the families with a member who has a severe mental illness have at their disposal? Who or what will they turn to, and in what order--mental hospital, traditional healer...?

The families with a relative who was mentally ill would often consult an *iggirha* first, and only when the person became assaultive and caused some damage, consider the mental hospital. There were some exceptions, as when the legal system was involved; then hospitalization came first. By taking the patient into their homes, healers providing a nurturant and structured milieu, and were able to give a great deal of support. In the case of severe mental illness this was not enough, and patients usually persisted or relapsed into psychotic behaviour. The mental hospital, while achieving containment of the patient with an acute psychotic break, had difficulties in providing satisfactory care in the long run.

How does the community respond to the family of a psychotic person, and to the person himself/herself?

While the community avoided challenging a psychotic person so as not to provoke her/him, some people, particularly youngsters, were apt to tease a person with mental illness if s/he stood out. While "making an amusement" of a psychotic patient was socially acceptable, it was considered by some (in

the student essays) as cruel. Stigma was an issue, while not constituting a simplistic rejection of anyone who had been to the mental hospital. I developed the concept "passing muster" to account for the protective factors which counteracted stigma. The families of patients were not shunned or blamed.

The family and the community had a way of going along with the ill person's requests, even if these were unreasonable. A shop keeper would give the person what he wanted even if he/she did not have the right change. At the same time, patients complained that they were not trusted with anything of importance, even with tasks like going to the store. People would avoid patients known to be assaultive, but would not take action against them unless under extreme circumstances. The mental hospital staff criticized the way the village people handled the person with a mental illness, saying that they do not allow any independence and that the patient loses all the skills learned in occupational therapy.

How does the family and the individual respond to the community?

The answer to this question is not a simple one, in that responses of families and individual patients differed. The following examples are illustrative of some of the variants. There were instances where the individual was suspicious of his/her neighbours, or the family hostile. The latter occurred in one case when the community judged the family as being

neglectful of the patient and exploiting him for his disability grant. More often the person with a mental illness made use of social resources like traditional beer-drinks, or rituals, when food and company were shared freely. When patients were "relapsing", and out of control, their relationship with the community understandably deteriorated, with little trust on either side. This is where interactions were dominated by the illness.

The *amafufunyane* concept led to blame being affixed to neighbours, friends or other people, creating at times conflict and distance between the patient, backed by his/her family, and the targeted person in the community. One family expressed self-righteous anger and went as far as to break the door of the accused one's house, and indignantly reported the matter to the headman. The attacked, in turn, became defensive and also complained to the headman. The headman's response was that there was no proof, but both parties, on that occasion, walked away satisfied that he had been sympathetic to their cause. On being asked how he achieved this, his answer was "you don't fight fires with fire".

Are there benefits/disadvantages to having a mentally ill member in the family?

When a relative with a mental illness was discharged from the hospital back to his/her family, it often meant another mouth to feed, and someone who would not be able to contribute. High rates of unemployment made for even less opportunity for those

who were functionally impaired. Disability grants were much prized, but extremely difficult to obtain. In at least one case the mental illness benefited the family, who lived off the patient's disability grant.

The presence of a mentally ill member living in the tiny houses typical in Msobomvu added danger and stress to all concerned. Younger children and girls often ran away from the abusive behaviour of the patient. Injuries to family members were sometimes reported.

What have the individual's/family's experience been with the Western and traditional healing systems?

The persons with a mental illness and their families made use of both the traditional and Western medical systems, depending on their financial status. In regard to the treatment of psychosis, the traditional healers were, overall, not seen as having helped, though people were not always sure. One patient remarked that his just being alive was indication that he had been helped. Tragically, he is not alive any longer, having died after drinking poisoned beer.

The mental hospital was said to have made a difference, but patients usually relapsed since they did not continue taking their medication. This was understandable for a number of reasons, some cultural, as when treatment was expected to cure the illness, rather than prevent relapse. Also, miscommunication between patients and the hospital system

affected the quality of psychiatric care. Generally patients did not dislike the mental hospital. One patient insisted on returning there, even threatening to kill someone, in order to gain a permanent stay.

Do belief systems in regard to traditional healing change with Western education?

High school students (standards 6 and 9), and first year and third year university students revealed changes in the way they conceptualized mental illness as a function of their educational experiences, but Western education did not dislodge their fundamental cosmology.

Most students adhered to some form of supernatural causation, the first year university students taking the most critical stance towards traditional beliefs. When it came to confidence in the efficacy of the traditional healers, differences amongst the students were negligible. As regards the hospital, first year university students had an overriding percentage of positive responses. I view this as being because first years were new in their role as students, trying to adapt to the challenges of their curriculum. By the time students got to third year, they had consolidated their position in opposition to an education which had become associated with the political power structures, and had returned to identifying very consciously with their Xhosa culture.

The Cognitive Ecology

I have attempted to map the world of mental illness in a rural community. This map has therefore a real geographic dimension, as well as a temporal one. The main study was completed in the historical time just before the military coup which toppled Lennox Sebe, the former president of the erstwhile Ciskei, and therefore a few years before the end of apartheid rule and its separate homelands, when the Ciskei became once again fully integrated into South Africa. I continued to track the fortunes of individuals, as best as I could until the present. Individuals were rarely chosen for interviews because of their expert knowledge[90]; instead they stood as representatives of people struggling to cope in a common, imperfect world.

The Student Narrative: Belief versus Efficacy

The research followed an ecological design (Bronfenbrenner, 1977) which focused on the mapping of the cultural and "real" worlds of people who were suffering from a serious mental illness. The illness cosmology was explored through various routes. One pathway to the culture's experience and definition of illness was the student narrative. By having high school and university students at different levels of education

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[90]Authors like Buhrmann (1984) have been criticized for making static generalizations about traditional healers based on a very limited sample, or, as in Buhrmann's case, the "*Thiso* school". The traditional healers in this study were simply chosen for the fact that they were the ones living in this village, not for their charisma or expertise. Contrary to much of the literature, they did not define themselves in specialized ways. They carried out both diagnosis and treatment.

articulate their beliefs about mental illness, and traditional and Western forms of treatment, the illness cosmology in relation to the two contrasting cultural systems revealed itself in dynamic interaction.

Beginning high school students were close to their traditional cosmology, and occidental psychologizing hardly figured as an influence on their thinking. First year university students, while intermediate educationally between the high schoolers and the more mature 3rd year students, were more rejecting of traditional attitudes, embracing Western psychological and biomedical concepts. The quality of their responses was often poor, material seeming only partially understood, or reported in parrot-fashion (see Craig, 1991). Third year psychology students had almost come full circle: they had not exchanged their cultural heritage for the Western academic biomedical one; instead they were firmly committed to a spiritualistic world-view (Horton, 1982), where much of mental illness could be traced to supernatural causation, while also accepting many organic and psychological forms of causation from their acculturation experiences with Western education.

Across the entire sample, there was no direct link between their conceptualizing (and endorsement) of traditional ways of thinking, and their confidence in the *efficacy* of the traditional healer. And as regards the hospital as a place of treatment, overall it also elicited rejections as did the traditional healer. The students' questioning of the efficacy

and integrity of the traditional healer raises the possibility that after all biomedicine, with its powerful potions, has insinuated itself more trenchantly into the culture than would appear at first glance, this aided by the undermining of Xhosa culture through colonizing forces that go back to the era of the "Great Xhosa Cattle-Killing Movement" (Peires, 1989). Thus, while the people still think in the terms of the traditional healer, and even adhere at times to their beliefs as a form of resistance (Mayer, 1980) against white domination, there is not a commensurate confidence in the healer's powers.

Some of the traditional healers themselves expressed concern about their profession. These included the feeling that *thwasa* did not work anymore because there were too many healers and not enough paying clients. They also protested their legal vulnerability in cases of the death of their clients.

The opportunity for "professionalization"[91] in the form of membership in the South African Traditional Healers' Council (SATHC) also revealed that traditional customs are under pressure, particularly from an economic point of view, since few people could spare the fees required for elaborate rituals, especially those required to becoming a full *igqirha*.

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[91]Professionalization and/or integration of traditional healers in a single health care framework with biomedicine has been debated extensively in the literature (Singer, 1977; Ademuwagun, Ayoade, Harrison & Warren, 1979, Holdstock, 1979; Kottler, 1988; Korber, 1990). Issues are complex both in relation to power and control, as well as clashing cultural assumptions.

SAC membership created expectations of a new golden age for Msobomvu traditional healers, for which they were ready to make considerable sacrifice in terms of membership fees and other associated expenses. Sadly, the SAC was later exposed as representing an attempt by government agencies to gain control over rural black culture. This is only one of the ways the "traditional" in the South African context had been manipulated[92] for political goals.

This accords with the views of Boonzaier and Sharp (1988), that the world of the traditional Xhosa healers and their patients is far from the pristine picture created by many of those people who have authored papers on traditional healing practices. The enactment of seemingly established rituals is constantly adapting to changing conditions, so that people can cope and survive in a world of deprivations. In South Africa historically, one needs to remember, very different soil was allocated for the growth of its people, where the major demarcation was made according to ethnicity. These boundaries around the technologically advanced developed world and the "culturally" different developing world, artificial though they are, were constantly reinforced. In fact, as Boonzaier & Sharp (1988) point out, the members of the so-called underdeveloped world in South Africa have played a major role in building the industrialized developed world and are

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[92]For a thorough review of the way concepts like "traditional", "first world and third world", "community" and even "childhood" have been manipulated for political ends, see Boonzaier & Sharp (1988).

continuing to participate in it.

Spiritualistic Explanation and Cognitive Development

As we look at the students' cognitive perspectives, even when at the university level they achieve a bicultural integration of sorts in their understanding of mental illness, the apparent lack of abstract critical thought, referred to also by Craig (1991), is notable.

Many different arguments have been advanced as to the development of cognition in cultures which use spiritualistic causal explanations as opposed to the mechanistic "scientific" framework of the West (Levy-Bruhl, 1985; Hallpike, 1979; Jahoda, 1982; Horton, 1982; Shweder, 1982; 1991). This is a highly complex and controversial area, where current authors tread warily, attempting to avoid the old traps of ethnocentrism and racism. Horton's defence of the rationality of traditional thinking, its origins being the world of human relationships, may help to explain the divergent trends between the spiritualistic causal theories of African cultures, compared to the mechanistic explanations in the modern industrialized countries of the Western world. But when it comes to individual development, Shweder's emphasis on the intentional world, and the fact that nothing is ever content- or context-free, may help to clarify some of the issues surrounding students' continued adherence to a spiritualistic causal framework. Research in relation to minorities has shown that when students identified the educational system with the

dominant power structure, and hence as one giving them a second-rate education, academic performance and receptivity to the cultural influences were compromised (Ogbu, 1994). This leads onto the next issue, Xhosa culture being sociocentric.

Xhosa Society: Significance in Relation to Others

We also need to consider value orientations in developing and developed societies, emphasizing as they do social and technological intelligence respectively:

> The strategy of socialization in technologically developed societies has been portrayed as maximization of cognitive and other skill development, whereas child socialization in developing countries has been described as survivalist (Oloko, 1994, p. 198).

Xhosa society, like most African societies, emphasized collectivism, where the person gains significance in relation to others. People in Msobomvu still attributed great importance to their clan names. The traditionalism in Msobomvu was supported by the fact that the population consisted predominantly of pensioners, women and children. Those that could make it in the world of work were absent for most of the year, in the service of economic survival. The exclusion of the younger generation from the decision-making process was therefore not challenged as it has been in the cities, where the political struggle was waged predominantly by the youth.

Everyday survival in Msobomvu relied on harmonious relationships with neighbours and the supportive family network. Few were economically stable enough to continue to

make it without needing the help of the extended family at some stage, university students being no exception.

There was constant awareness of the people's *relationship* to others around them. Envy was seen as the reason sine qua non, for bewitchment and mental illness. School failure, substance abuse, mental illness and other misfortunes could all be attributed to this alone. Belief in the power of envy conveyed the enormous risks attached to individualistic striving.

The Social World: Efficacy and Stigma

Student narratives also provided a window on the social world within which the mentally ill moved. There was no blame attributed to having a mental illness. Causes were *external*, and not the fault of the individual, unless involving some omission of custom, which was usually of a less serious nature. This was supported by actual cases later in my study, where individuals had attempted serious acts of violence, as when a mother attacked her children with an axe, or a young man tried to rape his sister-in-law. In both instances the protagonists were referred to as "good" people.

Yet distinctions were drawn: stigma was a factor in the social dynamics. In the case of the mother, surprisingly, stigma was absent. Blame was attributed to her husband for not supporting the family financially. Her illness was considered due to natural causes, since she was worried about feeding her children. Her repeated hospitalizations in a mental hospital

did not seem to alter this perspective. The young man, however, was considered mentally ill due to bewitchment, and since his problems had persisted over time, and he was, in the eyes of the village, "useless"--not being able to work or partake in the functions of family and village life--he was thus stigmatized. A productive role for the person with a mental illness as a protective factor mentioned by researchers in relation to mental illness in the developing world, could not be taken for granted by those living in Msobomvu. Even the disability grant, while providing a modicum of status and financial security to those who had one, was for most not a mitigating factor; only 3 of 14 patients had been successful in acquiring it at the time of this study.

Student narratives were certainly not homogeneous and unthinking; some expressed strong feelings of concern and empathy, while others described disgust and fear. The theme of "the mentally ill being an amusement" to others featured in many narratives, and played itself out before my eyes in the village. This was acceptable to respected residents, such as the village health workers, but was seen as uncaring by some of the students. Some of the patients themselves found this very painful.

Stoicism and Support

Overall the intent of much of the social interaction with people suffering from mental illness was to be helpful and avoid provoking them, and people showed extraordinary

tolerance. This characterized especially the more intimate situations with family members and neighbours; teasing seemed to happen in the more public domain, mostly by groups of boys. That children got away with this behaviour underscored the fact that generally individuals with a mental illness were not given the status of adults, although there were some exceptions.

The stoic tolerance that families exhibited for their relative's crazy behaviour, reflected in the student narratives, allowed actively psychotic patients "to wander about aimlessly," in the village. Generally only serious assaultive events led to involuntary hospitalization. While social rules seemed to demand that *imbeko* (respect) be given to the disturbed member of the household, expressed in acceptance and love, student narratives demonstrated a wide range of hostile feelings, which probably would not have been stated so freely in their own families.

Ukuthwasa, Amafufunyane, Idliso

The three indigenous diagnostic categories of *ukuthwasa*, *amafufunyane* and *idliso* constituted another feature of Xhosa cosmology of great significance for people with a mental illness. These categories were the most commonly used in illness discourse. *Ukuthwasa*, as representing the ancestral call to become a healer, was not considered a mental illness, even if the afflicted behaved in an out-of-control fashion. The cultural categories, however, allowed for this to turn

into a mental illness if the call had not been properly addressed. The "wounded healer" has made his/her appearance in many cultures, including our own Western psychological tradition (Devereux, 1969). The role of the traditional healer, however, did not seem an option for most people with a severe mental illness. None of the *amaggirha* of the Msobomvu showed any signs of psychosis, though the men, of which there were only three fully qualified, seemed troubled. One had a psychiatric history involving seizures which started after an accident. Of the three male *amaggirha* two are deceased since my stay in Msobomvu, and the third one moved away.

While *intwaso* often appeared as a diagnostic possibility in the life histories of Xhosa people with a severe mental illness, and sometimes attempts were made to qualify as a healer, nobody seemed to "come through." *Amaggirha* and persons with a mental illness alike knew of relatives who had been *amaggirha*, *ukuthwasa*, or simply *phambana*. This was most clearly indicated in the case of Ntuthuzelo, my interpreter. He had suffered from a mental illness for many years, and he had started training with an aunt who was a qualified *iggirha* but he became psychotic and was hospitalized; his mother, who has been treated with Western medicines for depression, still hopes to become qualified. His family has a rich heritage of traditional healers on both his mother's and his father's sides including a prophet who figured in Xhosa history, as well as a few relatives who were severely mentally ill. My tentative hypothesis was that in biomedical terms,

Ntuthuzelo's family seemed predisposed genetically towards bipolar illness.

Bipolar illness, often characterized by episodes of depression and/or mania, was more likely to be associated with *ukuthwasa*. Repeated manic episodes, however, destroyed any chance for the individual succeeding as a traditional healer.

It seems, therefore, that the traditional diagnoses provided the sufferer with a period of time during which judgment by the community as to the illness outcome was suspended. The *amafufunyane* sufferer too could have these creatures taken out, once they were made to talk. Blame here was attached to those who sent them, not to the person who was out-of-control and suffering. Ultimately, as indicated by the essays and in the interviews of patients in the Victoria East district, as well as the more detailed life situations of people with a mental illness in Msobomvu, the track record of the patient counted. I called this "passing muster."

Mental Illness and Coping

Diagnosis

Diagnostic and outcome research cross-culturally has suggested a better prognosis for the developing, as opposed to the developed, industrialized world (Torrey, 1988; Jablensky, Sartorius, Ernberg, Anker, Korten, Cooper, Day & Bertelsen, 1992). This presupposes a unitary disease model and equivalent

syndromes across the globe. The World Health Organization has been engaged in finding a common language to describe and compare the major mental disorders in different parts of the world (WHO, 1973), but the difficulties inherent in this practice may be obscured rather than revealed by a consensus of this nature. Consider Kleinman and Schweder's unpacking of the parameters and meaning of the concepts of neurasthenia in China and depression in the United States and Europe (Kleinman, 1982; 1986; Shweder, 1991), as well as Guinness' (1992) detailed analysis of mental illness in Swazi society. While neurotransmitter malfunctioning in psychosis may be comparable across human brains, the physical and cultural contexts have significant influence on the psychotic manifestations in the individual sufferer. In the impoverished developing world, for example, a higher prevalence of gross organic damage is demonstrated by the greater incidence of epilepsy in these countries (Sartorius, 1993).

Diagnosis was shown to be a problem in relation to people with mental illness in this research. Like Guinness (1992), I too found that patients were usually hospitalized in response to florid psychotic and assaultive behaviour. The mental hospital functioned, according to my analysis, predominantly as an agent of control. This function was supported by lack of resources (no resident psychiatrist, lack of laboratory facilities) which, together with a cultural and language mismatch, led to diagnostic errors and reinforced the role of control as opposed to treatment. The total absence of what is

considered appropriate biomedical treatment for bipolar illness (Torrey, 1983; Fawcett, 1989; Saraceno, Tognoni & Garattini, 1993) did away with the necessity for a distinction between the mania in bipolar illness and acute psychotic symptoms in schizophrenia. The diagnostic practice in the mental hospital of this area therefore equated psychosis with schizophrenia. Virtually all patients discharged into the Victoria East District carried this diagnosis (except for obvious organic/substance abuse/senile psychoses), and were "maintained" on neuroleptics (that is when the patient complied). Some of the medical personnel were aware of the over-diagnosis of schizophrenia and under-diagnosis of the affective disorders. One wonders if this apparent misdiagnosis was not partially motivated by cognitive dissonance, since doctors generally want to do the best for their patients.[93]

Outcome

The rehospitalization rate of 13% at the end of one year and 21% by the end of the second year for all patients discharged into the Victoria East district, does not compare unfavourably with the results obtained in the Expressed Emotion research in England (Leff & Vaughn, 1981). However, hospitalization is a social intervention (Wing, 1968), and can vary widely according to cultural setting. An additional 11% of the

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[93]One argument countering the use of lithium in this situation was that with a population as uneducated as the rural Xhosa, there were too many risks involved, as serum levels have to be monitored. However the long-term effects of medicating patients with neuroleptics inappropriately, since neuroleptics control the acute manic symptoms only, has risks of its own.

patients in the community were actively psychotic and potentially assaultive, but were not readmitted, except for one. In the final analysis, therefore, relapse rates do not look as positive as they had seemed. Closer scrutiny of people's lives in the village revealed the day-to-day struggle with isolation, stigma, economic concerns and the side effects of medication. None of the previously hospitalized patients had regained proper work, the acid test of being cured in this context. Since work could generally only be achieved by entering the urban areas, more often by becoming a migrant worker, this was out of reach for the more vulnerable[94]. There were, however, some amongst those identified by the community as having a mental illness, who were different. These were five women, four in their late teens, who were considered bewitched. They had all consulted the *amagqirha,* a few claiming to be cured. While some had experienced episodes of out-of-control behaviour, their problems varied, usually involving somatic components, and all appeared more functional than the residents that had received treatment at a mental hospital. They were not stigmatized by the community.

At home, with a packet of pills in their pocket, and the task to prove themselves cured, their problems were not over. While careful diagnosis and treatment was lacking in the mental hospital, it was worse back home, with the local hospital some distance and a R3 taxi ride away. The patient often

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[94]McAlister (1980) describes how the departure of the Xhosa migrant worker is conceptualized as going into a danger zone--going to war.

experienced uncomfortable side effects which he/she felt stopped him/her from living a normal life. It was clear that this was no cure. There were a number of options, the most common being that the patient "defaulted" medication, or possibly started taking the neuroleptics on an "as needed" basis. Another option, depending on the financial resources, was to consult an *igqirha* hoping for a cure.

Sooner or later the psychotic symptoms reappeared, and if the person became seriously assaultive, rehospitalization occurred. The time span between hospitalizations varied greatly, which did not necessarily relate to a more favourable outcome. It was often delayed only because there had not been a sufficiently serious event to trigger involuntary admission. The families as well as the rural communities had a long fuse.

The traditional healers in this study, while helpful in relation to the five cases where no hospitalizations were involved, were unable to affect the psychosis. With one young woman who was out of control, the community's inability to rapidly access the help she needed led, tragically, to her death.

All the patients with a prolonged mental illness in Msobomvu had stories about the failures of traditional healers. The families, and sometimes the patient too, still had hopes of finding a more powerful healer who would effect a cure. Local healers sometimes referred to some of these cases, reporting

that the families had not come through for the client, or that the patient had run away.

Passing Muster

Passing muster is the metaphor I applied to the process of acceptance and rejection by the community of members with a mental illness. Contrary to expectations, and to what I was told by the mental health workers, a stint in the mental hospital did *not* result in inevitable rejection by the community. The community's assessment of the person was much more rational and complex. It took into account an array of factors such as the person's social relationships (having a family, having a girlfriend or boyfriend), a common-sense reason that could be identified as the proximate cause of the illness, and whether the illness had struck in old age, after the person had led a respectable life including having managed the responsibilities of a family. These characteristics all seemed to work as protective factors in relation to community stigma.

The community initially gave the person the benefit of the doubt, and time to rehabilitate. The traditional healer was part of this process by locating the cause of the problem. Blame was therefore *externalized*, and ideally, as in the *amafufunyane* concept, the bewitchment was turned back on the one who had caused it. When this did not help and the person continued in his/her illness, this often started a long search for a cure, involving other "more powerful" traditional

healers, and Western medical services. Once the person became physically assaultive, causing real damage, the mental hospital was resorted to.

Illness paradigm and treatment

Choice of healers or hospital was often dependent on the financial resources of the family. The families would, if they could afford it at all, even consult private medical doctors in town, rather than the mobile clinic or the hospital, where nurses were often perfunctory and the waiting long. Traditional healers were said to be more expensive than the hospital.

The patient and his/her family usually had a number of probable *causes of the illness* in mind: these were almost always traditional bewitchment concepts, and had been determined through a *vumisa*--the traditional diagnosis. When it came to illness they were firmly grounded in their Xhosa culture. The culture of biomedicine as experienced by the patient and his/her family through their contact with the clinic, the local hospital, or the mental hospital, while perceived as different, did not have any impact on their *understanding* of the illness. I was repeatedly told that hospitals do not explain what is wrong, "they just provide treatment." Compliance was expected through deference to authority, rather than the patient being seen as making rational choices.

There were some explanations which were said to be Western medical explanations. One which stood out because it was so frequently quoted was that epilepsy was caused by worms. People thought that the mental hospital generally did not cure the illness but that it calmed the person down. Thus while the patient in the mental hospital was exposed to a very different world from the village, where perhaps some of the supernatural definitions would be challenged, there was *no conflict of paradigms* since no alternative explanation was offered[95].

People with a severe mental illness had little of the benefits that state-of-the-art modern psychiatry has to offer. The hospital had neither the trained personnel nor the choice of medication at its disposal. Cultural and communication gaps did not help. Added to this were the issues of power and authority which affected staff and patient relationships. Complaints about discomfort in response to the medication at a rural clinic were dismissed as "just side effects". Far from being passive recipients, the patients made their own decisions as to whether and when to take "the treatment." My interpreter, whose case history suggested a bipolar rather than a schizophrenic disorder, skipped his Mellaril whenever he worked for me, he later admitted. The medication, he complained, sedated him, so that he could not function.

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[95]The hospital was rarely experienced in completely negative terms; it had much to offer to someone from an impoverished rural background (three square meals a day, blankets and entertainment).

In all, the stories of the people with a mental illness in Msobomvu, and the case histories of patients discharged into the Victoria East District in the former Ciskei, do not accord with the more benign picture of mental illness in developing countries, as compared to the Western world, reported in the findings of the World Health Organization (Jablensky, Sartorius, Ernberg, Anker, Korten, Cooper, Day, and Bertelsen, 1992). Protective factors, such as subsistence farming (Warner, 1985) did not work for the patients in the community of Msobomvu, and while the families and the community showed a remarkable tolerance towards the ill person, the emotional cost to all was profound.

Postscript

Since my involvement continued over time, during which major political changes occurred in South Africa, I became increasingly aware of the boundedness of history. What seemed to be hewn in stone is so no longer. However, with my continued tracking of events and people, and a visit to Msobomvu in June this year, I found that much has also remained the same. There is now a proper clinic in Msobomvu, which is supposed to have a permanent nursing sister present, and they are to get a regular visiting doctor. Reliable sources informed me that this was not likely to happen in the foreseeable future, and that the house allocated for this would just remain empty. At Tower Hospital the dominant diagnosis is still schizophrenia, and neither lithium nor any

of the other forms of treatment for bipolar illness are available. The hospital is still waiting for a permanent psychiatrist.

People's lives have changed. Seven of the people from the patient and traditional healer group are no longer alive. Two were young and their deaths were avoidable. The taxi fare to town has gone up from R3 to R5 one way. One individual's disability pension has been suspended, but two have since obtained a DG. People cope as best as they can, but it is a time and a place of scarce resources. You take herbs or you take treatment from the hospital, or both. You do the best you can.

For biomedicine in the rural Xhosa context to be more than an agent of control in the fight against mental illness, the availability of essential medication has to be assured. To be truly effective, its delivery will have to be considered. Any treatment plan will of necessity have to involve culture, context, and physiology, including the neurotransmitter substances, as discussed in this study; it will have to be truly ecological.

It would be presumptuous for me to make specific recommendations for social policy as it applies to the delivery of mental health services in the rural areas, without a thorough acquaintance with fiscal issues and priorities in the new South Africa. There are, however, implications which

clearly emerge from this study, and it is my hope that the research will speak, particularly through the personal narratives of the patients, of their struggle and the factors that exacerbate their hardships. These factors include the failure to use appropriate medication and to have the structures in place (eg: lithium serum level testing) that makes possible correct diagnosis and appropriate treatment; the dominance of authority and status in health workers over the needs of the patient, this often resulting in demeaning and perfunctory treatment; the lack of linkages between medical services, the village health workers, and the system of traditional healers; the arbitrariness of the allocation of resources (the DG); the failure to develop appropriate after-care and monitoring of patients' continued use of medications; and the need in general for the purveyors of biomedicine to provide a more user-friendly service.

GLOSSARY OF XHOSA TERMS

Abantu abamhlophe White people who are ancestral spirits.
Amafufunyane Plural of Ifufunyane.
Amagqirha Plural of igqirha.
Amakosi A form of possession attributed to a "powder" that comes from Zululand used in divination, but considered dangerous.
Amakosi dances High kicking dances performed by some traditional healers.
Amasikizi Queasy.
Azikho zonke Person without a mind.
Emagezeni Lunatic asylum.
Idliso Poison, often thought of as a form of bewitchment.
Ifufunyana A grave ant.
Igeza Derogatory term for a person with mental illness.
Igogo A seer.
Igqirha Traditional healer.
Imbeko Respect.
Impundulu The lightening bird, companion to a witch.
Ingqondo emfutshane Mental illness; being short-minded; forgetfulness; mental retardation.
Inkathazo A burden.
Inkenkqe Moodiness; wildness (a sign of ukuthwasa).
Intwaso (Noun) The call to become a traditional healer.
Isigulo sengqondo Illness of the mind.
Isikova The owl, an omen for bewitchment.
Ixhwele A herbalist.
Izithunzela Zombies.
Le nto This thing, indirect way of referring to *intwaso*.
Muti Medicine.
Phambana Mad.
Rhorho Bugs; insects (associated with bewitchment).
Sail-on Crazy.
Sangoma A traditional healer in Zulu.
Thwasa See "intwaso."
Ukufa Kwesi Xhosa Being sick the Xhosa way.
Ukunyanga To heal, treat, cure.
Ukuphambana Being crazy.
Ukuthwasa (Verb) Being called to be a traditional healer.
Umbulini Nervousness.
Umlaza Ritually impure.
Umgqombothi Sorghum beer, often brewed at home.
Umthandalezi Faith healer.
uTikoloshe A short stocky fellow, companion to the witch.
Vumisa Derived from word for "to agree": a diagnosis by the diviner.

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