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MENTAL HEALTH IN NORTHERN MALAWI: A CULTURAL PERSPECTIVE

By

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A thesis submitted for the degree of

Doctor of Philosophy

Department of Psychology,

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Trinity College

2002

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SUMMARY

This thesis seeks to address a theoretical question: What is the experience of people with a mental disturbance, when they are introduced to a health care system which is ontologically distinct from their own cultural beliefs about health? This question was addressed in the context of a recently established biomedically orientated mental health service in Northern Malawi. Mental disturbance is predominately treated by traditional healers in this region. Two parallel studies were conducted; a longitudinal study which explored the explanation's patients in the mental health service held regarding their mental disturbance and a study which focussed on traditional healers in the extant healing system.

Chapter One aims to root the current piece of research in the context in which it was conducted. Background information and the history of the introduction of western models of healthcare to Malawi are provided. The Mental Health Service is described, and the biomedically orientated approach adopted by the Service outlined. The rationale for the study is stated and both the theoretical question and major research question are posed.

Chapter Two presents a review of the literature pertinent to the major research question. The psychological perspective concerning the role of culture in health, the development of a culturally competent mental health service, and the importance of the views of the patients in such a service are considered. Ontological differences in biomedical and African concepts of mental disturbance and treatment are also considered. Literature regarding treatment for mental disturbance and patient's understanding of mental disturbance is presented. Specific reference is made to research conducted in Malawi. Based on the literature reviewed, specific research questions are posed.

Chapter Three is devoted to methodological considerations which needed to be addressed given that this research was conducted in a country with a different culture and language to that of the researcher. Preliminary preparations undertaken to overcome potential difficulties and measures taken to address these methodological issues are detailed.

Chapter Four incorporates the literature review, the methodology, and findings from the traditional healers study. The main aim of this study was for the researcher to gain a clearer understanding of the cultural context in which Malawian health beliefs are embedded and attain a perspective on how *wasing'anga* (traditional healers) view mental disturbance, the causes of mental disturbance and their approach to treatment. Naturalistic Inquiry (Lincoln & Guba, 1985) provided the methodological framework. All eleven informants were *wasing'anga*. Participant observation and both semi-structured and in-depth interviews were employed for data collection. Analysis was conducted in accordance with grounded theory (Strauss & Corbin, 1992; 1998). Findings show that *wasing'anga* attribute mental disturbance to a wide range of causes, which are not confined to supernatural causes and employ a variety of treatments for mental disturbance.

Chapter Five presents the methodology for the hospital study. A longitudinal study was conducted which explored patients' explanations of mental disturbance. Semi-structured interviews were conducted with one hundred and forty seven patients, on admission to, on discharge from the hospital and at follow-up, between six months and twelve months post discharge. Translators were required; the added methodological dimensions introduced are detailed. Emotional and cognitive well-being of the participants was measured by two scales at each interview. Chi-square analysis was the predominant statistical analysis used. The qualitative analysis was conducted in accordance with grounded theory (Strauss & Corbin, 1992; 1998), enhanced by the data gathered in the traditional healers study.

Chapter Six presents the findings that emerged from both qualitative and quantitative analysis. Analyses of interviews reveal a range of complex explanations for the patients' disturbances involving *ulowe* (bewitchment), *mizimu ya a gogo* (ancestral spirits), physical illness, drug use and psychological problems. Although participants were admitted to a biomedically orientated service, only a small percentage of participants employed a medical explanation. Traditional explanations outnumbered medical explanations and increased over time. The majority of the participants were rated as not showing an improvement in their emotional or cognitive well-being during admission. A minority of participants maintained improvement post-discharge. Explanations for

mental disturbance did not appear to impact on emotional or cognitive well-being, insofar as this study could measure. Qualitative analysis illustrates the way in which explanations for mental disturbance are embedded in the culture and context of Malawi.

Chapter Seven presents a summary of the findings of each research question. A summary of the findings and conclusions of the traditional healers study and a synthesis of the findings of both studies are presented. Recommendations for the development of the service in a culturally competent manner are suggested, based on the findings of this thesis.

ACKNOWLEDGEMENTS

At the outset, I could not have imagined how many people would become instrumental in the shaping and realisation of this thesis; I would like to extend my gratitude to all the following people:

Dr. Mac MacLachlan, my supervisor, for his vision, knowledge and insight in the area; unflagging enthusiasm, and skilful supervision from across the miles and from a few doors away.

Dr. Pat Walsh, my co supervisor, for his support and advice.

The Hospitaller Order of St. John of God for facilitating many aspects of this research and their financial support. In particular I would like to thank Brothers Aidan O'Clohessy O.H., Laurence Kearns O.H. and Ronan Lennon O.H.

Agency for Personnel Services Overseas (APSO) for their funding throughout the course of this study.

To all of the participants in the study, for their time and their energy, Devlin Silungwe and Levi Soko for their part in interviewing participants, the staff who translated for me; Esther Mwanza for her patience and for sheer perseverance in transcribing and translating each and every interview, smiling; my colleagues in the Drop-in centre; Devlin and Esther for their sense of humour, being great companions and competent translators of both words and actions on many fieldwork trips. Fr. Boucher in Mua for another perspective, hospitality and access to his unique library; A dada Ndhlozi for driving me safely in all weathers; MZ 1611 for bearing up under the strain on most occasions; A dada Longwe, for his determination with the telephone system; Mrs. Moyo and Andrew Nyirenda for administrative support; A mama Maria Mbizi for her reliability; all who tolerated my chiTumbuka, those who actively taught me, and those who raised my awareness of Malaŵian culture, particularly my neighbours, Nyasulus and Mr. Thole, the museum curator.

Dr. Vivanda Phiri, for his generosity in offering me the opportunity to stay at his compound, amongst his family and patients, for our frequent and insightful 'panel discussions', and to his family for being so welcoming; *Ntchimi* Chikanje, for his openness in inviting me to attend so many aspects of his

professional life, introducing me to his colleagues, and the consideration shown to me on many occasions.

Hugh and Isabel, for their support and for sharing both their enthusiasm for research, and Jessie and Wilfie. My other friends in Malawi, both Malawians and *wazungu*, including Colm, Ingrid, Cathy, Gretta and J.J., Vikki, Br. John, Bernadette, Annet, Phil, Chinulas and Kerrs; my visitors who together created an enriching experience, which was much more than just a research project.

Dr. Howard Smith, Dr. Brendan Bunting, Dr. Myra O'Regan, Dr. Michael Gormley and Anne Walsh Daneshmandi for statistical advice and Aoife Brinkley for help with SPSS; Olga Horgan, Dr. Herzig and Dr. de Salis for taking the time to rate the interviews; Dr. Ian Grey and Dr. Ruth Emond for constructive comments; John Rowland, Audio Visual Media Services, TCD for technical assistance in editing the video; Dave Hennigan for IT support; Anne O'Neill for advice with formatting. The staff and postgraduates in the Department of Psychology, for their support and humour since my return, in particular the Health research group. Special thanks to Olga, Anne Marie, Clare, Karen, Anne, Deirdre and Olivio.

My parents for their unwavering support and encouragement, at each stage and in every aspect; my sisters Sara, Richenda, Judith, Pauline, Claire and my grandmother, each of whom helped in a different way; Pere, for unselfishly embracing this part of my life as part of his and for sharing his vitality with me when my energy was depleted; Mia, for the distances she has travelled with me during this period; Colm for enduring me on Mondays; Siobhan for her constant availability; Kay for the 'kitchen table sessions'; Heidi for her hands; Amy for her dependability and many others who offered welcome distractions. Kay, Elisabeth, Aoife and Alice for sharing the view. Anne for unerring optimism with technology. All my family and friends for accepting my absence, while I was in Malawi, and for their support during my 'transition period' in Ireland.

I once spent 5 days walking in Mount Mulanje in Malawi, my experience of the research process is analogous to this trip in many ways: the sunrises were inspirational filling me with energy, but as the days progressed, the track ahead becomes long and

winding, the destinations appear closer than reality, the sun exhausting, the *chiperoni* disorientating, however the magnificent and diverse scenery propelled me onwards, I found streams along the way invigorating, companionship sustaining, guidance from the porter familiar with the route reassuring, sunsets signalled the closing of another stage, and arrival at the journeys end intensely satisfying.

My thanks and appreciation to all of you who had a role in helping me complete this journey.

This thesis is dedicated to the memories of:

Alice Mc Avoy, without whom I may never have embarked on this journey and

Rosemary Conway, who helped me complete it.

Viwongo

Apo nkhayambanga, kuti nkhaghanaghana yayi umo wanthu wanandi wanga niwvirilira kuti ntchito iyi yi fiskike; ndipo nkhukhumba kuwonga wanthu awa:

Dr. Mac MacLachlan, musambizi wane mulala chifukwa cha zeru na vinjeru vyake, kweniso chifukwa cha kunweka na phamphu lake. Dr. Pat Walsh, chifukwa cha uphungu wake. Chipani cha St. John of God (Yohane Mutuwa Wa Chiuta) chifukwa cha ovwiri wamakopala kweniso muvyose ivyo vikakhumbikwanga kuti kafukufuku uyu wachitike. Mwa padela nkhuwonga Br. Aidan Clohessy O.H, Br. Laurence Kearns O.H na Br. Ronan Lennon O.H. Nkhuwongaso wa Agency for Personnel Services Overseas (APSO) chifukwa cha kunilipilira masambiro ghane.

Nkhuwongaso wose awo wakanivwira, Devlin Silungwe na Levi Soko pakunimasulira chitumbuka, Esther Mwanza chifukwa cha kuzizipizga kwake na kunweka pakulemba na kumasulira vilingwa na ntchezgo zose kwambula kudinginyika, nkhuwongaso wanyane waku Drop-in Centre; nkhuwonga Devlin na Esther chifukwa cha umoza na luso lwawo pakumasulira vinthu mumachitilo na mazgo apo tikendanga muvikaya vya awo tikawalinganga. Nkhuwonga Bambo Boucher waku Mua chifukwa cha kunipokelera makola na kuzomerezga kugwiriska ntchito vinthu vyake ivyo walikusunga mulayibrale yake; nkhuwongaso adada Ndhlozi chifukwa chakuniyendeska makola; galimoto MZ 1611 chifukwa chakuzizipizga unono wamisewu nyengo zinandi, adada Longwe chifukwa cha ovwiri wawo wa telephoni; Mrs. Moyo na Andrew Nyirenda chifukwa chakunivwira muma yendeskero nakachilitilo kavinthu; Amama Mbizi chifukwa cha magomezgeko ghawo; na wose awo wakapulikiska chitumbuka chane nakunivwira kuti nisambire chitumbuka, na awo wakani sambizga ukhalilo wa chiMalawi, wazgengezgani wane, banja la Nyasulu na adada Thole waku malo yakusungilako vinthu vyamwaka.

Nkhuwongaso Dr. Viwanda Phiri chifukwa chakunipa mwawi wakukhala pachikaya chake, pamoza nawaluwali, navidumbilano vyaku zilwa ivyo tikawanga navyo kweniso na mbumba yake chifukwa cha kunipokelera.

Ntchimi Chikanje chifukwa chakumasuka kwake pakunichema kuti nkhalawilire umo wakugwirila ntchito na pakunilongola kwa ntchimi zinyake.

Nkhuwonga Hugh na Isabel, chifukwa cha ovwiri wawo na kunisambizga lusolawo mu kafukufuku uyu, kweniso Jessie na Wilfie. Wanyane wose ku Malawi, wose wina Malawi na wazungu, Colm, Ingrid, Cathy, Gretta na JJ, Vikki, Br. John, Bernadette, Annet, Phil, Chinula na Kerrs; na walendo wane wose awo wakanisanguluskanga.

Nkhuwonga Dr. Howard Smith, Dr. Brendan Bunting, Dr. Myra O'Regan, Dr. Michael Gormley na Anne Walsh Daneshmandi chifukwa cha kunivwira na kawerengero kaivyo nkhasanga, nkhuwongaso. Aoife Brinkley chifukwa cha SPSS. Olga Horgan, Dr Herzig na Dr. de Salis nkhuwawonga chifukwa cha nyengo yawo pakupima na kuweleramo vilingwa. Nkhuwonga Dr. Ian Grey na Dr. Ruth Emond chifukwa chandamanga zawuzengi. Nkhuwonga John Rowland, Audio Visual Media Services, TCD chifukwa chakuzizipizya pakundovwira kujambula kanema. Dave Hennigan chifukwa IT. Anne O'Neill chifukwa formatting. Nkhuwongaso wakugwira ntchito na wasambiri wa Psychology chifukwa cha ovwiri na umoza wawo kufumila apo nkhawelera kufuma ku Malawi, chomene gulu la wa Health Research. Viwongo vyapadela nkhupeleka kwa Olga, Anne Marie, Clare, Karen, Anne, Deirdre na Olivio.

Nkhuwonga wapapi wane chifukwa cha ovwiri wawo na vikhwimisko panyengo zose; wabali wane Sara, Richenda, Judith, Pauline, Claire na agogo wane, wose wakani vwira munthowa zaku pambanapambana. Nkhuwonga Pere chifukwa cha kujipereka kwake na pakuzomera kuwa nane pamoza pa ntchito iyi na pakunikhwimiska apo nkhongono zikanimalira; Mia chifukwa cha kunilinda uko nkhendanga. Nkhuwongaso Siobhan chifukwa chakujipereka kwake nyengozose; Kay chifukwa chavidumbilano "vya kukhitchini" ivyo tikawanga navyo, Heidi na wose awo wakanipokerela, Amy chifukwa chakuba wakugomezgeka. Kay, Elizabeth, Aoife na Alice mose nkhumuwongani. Nkhuwonga banja la kwithu na wanyane wose chifukwa chakunizomerezga kuti nilute ku Malawi kweniso chifukwa cha kunipokelera na kunivwira kutinikhazikikeso ku Ireland.

Kafukufuku wane uyu waku kolelanako chomeni na ulendo wane wa mazuwa yankhonde pa phiri la Mulanje; mafumilo gha zuwa ghakanipanga nkhongono, kweni apo madazi ghakalutanga, nthowa yikawa yitali na yakuzweta, chilato chikawonekanga pafupi, zuwa likotchanga, mphepo yachiperoni yikaziziranga kweni kutowa kwa malo kukanipa nkhongo kuti nilutilire munthazi na ulendo uwu, nkhasanga milonga iyo yikawezelamo khumbiro mwaine, ulongozgi wamumanyi nthowa, wuka ni wezgeleska nkhongono, kunjira kwazuwa kukawoneskanga chigoti cha chigawa chinyake; ndipo mafikilo pachigoti yakawa yaku kholweska.

Viwongo kwa mose imwe mukanivwira kuti nifiske ulendo wane uwu.

Thesisi iyi nkhuyi peleka ku chikumbusko cha;

Alice Mc Avoy, kwambula iye mphanyi ulendo uwu nkhawuyamba chala na Rosemary Conway, pakunovwira nakunikhwimisya kumalizga ntchito iyi.

TABLE OF CONTENTS

Declaration i

Summary ii

Acknowledgements v

Viwongo viii

Table of Contents xi

List of Tables xiv

List of Figures xix

List of Photographs xx

Preamble xxii

Chapter 1: Introduction 1

Introduction 1

Background to study 2

Introduction of western models of care 6

Background to St. John of God Mental Health Service 9

Summary 15

Chapter 2: Literature review 17

Overview 17

Introduction 17

Literature review 22

Psychiatry 25

Treatment 34

Summary 47

Rationale of study 48

Objective of research 48

Research questions 48

Chapter 3: Methodological considerations 50

Introduction 50

Preliminary preparations and methodological issues 50
Translation 57
Summary 58

Chapter 4: Extant healing system 59
Rationale for present study 59
Literature review 59
Conclusion 67
Aim of study 68
Methodology 68
Methodological approach 70
Data collection 73
Ethical considerations 76
Data analysis 77
Summary 79
Findings 80
Section one: Introduction to terminology and concepts 80
Section two: *Kuchizga* (Treatment) 92
Section three: Experience of becoming a *ntchimi* 112
Section four: Professional status 118
Summary 119

Chapter 5: Methodology 122
Introduction 122
Qualitative and quantitative methodologies 122
Design of study 123
Rationale for design of current study 123
Procedure: Data collection 127
Participants 128
Accessing participants 129
Translated interviews 132
Post-interview methodology 135
Measuring improvement over time 136
Ethical considerations 142

Data analysis 143
Summary 147

Chapter 6: Results of hospital study 148
Introduction 148
Part one: Participant information and circumstance of interview 149
Part two: Analysis of interviews 165
Explanations for mental disturbance 196
Explanations for mental disturbance: Qualitative analysis 213
Summary 223
Part three: Improvement of mental health 225

Chapter 7: Discussion 246
Overview 246
Review of the research questions 246
Traditional healers study 247
Hospital study 249
Methodological issues 266
Conclusion 269
Concluding remarks 271

References 273

Appendices 284
Appendix A: Map of Malawi 284
Appendix B: Mission statement, philosophy statement and guiding principles of St. John of God 285
Appendix C: Glossary of terms 287
Appendix D: Participant information: Traditional healers study 289
Appendix E: Video to accompany Chapter four: Extant healing system 291
Appendix F: Constitution of the registered trustees of the herbalists association of Malawi (HAM) 293
Appendix G: Agenda for Herbalist Health Workers regional meeting for the North 16-19th June, 1996 294
Appendix H: Example of letter of request to District Hospital 295

Appendix I: Guidelines for translating interviews 296
Appendix J: Rating scale for standard of translation in hospital interviews 297
Appendix K: Translation recording form 298
Appendix L: Rating scales 299
Appendix M: Categories employed for quantitative analysis 300
Appendix N: Instructions for categorisation 301
Appendix O: Instructions for rating strength of evidence for emotional well-being scale & strength of evidence for cognitive well-being scale 303
Appendix P: Participant information 306
Appendix P: Participant information 306
Appendix Q: Reason for admission to hospital: Qualitative themes 311
Appendix R: Themes: Explanation for mental disturbance 312
Appendix S: Crosstabulations for explanations for disorder and type of disorder with sample at admission, discharge and follow-up 313

List of Tables

Table 1.1: Percentage of clients receiving the most common diagnosis received by patients in the hospital in 1997 and 1998 13
Table 1.2: Percentage of clients receiving most common diagnosis received by clients in the drop-in centre 14
Table 6.1: Number of participants interviewed at admission, discharge, and follow-up, at admission only, and at each interview time. 150
Table 6.2: Mean, median, mode, range and standard deviation (SD) of age of participants in years 151
Table 6.3: Level of education attained by participants in admission sample 152
Table 6.4: Number and percentage of patients referred to hospital by various referral agents 154
Table 6.5: Mean, median, mode, range, standard deviation (SD) and standard error (SE) of duration of admission in days 154
Table 6.6: Mean, median, mode, range and standard deviation (SD) of age of participant in longitudinal group 155

Table 6.7: Mean, median, mode, range, standard deviation (SD) and standard error (SE) of duration of admission 157

Table 6.8: No. of participants interviewed at admission only, admission and discharge, admission and follow-up and at admission, discharge and follow-up 157

Table 6.9: Results of t-tests for duration of stay in hospital across each group 158

Table 6.10: Variable name and categories with which chi-square analysis was conducted 159

Table 6.11: Results of chi-square analyses conducted on demographic and treatment variables of participants interviewed only at admission and participants interviewed again 160

Table 6.12: Results of chi-square analyses conducted on demographic and treatment variables of participants interviewed at discharge and participants who were not 161

Table 6.13: Results of chi-square analyses conducted on demographic and treatment variable of participants interviewed at follow-up and participants who were not 162

Table 6.14: Results of chi-square analyses conducted on demographic and treatment variables of those interviewed at all three interviews and those who were not 162

Table 6.15: Descriptive statistics for interview circumstances 164

Table 6.16: Descriptive statistics for interview circumstances (longitudinal sample) 165

Table 6.17: Reasons for admission to hospital given at admission, discharge, and follow-up interviews by total sample 186

Table 6.18: Results of chi-square analyses conducted on reasons for admission and participation at each interview stage. 189

Table 6.19: Frequency of changing reasons for admission to hospital between admission and discharge interviews. 190

Table 6.20: Frequency of changing reasons for admission to hospital between admission and follow-up interviews 191

Table 6.21: Percentage of participants in longitudinal group giving each reason for admission to hospital at admission, discharge and follow-up 193

Table 6.22: Frequency of changing reasons for admission to hospital between admission and discharge interviews 194

Table 6.23: Frequency of changing reasons for admission to hospital between admission and follow-up interviews 195

Table 6.24: Frequency of changing reasons for admission to hospital between discharge and follow-up interviews 195

Table 6.25: Range of explanations for mental disturbance and percentage of participants holding explanations at admission, discharge, and follow-up interviews 197

Table 6.26: Results of chi-square analyses conducted on explanations for mental disturbance and participation at each interview stage 200

Table 6.27: Percentage of participants with various explanations for mental disturbance at admission, discharge and follow-up interviews in longitudinal sample 204

Table 6.28a: Frequencies and percentages of explanations categorised as traditional explanations at admission interview 209

Table 6.28b: Frequencies and percentages of explanations categorised as traditional explanations at discharge interview 210

Table 6.28c: Frequencies and percentages of explanations categorised as traditional explanations at follow-up interview 210

Table 6.29: Gender breakdown among participants who indicated a traditional explanation on admission 211

Table 6.30: Gender breakdown among participants who indicated a traditional explanation on discharge 211

Table 6.31: Gender breakdown among participants who indicated a traditional explanation at follow-up. 212

Table 6.32: Percentage agreement for two raters on EWS and CWS for admission, discharge, and follow-up interviews 225

Table 6.33: Percentage agreement on strength of EWS for admission, discharge and follow-up interviews 226

Table 6.34: Percentage agreement on evidence of CWS at admission, discharge and follow-up interviews. 227

Table 6.35: Median, mode and range of scores given by each of the raters for admission interviews for the total sample 227

Table 6.36: Median, mode and range of scores given by each of the raters for discharge interviews for the total sample 228

Table 6.37: Median, mode and range of scores given by each of the raters for follow-up interviews for the total sample 229

Table 6.38: Difference in ratings across interviews for each rater for EWS and CWS 230

Table 6.39: Difference in ratings given by medical anthropologist between each interview for EWS and CWS 231

Table 6.40: Difference in ratings given by psychiatrist between each interview for EWS and CWS 231

Table 6.41: Difference in ratings given by psychologist between each interview for EWS and CWS 232

Table 6.42: Percentage of participants who improved, declined and showed no change in EWS and CWS between interviews in the total sample 233

Table 6.43: Percentage of participants who improved, declined and showed no change in EWS and CWS between interviews (longitudinal group) 235

Table 6.44: Results of chi-square analyses of the impact of patients' explanations (feeling mentally disturbed or not) on emotional and cognitive well-being 237

Table 6.45: Results of chi-square analyses of the impact of patients' explanations (traditional or non-traditional) on emotional and cognitive well-being 237

Table 6.46: Crosstabulation of explanation for disturbance at admission and changes in emotional well-being between admission and discharge (total sample) 238

Table 6.47: Crosstabulation of explanation for disturbance at admission and changes in emotional well-being between admission and follow-up interviews (total sample) 239

Table 6.48: Crosstabulation of explanations for disturbance at admission and changes in cognitive well-being between admission and discharge interviews (total sample) 239

Table 6.49: Crosstabulation of explanations for disturbance at admission and changes in cognitive well-being between admission and follow-up (total sample) 240

Table 6.50: Crosstabulation of explanation for disturbance at admission and changes in emotional well-being between admission and discharge (longitudinal group) 241

Table 6.51: Crosstabulation of explanation for disturbance at admission and changes in emotional well-being between admission and follow-up (longitudinal group) 242

Table 6.52: Crosstabulation of explanation for disturbance at discharge and changes in emotional well-being between discharge and follow-up (longitudinal group) 242

Table 6.53: Crosstabulation of explanations for disturbance at admission and changes in cognitive well-being from admission to discharge (longitudinal group) 243

Table 6.54: Crosstabulations of explanation for disturbance at admission and changes in cognitive well-being between admission and follow-up (longitudinal group) 244

Table 6.55: Crosstabulation of explanations for disturbance at discharge and changes in cognitive well-being between discharge and follow-up (longitudinal group) 244

Table S.1: Crosstabulation of explanation for disturbance at admission and type of disorder 313

Table S.2: Crosstabulation of explanations for disturbance at discharge and type of disorder 314

Table S.3: Crosstabulation of explanations for disturbance at follow-up and type of disorder 315

List of Figures

Figure 4.1: Schematic diagram relating the people who use *mankhwala* and ceremonies, and the outcome as described in the text 91

Figure 5.1: Longitudinal Design of the Hospital Study 126

Figure 5.2: Diagram of the research process (Interviews in English) 140

Figure 6.1: Reasons for admission to hospital given at admission 186

Figure 6.2: Reasons for admission to hospital given at discharge 187

Figure 6.3: Reasons for admission to hospital given at follow-up 188

Figure 6.4: Percentage of participants in longitudinal group giving each reason for admission to hospital at admission, discharge and follow-up 192

Figure 6.5: Percentage of participants holding each explanation on admission 198

Figure 6.6: Percentage of participants holding each explanation on discharge 199

Figure 6.7: Percentage of participants holding each explanation at follow-up 199

Figure 6.8: Frequency of changing explanations for mental disturbance between admission and discharge interviews 202

Figure 6.9: Number of participants who changed or did not change their explanation for mental disturbance between admission and follow-up interviews 203

Figure 6.10: Pattern of explanation between admission, discharge and follow-up interviews 204

Figure 6.11: Number of participants who changed or did not change their explanation for mental disturbance between admission and discharge interviews 206

Figure 6.12: Number of participants who changed or did not change their explanation for mental disturbance between discharge and follow-up interviews 206

Figure 6.13: Number of participants who changed or did not change their explanation for mental disturbance between admission and follow-up interviews 207

Figure S.1 Number of participants with psychotic and non-psychotic disorders holding explanations for mental disturbance at admission 313

Figure S.2 Number of participants with psychotic and non-psychotic disorders holding explanations for mental disturbance at discharge 314

Figure S.3 Number of participants with psychotic and non-psychotic disorders holding explanations for mental disturbance at follow-up 315

LIST OF PHOTOGRAPHS

Photograph 4.1: Female *sing'anga* pictured with her *mankhwala.* 82

Photograph 4.2: *Ntchimi* pictured with his pharmacopoeia. 82

Photograph 4.3: Infant wearing beads believed to protect against *visi lisi* 82

Photograph 4.4: *Mphini* being made where *mankhwala* will be applied 83

Photograph 4.5: Woman experiencing *kackechura* 86

Photograph 4.6: V.P.'s surgery at his compound. 93

Photograph 4.7: Facilities for patients and their guardians at V.P.'s compound. 93

Photograph 4.8: A female patient dancing *vimbuza* in the *templi* at V.P.'s compound. 94

Photograph 4.9: V.P. pictured outside his recently opened clinic. 94

Photograph 4.10: Female patients preparing *mankhwala* 103

Photograph 4.11: Young children at a *vimbuza* ceremony at C.M.'s compound 105

Photograph 4.12: *Vimbuza* drum with *nembe* 106

Photograph 4.13: *Ntchimi* in uniform playing a *vimbuza* drum 106

Photograph 4.14: V.P. wearing his black wig at a *vimbuza* ceremony 107

Photograph 4.15: *Ntchimi* wearing full ceremonial uniform. 108

Photograph 4.16: *Ntchimi* with wet flour pasted on his face. 108

Photograph 4.17: Three *ntchimi* preparing chicken for *chilopa* 110

Photograph 4.18: *Ntchimi* holding chicken with the knife poised to cut throat. 110

Photograph 4.19: Chicken with a *chizimba* being cooking in a *ndengere*. 110

Photograph 4.20: Trainee breathing smoke from cooking chicken through bamboo 111

Photograph 4.21: Trainee eating pieces of chicken with left hand 111

Photograph 4.22: Triumphant trainee returning with *mankhwala* 113

Photograph 4.23: *Mankhwala* in *mboni* plates before being concealed in the bush 113

Photograph 4.24: Experienced *ntchimi* holding up the coin the trainee successfully located on her person 113

Photograph 4.25: Some of the *ŵasing'anga*, not in uniform, and this researcher, pictured at the opening of the new *dimba*. 119

PREAMBLE

In Malawi, mental disturbance is predominately treated by traditional healers. In 1993, a biomedically orientated mental health service was established in Northern Malawi by a Mission organisation. Despite holding views concerning the causes and treatment of mental disturbance which are ontologically different to that of the community in which it is located, this Service aims to develop in a manner which accommodates the needs of this community. St. John of God Mental Health Service, in Mzuzu, employed a research psychologist (this researcher) to conduct a study that would provide information to facilitate such development, within this context. This research was framed by the theoretical question:

> What is the experience of people with a mental disturbance, when they are introduced to a health care system which is ontologically distinct from their own beliefs about health?

Current literature indicates that the information regarding the perspective of the patient is of critical importance in developing a culturally competent mental health service. Previous research conducted by MacLachlan, Nyirenda and Nyando (1995) in Malawi had focused on patients' attributions for mental disturbance in Zomba Mental Hospital (a government run hospital in Southern Malawi). Their research design, using semi-structured interviews, was adopted to explore patients' explanations for their mental disturbance in the St. John of God Mental Service, in Mzuzu. However, various amendments were required to make the study appropriate to the context of Northern Malawi. Further amendments were made in response to the emerging data in the early stages of the research. Furthermore, a need for the researcher to gain a clearer understanding of the cultural context in which Northern Malawian health beliefs were embedded was identified. This led to undertaking a second study, the 'traditional healing study', which ran in parallel with the 'hospital study'. The chapters in thesis could have been sequenced in a number of different ways. The following sequence was decided upon. The introductory chapter offers the background information regarding Malawi, the introduction of western models of health care and the burden associated with them. The St. John of God Mental Health Service is introduced and information pertaining to the services it offers is outlined. Chapter Two, the literature review, aims to place this study in the context of the existing literature. This piece of research was

conducted in a country with a different culture and language to that of the researcher. Consequently, various methodological considerations had to be addressed, such as language. Many of these issues were pertinent to both studies. Therefore, Chapter Three is devoted to explaining both the preliminary preparations that were undertaken to overcome potential difficulties, and measures taken to address these issues. It does not address the specific methodology of either study. The first study presented in this thesis is the traditional healers study, as the findings of this study inform the analysis and findings of the hospital study. The traditional healers study is housed in one self-contained chapter, incorporating a literature review, methodology and findings. In-depth and semi-structured interviews and participant observation were the methods employed in data collection. A short video accompanies this thesis, as an appendix, illustrating observations made during fieldwork. The following chapter, the methodology chapter for the hospital study, details the research design and the qualitative and quantitative analysis techniques employed. The research design was longitudinal and involved a series of three interviews, conducted on admission, at discharge, and a follow-up interview between six and twelve months post-discharge. Both the qualitative and quantitative results are given in Chapter Six. The seventh, and final chapter aims to summarise the research as a whole and draw conclusions from the findings.

CHAPTER 1: INTRODUCTION

INTRODUCTION

The magnitude of mental health problems in low-income African countries has been identified as a cause of deep concern. Effective treatment is a prerequisite in addressing this growing problem (Dejarlais, Eisenberg, Good & Kleinman, 1995). Frank and Frank (1991) state that "Cultural norms and world-views influence not only the definition of mental illness but also the nature of its treatment" (p. 19). In Malawi, mental disturbance is treated predominantly by traditional healers; their profession is representative of prevailing cultural norms and world-views regarding mental disturbance. Biomedical treatment is representative of cultural norms and the world-views held by many western societies; a world-view distinct from that which predominates in Malawi.

A need to address the mental health needs of those in the Northern region of Malawi, a small sub-Saharan country was identified by a western organisation, the Hospitaller Order of St. John of God. Subsequently a biomedically orientated Mental Health Service was established by this organisation. Thus, the opportunity arose to test a theoretical question:

> What is the experience of people with a mental disturbance when they are introduced to a health care system which is ontologically distinct from their own cultural beliefs about health?

This theoretical question was addressed in the context of the St. John of God Mental Health Service in Northern Malawi. The major research question which this study seeks to answer is: In what ways may the establishment of a Mental Health Service in Northern Malawi, which adheres to a biomedically orientated framework, meet the needs of those requiring treatment for mental health problems in Northern Malawi?

For the purposes of this thesis, the terms "biomedically orientated" and "traditional" are used throughout. These terms can be applied to types of medicine, treatment, beliefs, and explanations. When this terminology is used, it denotes where these forms of treatment and beliefs originated, and does not suggest that they are static, unresponsive or necessarily exclusive.

BACKGROUND TO STUDY

In order to have a full appreciation of the elements integral to the study, it is important to understand the context in which this study was conducted. Therefore, it is necessary to describe the environment in which the study is located. Information regarding Malawi, in particular the Northern region where the study was conducted, the historical context of biomedical orientated health care in Africa, and a brief outline of the mental health services is presented.

Republic of Malawi

Malawi is a small African country that occupies the southern part of the East African Rift Valley. As can be seen in the map (Appendix A), Malawi is landlocked and is bordered by Mozambique, Tanzania and Zambia. Lying between 9 and 17 degrees south of the equator, the climate is sub tropical; Malawi has a rainy season and a dry season. Topography in Malawi is varied, elevation ranges from 37 metres at the junction of the Shire River with the international boundary of Mozambique, to the highest point, Sapitwa, in the majestic Mulanje Massif at 3,002 metres. Lake Malawi, the country's distinguishing feature when looking at a map, stretches approximately two thirds the length of the country, covering an area of 24,400 square kilometres, approximately 20% of the total area (www.cia.gov/cia, January, 2001).

Demographics

According to the Malawi Population and Housing Census, conducted in 1998, while the current piece of research was in progress, Malawi has a population of 9.9 million. The Northern region, although the least densely populated, is the fastest growing region, and is inhabited by 1,233,560 people. The majority of the population in the Northern region live in rural areas; 1,073,889 were enumerated, accounting for 87%[1], of the population, with the remaining 13% living in urban areas. Females outnumber males, in both rural and urban areas, and in all age groups. At a regional level, there are approximately 30,000 more females than males. These figures imply a sex ratio, at a national level, of 96 males per 100 females (www.nso.Malawi.net, December, 2001).

[1] The raw figures presented in the Census information were calculated into percentages by the researcher for clarity in reading where appropriate.

Approximately half the population had access to at least one radio (Malawi Population and Housing Census, 1998). One television broadcasting station operates, which was established in 1999, during the research period (www.cia.gov/cia, January 2001).

Ethnic groups and language

A number of different ethnic groups, with distinct languages and customs are found in each region. The Chewa are the most common group in Malawi, generally concentrated in the Central and Southern Regions. The Tumbuka are the predominant group in the Northern region, although there are many Tongas located along the lakeshore of Lake Malawi. Other ethnic groups found in the Northern region are, for example, Ngoni, Nkhonde, Lambiya, Sukwa, Ndale, each with their own languages. The majority of local languages belong to the Bantu linguistic category (Schoffeelers, 1997). The official languages are chiChewa and English. Approximately 57% of the whole population use chiChewa as the language of communication in their households. Other languages are important regionally, chiTumbuka is the most widely spoken language in the Northern region. Figures indicate that chiTumbuka is the language used for communication at home by 9% of the whole population (Malawi Population and Housing Census, 1998). Apart from language, one other major distinguishing factor is that the north is patrilineal, while the remainder of the country, with few exceptions, is matrilineal.

Politics

The Republic of Malawi, formerly the British protectorate of Nyasaland, attained independence in 1964. From 1964, for a period of three decades, Malawi was ruled by a one party dictatorship. Multiparty elections were held in 1994 and a new democratically elected government came into power (Bandawe, 2000).

Economy

Malawi has been described as one of the poorest countries in the world, 60% of the population live below the absolute poverty line (Ministry of Health and Population, 1999). Bandawe (2000) reports the following information regarding the economy, based on information from the Reserve Bank of Malawi, published in 1998. The country is

predominately agricultural based with 85% of the population living in rural areas. Agriculture accounts for 40% of the gross domestic product (GDP) and is responsible for 93% of the country's export earnings and 80% of employment. Manufacturing industry only accounts for only 13-14% of gross domestic product. The Malawian economy receives multilateral aid from individual donor nations from the international monetary fund (IMF), World Bank and unilateral aid from individual donor nations. The gross national product per capita income is US$ 600. In 1998, GDP grew by 3.1%, which was smaller than the previous estimation of 4.1%. The main agricultural export has been tobacco; however due to the growing anti-smoking lobby worldwide the export trade has been threatened in recent years resulting in a devaluation of the country's currency, the Kwacha, by 60% in August 1998. Inflation was measured at 30% by the end of 1998.

Health

Malawi's health indicators are among the poorest in the world. Malawi has a live birth infant mortality rate of 134/1000. Fifty per cent of the children under the age of five are chronically malnourished. The reasons given for this are household food insufficiency due to poverty, poor weaning and feeding practises and frequent infections. Fifty-six per cent of the women attending antenatal clinics are anaemic (Ministry of Health and Population, 1999). Life expectancy at birth is currently 37.58 years (www.cia.gov/cia, January 2001). HIV/AIDS was the leading cause of death among the productive 20-48 year age group (Ministry of Health & Population, 1999). An estimated 1 million Malawians are said to be carrying the HIV virus, with over 200,000 deaths attributed to AIDS so far (Bandawe, 2000).

Based on Ministry of Health and population figures, Bandawe (2000) writes that the Ministry of Health and Population's budget was MK 1.403 billion (US$32 million). Approximately US$9 million was allocated for the purchase of drugs and pharmaceuticals. The third national health plan was implemented from 1986-1995, however evaluation of this plan had not been undertaken by 1999. Health Service delivery is based on the primary health care approach. Efforts are aimed at the most vulnerable groups: maternal and child health, water and sanitation and encouragement

of early treatment of disease. Mental health is not included in this list, it could therefore be surmised that mental health is not seen as a priority.

INTRODUCTION OF WESTERN MODELS OF CARE

Kortmann (1987) points out that in most developing countries western medicine exists parallel to a well-developed system of traditional beliefs and healing practices, which were available long before the beginning of modern medicine. Traditional healing practises will be dealt with at length in Chapter Four. A brief history of the arrival and development of western, biomedically orientated health care will be introduced in the following section, framing the current health care situation in its historical context.

Swartz (1998) states that the international spread of mental health specialities, including psychiatry, has been associated with the spread of colonialism. Consequently, psychiatric practises, like biomedicine in general, have been associated with the interests of colonisers in many other parts of the world, including Africa. Dejarlais, Eisenberg, Good and Kleinman (1995) suggest that the diversity of the systems which exist in different African countries have arisen from the local experience of colonial medicine, combined with particular trends in psychiatric theory and consequently treatment which were in existence at that time. They comment that colonial administrations built asylums that reflected British, French, German or Dutch theories of madness and its management; asylums were often part of a legacy of a "retreating tide of colonialism" (p. 56), which included a central bureaucracy, a national school system, and a police force.

A paper written concerning the development of Zomba Mental Hospital in Malawi, exemplifies this. Vaughan (1983) traces the development of Zomba Mental Hospital from its infancy, as a wing of the Central Prison in 1910, which developed into Zomba Lunatic Asylum in the colonial period of Malawi, then Nyasaland, and suggests there was no clearly thought out policy towards insanity on the part of the colonialists. However she writes "legislation associated with it [Zomba Mental Hospital] reflects the ambiguities, uncertainties and dangers felt by Europeans to be inherent in a situation of their own making, as well as the development of thought on their responsibility for African 'welfare'" (Vaughan, 1983, p. 219).

The thoughts at that time were that the 'native' who was mad in a 'native' fashion was quite harmless, a belief that he was either possessed by spirits, or the victim of witchcraft, was nothing more than "an extension of the beliefs and 'irrationality' of his own society" (Vaughan, 1983, p. 219). She continues to say, citing Duff (1932), a colonial administrator: "The real problem was seen to lie with Africans whose 'brains had been turned by a little schooling', the idioms of whose madness was motor cars, bicycles, kings of England and silver mines; who flung back at the conquerors their own images of superiority in disturbingly distorted forms" (p. 219).

Vaughan suggests that the only plausible reason for the opening of a mental institution, when expenditure on medical facilities was almost non-existent, was that a type of colonial institutional convention prevailed at the time. Establishment of lunatic asylums in the colonies served to separate the criminally insane from the other prisoners, as those who were insane created a disturbance. She notes that colonial reasons for establishing asylums are similar to those described by Foucault for the establishment of asylums in eighteenth century Europe.

Vaughan proceeds to describe the development of the asylum, which culminated in the building of a mental hospital, which was controlled by the medical department as opposed to the prison, the introduction of drug therapy and electro convulsive therapy, and the appointment of a psychiatrist in 1955.

Concluding that the history of Zomba Lunatic Asylum in the colonial period is an almost parallel reflection of the development of conceptualisation of mental illness, and treatment in Europe, she points outs that a major complication existed; not only were the people receiving this treatment a subject people, but they were also people from a different culture.

Several decades later, serious challenges continue to be encountered in efforts to bring the benefits of contemporary psychiatric care to sub-Saharan Africa where grave economic problems persist (Dejarlais, Eisenberg, Good & Kleinman, 1995). Paucity of resources, a scarcity of trained personnel, combined with a lack of sustained public investment reflects the low priority given to care for the mentally ill. Consequently, chronic shortages of psychiatric facilities, trained staff and psychotropic medication

prevail, making it impossible to offer comprehensive care to those suffering from mental illness. In Zimbabwe, the ratio is 10 psychiatrists for a population of 10 million, the ratio in the United States is 170 greater, excluding psychologists and psychiatric social workers which do not exist in these countries (Dejarlais et al., 1995).

Malawi has had to contend with many of the above-mentioned issues regarding introduction of psychiatric services. Zomba Mental Hospital, until recently was the only in-patient facility for psychiatric patients. Zulu (1997) describes the difficulties encountered in providing care to psychiatric patients in this hospital. When established in 1953, there were 322 beds, however a daily occupancy of up to 500 patients was not unusual. In recent years occupancy has reached 700 patients. Under funding results in two to three patients sharing one blanket. In addition, there are not enough mattresses or sleeping mats, cups or plates for the patients, no opportunity for rehabilitation is in place, and there is an absence of a consistent supply of medication. It is staffed by one tenth of the nurses required and at the time of publication no psychiatrist was employed. In 1996, only one fifth of the budget requested from the Malawian government was approved but the whole amount granted was not actually received (Zulu, 1997).

Without negating the benefits received by health services in developing countries through foreign aid, nor disagreeing that the incorporation of health practises from one culture into another can be beneficial, Carr, McAuliffe and MacLachlan (1998) assert that biomedical health services provided in developing countries do not reflect the societies dominant models of health and illness, and the establishment and development of biomedically orientated health services can be viewed as a form of "cultural invasion" (p. 170). Writing from a health promotion perspective, they would suggest that neglecting the significant differences that exist between biomedically rooted models and indigenous models of health may prohibit the effectiveness of promotion of health in these countries.

Malawi, like so many other developing countries as acknowledged by Kortmann (1987), has a rich heritage of indigenous health care, practised by traditional healers. Indeed,

Northern Malawi has been home to a number of infamous *ntchimi*[2] (Friedson, 1996). In stark contrast to the bleak picture of biomedically orientated psychiatric care in Malawi, described earlier in this chapter, the availability of traditional health care is much more abundant. Figures suggest that in 1993 there were 65,000 *ŵasing'anga*[3] (traditional healers) in Malawi (Ndibwami, Henry & Saka, 1993). Chapter Four offers a much fuller description of the extant healing system which operates in Malawi.

Dejarlais, Eisenberg, Good and Kleinman (1995) recommend that the application of current psychiatric knowledge in local communities in low-income countries should strive "to enhance existing local strengths rather than attempt to eliminate what might be viewed as irrational or traditional from the perspective of contemporary biomedicine" (Dejarlais et al., 1995, p. 54). Such treatment should reflect the local ethno-medical systems and its potential for providing accessible treatment.

Background to St. John of God Mental Health Service

The Hospitaller Order of St. John of God (henceforth to be termed the Order) is a mission organisation founded in Granada, Spain in the 1540s, by a man now known as St. John of God. A network of services has developed worldwide, the Order specialises in mental health and learning disability, for both children and adults. Services are found in the following countries: Ireland, United Kingdom, United States of America, South and Central America, Spain, Portugal, Korea, Papua New Guinea and Africa. The Order is comprised of several Provinces, each Province taking responsibility for the services provided in a number of countries. The service in Malawi is part of the Irish Province, which also includes Korea and New Jersey, USA. The headquarters are based in Ireland.

Establishment of the St. John of God Service in Malawi

Kearns (1999) cites a statement made in 1988, at a large meeting of the St. John of God brothers, from all countries:

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2 *Ntchimi* is a specific type of traditional healer and this term will be explained in greater detail in Chapter Four.

3 *Ŵasing'anga* is the chiTumbuka term referring to all types of traditional healers. Further explanation is offered in Chapter Four.

> The most urgent call on Hospitality today comes from the developing areas of the world which legitimately claim from us an equitable share in the material, personnel and spiritual resources which have been entrusted to us. Therefore, the order will give concrete responses to the expectations of Africa, Asia, Latin America and Oceania. (General Chapter, Rome, 1988)

This statement led the Irish Province to consider the contribution they could make to the situation. A study of the "needs of the people in Africa" (Kearns, 1999, p. 2) was undertaken by the Brothers in the Order and some senior Irish personnel. Africa was chosen because of the existing links with Europe and the African missionary tradition in Ireland. Four African countries, Malawi, Nigeria, Tanzania and Zambia were all considered. The rationale for choosing Northern Malawi was that a compelling proposal was made to the Order by the then Apostolic Vicar of the Diocese of Mzuzu: there was no mental health service in the Northern region and there was only one psychiatrist, based in the Southern region, who incidentally had already left by the time the Order arrived. In addition, there was an existing network of primary health clinics established in the region, by St. John's Mission Hospital, run by the Medical Missionaries of Mary, a missionary organisation also from Ireland. These clinics had no mental health component, but provided an opportunity to integrate a community based primary mental health care system into a health care system developed by the general mission hospital (Kearns, 1999).

In 1993, the Irish Province of the Order accepted the invitation of the Catholic Diocese of Mzuzu to come to Malawi to initiate the development of a community–based mental health service in Mzuzu, under the auspices of the Christian Hospitals Association of Malawi (CHAM) and Mzuzu Diocese (Kearns, 1999). The St. John of God Mental Health Service (henceforth to be called the Service) is based in Mzuzu, Mzimba District, in Northern Malawi (see map Appendix A). Mzuzu is the administrative capital of the Northern region.

Components of the Service

Those aspects of the Service pertinent to the research process and participants involved are now reviewed. The staff employed are described and the four main components of the Service, St. John of God Centre, House of Hospitality, Centre for Living and Outreach Clinics are outlined briefly.

Staff

The staff complement at the beginning of the present study stood at 56, with 48 Malawian and eight expatriate staff. The psychiatrist, psychologist, rehabilitation co-ordinator, psychiatric nurse tutor, two psychiatric nurses and the administrator were lay expatriate staff, while the Director was an Irish Brother in the Order. The clinical team comprised of a Principle Clinical Officer (with one year training in psychiatry in Ireland), a psychiatrist, a clinical officer, a psychiatric nurse tutor, a research psychologist (author), a rehabilitation co-ordinator, five psychiatric nurses, four Enrolled nurses/midwives and thirteen Mental Health Workers (MHW), the equivalent of which in Ireland would be nursing assistants. MHWs receive all their training at in house programmes, and generally have no previous professional training in the area. Over the research period, there were some changes in staffing. By the completion of the fieldwork phase there was no longer a psychiatrist or a psychologist, and all the nursing staff were Malawian. The only remaining roles filled by expatriate staff are those of the Director and of psychiatric nurse tutor, both of whom are Brothers in the Order of St. John of God.

The St John of God Centre

The St. John of God Centre is locally referred to as the Drop-in Centre, and will be referred to as the Centre in this thesis. The Centre functions as a drop-in centre offering the community, the family and individual clients a range of mental health services:

- Out patient service: clinical assessment, advice and treatment.
- Mental health information and education
- Mental health training, education and research
- Home visitation, follow-up and after care

The out-patient department sees an average of four new people a week, and the average number attending for counselling and review is forty-five (Annual Report, 1998).

The House of Hospitality

The House of Hospitality, locally referred to as *chipatala cha wanthu wa kufuntha* (hospital for the mad people), will henceforth be referred to as the hospital. The hospital provides short stay residential care and treatment for adults in an environment perceived to be "conducive to maximizing well-being of each person with the resultant

enhancement of his/her quality of life" (Annual Report, 1998, p. 18). It offers assessment, treatment, rehabilitation, education, care, and advocacy. It is a 24-bedded treatment centre for adults with acute mental illness requiring hospitalisation in a safe environment. It is non-custodial. Referrals come from government and mission hospitals and clinics, the drop-in centre and a variety of private and community sources (e.g. schools, clergy). The average length of stay is six weeks (Kearns, 1999). Patients are provided with their meals in the hospital, and clothes when required. Bedding is provided for each bed and laundered in the hospital. Visitors are welcome within the scheduled visiting hours. In contrast to the usual custom in mission or government run hospitals, where the responsibility for providing meals, laundry and personal hygiene of the patient is taken on by the guardian(s), this hospital takes the responsibility for all these aspects of care.

The St. John of God Centre for Living

The St. John of God Centre for Living (generally referred to as the 'rehabilitation centre' and henceforth to be referred to as such) aims to provide rehabilitation services, which are community based, affordable, accessible, and holistic. Vocational assessment, vocational preparation through skills-based training programmes, access to vocational training and services at national level and follow-up are provided through the rehabilitation centre (Annual Report, 1998).

Outreach clinics

Clinical teams from the Centre provide outreach clinics to nine villages in the Mzuzu area. Local mental health volunteers are sought in each village and are given training in recognising people with a mental disturbance. There are volunteers attached to each clinic. These volunteers are responsible for making the arrangements for people who need assessment or treatment to attend the next clinic (Kearns, 1999).

Provision of care

The drop-in centre was opened in the Centre of Mzuzu in October 1994 and the Hospital was opened in May 1995. Both were purpose-built. In 1997, the year the present study began, 161 patients were admitted to the admission unit, and 1,790 clients attended the St. John of God Centre, 240 of which were new clients. In 1998, 194

patients were admitted to the hospital, 40 of whom had a previous admission. A total of 1,992 attended the St. John of God Centre, 179 of which were new clients. These figures indicate an increase in the number of people using both services.

Mental health problems

A wide variety of diagnoses were received by patients based on the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV). In 1997, there were 15 different categories of diagnosis (Annual Report, 1997) and 28 different categories of diagnosis in 1998 (Annual Report, 1998). The categories are not identical and so do not facilitate comparison to any great extent. According to the Annual Report figures for 1997 and 1998, the most frequent diagnosis is that of schizophrenia, both in the hospital and in the drop-in centre. Table 1.1 gives the figures for diagnoses received in the hospital in 1997 and 1998.

Table 1.1: Percentage of clients receiving the most common diagnosis received by patients in the hospital in 1997 and 1998

Diagnosis	Percentage of patients in 1997	Percentage of patients in 1998
Schizophrenia	34%	25%
Schizophreniform, Brief & Related Psychotic Disorders	17%	–
Brief Psychotic Disorder	–	16%
Unspecified mental disorder	–	4.6%
Other	12.4%	–

Note: dash indicates that those criteria were not used that year.

Of the diagnoses received by patients in the hospital in 1997, schizophrenia accounted for 34%, and for 25% the following year. For the purposes of the Annual Report in 1997, diagnosis for Schizophreniform, Brief and Related Psychotic Disorders were grouped together and accounted for 17% of the diagnoses received, the second most common diagnosis. In 1998, schizophrenia accounted for 25% of the diagnosis, with Brief Psychotic Disorder accounting for 16% of diagnosis. Only the most common diagnoses are included in the Table 1.1. From these figures, it is clear that the majority of the patients are suffering from a psychotic disorder.

In the drop-in centre, a similar trend was evident as can be seen in Table 1.2. Schizophrenia accounted for 50% of the diagnoses in 1997 and 46% in 1998. In 1997, Mania and Hypomania was the second most frequent diagnosis (13%) and in 1998, it was Single Manic Episode (12%). Notably in 1998, 8% of the diagnoses (159) were Unspecified Mental Disorders, the third largest category. This category was not present in 1997, and comprised only 0.05% of the diagnoses in the hospital (Annual Report, 1997; 1998).

Table 1.2: Percentage of clients receiving most common diagnosis received by clients in the drop-in centre

Diagnosis	Percentage of clients in 1997	Percentage of clients in 1998
Schizophrenia	50%	46%
Mania & Hypomania	13%	-
Single Manic Episode	-	12%
Unspecified Mental Disorders	-	8%

Note: Dash indicates that those criteria were not used that year.

In contrast with the hospital, the commonly treated disorders are not only of a psychotic nature. It could be surmised that the category Unspecified Mental Disorder indicates a difficulty in comfortably diagnosing some clients using DSM-IV.

Treatment

Malawian clinical officers (CO) from both the hospital and the drop-in centre have been given training in psychiatry in both Ireland and South Africa. DSM-IV is employed to make diagnoses. Equipment and up-to-date psychotropic medication is continually shipped from Ireland. This medication includes anti-psychotic medication such as Chlorpromazine, which can be taken orally or injected, antidepressants such as Amitriptyline and Imipramine and sedatives such as Diazepam and Lorazepam. Examples of anticonvulsants prescribed are Phenytonin and Phenobarbitone. Patients receive medication from a medicine trolley, administered by a psychiatric nurse each morning, afternoon and evening. The difficulties experienced by government-run hospitals, in ensuring a steady supply of medication due to a limited budget and in country distribution, are therefore bypassed with the importation of medication from Ireland. In addition to drug therapy, counselling and electro convulsive therapy (ECT)

are available. A small number of MHWs attended a short training course to equip them with basic counselling skills. Two Canadian trained counsellors, working in Mzuzu provided the training, based on western psychotherapy. The trainers came from a nursing and pastoral care background. Counselling is offered on an individual and sometimes family level. At the time of research, if a number of patients had a history of alcohol or drug misuse group work was offered, and was met with varying degrees of interest and participation on the part of the patients. ECT was used where it was deemed appropriate although the hospital did not have equipment on site. The ECT equipment used during this period was located in the neighbouring general hospital. This treatment was used with only a very small number of patients.

Objective of Service

The objective of the service is to contribute to the improvement and maintenance of mental health of all Malawians in the Northern region by providing services, which support the development of the primary health care system to which the Government of Malawi and the World Health Organisation (WHO) are committed. The guiding principles of the Service also state that: "An indigenous system of mental health promotion and care should embrace what is positive in the traditions, beliefs, customs and cultural heritage of the local community." The mission statement, philosophy of care and guiding principles can be found in Appendix B.

SUMMARY

The main aim in this chapter has been to contextualise the current piece of research and to consider the rationale for embarking on such a study. The introduction highlights that, in Malawi, it is predominantly traditional healers who treat mental disturbance.

Information regarding the people and the region roots the study in the context in which it was conducted is included. An outline of the historical context of the introduction of western models of health care, with specific reference to Malawi, describes the current situation, in terms of health care, for those who are mentally ill in Malawi. Mental health has not been prioritised in the current primary health care efforts. The major existing facility for treatment was developed from a western colonial system. Difficulties that burden this approach both in Malawi and elsewhere are highlighted.

The extant healing system in Malawi was introduced briefly; this area is treated more fully later in this thesis.

A description of the various components which make up the Service, including the hospital, the drop-in centre, the rehabilitation centre and outreach service was given, not only for contextualisation purposes but also provides a basis from which to understand certain aspects of the methodology of the study. The mental health problems which are treated and the biomedically orientated approach adopted by the Service was outlined. Finally the objectives of the Service were stated.

CHAPTER 2: LITERATURE REVIEW

OVERVIEW

As stated in Chapter One, the major research question to be addressed in this thesis is: In what ways may the establishment of a Mental Health Service in Northern Malawi, which adheres to a biomedically orientated framework, meet the needs of those requiring treatment for mental health problems in Northern Malawi? This chapter reviews the literature pertinent to this question. The introduction includes the psychological perspective concerning the role of culture in health, the development of a culturally competent mental health service, and highlights the importance of the views of the patients in such a service. The literature review is composed of two sections. The first section considers the context in which Malawians' beliefs about health and illness are embedded, the basic tenets of psychiatry, as the biomedical approach to mental illness, and finally focuses on psychotherapy as a treatment for mental disturbance. The second section attends particularly to the literature regarding treatment sought for mental disturbance and patient's understanding of their mental disturbance. Specific reference is made to research conducted in Malawi. Based on the literature reviewed, specific research questions are posed.

INTRODUCTION

Psychological perspective

In recent years, there has been a growing emphasis on the role of culture in health and illness, including mental disturbance. The study of how cultural factors influence various aspects of health has taken place around the globe and, as Berry points out, has been: "driven by the need to understand individual and community health in the context of indigenous cultures of the people being examined and served" (Berry, 1997, p. 98). Berry describes the study of culture and health as "... inherently interdisciplinary ..." (p. 98) as much of the work has been carried out by medical anthropology, transcultural psychiatry and cross-cultural psychology. Landrine and Klonoff (1992) assert that: "... the health beliefs of professionals and lay persons alike are structured and informed by a cultural context from which they cannot be separated and without which they cannot be fully understood ..." (p. 267). On that basis, Landrine and Klonoff have called for

psychology to place more weight on cultural factors in health. The necessity of taking culture into consideration is also highlighted by MacLachlan (1997) who states that: "Different cultures create different causes, experiences, expressions and consequences of suffering, be it physical or mental. A complaint makes no sense in a cultural vacuum because its meaning cannot be accurately communicated" (MacLachlan, 1997, p. 106).

The emphasis in this literature review is primarily on the psychological literature relevant to Africa, and specifically research findings in Malawi. Unfortunately, there is a dearth of literature and research focussing on psychological issues in Africa (Koinange, 2001) which, it has been argued, can be attributed to a lack of interest in Africa countries in promoting psychological research, and further exacerbated by a lack of finance to publish the research which is conducted (Madu, 1997). Carr and MacLachlan (1998) reviewed the contribution psychology has made to the developing world. Their findings suggest that while psychology has contributed most to the area of health and welfare, approximately only thirty papers were published in a ten-year period, on a range of diverse topics.

Development of a culturally competent mental health service

A term which has been introduced to the literature relatively recently is "culturally competent mental health service" (Guarnaccia & Rodriguez, 1996). These authors use the term to describe a service that places emphasis on the need to be sensitive to the expressions and needs of culturally different populations, and the need to be skilled in serving those populations. The concept of culturally competent health services came into being to describe the provision of appropriate health care in a multicultural society. However, many of the issues are pertinent, and transferable, to the situation where a biomedically orientated model has been introduced into a community which does not share the same approach to treating mental illness. Therefore, the term culturally competent mental health service will be borrowed in this thesis. For ease of reading, it will be abbreviated to culturally competent service, where appropriate.

Guarnaccia and Rodriguez (1996) assert that the meaning attached to *culture* by the service, and the intended use of culture, needs to be given sufficient consideration in planning a culturally competent service. They contend that previous work in the area

has failed to give adequate attention to the concept of culture, and subsequently, development of the programmes has been inhibited, resulting "… in an impoverished understanding of the multiple and complex interactions of culture in the development of programs" (p. 420).

Guarnaccia and Rodriguez (1996) state that a simplistic view of culture, such as creating a physical atmosphere and merely hiring people who speak the local languages is inadequate. Greater efforts must be made to incorporate the multiple dimensions of culture. A single interpretation is insufficient when attempting to understand what culturally competent services are. The development and integration of a comprehensive definition of culture into the provision of mental health services is required.

Culture is a multifaceted and elusive concept. A plethora of approaches and definitions exist for the concept of culture. However, most prevalent in the literature is dissatisfaction with how it is defined by different disciplines. With both competing and complementary definitions provided from psychological, anthropological, and sociological perspectives, it is felt that the most useful way to define culture in this thesis is in the context of culturally competent services. The definition employed by Guarnaccia and Rodriguez (1996) is the product of their critical review of the literature. They define culture as: "… both a product of group values, norms, and experiences and of individual innovations and life histories" (p. 421).

Guarnaccia and Rodriguez arrived at this concept of culture having considered and combined several views of culture. They refer to the static view of culture, as a distinctive set of beliefs, values, morals, customs and institutions that people inherit through growing up in a culture (citing Favazza & Oman, 1977; Helman, 1990; Sue & Sue, 1990). This aspect of culture focuses on the notion of culture arising from a generalised society without adequate attention to the dynamic nature of culture. Although not discarding the import of a person's cultural inheritance, Guarnaccia and Rodriguez also draw on the more dynamic approach of Geertz (1973) and Good (1994). Both Geertz and Good understand culture as a process in which views and practices are dynamically affected by social transformations, social conflicts, power relationships and migrations. Still more, Guarnaccia and Rodriguez include the emergence of culture from the daily social practices and life experiences of individuals and small groups in

their definition. This addition draws on the perspective of Ware and Kleinman (1992) who pinpoint the processes of social interaction in neighbourhoods, villages, and social networks as the place where culture is enacted.

On a more practical level, it is important to consider how views of culture are implemented in mental health services. Guarnaccia and Rodriguez identify six ways in which culture can be implemented in a health service. Some views are more likely to be implemented than others. The sequence followed in the list below indicates the likelihood of different views being incorporated into the planning of a culturally competent service. The first view listed is the least likely to be introduced, while the last is most likely to be introduced:

1. Culture as views of mental illness
2. Culture as shared values
3. Culture as events and celebrations
4. Culture as signs and symbols
5. Culture as language
6. Culture as ethnic identity

The least likely view on culture to be incorporated is culture as views of mental illness. Guarnaccia and Rodriguez (1996) state that understanding cultural categories of illness and the cultural resources available to people in distress are important in the development of culturally competent services. A brief explanation of how culture can be introduced in a culturally competent manner, but often is not according to Guarnaccia and Rodriguez follows. Attempts are made to introduce culture as shared values. For example, knowledge of religious ideas and practices of clients is an important addition in assessment. It can be used to put in context both the source and content of some delusions and hallucinations, and can also be used as a source of solace and support. However, the emphasis on values often gets translated into a listing of common value positions in different ethnic groups. Values are not shared equally in all ethnic groups. Introducing culture as events and celebrations is an opportunity to foster patients' abilities to respond to crisis through culturally meaningful ways, another important element in treatment, often overlooked. Signs and symbols have power for both clients and providers alike, the choice of material signs and symbols make important statements about the identity of the programme. However viewing culture as material signs and symbols alone is not enough. Similarly, culture as language, is often a central

focus in the provision of culturally competent services, given the importance of talking in this sphere. However, in and of itself, it is not adequate. While culture as ethnic identity is the most likely to be used, broad notions of ethnic identity do not provide the level of understanding needed for program development and implementation.

It could be argued, that the aspects of culture which are mostly likely to be introduced into a health service, are those aspects required to operate a service on a practical level. Culture as language is an example of this. Those aspects that require a departure from the standard practise of psychiatry, are the least likely to be introduced, as evidenced by the fact that cultural views of illness are the least likely to be introduced in the assessment made by Guarnaccia and Rodriguez

Despite the fact that Guarnaccia and Rodriguez (1996) assert that views of mental illness are the least likely to be taken into consideration in the development of a culturally competent service, the literature emphasises the importance of understanding local explanations for mental illness. Kleinman (1980) developed the concept of explanatory models to explore local understanding of mental illness, including the explanatory models of those who suffer mental illness, arguing that beliefs about mental illness are closely related to beliefs about treatment. deVries advocates that psychiatry should "... return to our science, the voice of the patient, and his or her environment so that it may be heard ..." (deVries, 1997, p. 211). He suggests that this in turn will enable practical planning for mental health services and treatments that are tailored for both individuals and specific groups with a cultural context. A thread running through the literature suggests that a mental health care system, which is sensitive to the views of the patients, can be more effective.

Pederson (in Dejarlais, Eisenberg, Good and Kleinman, 1995) argues that a health service for indigenous people founded on the views of the people who will use it, will provide a more successful mental health service than if it were based on western values.

With specific reference to Malawi, MacLachlan, Nyando and Nyirenda (1995) argue that knowledge regarding patients' beliefs about the causes of their problem is required. Based on research conducted in a Zomba Mental Hospital in Malawi (see Chapter One), they state that: "a good mental health service should also be take into account the beliefs

of those it is serving" (pp. 79-80). They suggest that patients' understandings of their disturbance can influence the likelihood of a particular form of treatment being accepted by the patient. Similarly, in South Africa, Lund and Swartz (1998) note in discussing their study of Xhosa speaking South African psychiatric patients, that an understanding of the explanatory models of psychiatric patients can usefully inform the planning of more efficacious mental health services. Petrie and Weinman (1997), in the United Kingdom, also point out that understanding illness perceptions held by patients can be used in clinical settings to improve the management of illness.

Given the importance ascribed to the benefits of understanding the patients' understanding of their illness, and the fact that it is an often ignored aspect in the development of a mental health service the patient's understanding will be the focus of this thesis.

LITERATURE REVIEW

Introduction

As stated in the overview of this chapter, this literature review falls naturally into two sections. The first section addresses three issues essential in focusing this review on the patients' circumstances.

Firstly, it is important to understand the perspective of a person suffering from a mental disturbance, in Malawi. By framing the beliefs of the patient in the context in which they originate, a clearer picture can be seen. Secondly, it is essential to consider the basis of treatments provided by the Service. The origins of psychiatry, which is based on the western biomedical perspective, will be considered. It is acknowledged in some quarters that transferring psychiatry to an African context poses problems. Specific reference will be made to the employment of DSM-IV, a diagnostic tool developed in a western context, which is now widely used in Africa. Thirdly, psychotherapy is a treatment for mental disturbance, common to both traditional healing and psychiatry. The role of psychotherapy in Africa will therefore also be considered.

It is important to note that the intention is not to polarise the traditional African and western world-views but simply to acknowledge that the understanding of mental illness

in the West is rooted in a philosophy distinct from the African philosophy regarding health and illness. Morris wisely remarks that there is "… nothing to be gained by the creation of an opposition between western medicine and the procedures of a *sing'anga* [traditional healer] …" (Morris, 1986, p. 371).

This summary of the traditional and biomedically orientated approaches comes with the qualification that it is not possible to adequately represent either within the confines of this thesis. Furthermore, Swartz (1998) cautions that it is inaccurate to generalise about how biomedicine is conducted world wide, and to conceptualise traditional healing as a single unified system.

The second section is based on the available research conducted in Africa, with specific reference to Malawi, where possible. Attention will be turned to the research that explores patients' explanations for their mental disturbance and pathways to care.

Understanding the African perspective on mental disturbance

The following section aims to give a brief description of how illness is traditionally conceptualised by Africans within their world-view. In Africa, it is estimated that traditional healers and religious faith healers treat approximately 80% of mental disturbances (Madu, 1997). The term traditional healer is a blanket term introduced by the World Health Organisation in 1979 to include all types of indigenous healers. It is used to denote practitioners of medicine outside the formal biomedical sector, and includes spirit mediums, herbalists and faith healers such as prophets. Helman (2000) describes traditional healers as sharing the same basic cultural values concerning the origin, significance and treatment of ill health. Their approach is usually a holistic one, dealing with all aspects of a patient's life, including relationships with other people, with the natural environment and with supernatural forces, as well as any physical or emotional symptoms. Herbalism (Morris, 1986; 1996) and rituals (Kiev, 1989) are integral aspects of healing in this context. Morris describes a strong heritage of herbalism in Malawi. Kiev (1989) defines traditional healing rituals as: "… culturally organised, symbolically meaningful events, which provide standardised therapeutic experiences for the reduction of anxiety and emotional distress for individuals suffering

from a variety of psychiatric illness" (p. 473). A more detailed description of the traditional healing system in Malawi can be read in Chapter Four.

Ebigo (1989), in describing the African attitude towards illnesses, draws from a broad range of studies conducted in Africa. He points out that despite diverse cross-cultural and ethnic differences in Africa, there is nevertheless a general belief that both physical and mental illnesses originate from various external causes. Ebigo comments that one common element prevails and that is "the African belief that physical or mental illness is a result of the distortion between the individual and the cosmos, which may mean his family, society, peers, ancestors, or a deity" (Ebigo, 1989, p. 91). He quotes Baasher (1975) to further illustrate the breadth of these causes: "... breach of taboo or customs, disturbances in social relations, hostile ancestral spirits, spirit possession, evil machination and intrusion of objects, evil eye, sorcery, natural causes and affliction by God or gods."

The African way of thinking is often characterised as being without demarcations between the living and the nonliving, natural and supernatural, material and immaterial, conscious and unconscious (Lambo, 1969) and understanding of health and illness is reflective of this. Belief in spirits and bewitchment, an integral part of the total system of religious ideas and assumption, is normal and accepted. Rejection of such beliefs would be viewed as abnormal according to Lewis (1989).

Morris (1996) states that: "It has long been known that African conceptions of diseases causation are complex and by no means monolithic"(p. 105). Morris is critical of the literature on the system of African disease causation, suggesting that it misrepresents the reality. Misrepresentation occurs because the literature focuses on the supernatural elements of witchcraft and sorcery, and spirits to the exclusion of other etiological factors involved in disease causation. He attributes this to a failure to distinguish nosology (the principles behind disease classification), and etiology (the underlying causes of affliction) at a conceptual level, which has "led to a lamentable tendency, reflected in the writings of many scholars, to view all illnesses as caused by witchcraft or other mystical forces" (p. 104).

Findings from Janzen's study of therapy of the BaKongo in Lower Zaire provide a good illustration that Africans views of illness are not limited to supernatural causes. Janzen (1978) writes that the BaKongo distinguish "... between an illness that is natural in cause, which they call an illness of God ... and one that entails human causes, which is an illness of man" (p. 8).

Accelerated modernisation, urbanisation and socio-political change has led to the opinion that there is a move away from more traditional beliefs towards a more western, biological conception of illness (Peltzer, 1987; Ebigo & Ihezue, 1981). These changes have also impacted on the roles of the traditional healers who have become increasingly specialised and differentiated (Edwards, 1986).

In summary, this section has considered the African perspective on mental disturbance. Traditional healers and their role have been broadly described. The roots of the beliefs commonly held regarding disease causation are noted, and the notion that Africans attribute all illness to supernatural causes has been challenged. It is evident from the writing of Morris and Janzen that this is not the case. A move towards a more biological understanding of illness has been attributed to increasing modernisation, which has also impacted on traditional healers.

PSYCHIATRY

Swartz (1998) describes psychiatry as a branch of western biomedicine which is a western product, and he emphasises that Cartesian dualism is integral to this world-view. Radley (1994) views biomedicine as the western way of understanding and treating disease. It applies the concepts of physiology, anatomy and biochemistry in explaining questions of the origins and treatment of disease. Scientific investigation of causal relationships underpins biomedical concepts of disease and its treatments. Central to biomedicine is the notion of Cartesian dualism, which privileges the body by reducing all problems to their pathologies, which are understood as bodily disease (Radley, 1994).

The biomedical perspective is concerned with the curing of disease and treatment of symptoms where the physician-scientist is a technician applying a high level of skills to

physiological problems (Swartz, 1998). In biomedicine, diagnoses are assumed to relate directly to underlying physical pathology, and treatment involves eradicating the sign and symptoms of the pathology.

Gray (1998) emphasises that biomedicine is a product of western culture, and must be understood as such, as it draws on some of the predominant western philosophical traditions. Following from this he writes that:

> Assumptions which thus permeate biomedicine include (1) that the natural order is autonomous from human consciousness, culture, morality, psychology and the supernatural; (2) that truth or reality resides in the accurate explanation of material (as opposed to spiritual, psychological or political) reality; (3) that the individual is the social unit of primary importance (as opposed to society); and (4) that a dualistic framework (e.g. mind/body) is most appropriate for describing reality. (Gray, 1998, p. 57).

It is acknowledged in the DSM-IV that no definition can actually specify exact boundaries for the concept of mental disorder; a consistent operational definition that can cover all scenarios is lacking. In DSM-IV it states that:

> ... each of the mental disorders is conceptualised as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (p. xxi)

In addition, to qualify as mental disorder the illness must not be an expected or culturally appropriate response to a particular event. Mental disorders may result from biological, developmental, or psychosocial factors and fall on a continuum according to degree of impairment and distress (American Psychiatric Association, 1994). Standard diagnostic methods are used in biomedicine, and in psychiatry the current diagnostic tools are the DSM-IV, which was published by the American Psychiatric Association in 1994 and the ICD-10 classification of mental and behavioural disorders (ICD-10) published by the WHO in 1992.

Major mental illness is conventionally treated pharmacologically with drugs, or psychotherapy. One or more of these approaches may be used in conjunction with each other (e.g. Caine & Lyness, 2000).

Presented in this section is the proposition that psychiatry is rooted in western philosophy, and is therefore a product of western culture. Mental illness, its diagnosis and treatment, within the psychiatric paradigm were briefly reviewed. Of relevance to this thesis is that the Mental Health Service under study operates from the premises of psychiatry.

The use of DSM-IV

A useful illustration of some of the problems encountered in the application of psychiatry outside of the context in which it was developed is the use of DSM-IV in Africa. As a diagnostic tool, DSM-IV is utilised in many countries. It is the most widely used diagnostic classification manual in Africa (Swartz, 1998). The DSM–IV has been criticised as a primarily universalist product of North American psychiatry. The dominance of these systems reflects the domination of North American psychiatry internationally (Swartz, 1998).

Fundamental to an understanding of the difficulties posed by using a diagnostic tool developed in another culture is the opposing emic and etic approaches to cross-cultural psychiatry. Cross-cultural psychiatry research has polarised into two schools of thought; the etic approach advocates the universality of mental illness while the emic approach argues that mental illness categories need to be generated from within cultures (Littlewood, 1990). The former approach assumes that psychiatric taxonomies of mental illness and their instruments designed in the west are globally applicable. On the other hand, the emic approach, rooted in anthropology evaluates phenomena from within a culture and its context, aiming to understand its significance and relationship with other elements within the culture (e.g. Littlewood, 1990).

Patel and Winston (1994) argue just as there is no question about the universal experience of infectious disease or malignancy, there is no doubt that mental illness is a universal experience. However, this does not imply the universality of specific categories of mental illness as defined western diagnostic criteria. The "new cross-cultural psychiatry" emphasises that equal value needs to be ascribed to folk beliefs about mental illness and its categorization as to the western biomedical system of psychiatry.

Kleinman (1977) challenged the assumption that western diagnostic categories were culture free, instead he described these categories as explanatory models, specific to the western context in which they were developed. Instead Kleinman dubbed this "category fallacy" and advocated a new perspective. He specifically dismissed the notion that depressive reactions were the same across all cultures. Littlewood (1990) acknowledges that the challenge presented to current psychiatric thought by Kleinman "proclaimed the arrival" (p. 308) of the "new cross-cultural psychiatry".

Extensive criticism was levelled at DSM-III for the universalist approach which gave relatively little attention to cultural factors. In response to this international advisors were called in to "ensure cultural sensitivity, applicability for international mental health professionals and greater compatibility with ICD-10" (DSM-IV, 1994, p. 864), and so DSM-IV does pay more attention to cultural factors than its predecessor.

However, the efforts made by these advisors to influence the construction of DSM-IV were not as far reaching as some had hoped, though there were significant advances on DSM III. One important achievement is that cultural factors are considered throughout the DSM-IV and not just added as an afterthought. Attempts to change the approach to the DSM-IV in the light of cross-cultural evidence were not fully realised. An article entitled "The Place of Culture in DSM-IV" assesses the successes and limitations regarding the effort to incorporate cultural knowledge and perspectives into DSM-IV as proposed by the group of experts. It is stressed that "careful consideration of culture in psychiatric diagnosis is a clinical issue of compelling importance" (Mezzich, Kirmayer, Kleinman et al., 1999, p. 458).

Mezzich et al. (1999) state that much progress has been made in cross-cultural psychiatry, psychology, medical anthropology and sociology, all disciplines that study psychopathology and the interaction with culture. However, they argue that, despite this knowledge, important recommendations were either minimised or ignored. For example, cultural formulation guidelines for diagnosis were relegated to the ninth appendix without the case illustrations that accompanied them. The cultural perspective was reduced to an addendum in the introduction implying that it represents universal, atheoretical and hence, "culture-free" categories. Furthermore, cultural considerations for specific disorder were included in a simplified way and material presenting any

challenge to the presumed universality of standard diagnostic categories and criteria tended to be ignored

Mezzich et al. (1999) warn that as pathology has been conceptualised as being rooted and fixed in the biological individual in the DSM, it ignores that many psychiatric problems are constituted by economic, family and social and cultural predicaments. Therefore a risk exists that "a diagnostic process exclusively centred on individual pathology may work against a clinically accurate and professionally and morally adequate response" (Mezzich et al., 1999, p. 461-2).

A process of recognising the importance of cultural diversity in mental health work has begun. However, the adaptations to the DSM system as a result of cultural conditions are not fully thought through or integrated in to DSM-IV thinking, nor have the challenging issues raised by cultural relativism been taken on. Of the 182 international advisers involved in the process of revising DSM-III only three were located in sub-Saharan African countries (Swartz, 1998). Swartz, a clinician working in South African, views DSM-IV as retaining emphasis on certain core values of western psychiatry, and biomedicine as a whole. Notably, he questions the benefits of "… trying at times to fit our patients and ourselves unthinkingly into this foreign mould …" when "our society [South Africa] does not look like the mainstream American society that created DSM-IV" (Swartz, 1998, p. 60).

Cuba and China are examples of countries that have developed psychiatric classifications, based on ICD-10, relevant to their respective cultures. Mezzich, Otero-Ojeda, and Lee (2000) state that "… national adaptations of ICD represents attempts at resolving the tensions between universalistic and local perspectives and needs …" (p. 352). *Tecero Glosario Cubano de Psquiatría* [GC-3] (The Third Cuban Glossary of Psychiatry) as is clear from the title, is now in its third edition, since its development in 1975. In the development of the Glossary, Mezzich et al. (2000) comment: "They [the authors] attempted to reflect the realities and needs of Cuba in particular, within the general framework of Latin American culture." Responsibility to the local population combined with an endeavour to construct an international classification from a bottom-up perspective, formed the basis for undertaking to develop the Cuban Glossary. Mezzich et al. write that only the required amendments were made to ICD-10 to make it

both applicable and valuable to psychiatric care in Cuba. For example, both widely known folk syndromes and syndromes and idioms of distress, as recorded by psychiatrists in Cuba, have been incorporated. The example provided by Mezzich et al. describes a syndrome *abríu* whereby some children are believed to be able to "exercise a malign supernatural influence on their relatives" (p. 849), which can result in illness or death. Motivation to prepare the first Latin American Glossary of Psychiatry has stemmed from the development of the Cuban Glossary.

In summary, this section has highlighted the fundamental difficulties that exist in utilising DSM-IV outside the context from within which it has been developed. While acknowledging that mental illness is a universal experience, the idea that specific categories of mental illness are universal has been challenged, even within psychiatry. It is apparent from this review of the DSM-IV that a discontent exists regarding the approach adopted to culture. Although improvements to DSM-III have been implemented, it is the relevance and applicability to Africa that has been questioned vigorously, and the current approach deemed insufficient by the experts in the field. *Tecero Glosario Cubano de Psquiatría,* a psychiatric classification developed from ICD-10 to be relevant and clinically applicable to Cuba, is illustrative of steps some countries have taken to ensure the cultural validity of the diagnostic tool used.

Psychotherapy

A type of intervention, common to both African and western treatment is that which Frank and Frank (1991) generically term psychotherapy. Psychotherapy comprises forms of treatment or therapies "which rely primarily on the healer's ability to mobilise healing forces in the sufferer by psychological means" (Frank & Frank, 1991, p.1). The available literature concerning psychotherapy as a treatment for mental illness in Africa, will be briefly considered. In Africa, psychotherapy could be regarded as being two pronged, with both indigenous and western psychotherapy available. Frank and Frank (1991) in their book *Persuasion and Healing. A Comparative Study of Psychotherapy* identify features common to various forms of psychotherapy in a variety of cultures. Of relevance to this review is the inclusion of healers in what they term non-industrialised societies, which encompasses healers in African societies.

Frank and Frank (1991) describe all psychotherapy as being characterised by three elements: a healing agent, usually trained in a socially sanctioned method of healing, a sufferer who seeks help from the healer, a healing relationship which is a quite structured series of contacts between the healer and sufferer where it is the aim of the healer to bring about relief of symptoms, sometimes with the aid of a group.

In the opinion of Frank and Frank (1991), all psychotherapies share at least four effective features: an emotionally charged, confiding relationship with a helping person (often with the participation of a group); a healing setting; a rational, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them; a ritual or procedure that requires the active participation of both patient and therapist and that is believed by both to be the means of restoring the patient's health.

The type of suffering which leads people to seek help from healers in any culture, are classified in terms of theories that are products of that culture (Kleinman & Good, 1985). Consistent with their world-view, western industrialised societies consider psychotherapy to be "... the systematic application of scientific understanding of human nature to the treatment of the mentally ill" (p. 39).

Frank and Frank (1991) use the term religiomagical healing, to describe psychotherapy in non-industrialised countries. Religiomagical healing began before recorded history and regards suffering as stemming from a supernatural cause. Treatment generally involves a highly charged ritual, which the sufferer and sometimes members of their family participate in with the aim of regaining the balance.

A theme evident throughout their work is that, although the diversity of healing methods across cultures is enormous, and the disparity in the theoretical foundations is great, both western and religiomagical types of healing methods share many commonalities, not least their enduring presence in all cultures, which they would suggest is evidence of their power. However, no evidence exists to support the notion that one particular therapeutic method is more effective than another (Frank & Frank, 1991).

Hubble, Duncan and Miller (1999) reviewed the available literature on the components of effective therapy. While the empirical evidence suggests that psychotherapy is effective, there is no evidence to suggest that one type of psychotherapy is more successful than any other: "… we found that the effectiveness of therapies resides not in the many variables that ostensibly distinguish one approach from another. Instead it is principally found in the factors that all therapies share in common" (Hubble, Duncan & Miller, 1999, p. xxii). One of the common features identified was therapeutic alliance, which is comparable to Frank and Frank's feature of a confiding relationship with a helping person.

Western psychotherapy in Africa

Contrary to the degree of success of western psychotherapy in the West, as evidenced by Hubble et al. (1999), the situation of western psychotherapy in Africa does not appear to be as healthy. Madu, an African psychotherapist in Nigeria, documents that, in most parts of Africa, formal psychotherapy is still struggling to gain ground (Madu, 1997). He gives the example of Nigeria, which in 1995 had a population of 100 million people, yet there were only 10 qualified indigenous psychotherapists.

Central to Madu's chapter is a review of practical problems faced as a client-centred psychotherapist working with people in single therapy in Nigeria. It is acknowledged that the belief system of a psychotherapist who has been trained in Europe may not correspond with the belief system of the client, which in itself poses problems. Individual therapy, being a one-to-one discussion, is viewed with great suspicion; it is not usual to isolate oneself and exclude other family members and friends from a discussion regarding treatment of a person. Madu describes the expectations of the clients as passive or dependant. Clients are not satisfied with *just* therapy, wanting something more concrete, like medicine, to take away with them from a therapy session. Therapy that attempts to promote self directive behaviour, creating circumstances whereby the client can make independent decisions, is not well received by the client (Madu, 1997).

On a more practical level, Madu identifies other problems which also exist. Clients are inconsistent in keeping appointments, or are not punctual. Language barriers present

problems in a multilingual country such as Nigeria. It is only possible to treat clients who speak the same language. He also suggests that, due to ignorance, clients do not understand what psychotherapy is, when it is appropriate, and, if a medical doctor refers them, they do not value it. The lack of psychological instruments developed within the culture, and the poor reliability and validity of western instruments in those settings, pose further problems for psychotherapists.

Madu (1998) laments that neither the psychotherapeutic components of traditional African healing, nor the increasing religious faith healing in Africa, have been properly or sufficiently documented or published. However, one recent study conducted in the Northern Sotho region of South Africa suggests that many parallels could be drawn between the healing processes employed by indigenous healers and western psychotherapy (Sodi, 1998). This study acknowledges that, even though these treatments have been informed by distinct cultural traditions, it would appear that they share some fundamental features. For example, phases of indigenous healing process were identified to be parallel, even on a superficial level, with some western psychotherapies, such as establishing a therapeutic relationship with the patient, establishing the nature of the problem and negotiating the termination of treatment.

In considering psychotherapy, from the broad perspective adopted by Frank and Frank (1991), it can be seen that psychotherapy, as developed in western societies, shares the crucial ingredients for effective therapy with psychotherapy employed traditionally by indigenous healers in 'non-industrialised societies'. Indeed, recent evidence concerning western psychotherapies highlights that it is not in fact the particular type of therapy that effects change, but the features common to all psychotherapy (Hubble, Duncan & Miller, 1999).

In summary, it can be said that, despite the common ground, a number of difficulties arise when western type psychotherapy is transported to African culture. Furthermore, there is a lack of documentation regarding traditional healing methods in Africa. However, emerging studies suggest that parallels can be drawn between the approach of traditional healers and western therapies.

TREATMENT

Treatment choices for mental disturbance

Frank and Frank (1991) define treatment as "attempts to alleviate suffering and disability" (p. 1). At the outset, it was highlighted that different world-views on health and illness correspond with the development of different treatments for mental illness. However, in Africa the reality, as Kortmann (1987) points out, is that biomedical and traditional treatment are both available. Northern Malawi is no exception, with a strong heritage of traditional healers (Peltzer, 1987; Morris, 1986; 1996), Zomba Mental Hospital (see Chapter One) and the establishment of this Service. Swartz (1998) argues that it is an oversimplification to expect that those who are ill will rigidly adhere to the treatment that reflects their world-view regarding health and illness. Furthermore, he points out that making a decision about a choice of treatment is not necessarily based on a world-view. Decisions can be a function of which treatment can adequately address particular problems. A study conducted by Ager, Carr, MacLachlan and Kaneka-Chilongo (1996) illustrates this point. They found that while the treatment sought for malaria or schistosomiasis in a rural community was of a biomedical nature, they attributed such illnesses to a non-medical cause.

Bourguignon (1989) suggests that the choice of treatment is determined by the perceived cause of the disturbance, which is related to the philosophical basis of the etiology. A pervasive belief exists that illness caused by spirits or bewitchment can only successfully be treated by traditional healers or spiritualist healers, whereas those with a 'natural' causation can be treated biomedically. Despite this, she concludes that neither system is used exclusively, and that the belief in either a western biomedical philosophy or African philosophy does not preclude one from seeking treatment in a system that their world-view does not subscribe to.

Recent studies are further examples of the routes patients and their families travel when seeking treatment. Studies indicate that even some of those who are seeking help in a biomedical hospital have already consulted healers. Gureje, Acha and Odejide (1995) indicate that in a study of pathways to psychiatric care in the city of Ibadan, Nigeria, 19% of the patients had first sought care with a traditional healer and a further 13% with religious healers, and they comment that many more of the patients may do so at

another point in time. They observe that these figures reflect only those who have also sought psychiatric care; those who do not use psychiatric care are not included. They suspect that the real percentage of the population as a whole who seek help from religious or traditional healers is greater. Zoller (1997), a European psychologist in a psychiatric hospital in Ghana, used a questionnaire to elicit information regarding the acceptance of traditional methods of treatments from 197 in patients in the hospital. Her findings show that 40% of the patients in the hospital in which she was working, had consulted what she curiously describes as an "alternative psychiatric institute" when referring to traditional healers. While the hospital patients were very willing to discuss traditional methods, the staff, in general were reluctant and unwilling to answer questions on the topic. It is surmised then, that given the prevailing climate in the hospital, the actual figure may be much higher. No significant correlation was found between education and attending a 'traditional place' and no significant difference between the number of men and women attending (Zoller, 1997). Ben-Tovim (1987) conducted a similar study in Botswana and found that almost 50% of the interviewed out-patients had also sought help for their problems in the traditional sector.

These findings clearly indicate that treatment choices do not depend on the patient's understanding of how illness was caused. Furthermore, belief in one type of treatment does not preclude seeking treatment in a system that does not match the patient's world-view. Neither traditional or biomedical treatment is used exclusively, and it would appear that the use of both systems simultaneously occurs.

Impact of westernisation on treatment choices

As previously mentioned, westernisation, or urbanisation, is viewed as having an impact on understanding of health and illness in Africa. This section considers the studies that inform this view.

Madu (1997) cites Ebigo and Ihezue (1981),[4] who identified three types of clients in Nigeria: traditional, mixed, and western orientated types. In Ebigo and Ihezue's classification, those considered traditional grew up and spent most of their formative years in rural areas, some of whom moved to townships at a later stage. Their world

[4] Ebigo and Ihezue (1981) article is written in German.

image may be described as being analogical, magical and pictorial. They go to traditional healers when they have health problems. The intermediate group, the mixed type, are described either as being born and reared in rural areas but having moved to a city to work and live as adults, or as having grown up in a city, but continue to have very strong ties to rural areas and their customs. They have a tendency to make use of two methods of healing at the same time, and some may also consult the religious faith healers. The western orientated types of client were born and bred in townships. This group are educated, as their parents are, mostly Christian or Moslems, and are in a monogamous marriage. From childhood, these clients have been treated in hospitals and have never thought of going to a traditional healer when they are ill.

With regard to Malawi, Peltzer (1987; 1989) emphasises that the country is in transition, with the impact of western ideas and concepts, particularly education, creating a conflict between traditional collective values and more individualistic western values. This results in three different personhoods: traditional personhood, transitional personhood and western personhood. The majority of Malawians in the rural areas can be called traditional persons and the majority of the urban population can be regarded as transitional. The western type was not yet common in Malawi at this time. According to Peltzer, the differences arise as a result of different socialisation in three dimensions – the authority, the group and the body-mind-environment dimension. A brief description of what constitutes a traditional and transitional personhood follows. Due to socialisation, the traditional person is ruled by the authority dimension. This dimension is based on the principles of age and seniority, consisting of the mother, elder siblings, father, elder ancestors (*mizimu*) and God (*Mulungu*). The traditional person is described as being more a "group person" than the transitional person, as they will have undergone a process of individuation. Traditional people are more likely to have supernatural theories of illness and misfortune as a result of their socialisation in the body mind environment dimension, and body mind unity exists to a greater degree. Peltzer defines the transitional person as one who is:

> ... in the process of crossing from traditional to western culture and may temporarily turn back, particularly in times of crisis. He is no longer traditional and not yet western, his mind is western orientated but he is still psychologically rooted in traditional culture. (Peltzer, 1989, p. 130).

The view that different sectors of the population are more inclined to chose a particular type of treatment may play a significant role in understanding Malawians' choice of treatment for mental disturbance.

Treatment choices in Malawi

Peltzer (1987) conducted a comprehensive study focusing on traditional healing practices, with particular reference to psychosocial health care in Malawi. Adopting a qualitative approach, he interviewed 40 healers and 960 actual and potential clients in 13 research sites, located throughout the country. One aspect of his research was health seeking behaviour in Malawi, which provides a useful context for the present study.

Peltzer (1987) suggests therapeutic pluralism is high, given that many of the interviewees utilised more than one type of health care. He found that traditional healers were more likely to be consulted for psychosocial disorders, which include mental illness. His findings would appear to indicate treatment choice was influenced by place of dwelling, gender and age and education. Urban dwellers used western health care more often than the villagers. Peltzer surmised that this could be due to the change in attitude and concentration of western healthcare in towns. However, a traditional healer was more likely to be consulted than western health care if the illness was attributed to a supernatural cause. He found that those with less formal education and with fewer skills were more likely to consult the folk sector. Nevertheless, some highly skilled and educated people did continue to consult healers. The older generation tended to view their illness as resulting from a supernatural cause more so than the younger generation, and consequently were more likely to consult a healer. Interestingly, the majority of the patients in Peltzer's sample were members of the Christian church, despite the fact that consultation with healers is discouraged in Christian churches. Peltzer found that the church influenced only a minority of cases in their treatment choice.

In his sample, females seemed to consult traditional healers slightly more frequently than men. Peltzer offers two explanations for this. Firstly, women have the emotional-expressive role in the family in Malawi. Women may therefore take psychosocial problems to the healer either as a representative of the family, or as a patient herself, or in some cases, for both reasons, as psychosocial problems are predominantly attended to

in the traditional healing sector. Secondly, she may consult the healer more as she is less formally educated and more religious. Males, on the other hand, appeared to attend western medical care more often. He uses the example that the number of male patients in the mental hospital in Malawi is considerably higher than female patients. Another interesting angle to pursue in considering why women are more likely to attend traditional healers in Malawi is Schoffeeler's (1997) finding that it is particularly women who are affected by spirit possession. Perhaps this may contribute to the reason why more women attend traditional healers.

Spirit illness

According to Lewis (1966), the prevalence of spirit possession in women in Africa and elsewhere can be explained in terms of a reaction to their subservient position in a male dominated society "... as a compensation for their exclusion and lack of authority in other spheres" (p. 310). His main hypothesis is that the preponderance of female possession occurs as a result of cross sexual hostility in societies where men are dominant in the social structure. On the other hand, Wilson (1967), while agreeing that married women are more likely to become possessed in male dominated societies, challenges Lewis' conclusion. He puts forward a theory that it is intrasexual hostility, correlated with status ambiguity, that results in the phenomena. He argues: "spirit possession and similar states seem more closely correlated with social situation which regularly, though not necessarily, give rise to conflict, competition, tension, rivalry or jealousy between members of the *same* sex rather than between members of the opposite sexes" (p. 366). Schoffeelers (1997) argues that these two functions need not exclude each other. However, even when taken together, they do not do justice to this multifaceted phenomenon, as evidenced in the findings of his study of spirit possession in Malawi.

Schoffeelers' study of spirit possession in the Lower Shire Valley area of Southern Malawi between 1966 and 1967 incorporates both the Sena group, which is patrilineal, and the Mang'anja group, which is matrilineal. In defining spirit possession, he refers to a "state of real or feigned dissociation during which the spirits of deceased human beings are thought to act through a living person" (p. 102). However, his study does confirm that spirit possession is more prevalent among women, noting that "... women

are more apt to succumb to possession than men" (p. 112). Schoffeelers states that neither of the abovementioned theories provide an adequate explanation for all types of spirit possession in this locality. Different types of spirit possession exist, dictated by the type of spirit involved. Only the territorial spirit mediumship is more common in males; it does not result from stressful situations, but has a genealogical component, being passed through families. Also, this type of mediumship is politically orientated and men tend populate the political realm.

Comparing the incidence rates of domestic possession in the patrilineal and matrilineal groups, only women in the matrilineal group experience possession by foreigners. Possession by grandparental spirits occurs three times as often, and possession by witch spirits occurs twice as often in these women. It appears that the disproportionate frequency of spirit possession by the grandparental spirits in women can be explained by virilocality, although other factors may have a role, such as rivalry and status ambiguity. Within a patrilineal group, when a woman marries, she leaves her village to live in her husband's, and no longer has the supervision or support of her own kin. Grandparents as spirits seem to be a logical continuation of the role they played in the socialisation of grandchildren prior to their death. The suggested impact on women in a patrilineal group is important to consider in Northern Malawi because, as pointed out in Chapter One, Northern Malawi is patrilineal.

Spirit illness is called *vimbuza* by the Ngoni and Tumbuka in Mzimba District, and *mashawi* by the Tonga in the Northern Region. These names are used to describe an illness believed to be caused by spirits in the body of a human being (Peltzer, 1987). *Vyanusi* is an advanced form of *vimbuza* (Soko, 1988; Peltzer, 1987; 1989). Soko (1988), himself from the Mzimba District of Northern Malawi, writes that v*imbuza* has occupied an important place in Ngoni-Tumbuka society. And although, according to Soko, not much is known about the origin or the disease itself, there is some conjecture that *vimbuza* was beginning to become more common around the time of the Ngoni invasion of Northern Malawi, which was prior to the commencement of the colonial era in Malawi. The early Christian missionaries were aware of *vimbuza*, and knew that a *vimbuza* patient would resist staying in hospital. Soko quotes a remark made by a missionary doctor in 1925 who practised at a Loudan missionary hospital in Mzimba: "They [the Malawians] have a great advantage over you, that they have learned long

ago, a fact never taught in medical schools ... that magic of some sort is at the back of nearly all sicknesses. Therefore magic must fight the battle" (Soko, 1998, p. 13).

In Peltzer's study, he found that *vimbuza* seemed to be more common in the north, and more symptom descriptions were reported than spirit illnesses in the other regions. In his sample, 116 patients were suffering from *vimbuza*. Consistent with Schoffeelers' finding, he found that spirit illness was more common in females. Of those suffering *vimbuza*, 88% were women, the majority of whom were illiterate.

In summary, Peltzer's study found that treatment for mental illness was more likely to be sought from traditional healers. He also found that therapeutic pluralism was common, as many of his sample utilised more than one type of health care. His findings indicate that treatment choices are influenced by place of dwelling, age and education, gender.

Both Peltzer's and Schoffeelers' findings indicate that, at least up until 1987, spirit illnesses were very evident in Malawi, perhaps particularly in the patrilineal Northern Region, and, it would appear, particularly among women. It could be speculated that the preponderance of spirit illness amongst females leads to a greater likelihood of women attending traditional healers than men.

Causes of mental disturbance in sub-Saharan Africa

Before focusing on the causes of mental disturbance in Malawi, it is useful to view how such disturbances are understood in the region of Africa in which Malawi is located.

Patel's review of explanatory models of mental illness in sub-Saharan Africa reveals a diversity of explanations for mental illnesses in this region. Beliefs about the causes of illness include bewitchment, spirit possession, natural causes, excessive thinking, complications of malaria, drug use and studying too much (Patel, 1995). Given the probable influence of westernisation, as discussed earlier, it is of import to focus on contemporary studies. Patel, Gwanzura, Simunyu, Lloyd and Mann (1995) conducted an interesting study concerning the explanatory models of common mental disorders with patients currently receiving treatment in Harare, Zimbabwe, using both emic and

etic methods. General nurses in primary health care clinics and traditional healers in their own practice selected participants from current clients. The selection criteria dictated that, in order to be included in the study, the patient must have consulted the care provider with a problem related to mental illness in the previous week. The participants were interviewed using the Explanatory Model Interview (EMI) and the Revised Clinical Schedule devised in the U.K.

One of several areas addressed in the EMI is the perceived cause of the mental illness. Participants were asked to list up to three possible causes for their illness. Spiritual factors were frequently cited as causes of mental illness, with 45.5% of the participants citing this as a cause. Unfortunately, spiritual causes were not defined. It is not clear whether they refer only to spirits, or to supernatural causes in general. Other frequently cited causes were specific somatic diseases (17.3%), e.g. venereal disease; socio economic causes (19.2%), e.g. homelessness; psychological causes (18.2%), e.g. thinking too much; marital causes (19%), e.g. physical abuse by husband; bereavement (12%). When asked about the most important cause for illness, clinic attenders were more likely to identify somatic causes (17% *v.* 3.5%) bereavement (9.4% *v.* 1.8%) and psychological factors (15% *v.* 7%), while traditional healer attenders were more likely to identify spiritual causes (43.9% *v.* 9.4%).

Patel, Gwanzura, Simunyu, Lloyd and Mann (1995) surmise that it is possible that one reason for this finding is that their models of illness had been influenced by the care provider whom they had just attended. Equally, it could be that patients' explanatory model for illness influences their choice of treatment behaviour in seeking provision of health care. However, their study can confirm neither. The fact that spiritual causes were the most frequently cited in urban Zimbabwe, in this study, indicates the continuing importance such explanations hold for people.

Research in Malaŵi

Having considered the explanations of mental disturbance in sub-Saharan Africa, attention will turn to the research carried out in Malaŵi regarding the beliefs held about the causes of mental disturbance. A number of studies have been conducted. Peltzer (1987) interviewed both patients and healers regarding the causes of mental illness.

Several years later, a series of studies regarding Malawians' beliefs on the causation of illness was conducted (MacLachlan, Nyirenda & Nyando, 1995; MacLachlan, Banda & McAuliffe, 1995; Ager, Carr, MacLachlan & Kaneka-Chilongo, 1996; Shaba, MacLachlan, Carr & Ager, 1993; MacLachlan & Carr, 1994b). Although each of these studies was conducted in Central and Southern Malawi, these findings offer valuable information for the current study. Additionally, in 1998, research was conducted in Northern Malawi, by the St. John of God Mental Health Service Research Group, to ascertain local belief systems regarding health and illness in the catchment area of the hospital. Causes of mental disturbance were addressed specifically. Each of these studies will be considered in turn.

Peltzer (1987) interviewed the patients of traditional healers regarding the causation of a range of physical and mental illness. Responses were categorised as to whether the disorders were attributed to natural or supernatural causes. Witchcraft and sorcery were seen as two of the most predominant single causes of illness, including mental illness. Drinking beer and smoking cannabis were more frequently cited as causes of mental illness by urban dwellers. Urban dwellers also cited witchcraft and sorcery more frequently than spirit aggression. Peltzer postulates that ancestral spirits are still seen as an integral part of the village community, whereas this is not the case in the life of the urban dwellers. Furthermore, he suggests that, for the urban dwellers, sorcery and witchcraft may replace spirit aggression as reasons for illness.

Peltzer (1987; 1989) examines what he describes as the emic nosology of *vimbuza* independently from spirit disorders in the rest of the country, therefore providing information particular to the Northern Region. These patients reported a variety of 23 symptoms, including those which affect the head, the body, the abdomen. The most commonly cited symptom affecting the head is being troubled in dreams by ancestral spirits (94%). Seventy six per cent describe speaking in other languages that other people do not understand. Other descriptions included feeling a headache very much (80%), feeling dizzy (72%), falling down (36%). Symptoms affecting the body range from the body trembling (75%) to paralysis of the body (45%). Reported changes in behaviour included social withdrawal and behaving like a child. Loss of appetite (75%) and feelings of nausea (44%) are examples of symptoms which affect the abdomen.

Peltzer translates these symptoms into western psychiatric diagnoses, based on DSM-III categories. It is useful in this thesis to see how this spirit illness fits into a western psychiatric framework. Of the 23 symptom descriptions listed by Peltzer, 13 can be referred to as conversion, seven as symptoms of depressive neurosis, and four as symptoms of dissociative disorder. Peltzer surmises that *vimbuza* seems to be a psychoneurosis mainly of conversive or dissociative character and to a lesser extent a depressive neurosis. The remaining three symptom descriptions refer to an acute confusional or delusional state.

Bad ancestral spirits, too much thinking over personal problems, witchcraft and natural (e.g. if a mother has it, the daughters will also suffer) are all reasons cited for *vimbuza*. The transitional person in his sample refers to too much thinking and natural as causing *vimbuza* more often than the traditional person does, and is therefore less likely to see witchcraft and ancestral spirits as causes.

A series of studies carried out in Malawi, over a period of several years, highlight the prevailing understanding of health and illness in contemporary Malawi (MacLachlan & Carr, 1994a). The study most relevant to this thesis was conducted in Zomba Mental Hospital, the focus of which was on patients' attributions for their admission to hospital (MacLachlan, Nyirenda & Nyando, 1995). It was found that what were termed traditional attributions (i.e. involving bewitchment and ancestral spirits) were the most common attributions held by patients to explain being admitted to hospital (32 out of 103 patients). Also reported were plural explanations, where patients held combinations of medical, psychological, and traditional attributions. Attributions which involved elements from more than one category were given by 12 of the patients, the majority of which included a traditional element. Patients were classified as 'exhibiting psychotic behaviour' or 'not exhibiting psychotic behaviour'. Classification (psychotic or non psychotic) was not associated with attribution, nor was the gender of the patient. These results were considered in terms of the implications for the development of mental health services in Malawi, emphasising the importance of taking into consideration the attributions patients have for their mental disturbance.

It is useful to look at the findings of other studies in this series. Although not confined to mental illness, they offer an insight into the Malawian perspective on the causation of

illness and how these beliefs influence the type of treatment they seek. Ager, Carr, MacLachlan and Kaneka-Chilongo (1996), as referred to earlier in this chapter, conducted a study regarding the beliefs held about the cause, risk reduction and treatment of two diseases – malaria and schistosomiasis, both endemic in Malaŵi. They found that the majority of individuals sought medical treatment for both illnesses, even though many of them attributed the cause and risk of infection to non medical factors (such as bewitchment). All of the participants said that they would choose a medical form of treatment, such as the widely available drug, Fansidar, regardless of whether they thought malaria had resulted from bewitchment. These findings were interpreted as indicating that Malaŵians are able to tolerate a degree of "inconsistency" between what they believe causes these serious illnesses and what they do to treat them, reflecting a "tolerance" in integrating differing ideas about illness. Similarly, a study looking at beliefs regarding cause, cure and treatment of epilepsy, conducted by Shaba, MacLachlan, Carr and Ager (1993), found that participants held traditional, non medical views about epilepsy alongside medical views.

In terms of attributions for psychological disturbance, MacLachlan, Banda and McAuliffe (1995) found that pupils who had been involved in a case of epidemic psychological disturbance at a Malaŵian girls' secondary school could hold several causes simultaneously. These causes included what were categorised as psychological, medical and traditional causes.

A further study conducted by MacLachlan and Carr (1994b) with a university population concerning the credibility of different sources of information about HIV/AIDS, reiterates this point. Their findings suggest that those who endorsed the 'biomedical' group factor, which includes doctors and nurses, were no more likely to rate traditional healers as lacking credibility, or highly credible. It was therefore possible that both sectors could be endorsed as credible.

A coherent picture begins to emerge of how Malaŵians construe health and illness. More than one belief of health and illness can be held at once, described as "cognitive tolerance", a term coined by MacLachlan and Carr (1994a). Also evidenced is that a belief in one health care system does not preclude utilising another, or both, in keeping with the findings of Bourguignon (1989) and Peltzer (1987). Such "cognitive tolerance"

has been described by MacLachlan (2001) as a possible reflection of pluralistic and pragmatic integration of different ontologies.

An exploratory qualitative study conducted in Northern Malawi in 1997 and 1998, by the St. John of God Mental Health Research Group (of which this writer was a member), explored local people's understanding of mental disturbance (Herzig, deSalis, Chilale & Smyth, 1998). That study offers an insight into Northern Malawians' current understanding of causes of mental disturbance. We used two research sites: a rural, predominately Tongan village, and an urban township in Mzuzu, with mixed ethnicity. A semi-structured interview was developed, with a range of open-ended questions exploring commonly held beliefs regarding many aspects of mental health and illness. A number of areas were explored, including perceived causes of mental illness and recognition of mental illness.

A wide range of informants were sought: traditional healers, relatives of people with a mental disturbance, people who have suffered a mental disturbance; people with authority in the community such as primary health care volunteers, teachers, village headmen, and church leaders. Children, adults and elderly people were interviewed. In total, one hundred informants, fifty from each site, were identified and interviewed.

Informants were asked a question about the causes for mental disturbance. The question was open-ended and no restriction was placed on the number of causes they could give. *Chamba* (marijuana) was the most commonly cited cause for mental illness, given by 95% of the informants; bewitchment was seen as a cause by 86% of the informants, while 57% felt that thinking too much/worry could cause mental disturbance. *Mizimu* (spirits)/untreated *vimbuza* (spirit illness) were considered a cause by 49%, and the remaining eleven themes were as follows: alcohol (41%), physical causes (33%), epilepsy (19%), natural/from God (18%), *mankhwala* (medicine),[5] drugs, misuse of traditional medicine (18%), hereditary (10%), shortage of senses (8%), too much reading/education (6%), lack of parental care (5%), bad ways (5%) (Herzig, deSalis, Chilale & Smyth, 1998; Herzig, 2000).

[5] See Chapter Four for a fuller explanation of this term and Glossary (Appendix C) for brief definition.

Comparisons of the responses between rural and urban samples indicate a very strong consistency of opinion regarding the role of *chamba*, alcohol, epilepsy, heredity, too much reading/education and a lack of parents/parental care in causing mental illness. Responses from informants in the rural area are more likely to indicate bewitchment as a cause, while responses from those in the urban area are more likely to respond with answers which fall into the categories of thinking too much (worrying), spirits or natural (God's will) or untreated *vimbuza.*

Our findings are not consistent with Peltzer's study conducted twenty years earlier. In comparing the two studies, it can be seen that the rural and urban participants in the more recent study are equally likely to see alcohol and *chamba* as a cause of mental illness, whereas, in Peltzer's study, it was urban dwellers who were more likely to attribute mental illness to these reasons. In Peltzer's sample, attributions of witchcraft were more likely amongst the urban dwellers and spiritual attributions more likely among the rural dwellers. In the study conducted by the Service, the reverse situation was found, with the urban participants citing spiritual reasons more frequently, and rural participants citing bewitchment more often as a cause of mental disturbance. Of course, the studies are not directly comparable, either in time or location. Our study was conducted two decades after Peltzer's study, and was confined to Northern Malaŵi, while Peltzer's was countrywide. It is not surprising that, with the passing of two decades, beliefs have changed. However, instead of a move away from beliefs regarding the role of spirits and witchcraft, which one could have speculated with increased urbanisation, spirits and witchcraft have remained central to Northern Malaŵians' explanation for mental disturbance (Smyth, 2000).

In summary, it appears that Malaŵians, like the rest of sub-Saharan Africa, hold a wide range of beliefs regarding the causes of mental disturbance. Indeed, one person may hold several seemingly contradictory beliefs, referred to as cognitive tolerance. While it has been suggested that westernisation and/or urbanisation has had some impact, lessening the beliefs regarding witchcraft and spirits as causes of mental disturbance, the research findings show that, as recently as the late 1990s, these beliefs are strongly held, even in more urbanised areas. These beliefs are held alongside, or in combination with, other beliefs regarding the causes of mental disturbance, such as *chamba*, alcohol, and thinking too much. A particular belief about the cause of one's illness does not

dictate the type of treatment that will be sought, or restrict the patient to seeking only one type of treatment.

SUMMARY

There is a growing emphasis in psychology in recent years on the importance of the role of culture in mental disturbance. Culturally competent health services as a concept was introduced before looking at the views of culture. It was argued that careful consideration of how cultural factors should be incorporated into a service in order to ensure that it is culturally competent. In the opinion of Guarnaccia and Rodriguez (1996), views of mental illness are the least likely to be introduced. Attention is then turned to research that accentuates the benefits of taking into consideration the views of those seeking treatment. Therefore patients' understanding of their disturbance was stated to be the focus of this research.

The first section of the literature review deals with three main issues: the context in which Malawians' beliefs about health and illness are embedded, the basic tenets of western psychiatric treatment, and psychotherapy as a treatment for mental disturbance as available in Africa. In considering the use of western psychiatry outside a western context, the discontent expressed in some quarters regarding the use of DSM-IV in Africa was highlighted. Attention was drawn to the difficulties experienced by African psychotherapists in using western psychotherapy as a treatment for mental disturbance in Africa. The second section turns to the literature regarding treatment choices in Africa, then to explanations for mental illness in sub-Saharan Africa, before specifically examining the body of information pertaining to understanding of mental disturbance in Malawi. The research consistently shows that Malawians can tolerate more than one belief concerning the causation of their illness. Despite the suggested effect of westernisation and urbanisation, traditional beliefs for the causes of mental disturbance, such as bewitchment and spirits, are still pervasive and exist alongside beliefs that *chamba* and alcohol, too much thinking and epilepsy can cause mental disturbance. Furthermore, the findings suggest that ontological beliefs do not dictate the type of treatment sought.

RATIONALE OF STUDY

The motivation behind this thesis was to contribute to the development of a mental health service that would accommodate the needs of the local people. In this sense, this thesis can be described as opportunistic. The establishment of a new Service with a commitment to delivering mental health care, appropriate to the needs of those it serves, combined with increasing awareness of the benefits of doing so, afforded an opportunity to conduct the current piece of research. Consequently, although the research questions are operationalised in terms of service delivery, they are theoretically derived.

OBJECTIVE OF RESEARCH

The main objective of this thesis is to attempt to understand the cultural context of mental health in Northern Malawi, and to identify ways this knowledge can contribute to the development of a mental health service which meets the needs of the local people.

One aim of this study was to provide a hitherto unchartered account of explanations of mental disturbance from those who have been admitted to hospital in Northern Malawi and subsequently diagnosed as suffering from a mental illness. A second aim was to become familiar with the extant healing system as a means of conducting the research in a culturally informed manner.

RESEARCH QUESTIONS

This piece of research seeks to build on the study conducted in Zomba Mental Hospital, Southern Malawi by MacLachlan, Nyirenda and Nyando (1995) as it explores patients' attributions for mental disturbance in Malawi, as previously outlined. This thesis seeks to answer the following questions:

1. How do patients explain the cause of their mental disturbance?
2. Does the mental health of patients admitted to the hospital improve while they are hospitalised?
3. Do explanations held by patients regarding the cause of their illness impact on the improvement of their mental health?
4. If improvement occurs, is it maintained post discharge?

5. What recommendations can be made for the development of culturally sensitive health services in Northern Malawi?

This information should enhance the knowledge of local understanding of mental disturbance and therefore can be used to identify measures that could be implemented to ensure that the Service develops into a culturally competent service that meets the needs of the local people.

CHAPTER 3: METHODOLOGICAL CONSIDERATIONS

INTRODUCTION

This research was conducted in a country with a different culture and language to that of the researcher, which presented certain methodological issues that needed to be addressed. Research with a cross-cultural element can be fraught with many methodological problems (Triandis & Berry, 1980; Brislin, 1980). This chapter aims to explicate both the preliminary preparations that were undertaken to overcome the potential difficulties, and the measures taken to address the methodological issues. These considerations are pertinent to both the study conducted in the hospital and the research carried out with the traditional healers.

For the sake of clarity, the research carried out with the traditional healers will be referred to as the 'traditional healers study'. The research conducted with patients in the hospital will be referred to as the 'hospital study'.

PRELIMINARY PREPARATIONS AND METHODOLOGICAL ISSUES

Before data collection could begin in earnest, various issues had to be taken into consideration, which included language issues and appropriate interview techniques.

Language issues

Duranti, an anthropologist, writes: "However clumsy and inadequate ethnographers' attempts to speak the local language might sound, they symbolise a commitment, and show respect and appreciation for the cultural heritage of the people they study" (Duranti, 1997, p. 111). Furthermore, Duranti (1997) points out there is no question that fieldworkers should try their best to become familiar with the language(s) used by the people they are studying, not only from the point of view of being able to conduct interviews without interpreters, but also for understanding what is going on. He cites Witherspoon:

> The greatest value of learning the language of another people does not come from being able to interview informants without interpreters or from providing native terms in ethnographic writings; it comes from being able to understand what the

> natives say and how they say it when they are conversing with each other. (Witherspoon, 1977, p.7)

Prior to the commencement of the research, this researcher made arrangements to organise and attend language classes in chiTumbuka, the most commonly spoken local language in the region. Classes were continued for the two and a half years she lived there, and every available opportunity was taken to converse with hospital staff and local people in an effort to improve her ability to communicate in the local language. In addition to learning greetings and pleasantries, sustained efforts were made to get to grips with the language. Particular emphasis was given to becoming familiar with vocabulary related to health, illness and mental disturbance. Obviously, time and exposure were essential ingredients and progress (although sometimes stumbling) was made throughout the duration of the fieldwork. A level of fluency that would allow her to conduct interviews alone was not the intention, but rather an ability to facilitate discussions of issues associated with health, illness and mental disturbance.

Cultural issues

Interviews were the primary form of data collection employed in both studies. Cross-cultural interviews face specific difficulties (Pareek & Rao, 1980). Various cultural factors (amongst other factors) can influence the authenticity of the responses from respondents. Authenticity may be defined as "the total capability to get unbiased and genuine responses from the respondent" (Pareek & Rao, 1980, p. 154).

Brislin, Lonner and Thorndike (1973) identified four main factors that have been found to influence the authenticity of responses, and they are as follows:

1. Interviewer related factors
2. Interview related factors
3. Respondent related factors
4. Cultural factors

Based on these factors, steps were taken in an endeavour to maximise the authenticity of responses in the interviews. These steps are outlined below.

Interviewer related factors

Interviewer affiliation

Interviewer affiliation refers to the organisation to which the interview is affiliated. This can present a problem. The participants in both studies were aware that this researcher was working in the Service, which was associated with both Christianity and western medicine. Potential consequences in the interview were that participants might have been reluctant to give answers that diverged from what they perceived to be western 'biomedical' ideas. This issue is equally applicable in the hospital study and the traditional healer study. The extent of this problem is difficult to quantify. Efforts to overcome this were undertaken, for example, by communicating where possible in the local language, using vocabulary that demonstrated knowledge of local health beliefs and concepts.

Interviewer image

It is important that the interviewer creates a favourable image by establishing rapport with the respondents. One way this was achieved was by greeting the participants in the customary fashion in Malawi.

Respondent interviewer distance

Respondent interviewer distance is composed of two biases. Firstly, status distance bias could potentially present a difficulty in this study. Unfortunately, in the researcher's own experience, a certain perception exists regarding *wamuzungu* (westerners). Westerners are often considered to undervalue and even discredit traditional beliefs and customs. It could be surmised that this perception is possibly a consequence of the cultural heritage of colonialism. This situation may introduce a perceived status difference between the interviewee and interviewer, from the point of view of the interviewee, which may intrude on the interview. Secondly, the more obvious bias is termed "racial difference bias" by Brislin, Lonner and Thorndike (1973). The fact that the interviewer was not African may discourage the participants from divulging information that they knew to be part of African culture, which is not seen to be part of western culture. In an attempt to minimise this as a problem, efforts were made to demonstrate that this researcher had a genuine interest by using the local language,

showing knowledge of local customs and beliefs, and discussing local issues when possible. In an effort to evaluate the extent of this problem, Malawian interviewers also carried out some of the interviews in the hospital study. This allowed the comparison of the content of those interviews conducted by Malawians to that of the interviews conducted by this researcher.

Respondent relevance

Respondent relevance is the extent to which the interviewer can make the respondent feel that the interview is valuable to the researcher. This can have a bearing on replies given. Making the participant feel that both they and their values are important to the interviewer is crucial. Disinterest can be communicated through various different non-verbal cues. The interviewer was acutely aware of the potential of appearing as if interest had been lost while a question was being answered in the vernacular, particularly if a local language with which she was not familiar was spoken. A conscious effort was made to demonstrate interest at all times in order to maintain the confidence and respect of the interviewee.

Interviewer bias

Interviewer bias refers to the communication of one's own opinion to participants, which can obviously impact on the authenticity of the responses. The researcher undertook to avoid this risk. This risk was also addressed in the training of the interviewers.

Interview related factors

Location of the interview

The location of the interview is important and is addressed in the respective methodology chapters of each study.

In the hospital study, all of the admission and discharge interviews were obviously conducted in the hospital. Where possible, the counselling room was used, as it was not the same room as clinical officers interviewed patients in. However, this was not always possible. The follow-up interview took place in a variety of different settings, which is

dealt with in Chapter Six. Regarding the interviews conducted with the traditional healers, the location was left to the discretion of the *ŵasing'anga* (healer) involved, or the *ŵasing'anga* who had arranged the interview.

Thematic sensitivity

Thematic sensitivity refers to how sensitive areas may be tackled or be brought up in an interview. The researcher made a concerted effort to become acquainted with areas that were generally not appropriate to discuss 'between strangers' in Malaŵi, as would be the case in the interview setting. Once aware of these issues, advice on the most sensitive way to deal with them was sought from colleagues and neighbours. For example, issues relating to witchcraft or information about bewitchment could sometimes be deliberately vague or oblique. I was advised not to try to pursue this information by direct questioning. Becoming familiar with the various expressions which did not explicitly refer to bewitchment helped to overcome this problem.

Cultural relevance

Brislin, Lonner and Thorndike (1973) highlight that consideration should be given to the special cultural characteristics, customs, and norms of the group studied. To create a climate conducive for communication, the language used in the interview should reflect the interviewer's understanding of cultural norms. This can make a pronounced difference in creating the proper climate for communication. As noted before, this was undertaken.

Sequencing questions

The sequencing of items can influence the authenticity of the replies in an interview situation (Brislin et al., 1973). Care was taken to ease the participant into the interview gently, asking neutral questions initially.

Length of interview

Brislin (1980) includes the length of the interview as a factor that needs to be taken into consideration. If the duration of an interview is longer than ninety minutes, fatigue could cause less authentic responses. Although the suggested length was ninety minutes,

in the case of the interviews conducted with those who were patients in the hospital, appropriate breaks were taken if required, or if it appeared that an interview was going to continue for longer than forty five minutes. The researcher felt this was particularly important in translated interviews, both for the participant and the translator.

Respondent related factors

The respondent related factors identified by Brislin, Lonner and Thorndike (1973), which are most pertinent to the type of interviews employed in the present study, are detailed below.

Previous experience

It has been suggested that previous positive experiences of being interviewed are more likely to result in authentic responses. This is a particularly salient issue in the context of the hospital study, being a longitudinal study, with interviews on three occasions. Thus, it was important that the interviewer made a good impression on the first occasion, both for the quality of the information in that interview, and for subsequent interviews.

Cultural factors

Courtesy norms

Courtesy norms in the culture are important to understand. In some cultures, the participants tend to give answers that they think could please or satisfy the interviewer. It is suggested that if the interviewer's appearance and dress is similar to those whom they are interviewing, courtesy bias can be reduced. Care was taken that dress was in keeping with Malawian women. At the time of interviewing, it was not usual for women to wear trousers, shorts, dresses or skirts that did not reach knee length. Long skirts or dresses made from local fabrics were often worn. *Vitenje* (sing. *chitenje*) were worn when attending traditional ceremonies. *Vitenje* are lengths of fabric, approximately two metres in length, which can be fashioned into a wraparound skirt. The majority of Malawian women wear *vitenje*.

Reticence

In some cultures, it is customary not to come directly to the point. The researcher recognised this as customary in Malawi. It is suggested that opening the interview in the vernacular can reduce this. This recommendation was observed. It came to the researcher's attention that it was not uncommon for women to interact in a more "bashful" way, less likely to make eye contact, or decline to answer questions, or give short answers. This type of behaviour is described as *soni* in the vernacular, and was described to me as a characteristic socially encouraged in women. Behaving without shame or respect leads a woman to be described as not having *soni,* which is not a desirable characteristic. This behaviour can present some difficulties in an interview setting, but once it had been identified as a cultural response, it was less difficult to manage. The researcher was also less likely to interpret it as a symptom of disturbance.

Game playing norm

In some cultures, it is recognised that people may enjoy 'playing games' with interviewers who are not local by giving unauthentic answers. The researcher was aware of that possibility, but was satisfied that this was not the case in the interviews conducted.

Cultural familiarity

Familiarity with the cultural aspects of a community is necessary. In addition, the interviewer must know the cultural norms of the people to be interviewed and establish acceptable channels of communication. This researcher lived in the community for two and a half years. Others involved in the research process (translators and other interviewers) were from Northern Malawi.

Summary

Every endeavour was made, at all times, to communicate interest in the culture, be culturally sensitive in the language used, topics addressed and appearance, in order to maximise the authenticity of responses.

TRANSLATION

This researcher did not attain a level of fluency in chiTumbuka which would enable her to conduct interviews alone. Therefore, a translator was required to conduct interviews in the numerous local languages (chiTonga, chiNg'oni, chiLambiya, chiSuskwa, chiNdale for example). Swartz (1998) states that interpreted interviews (interviews that use translators/interpreters) are difficult for all concerned – the interviewer, the participant and the interpreter. Such interviews are described as time consuming and can present an awkward situation to manage socially. The importance of recognising these difficulties is stressed and he suggests trying to anticipate these difficulties.

Common errors that interpreters make in translating interviews, according to Vasquez and Javier (1991), include the following:

1. **Omission:** The interpreter fails to relay all, or indeed, any of the information the speaker offers. This happens particularly when the answers are very lengthy.
2. **Addition:** The interpreter, often in an attempt to help the interviewer understand the information, adds to what the speaker has said.
3. **Condensation:** The interviewer receives an abridged version of what the speaker has said, often a reflection of the interpreter's own 'interpretation' of what the speaker has said, which may differ markedly from what the speaker had intended to convey.
4. **Substitution:** The interpreter relates back information that has not been given in the place of what has been said.
5. **Role exchange:** The interpreter takes on the role of the interviewer, replacing the interviewer's questions with his or her own.

Each of these issues was addressed in the training of translators. Identification of these errors in the interviews will be addressed in Chapter Five.

Duranti (1997) has a note of caution regarding relying heavily on bilingual speakers. There are usually important reasons why certain individuals know a second language; they are often people who have lived or worked outside of the community for a certain period. He suggests that, although this means they are more capable of taking the point of view of the researcher and understanding his needs, equally they are perhaps not the most typical individuals in the community.

The translators employed for both the hospital study and the traditional healers study had never lived or worked outside the Northern region of Malawi. It is acknowledged that their proficiency in English was because both had completed secondary education. In the case of the transcriber, and the translators for the traditional healers study, they were employed because of their demonstrated knowledge and sensitivity regarding the local culture(s).

SUMMARY

The researcher took cognisance of all possible confounding issues regarding interviewing and translation. They were duly taken into consideration in the design of the study, with the aim of maximising the quality of the data collected and authenticity of responses.

CHAPTER 4: EXTANT HEALING SYSTEM

RATIONALE FOR PRESENT STUDY

The rationale for this study developed from the realisation on the part of the researcher that my understanding of the health beliefs and customs in Northern Malawi was not adequate to do justice to the analysis of the data collected in the longitudinal hospital study. Having studied and worked in Europe, my background was western in perspective, and while the differences that exist between the western and African perspectives were acknowledged, greater understanding was deemed necessary to lend sufficient integrity to the analysis.

The main aim of this study is to understand the cultural context in which Malawian health beliefs are embedded. Accurate understanding of this context should facilitate the analysis of the interviews conducted with patients in the hospital and yield useful contextual information on how the extant healing system manages mental disturbance in Northern Malawi. Such information would also be vital for making recommendations for the development of a culturally sensitive service.

LITERATURE REVIEW

Introduction

It is estimated that traditional healers provide care for 80% of problems related to mental disturbance in sub-Saharan Africa (Madu, 1997). There is a paucity of information concerning the local healing system in Malawi, in particular Northern Malawi, and the role such a system plays in the treatment of mental disturbance. Morris (1996) recalls his alarm, when embarking on his research in Southern Malawi in 1979, on discovering the absolute dearth of research conducted on matters pertaining to health. His own area of ethnobotany is intertwined with areas such as medical practices, disease concepts and ritual practices. Two decades later, research remains scarce, with only one major contribution to the field by Peltzer (1987). As detailed in Chapter Two, Peltzer conducted a comprehensive study focusing on traditional healing practices with particular reference to psychosocial health care.

Rev. T. Cullen Young provided early written documentation of "medicine men" in Northern Malawi (then Nyasaland). In 1929-30, he came into possession of what he describes as the "*materia medica*" (p. 229) of a medicine man, complete with medicines for a wide range of illnesses and diseases, and the constituent ingredients. He also had information, of a similar nature, regarding two other medicine men from Northern Malawi. Being neither a botanist nor a medical doctor he acknowledges his limitation and simply lists the 116 different diseases for which medicine was available, and lists the trees, shrubs grasses, and non-vegetable matter used to make the medicine. These had been recorded in the vernacular and were translated by him where possible into English (Cullen Young, 1932). The existence of such detailed information, documented by the medicine men and published early last century is noteworthy, providing definite evidence of a systematic approach to herbalism at that time.

Although the focus of Morris's work (1986; 1996) is focused on ethnobotany, detailed research with healers in Southern Malawi was central to his fieldwork. While he does not deal specifically with mental disturbance, he does pay attention to disease concepts, which include mental disturbance. Bearing in mind that the Northern region is not included in his ethnographic work, he nevertheless contributes to the understanding of the extant healing system. More recently, an American ethnomusicologist, Steven Freidson, published a book regarding the role of music in healing rituals in Northern Malawi, with a focus on the Tumbuka (1996). Although traditional healers were his main informants, his existential phenomenological approach does not impart definite information regarding the extant healing system, his focus being to bring to the fore the importance of the role of music in what he describes as "a health care system populated by dancing prophets, singing patients, and drummed spirits" (Freidson, 1996, p. ix). However, this is by no means reflective of the healing system as a whole, with herbalists outnumbering diviners (Morris, 1996) and, in Peltzer's sample, the majority were herbalists or herbalists diviners.

Thus, in this review, it is, in the main, findings from both Peltzer (1987) and Morris (1986; 1996), which will be drawn upon to illustrate aspects of the extant healing system in the Northern region. However, it must be borne in mind that, although some of the material is relatively recently published, the background depicted by this

information is based on fieldwork undertaken in 1979 and the mid to late 1980s. Some of Morris's fieldwork dates from as far back as 1958-1965.

Several areas will be considered in this literature review. The different types of healers which are found in Malaŵi will be defined and a short description of their training given. Their accessibility to the population will be considered, and healers' religious affiliation mentioned. Attention will then turn to the role of the traditional healer and this will be viewed in terms of the range of illnesses and problems they treat, the diagnostic methods they employ, and the treatment they offer to their patients. A focus on the information most relevant to the understanding and treatment of mental disturbance will be retained.

Types of healers

Morris (1986) points out that the term *sing'anga,* the indigenous term for all healers, is a blanket term, like the English term traditional healer. Both terms incorporate a wide variety of healers that exist in Malaŵi. *Sing'anga* is used as a broad term to cover midwives, village and market herbalists, as well as doctor-diviners. He points out that common language categories or indeed the literature do not always draw a distinction between the various types of healers.

Important to note is Morris's belief that "... herbalism and divination are inextricably linked in the Malaŵian therapeutic context ..." and, leading from that, he states that "... to neglect either the empirical or the religious aspect of their ethnomedicine is misleading and one-sided" (Morris, 1986, p. 376).

Peltzer (1987) divides *sing'anga* into two main categories: the herbalist and diviner/herbalist, *sing'anga* (pl. *ŵasing'anga*) and *ntchimi,* respectively. As the name suggests, herbalists use the knowledge they possess regarding the medicinal properties of plants to treat their patients. *Ntchimi* (diviners) call on their spirits to diagnose and help them treat their patients successfully.

Morris (1986) further divides the category of herbalists into the village herbalist, the market herbalist and the doctor-diviner. According to him, village herbalists have an in-

depth knowledge of plant medicines, and make themselves available for 'consultations', but this is not their full time occupation. Women in the village tend to have a specialised knowledge of herbs, focused on medicines used in childbirth, children's illnesses and menstrual problems.

Market herbalists sell their medicines from stalls displaying various parts of animals (snake skin, porcupine quills, for example) alongside roots, leaves, bark, various other plant matter and a collection of preparations, all of which have medicinal properties. These stalls can be found in all the main markets in Malawi. Morris (1986) describes the function of the majority of village and market herbalists as dispensing herbal medicines. They discuss the nature of the problem, which can be a disease or misfortune, and may carry out a physical examination before prescribing and selling the appropriate treatment. The advice of herbalists will be sought for problems related to witchcraft and sorcery, and can be treated with herbal medicine from their pharmacopoeia. Generally, herbalists would not ascertain treatment through divination, although some market herbalists may practise divination. Hence, no clear distinction exists between herbalists and diviners. Morris argues that the empirical knowledge of plant medicine held by *wasing'anga* healers is often neglected.

Morris (1986) describes *ntchimi* as men or women of professional status, who, after experiencing a divine call, which could occur through either a dream or a traumatic illness, will undergo formal training as a diviner. Discovering the underlying etiology of disease and suffering is their concern. The treatment chosen is based on the causal agent of the illness.

Accessibility of *wasing'anga*

Peltzer (1987) found there was a higher ratio of *sing'anga* in the village sites than the urban sites. In village sites, the ratio between the healer and adult population was 1 : 20 and in urban ones, the healer: adult ratio was 1 : 75. Morris (1986) estimated that, in the southern district where he conducted his fieldwork, there was a ratio of 1 : 275. More recent figures suggest that there are 65,000 *wasing'anga* in Malawi as a whole, and an estimated patient : healer ratio of 1 : 123, compared to a ratio of 1 : 50,000 for medically qualified personnel (Ndibwami, Henry & Saka, 1993).

The number of patients attended to by a healer in a village site would not usually exceed 5-10 patients per week, and, generally, these healers did not have inpatients. The healers in the village were more or less part time, in contrast to the healers who had the outpatient and inpatient sites, and were full-time practitioners. Full-time practitioners may have up to 55 inpatients at any given time, and see approximately 45 outpatients per week (Peltzer, 1987).

Religious affiliation

Peltzer found all healers were affiliated to a church and many continued to attend, despite the fact that their profession is frowned upon by the missionary churches. Some healers were discouraged from attending due to their own disinclination or, in some cases, the hostility of other members of the church.

It is interesting to note that some of the missionary churches forbid attending a *ntchimi.* The Anglican Church in Northern Malawi always asks that the member will renounce spirits before they are baptised or confirmed (personal communication, Bishop J. Biggers, Anglican Bishop of Northern Malawi, March, 1998). Central Church of African Presbyterianism (C.C.A.P.) actively discourages members of their congregation from attending traditional healers. Ignoring this can lead to excommunication (Freidson, 1996). In the same vein, a *ntchimi* cannot be a member of the Catholic church; they would be excommunicated. However, there is no prohibition against a herbalist being a member of the Catholic church (personal communication, Bishop J. Zuzu, Catholic Bishop of Mzuzu Diocese, May, 1999).

Role of the healer

Diagnosis

Those who require treatment are usually accompanied by family members or close neighbours when attending traditional healers for consultation or treatment. Clients openly voice their complaints or problems in the presence of those accompanying them, and indeed, other patients may be within hearing range. *Ntchimi* do not usually 'examine' clients in a western sense. There is an assumption by clients that the *ntchimi* already knows the cause of the illness or problem from a supernatural source,

consequently such examination is not necessary (Peltzer, 1987). In fact, as Morris (1986) points out, the person who requires treatment does not need to be present at divination. The guardians, those who accompany the patient to the diviner, act as mediators between the sufferer and the diviner. Morris likens the guardians to what Janzen (1978) in his study terms the "therapy managing group".

Various methods of diagnosis are employed; a herbalist is likely to use an interview and a physical examination, while a diviner may use instrumental divination (*kuchima*) or medium divination, which is through his ancestral spirits (*kulosa*).

Peltzer (1987) observed that traditional healers often used paraphernalia in divination or diagnosis. Examples of typical paraphernalia are special uniforms, signs worn on the body or specially furnished rooms. Furthermore, and of particular note in the case of the current study, paraphernalia was typical in the Northern region, whereas the healers in other regions practised in ordinary clothes. In the same vein, Morris (1986) notes that: "As it is essential to create for the therapeutic process a setting which instils in the patient a feeling of security, hope and optimism, diviners in Malawi are skilled in the ceremonial" (p. 372).

When treating a case of affliction caused by witchcraft, the healer has to deal with both the symptoms of the disease and with the instruments of affliction sent by the witch. The afflictions sent by witches, resulting in illness or misfortune, are closely associated with animal or human substances, and are known as *nyanga* (see Kubhik & Soko, 1998). Medicines are given to cure the symptoms, with the purpose of healing (*kuchira*) and also to prevent further harm from witches.

Morris describes jealousy and resentment harboured in the community as precipitants of sorcery and witchcraft. It is the role of the *ntchimi* also to identify these tensions. Ultimately, further illness and misfortune caused by harmful medicines or influences can only be averted if the social situation is rectified (Morris, 1986).

Causes of mental disturbance

As part of Peltzer's study, he interviewed 40 traditional healers about the causes of both mental and physical illness. Peltzer's findings indicate that psychosocial disorders such as mental illness were considered more likely to be a result of supernatural causes, such as witchcraft and spirits, whereas physical illness was more likely to be viewed as being the result of natural causes, such as infection, passed through the family, or accidents. In comparing the responses of healers to patients he interviewed on the same issues, he found that healers were more likely than their patients to attribute disorders to supernatural causes, with the exception of one case where the situation was reversed.

Efficacy of treatment

Peltzer (1987) followed up patients who were suffering from major psychosocial disorders, which included mental illness. Follow-up took place three months after initial contact in the episodic outpatient setting, and for those who had been treated as an in-patient between six and twelve months. He defines the episodic outpatient setting as one in which the healer may be consulted either one or more times by a client with a specific illness. It would appear that the inpatient healing setting is one in which the client stays at the healer's compound. The evaluations of the results for the follow-up were primarily based on the subjective opinion of the client and their relatives regarding the extent of their improvement. He also conducted his own assessment through one or several in-depth interview(s).

In his sample, he classified thirty patients as experiencing a functional psychotic disorder. The inpatient setting is the most common way for these patients to be treated. Of the fourteen who had been treated in the episodic outpatient clinic, three had improved. Seven of the sixteen patients seen at an inpatient setting improved. A further five showed no improvement and the four (twenty-five per cent) could not be followed up.

Training of healers

Most of the healers in Peltzer's research had learned their healing art from either a parent or another relative, through accompanying them when they were collecting herbs or treating patients. Almost half (45%) of the healers in Peltzer's sample received a

"special calling" (p. 75) in the form of symptoms, illnesses or dreams. Mental and/or spiritual disorder (Peltzer's classification) was frequently mentioned. Such disorders were often characterised by social withdrawal and sometimes accompanied by a loss of appetite and weight. Over one-third (35%) of the healers received a calling from ancestral spirits.

Peltzer states that the duration of the training period is dependant on the motivation of the trainee, how well they can support themselves financially, and their intelligence. Training lasts at least one year, but does not exceed five or six years. An experienced healer is responsible for giving training; generally, healers with more patients have more trainees and their trainees are less likely to be related to them.

Once healers have acquired their skills and knowledge, they have to actively maintain them. One method involves the exchange of information with other healers, or consultation with someone more qualified. Peltzer describes this method as "instrumental". In other instances, it is "symbolic", which involves observing the obligations to please the ancestors. To illustrate the latter, he gives an example of one *ntchimi* whose spirits instructed him to sacrifice a cow and two white pigeons on the highest peak of the local mountain to ensure that the *ntchimi* would be well protected.

Cost of treatment

Both Morris (1986) and Peltzer (1987) concur on the variability of the cost of treatment. The nature of the substances administered, the kind of disease treated and the relative wealth (or poverty) of the person as perceived by the healer are all factors in arriving at a price. Peltzer comments that some healers will not charge, as it is their vocation; other healers receive payment in kind, not in money.

Professional status

A number of different healers' associations exist, but not all healers belonged to an association (Peltzer, 1987). Msonthi (1986) states that the main herbalist association recognised by the government in Malawi is called the Herbalists Association of Malawi, (HAM). It has the largest registered membership. According to Msonthi, HAM work alongside both the University of Malawi and Ministry of Health officials. HAM

members are awarded certificates when it has been proven that their plant samples are biologically active. A list of certified charges ensure uniform charges by practitioners registered with HAM for treatment received by patients.

Future of *Ŵasing'anga* in Malaŵi

Morris (1996) concludes that: "... the scope of both medicine (*mankhwala*) and the traditional healers (*sing'anga*) in Malaŵi extends well beyond the treatment of 'illness' or 'sickness' or 'ill health'. Fundamentally, herbalists in Malaŵi are concerned with the restoration of a persons well-being (*moyo*) and this has both a social and individual component" (p. 196).

He is critical of the notion put forward by some (e.g. Ngubane, 1977) that herbalists or diviners are concerned only with disease, or that their role is simply to restore social or cosmological harmony, as in his opinion it is a limiting perspective. He points out that, in Malaŵi, seeking medicine to gain employment or for sexual potency reflects individual needs and aspirations, needs "which are beyond the scope of western medicine" (p. 196), drawing on Peltzer's data which indicated that twenty eight per cent of the cases recorded at healing sites were to do with social problems (unemployment, business, love) to bolster his conclusion. Morris appears confident that herbalism in Malaŵi will survive.

Conclusion

As indicated at the beginning of this literature review, there is a dearth of research regarding the extant healing system in Malaŵi. However, the existing literature has provided a picture of the role of the *ŵasing'anga*, from as early as 1932. Different types of *sing'anga* that exist in Malaŵi have been described. Important to note is the differentiation between *ŵasing'anga* and *ntchimi* and equally important is the fact that there can be an overlap in these roles. The causes which *ŵasing'anga* attribute to mental disturbance are pertinent to this thesis. Causes of mental disturbance cannot be isolated from the broader picture of the extant healing system. With the available information, it can be seen that, at least up until the mid 1980s, *ŵasing'anga* in Malaŵi are widely consulted and attend to a broad range of illnesses and problems in their communities.

AIM OF STUDY

With the noted lack of recent research concerning the extant healing system in Malawi, the aim of this study was for this researcher to gain an understanding of the extant healing system, insofar as it was necessary to attain a perspective of how *wasing'anga* viewed mental disturbance, what they considered the causes of mental disturbance to be, and finally, their approach to treatment.

Identification of medicinal plants and herbs, used as medication, in measuring the success of treatments, assessing or indeed questioning their healing skills, was not the focus of this research. Furthermore, this study did not purport to be an all-encompassing ethnographic study of traditional healers in Northern Malawi.

The fundamental rationale for undertaking this study was to make it possible to contextualise the understanding that participants in the hospital study have of their disturbance in a holistic way. It was hoped that the information gathered by investigating the approach of the traditional healers would contribute to the accurate analysis of the participants' interviews.

METHODOLOGY

Overview

This section contains methodological considerations particular to this study, the methodological approach employed, the procedure followed, and finally the approach to data analysis.

Introduction

As a qualitative approach has been adopted, this section is written in the first person, active voice, which is standard protocol in qualitative research. Fischer (1998) states that there are two reasons for this. Firstly, the use of the active voice "serves as an implicit reminder that qualitative researchers are themselves research 'instruments'" (p. 111). Secondly, this tense highlights that researchers are actual individuals as opposed to mechanical instruments.

Some Malawian terms and concepts are introduced in the following sections. Very brief direct translations are given in parentheses. These terms are listed in the Glossary (Appendix C) which can be used as an easy reference. The meaning of many of these terms cannot be conveyed by a direct translation. A detailed explanation for such terms is offered later in the chapter.

Methodological considerations

Potential difficulties, both of a practical and a cultural nature, became apparent shortly after the decision to embark on this study. Firstly, with no opportunity to avail of language training in Ireland, I arrived without being able to speak the local language, chiTumbuka. Secondly, it was not clear to me how I would be perceived in a country where women of my age are typically married with children and living in extended family networks. I was single, childless and living far from my family. It would be fair to state that I did not conform to the female norm in Northern Malawi. Thirdly, Malawi has a history of British colonialism and European missionaries, two influences largely responsible for the introduction of western health care systems. Being White, and attached to a mission organisation, again it was not clear how I would be viewed by the traditional healers I wished to make contact with. However, both Peltzer (1987) and Freidson (1996) found the healers in Northern Malawi welcoming. Nevertheless, Ngubane recounts how her own personal background as a Zulu presented difficulties at times when she was conducting anthropological research in a Zulu community (Ngubane, 1977).

Additionally, *wasing'anga* are highly respected members of the community and I was unsure as to the most appropriate manner in which to approach them.

Superimposed on the abovementioned considerations were the constraints of a time-limited stay, and the practical implications of conducting a longitudinal hospital-based study simultaneously. While it seemed that a more informed understanding of the local healing systems would complement the main body of work, there was no way of knowing how much progress could be made. Of course, I could only hope to understand those areas about which the *wasing'anga* were willing to offer information. I recognised that initial approaches would have to be tentative, and slow progress could be expected.

It must also be acknowledged that a background in psychology as a discipline lends a different set of skills, and indeed biases, than, for example, an anthropological or psychiatric background.

There were several priorities when deciding on the approach. It was vital to be culturally sensitive, to employ a systematic method of collecting information that would ensure distortions in the data collected were kept to a minimum, and to acknowledge at the outset that the nature of the area of study was unknown.

METHODOLOGICAL APPROACH

Taking the abovementioned issues into consideration and given the exploratory nature of this study, it appeared that the most appropriate approach that I could adopt would be of a qualitative nature. Elliott, Fischer and Rennie (1999) state that in qualitative research "... the researcher attempts to develop understandings of the phenomena under study, based as much as possible on the perspective of those being studied" (p. 216).

From within the qualitative approaches, I identified aspects of Naturalistic Inquiry (Guba & Lincoln, 1985) as the most suitable. I have thus borrowed heavily from Naturalistic Inquiry, both for data collection and analysis, as the two facets are inseparable in this approach. Naturalistic Inquiry advocates that research should be carried out in natural settings, suggesting that realities cannot be understood in isolation from their contexts. In Naturalistic Inquiry, one of the basic precepts is that the research design is allowed to emerge, rather than be constructed preordinately. This was the main reason for selecting this approach. The unpredictability of the circumstances meant that the research design needed to be flexible enough to accommodate emerging possibilities for data collection. Lincoln and Guba maintain that what emerges as a function of the interaction between the inquirer and phenomena is largely unknown in advance for a number of reasons. These reasons include that the inquirer cannot know sufficiently well the patterns of mutual shaping that are likely to exist. Also, the various value systems involved (including the inquirer's own) interact in unpredictable ways to influence the outcome.

Procedure

Language

First and foremost, it was necessary to learn how to communicate in a local language. This is discussed in detail in Chapter Two.

Informants

Seeking informants.

Purposive sampling is integral to Naturalistic Inquiry, as it increases the scope and range of data exposed, as well as the likelihood that the researcher would uncover the full array of multiple realities. Using purposive sampling means seeking out the settings, individuals and groups, and where, and for whom, the processes being studied are most likely to occur. Utilising purposive sampling optimises the investigator's ability to take adequate account of local conditions, mutual shapings and local values.

Ŵasing'anga are not a homogenous group. It was therefore essential that different types of *ŵasing'anga* were included in the sample. More specifically, I needed to locate *ŵasing'anga* who treated people with mental disturbance. Additionally, it was important that the *ŵasing'anga* would be open to being involved in a research project, conducted by a researcher attached to a western biomedical health service. It was also important that I could communicate with them. My preference was that they spoke chiTumbuka, as opposed to any of the other local languages, and that they would facilitate a translator when required. Relative geographical proximity and accessibility to their compound were important issues, for two reasons. Firstly, the poor conditions of the roads in some parts of the region made travel arduous, particularly in the wet season. Secondly, I wanted to be able to make as many field trips as were required.

It was not respectful to approach *ŵasing'anga* without being introduced. I made my neighbours and colleagues aware that I was interested in making contact with healers, my hope being that this would lead to introductions. How these introductions happened are detailed below.

Informants

Primary informants

The two informants most central to my work were Dr. V.P. and *Ntchimi* C.M. An anthropologist, also working in Northern Malawi, introduced me to Dr. V.P[6]. *Ntchimi* C.M. was introduced to me by a work colleague. Prior to that, I had introduced myself, by letter, on the advice of a development worker who knew him through a committee they had both been involved with.

Both these healers not only facilitated interviews but also invited me to a number of ceremonies and events, and furthermore facilitated introductions to other *wasing'anga* and *ntchimi.*

Secondary informants

C.M. introduced the following *wasing'anga* to me:

Ntchimi M.B., W.M., M.M., V.Z., A.M., F.N. and Dr. K.F.M., all of whom had been trained by him.

I interviewed two herbalists:

Dr.B.N., who was the grandmother of one of the clients in the Service. This herbalist was introduced to me by her daughter, the mother of the client; and *Sing'anga* J.M.F.M., a herbalist with a stall situated close to the drop-in centre where I worked, was also introduced to me by one of my work colleagues.

Wasing'anga who attended traditional healing ceremonies to which I had been invited also contributed to the information gathered and observations made, although they were not interviewed. Brief background information for each of the secondary informants can be found in Appendix D.

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[6] It is common for *wasinganga* to use the title Dr. to denote their profession, but it does not mean they have Western medical training

Contact with informants

Dr. V.P.

Initial contact with Dr. V.P. was made in November 1997, almost nine months after my arrival, and was maintained until my departure in August, 1999. On many occasions, I stayed at his compound, with his family and patients, for periods of up to a week. On several occasions, I had overnight stays when a ceremony was to be carried out. There were times I spent only one day in the compound, and sometimes we would meet in my home in Mzuzu. I also accompanied him on two *mankhwala* collecting trips. Dr. V.P. is the most senior *sing'anga* in Nkhata Bay District, and District Chairman of the Herbalist Association of Malawi (HAM). Although he is Tongan, he also speaks both chiTumbuka and English.

Ntchimi C.M.

First contact was made with C.M. in January 1999, seven months before completion of fieldwork. In general, interviews with him were conducted at his compound in his 'surgery', as he termed it. I attended a number of the weekly *vimbuza* ceremonies (divining and healing ceremonies) at his compound. He also invited and accompanied me to other ceremonies and *wasing'anga* meetings. It was through these ceremonies and meetings that I met the other *wasing'anga* who were my secondary informants, mentioned above. He is the most well-known *ntchimi* in the Northern region, located in Mzimba District, and is District Chairman of HAM.

DATA COLLECTION

Lincoln and Guba (1985) emphasise the use qualitative of methods of data collection because of the sensitivity and adaptability associated with these methods. The researcher is the primary data gathering agent. These qualities are important in conducting an exploratory piece of research in a culture specific context.

Grounded theory

Within Naturalistic Inquiry, grounded theory is the method used for data collection and analysis (Lincoln & Guba, 1985). Strauss and Corbin (1992; 1998) describe grounded theory as theory derived from data that has been systematically gathered and analysed throughout the research process. Grounded theory is an iterative process, requiring movement between data collection and analysis. This method ensures that the findings are 'grounded' in the data, providing a more accurate picture of reality. In addition, it is more likely to be sensitive to contextual values, not just investigator values. Of central importance to this study is that grounded theory aims to generate local, contextual understanding that is of relevance to those who are being studied.

Data collection and analysis in this study are based on procedures in grounded theory as expounded by Strauss and Corbin (1992; 1998). This approach can be used to generate theory; however, given the exploratory nature of this study, analysis is used only to generate themes and meaning.

Lincoln and Guba (1985) advise that an instrument devised *a priori* does not have sufficient adaptability to both encompass and adjust to the variety of situations encountered. A variety of qualitative methods were employed: semi-structured, in-depth interviews and participant observation, depending on the appropriateness of each in the given circumstances. Again, depending on the appropriateness, practicalities and ethical considerations, notebooks, tape recorders, cameras and a video camera were employed. As rapport developed between the informants and myself, it became increasingly acceptable to progress from recording data in a notebook, to using a tape recorder, a camera and finally, in some instances, a camcorder. Obviously there were occasions when neither a tape recorder nor notebook were appropriate, or, in the case of impromptu meetings, available. In these circumstances, field notes were recorded immediately afterwards.

Many pitfalls are associated with interviewing where the interviewer and interviewee are from different cultural backgrounds, as highlighted in Chapter Two. The measures outlined previously were taken to ensure that these issues had minimal impact on the data collected.

Fieldwork was carried out in a variety of different locations and circumstances: visits to traditional healers' compounds, for periods of up to a week, participant observation at various ceremonies including *vimbuza,* a healing ceremony and *chilopa* (pl. *vilopa*), a sacrifice as part of a healing ceremony. I also attended a ceremony involving several *ŵasing'anga* making a petition to *mizimu* (spirits) for a *ntchimi* who was ill, and an *Ngweleweta* (an occasion where a trainee *ntchimi* is examined). Shortly before I left, I attended the opening of a *templi* (the place where many ceremonies including *vimbuza* are conducted). In addition, I was invited to attend the 1999 HAM Annual Regional Meeting. I also accompanied V.P. on medicine collecting trips. Each of these occasions provided opportunities to gather information.

Supplementary to these events, I was also invited to various occasions which gave me opportunities to chat informally about relevant issues and gain insights into other aspects of life in Malaŵi. Also of importance, invitations to these occasions gave me, as a 'foreigner', a sense of acceptance amongst the community in which I was living. These occasions included the election of a new Village Headman, a traditional wedding, and *chinamwali*. *Chinamwali* prepares a woman for the birth of her first baby and is held in the seventh month of pregnancy. Four *mphungu* (experienced women), two from the mother's village and two from her husband's village, advise and pass on their knowledge to the mother-to-be. Only females are permitted to attend *chinamwali*. Other invitations to visit the *kaya* (village of origin) of colleagues and friends, and invitations to watch traditional dances such as the *Malipenga* in Usisya were taken up.

Translators

In many cases, a translator was required, as my level of chiTumbuka was not adequate to conduct the interview alone. Two translators were employed, one male, one female. Both had a very proficient level of English, good knowledge of local languages, and interest in the area of health and illness, and traditional healing. Both translators were from Northern Malaŵi, and had lived there all their lives. Duranti (1997) suggests that researchers need to exercise caution regarding reliance on bilingual speakers in the community. This is discussed in Chapter Two. Fortunately, one informant, Dr. V.P., had a very good command of English and translators were not required. The translator transcribed the audiotape, or videotape, as soon as possible after the fieldtrip.

ETHICAL CONSIDERATIONS

Informed consent: Participants were informed of the purpose of the research by the researcher. Verbal consent to participate in the research was obtained from the participants. Permission was gained prior to use of a tape recorder or video recorder. A demonstration of what was entailed was provided for any participant who was not familiar with the instruments, and they were given the opportunity to listen to or watch themselves prior to the instrument being used. Permission was also secured before taking photographs.

In the case of attending *vimbuza*, *chilopa* and other ceremonies, which involved a group of people, formal permission was sought from the *ntchimi* in charge to record the event, with whatever means were appropriate to the occasion (camera/video camera/tape recorder/pen and paper). The *ntchimi* conducting the ritual conveyed his consent to those present and informed the *mizimu,* if it was a ritual involving *mizimu.* Due discretion was exercised. For example, using flash photography at a crucial therapeutic moment was avoided. Advice was sought as to when not to take photographs/use a video camera.

Generally speaking, use of cameras and video equipment was welcomed. In the later stages of the research process, requests to use such equipment were made by the *ŵasing'anga* themselves.

Confidentiality: Although the *ŵasing'anga* were not concerned with protecting their identity, their names have not been used. Information obtained in interviews was treated as being confidential; for example, the practices of one *sing'anga* were not shared with another.

Access to data: Access to interviews, photographs, videos was offered to participants. Once developed, copies of photographs taken were supplied to those who had their picture taken. Where possible, the video material was played back for the people who had been involved. Scarcity of television sets and video recorders presented problems in fulfilling this ideal. Relevant participants were assured that they would be furnished with copies of the video material once ready.

Reimbursement for interviews: It was made clear at the outset that financial remuneration would not be given for participating in interviews. Photographs were promised and this was fulfilled. A meal frequently accompanied ceremonies. Food was always contributed. Glass jars and bottles, particularly those with screw tops, were a scarce commodity in Malaŵi, and were one of the preferred methods of storing some *mankhwala,* and other household necessities, such as paraffin. These were given to the *ntchimi* in charge of a ceremony to distribute to the other *ntchimi* present. When I was staying with *ŵasing'anga,* I brought enough food to contribute to my keep for the duration of the stay.

DATA ANALYSIS

Introduction

Strauss and Corbin (1998) emphasis the importance of maintaining a balance between objectivity and sensitivity to the data while immersed in it. Unlike in quantitative research, qualitative researchers acknowledge the researcher's own role in the research process and are explicitly concerned about the impact researchers' biases and pre-conceived notions may have on the data. One must recognise that the "researchers' understanding are often based on the values, culture, training and experience that they bring to the research situation and that these may be different from their respondents" (Strauss & Corbin, 1998, p. 43).

Qualitative analysis

Analysis was conducted in accordance with a 'grounded theory' approach (Glaser & Strauss, 1967; Henwood & Pidgeon, 1996; Strauss & Corbin, 1998). As grounded theory is an iterative process, interaction between data collection and data analysis is essential. The analysis in grounded theory involves moving from raw data transcripts to the generation of descriptive codes. In effect, analysis began before data collection was completed. New information often generated new queries and new angles to pursue. As a result of the emerging information, not all *ŵasing'anga* were asked the same questions at each interview, depending on their area and the type of information I was seeking at that time. Progressively, the in-depth interviews became more focused.

After the fieldwork period was completed, all the material was reviewed and the issues central to the thesis (issues pertaining to causes and treatment of mental disturbance) were identified and separated. Due to the large volume of material generated by interviews, and the participant observation field notes and video material, it was necessary to limit the number of areas to be analysed. Relevant field notes and interviews, which included information pertinent to mental disturbance, were word processed. Both the local language and English were included. Analysis was systematically conducted in a series of steps outlined below, based on procedures recommended by Straus and Corbin (1998) and Pidgeon and Henwood (1996).

1. The material was reread several times and divided into similar areas (i.e. causes of mental disturbance, accounts of becoming a healer, etc.). Analysis was then conducted within each of these broad areas. Where information was pertinent to two or more areas, it was duplicated.
2. Categories were identified. Categories are concepts derived from within the data. They were given a preliminary label.
3. Memo writing served to further the analysis highlighting links between areas. Memo writing aids in externalising the analysis, as it involves writing ideas, theoretical reflections, links or departures from the literature (Strauss & Corbin, 1998).
4. A process of "constant comparison" (Glaser & Strauss, 1967), which involves exploring similarities and differences in the corpus of data collected in the transcripts, was utilised.
5. All the material was reread, checking for the occurrence of categories that had been missed. Text was copied and pasted under the corresponding heading (using Microsoft Word word processing package). This ensured all occurrences of a category were grouped together. A category was considered "saturated" (Strauss & Corbin, 1998, p. 136) when no new information emerged during coding.
6. The material collected in each category was then reread. Categories were integrated or further split, as appropriate. Importance was attached to giving a category a name that reflected the content.

7. Finally, the transcriptions were reread to ensure that the identified categories reflected the data, therefore validating analysis.

8. Elliott, Fischer and Rennie (1999) recommend including a credibility check as good practice in qualitative research. Asking the participants to check the portrayal of information in the study is one such method. However, as none of the *ŵasing'anga* had adequate reading skills for this task, one of the translators read the analysis with a view to assessing it as an accurate representation of the interviews and ceremonies he had attended with me. He verified that this was the case.

SUMMARY

Undoubtedly the approach described is not the only one that could have been utilised, but, as outlined at the beginning of this chapter, it is an appropriate method in the context of the research.

I adopted a qualitative approach as this was an exploratory study. In keeping with the current guidelines for best practice in qualitative research, I have included relevant details of my background, and some descriptive data about the participants involved.

I borrowed heavily from the premises of Naturalistic Inquiry (Guba & Lincoln, 1985). Data collection and analysis are based on Grounded Theory as expounded by Strauss and Corbin (1992, 1998). Data was collected using both semi-structured, in-depth interviews and participant observation. Two *ntchimi* were my primary informants, and were central to my research. These *ntchimi* both invited me to a variety of ceremonies and occasions including *vimbuza*, *chilopa* and *ngweleweta*. They introduced me to other *ntchimi* and *ŵasing'anga,* who became secondary informants. Fieldwork was carried out in a variety of different settings, including the ceremonies to which I was invited. I stayed at the compound of one of the *ntchimi* on a number of occasions, for varying periods. Depending on the situation, notebooks, tape recorders, cameras and/or a video recorder were used to record information. All opportunities to gain insight to life in Malaŵi were availed of which enhanced my insight and the analysis process.

FINDINGS

Overview

A synthesis of information gathered from interviewing *ŵasing'anga*, and participant observation at healing ceremonies is presented. Given that this dimension of the study was prompted by the need to contextualise the explanations offered by the participants in the hospital study, not all of the issues that arose in the field have been included in this analysis. In an effort to retain the focus on understandings of mental disturbance[7], analysis is contained within three sections. The sections are not mutually exclusive, but are presented as such for ease of understanding. The first section is aimed at acquainting the reader with the terms and concepts central to understanding mental disturbance in Northern Malaŵi. The second section focuses on signs, explanations, and treatment for mental disturbance. The third section presents several accounts concerning the experience of becoming a *ntchimi*. The fourth and final section considers the professional status of healers in Malaŵi.

It is important to note that the explanations and descriptions contained in this chapter are a necessarily superficial treatment of a very complex area, as it is written for the purposes of contextualising research to be reported later. A schematic diagram (Figure 4.1) summarising the information is provided at the end of Section One.

SECTION ONE: INTRODUCTION TO TERMINOLOGY AND CONCEPTS

This section is intended to convey the meaning of specific terms and concepts pivotal to understanding the cause and treatment of mental disturbance in Northern Malaŵi. Littlewood (1990) comments that a balance must be sought between using an understandable, but a flawed, English translation, or the local language when documenting studies from a culture that uses a language other than English. Literal translation of various words and terms from chiTumbuka into English is neither accurate nor meaningful. I have taken the approach that, where no equivalent exists in

[7] Mental disturbance is the generic term Malawians generally use in English to describe mental health problems, which can range from mild to severe problems. In a western biomedically orientated framework, this term can be understood as encompassing both neurotic and psychotic disorders.

the English language, the vernacular will be retained in the text. Full descriptions will be provided. The glossary of terms in Appendix C provides an easy reference guide. In cases were the vernacular word is only used once or twice and is not fundamental to understanding, an English meaning is given in parentheses in the text.

Ŵasing'anga / traditional healer

Two types of healer exist in Malaŵi; both fall under the broad term *sing'anga (*pl. *ŵasing'anga).* However, there is a distinction between an herbalist, who in the vernacular is a *sing'anga,* and a *ntchimi,*[8] a healer who uses their *mizimu* (spirits) to *kuchima* (divine or diagnose). A *ntchimi* is generally also an herbalist, but this is not always the case. Some *sing'anga* refer to themselves as African Doctors. *Sing'anga* who are only herbalists often operate from a stall from where they are available for consultation and sell *mankhwala.*

Mankhwala

Mankhwala[9] is generally translated as medicine in English. However, it is a poor translation. This term conveys a much broader meaning than the western notion of medicine implies. The local system of treatment is most commonly referred to as *mankhwala ya chifipa*, which translates literally as black medicine, meaning African medicine, distinguishing this treatment from *mankwhala ya muzungu*, which in its original form literally meant the medicine of the strangers. However, this term now refers to medical treatment established by western organisations.

Mankhwala incorporates various treatments given by a *sing'anga*; preparations in the prevention of illness and maintenance of health, and preparations that cause *masoka* (misfortune) or illness by *ŵafwiti*[10] (witches). Pharmaceutical medicine introduced by western organisations and biomedically orientated hospitals is also called *mankhwala.* From the *sing'anga* pharmacopoeia, *mankhwala* can include *misisi* (roots), *makungwa* (bark), *mahambo* (leaves), *vipaso* (fruits of trees or bushes) and animal substances. Photograph 4.1 shows a *sing'anga* with her store of roots, bark and leaves on top of the

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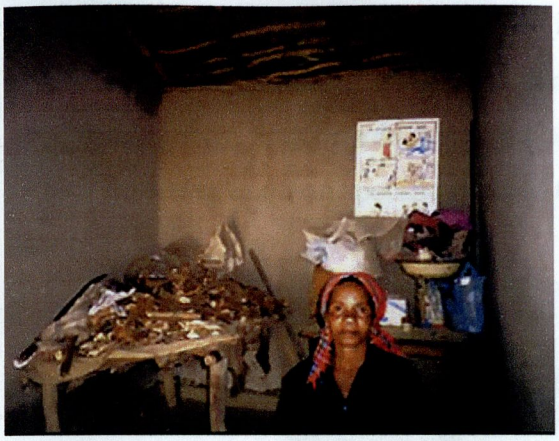
8 There are two spelling of this word *ntchimi* and *nchimi*, the former will be used throughout.

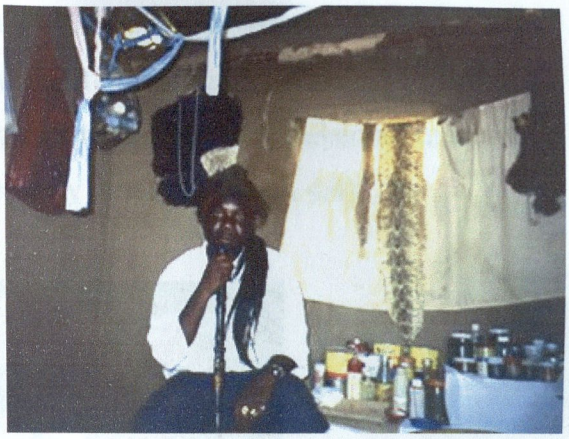
9 The terms *mankhwala, minkhwala* and *munkhwala* are used interchangeably in common usage. *Mankhwala* will be used throughout this thesis.

10 *Ŵafwiti* is explained later in this chapter.

table to the left of the photograph. Photograph 4.2 shows a *ntchimi* with his *mankhwala* contained in screw top jars and some dry snake skin hanging over the curtain.

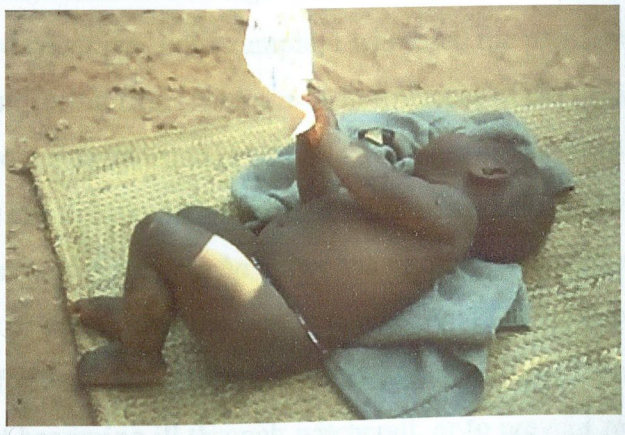


Photograph 4.1: Female *sing'anga* pictured with her *mankhwala.*



Photograph 4.2: *Ntchimi* pictured with his pharmacopoeia.

Not only is *mankhwala* used for curative purposes, but it also has a protective function. *Mankhwala* is not restricted to herbal preparations; it also refers to objects that can be worn. For example, infants are often seen wearing beads around their waist, to protect them from *visi lisi* (epilepsy), as can be seen in Photograph 4.3.



Photograph 4.3: Infant wearing beads believed to protect against *visi lisi*

Placing *mankhwala* in the fields can protect crops from thieves, or, in a house, can counteract bewitchment. One *sing'anga* reported that the most common request for *mankhwala* at his stall is for *chithumwa* (good luck charm) usually carried on the person, perhaps concealed in the pocket or sewn into the shirt collar.

Various forms of *mankhwala* are utilised in a variety of ways. It can be ingested with food; commonly, it is mixed into *bala* (a porridge like mixture), or it can be taken orally, added to liquid which is then swallowed. *Mankhwala wa kugeza* is medicine added to the water that a person is bathing in. I witnessed this type of *mankhwala* being given to a woman suffering from a *vimbuza* (a spirit illness) in the concluding part of a healing ceremony. *Mankhwala* can also be applied to *mphini* (tiny incisions) made with a razor by a *sing'anga* on specific parts of the body (see Photograph 4.4).



Photograph 4.4: *Mphini* being made where *mankhwala* will be applied

Certain types of *mankhwala* require an active ingredient to make it effective. The term *chizimba* (pl. *vizimba*) refers to this ingredient. This type of *mankhwala* will be inert without the required *chizimba.* For example, I witnessed the preparation of *mankhwala* given to a woman suffering from *vimbuza.* A few pinches of the dried adder skin was the *chizimba.* Without this addition, I was told, the *mankhwala* would be ineffective. Not all *mankhwala* requires a *chizimba*; most regular *mankhwala* does not. Generally, *mankhwala* which requires a *chizimba* either has a protective purpose against harm, or is to create success or prosperity. Protection is often required for the body, for property and relationships (for example, a troubled marital relationship). Protection for the body is sought to prevent becoming ill through witchcraft, or to prevent recurrence of an illness caused by witchcraft. Such protective *mankhwala* can be procured from *wasing'anga.* The use of *chizimba* is often associated with witchcraft and this aspect will be expanded upon in the section pertaining to witchcraft later in this chapter.

Mizimu

Mzimu literally translates as 'spirit' in English (pl. *mizimu*). However, *mizimu* in Malawi hold very different connotations to those conjured up by the common western concept of 'spirits'. *Mizimu* hold a central role in the lives of *ntchimi*, and, generally speaking, for the majority of Malawians. Understanding of *mizimu* has particular import in the realm of health and sickness. *Mizimu* can play a dual role as both protectors from and creators of states of distress. It is in the context of health and illness that the concept of *mizimu* in Malawi will be considered.

Several in-depth discussions with V.P. crystallised the meaning of *mizimu* in Malawi for me. I did not have the opportunity to explore the topic to the same extent with other *wasing'anga.* Therefore, most of the information in the following section is based on several discussions with V.P. However, information from the other informants did correspond to what was imparted to me by V.P. Where a marked departure from V.P.'s information occurs, the additional information is included.

Several different categories of spirits have a role in the lives of Malawians, particularly *ntchimi*. For clarity, I will draw on the categorisation V.P. used in explaining *mizimu* to me:

(1) *Mizimu ya agogo* (Ancestral spirits)
(2) *Mizimu yakwendakwenda* (Lingering spirits)
(3) *Mizimu uheni* (Evil spirit)
(4) Holy spirit

In my sample more emphasis was placed on the first two categories in relation to mental disturbance, therefore only a cursory treatment will be given to the third and fourth categories. Not all informants divided *mizimu* into these same categories; broader categories were employed by some.

Some *ntchimi* describe *mizimu* in terms of *mizimu yiweme* (good spirits) and *mizimu uheni* (bad spirits), this explanation differentiates between *mizimu ya agogo* and the Holy Spirit that are intrinsically 'good', and lingering spirits and evil spirits, which are associated with causing ill health and disruption.

Each type of spirit will be considered in turn according to V.P.'s categorisation, first of all looking at the *mizimu yiweme* before turning to the *mizimu uheni*.

***Mizimu ya agogo* (ancestral spirits)**

Mizimu ya agogo (ancestral spirits) are the spirits of dead relatives, they are the most powerful spirits, and it is these spirits that a *ntchimi* needs to diagnose. A variety of names are used to refer to *mizimu ya agogo*. *Viwanda* are local ancestral spirits. Sometimes ancestral spirits are referred to as *mizimu yamaphiri,* they are spirits which reside in the mountain which means they are very powerful ancestral spirits. They are intrinsically good; they come into a person to guide and protect them from witchcraft and other dangers, they are kind and gentle, but you have to show them respect and obey their wishes, which is generally for your own benefit. V.P. explains:

> They can ask for a *chilopa*[11] [specific type of sacrifice] or *sadaka* [feast], but they do so in a good way, so if you explain that you have no money to do that just now, as it can be expensive, if they ask for a goat, they will understand, but you should not fail to do it. Neglecting to observe the requirements can result in *kusuzgo* (being troubled by spirits, literally to give problems), and they can get angry if you don't obey the advice they are giving you.

V.P. illustrated how *mizimu* expect fulfilment of obligations, with an example. The spirit of his recently deceased uncle troubled him, as he and his family had not observed the tradition of bathing in *mankhwala* as a means of protecting themselves against the *mizimu* of a recently dead person: "When my uncle passed away, we didn't do *mankhwala*. A week later, he troubled me in my dream because the graveyard was not well kept, 'my house is not okay.' I was very sick with a confused headache. I arranged a day to make the graveyard better. Up until now I am fine" (V.P.).

Ignoring the wishes of *mizimu* can result in falling ill, including becoming mentally disturbed: "If a spirit has made a person sick, then that spirit is a good one, because that means that the person has done something wrong and the spirit does not want that" (W.M).

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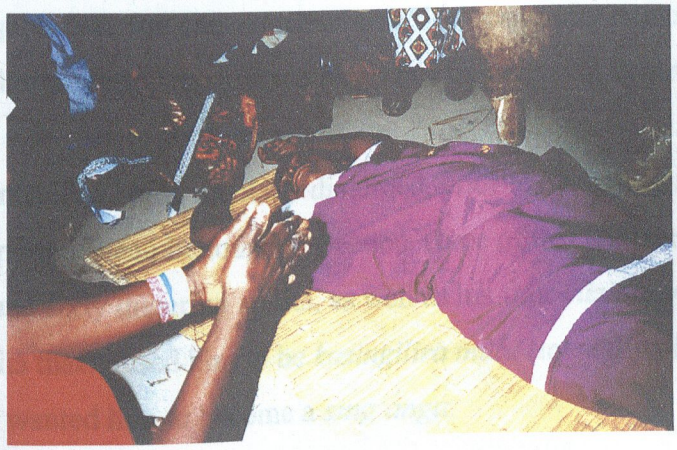
[11] *Chilopa* is dealt with more fully in the treatment section of this chapter

However the presence of *mizimu ya agogo* does not mean that they are responsible for the illness, they can be there in their role as protectors, intervening with illness caused by either witchcraft or lingering spirits. V.P., when describing their capacity to protect, commented that *mizimu ya agogo* can communicate the following type of message to a *ntchimi* when someone is ill, giving specific instructions: "... we are here, this one is suffering from such and such an illness. We're here to protect. If you want help, give this medicine, or a sacrifice".

For *ntchimi*, *mizimu ya agogo* can come through dreams, *mboniwoni* (visions) or can come through hearing a voice while you are awake (also called *mboniwoni*), particularly with well trained *ntchimi*. V.P. explained: "You can dream about *mizimu* and when you wake up those dreams are with you, like a computer that keeps everything. So when you are awake you can think you had a dream and you remember something. I had a dream of a certain root, from a certain tree, then you go into the bush to look for it and that is how you identify the tree." He continues: "without dreams you cannot become a doctor." These spiritual dreams are *nchimi ndimaloto,* and, as noted above, without these dreams from your *mizimu,* you cannot be a *ntchimi*.

Mizimu ya agogo are stronger than lingering spirits (*mizimu yakwendakwenda*). When *mizimu ya agogo* are present at the same time as lingering spirits, a struggle can ensue, which can result in what is termed 'death'. As V.P. related: "They always fight each other and cause death – some people can even die for hours, that's *kachekura* (death due to spirits struggling) that means good spirits are struggling."



Photograph 4.5: Woman experiencing *kackechura*

I only witnessed one example of such case, when I attended a *ngweleweta* ceremony (ceremony where a trainee healer is examined). In the early hours of the morning, a woman was carried into the *templi* (where ceremonies are conducted), who apparently was experiencing *kachekura*, also described to me as "being temporarily dead" (see Photograph 4.5). Drumming and clapping were required to "bring her back to life" and then she had to dance vigorously in order to strengthen her *mizimu ya agogo.*

It is common for *ntchimi* to have a *sadaka* once every year or two to show respect for their *mizimu ya agogo.* Often it leads to the strengthening of the existing *mizimu ya agogo.* Other *ŵasing'anga* are invited. Unfortunately, I did not have the opportunity to attend one of these ceremonies during my fieldwork.

Holy Spirit

The Holy Spirit refers to the Holy Spirit as written in the New Testament Bible and has a protective function. References to the Holy Spirit in interviews and discussions about health and mental disturbance were sparse and as a result not pursued.[12]

***Mizimu yakwendakwenda*/Lingering spirits**

Mizimu yakwendakwenda are lingering spirits and are described by V.P. as "in and out spirits". He describes them as just coming in and out of a person, and they are mainly responsible for illnesses. He continues: "... lingering spirits, don't come from own ancestors, come from anywhere to look for a person to enter." He continues to describe how *mizimu yakwendakwenda* can lead you to do harm to yourself: "lingering spirits can make you step on fire, you can even be burnt. They can make someone look here and there, and talk nonsense – *kuyoghoya bwekebweka,* behaving in a nonsense way."

V.P. described himself as being mentally disturbed, prior to becoming a *sing'anga*. His account of his experience can be found in Section Three of this chapter. At this time, he recounts that he had sixty lingering spirits, as well as his four *mizimu ya agogo*. It was the lingering spirits that caused him to be *kuzingilira mutu* (mentally disturbed). His *mizimu ya agogo* wanted him to become a *sing'anga.*

[12] The Holy Spirit is important in the faith healing tradition. It is beyond the scope of this study to address this area.

In addition to leading you to danger, lingering spirits can cause a variety of spiritual illnesses, some of which are listed here: *chawangowango* (spirit headache), *kadulola* (eye pains), *jalamakhutu* (ear pains), *kachichuru* (joint pains), *kabalamula* (heart pains), *kacheku* (leg pains), *phola msana* (backache), *kachekulu* (hand pain), *kavundula* (abdominal pain). In addition, the person may have *mutu* (a headache), *mtima yakwendakwenda* (pumping heart) or *kuzilika thupi* (body weakness). These pains can last for ten or twenty minutes or up to an hour initially. V.P.'s account of becoming a healer highlights how lingering spirits can cause *kuzingilira mutu* (mental disturbance) that may last for a few days or just a few hours.

Spirits of children can be lingering spirits, as they are not old enough to be able to direct their relative, but they can never be *mizimu ya agogo*. *Mizimu ya agogo* (ancestral spirits) are always older than the relative they are directing or guiding.

***Vimbuza* spirits**

Vimbuza is a specific type of spirit which can cause a particular illness also called *vimbuza*. *Vimbuza* is the term in chiTumbuka. These spirits are also referred to as *Maschawi* in chiTonga. Having these spirits does not allow the sufferer to heal people as traditional healers' spirits will, as was pointed out by one of the healers: "I have *vinthenda vamizimu* not *zavimbuza*, one who just has *vimbuza* dances and does not tell other people's illnesses."

***Mizimu uheni*/Evil spirit**

Mizimu uheni is an evil spirit, and is an ancestral spirit, the spirit of your own relative. V.P. used the following example to explain this type of spirit to me: "... if my father is a witch, then after his death, if I have dreams, I can dream medicine to bewitch someone. That bad spirit can come directly to me."

Mizimu who give instructions for *mankhwala gha ulowi* (medicine for witchcraft), as opposed to *mankhwala,* which can be used positively, are considered evil spirits. In contrast to the messages given by *mizimu ya agogo, mizimu uheni* can give instructions for medicine to cause illness or death, according to V.P. He gave the following

example: "... take this root, if you mix this root with a needle and curse someone that one will die, so when you wake up and do it, you can cause someone to die."

C.M. drew a distinction between the types of spirits that come to *ntchimi,* commenting that: "Bad *mizimu* are examples of those who go into a person who goes around killing other people[13] ... that's a bad spirit. Such types of spirit do not come into us." C.M. also commented that: "Bad spirits come into a person in the same way as good spirits do."

Mizimu play a pivotal role in the life of a *ntchimi.* Without their spirits they cannot diagnose or treat illness. Neglectin *mizimu* can have repercussions on the lives of ordinary people in terms of their health and behaviour.

Ŵafwiti

The role of *ŵafwiti* (witches) is important in the understanding of health and illness. A vital distinction exists between the role of the *sing'anga* and the witchdoctor. Confusion arises, possibly as a result of the term 'doctor' being incorporated into the label witchdoctor, which incidentally is an unfaithful English translation of *ŵafwiti* (witches). Witchdoctor and traditional healer are not terms that can be used interchangeably. A very definitive distinction exists between the respective roles. *Ŵasing'anga* are healers, their concern is the well being of the person they are treating; on the other hand, *ŵafwiti* are witches who use their knowledge to cause misfortune, illness, mental disturbance and even death by *ufwiti* (witchcraft). It is offensive to refer to *ŵasing'anga* in Northern Malaŵi as witchdoctors.

Mankhwala gha ulowi or *ny'anga* refers to the preparations employed by *ŵafwiti* in witchcraft to cause misfortune, illness or death. These *mankhwala* can be placed in the home of the person, or specifically on the fire in the house of the parent, if the malevolence is directed at a co-wife[14].

Witches or sorcerers also use *vizimba* in their *mankhwala gha ulowe*; however, they have a reputation of using parts of the human anatomy, either removed from a living

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[13] "Killing other people" in this context refers to bewitching people with the intent of killing them.

[14] Wife in a polygamous marriage.

person or someone killed magically so that the particular part can be removed, or blood could be drawn. A frequently cited example is the ability of a witch to remove all the bones from someone's body, leaving only a heap of flesh. As previously stated, the type of *mankhwala* which requires this type of *chizimba* is sought to gain success or prosperity. *Kukhwimira* is the verb ascribed to the action of using a *mankhwala* requiring a *chizimba* for such a specific purpose.

Summary

This section has focused on important terms and concepts which are required in the understanding of the causes and treatment of mental disturbance in Northern Malaŵi. Figure 4.1 on the following page illustrates the information provided in this section. The distinction was drawn between *sing'anga* who are herbalists and *sing'anga* who are *ntchimi*, and use their spirits in their healing art. The range of treatments, referred to as *mankhwala* in the vernacular, was described. Different types of *mizimu* and the role they play in the context of health and illness were considered. Attention was drawn to the harmful role of *ŵafwiti* and the negative impact they are believed to have on the health and fortune of Malaŵians.

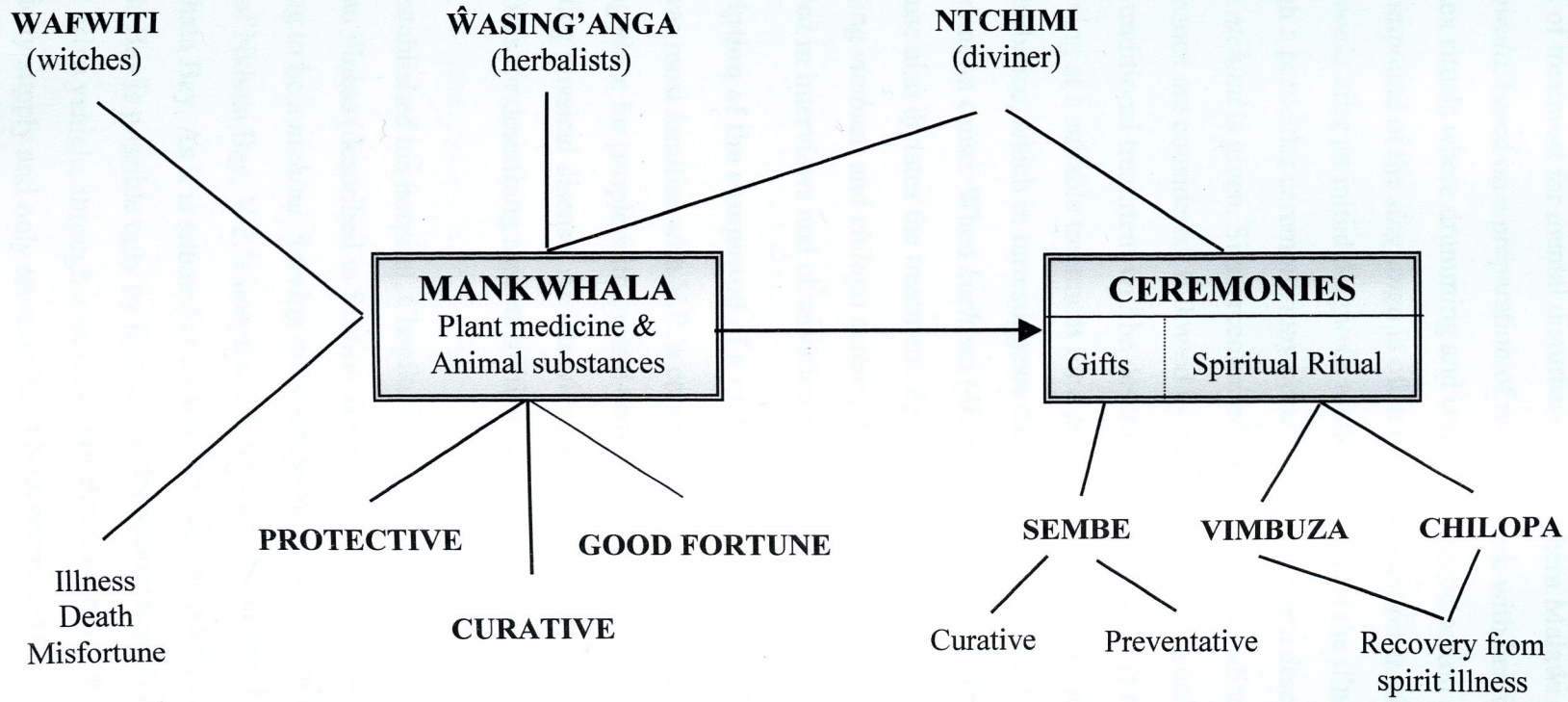


Figure 4.1 Schematic diagram relating the people who use *mankhwala* and ceremonies, and the outcome as described in the text

SECTION TWO: *KUCHIZGA* (TREATMENT)

Overview

Forms of treatment for mental disturbance in Northern Malawi encompass taking *mankhwala,* based on a preparation of roots and bark with healing properties, and complex rituals where drumming and community participation play an integral role. The compound of the *sing'anga* is often the focal point for treatment. Receiving *mankhwala* after an initial diagnosis to the resolution of the illness or disturbance through a particular ceremony may occur here. Therefore a description of the compound of one *ntchimi* is given. Signs recognised by *sing'anga* as indications of mental disturbance are considered, followed by causes of mental disturbance and finally some of the traditional treatment will be described. This sequence is reflective of the process of arriving at a suitable treatment for a particular disturbance; signs can dictate the type of disturbance, which in turn suggests the cause. A decision for a particular treatment is dependant on cause. When *kuchima* (divination or diagnosis through *mizimu*) is used, the cause also dictates the treatment. Specific treatments for mental disturbance including *vimbuza* and *chilopa* ceremonies are described, based on both information gathered in interviews and observation at ceremonies.

Description of the compound of a *ntchimi*

As I was most familiar with V.P.'s compound, I will describe it to characterise the usual healing place for people with mental disturbance. He also treated other misfortunes including physical disease. As interviews with V.P. were conducted in English, some of the words for describing aspects of his work are borrowed from English.

V.P. established his hospital, Chapika Traditional Hospital, in 1983, after recovering from an illness (described in Section Three of this chapter) and having completed his training to be a *ntchimi.* Serving the surrounding densely populated rural area and the town of Nkhata Bay, V.P.'s hospital is located approximately 1 kilometre from the town of Nkhata Bay. As it is situated at the top of a very steep hill, access from the town of Nkhata Bay is possible only by foot. In the dry season, access can be gained by a four-wheel drive vehicle, through a second, very circuitous route. It is not connected to an electricity supply and only recently has it been connected up to running water. V.P.'s family, two wives, twelve children and his extended family, which includes both his

parents, a number of his brothers, their wives and children, all live in the same compound.

Patients are received in his surgery, a brick building with a straw roof and a red cross painted on the front (see Photograph 4.6).



Photograph 4.6: V.P.'s surgery at his compound.



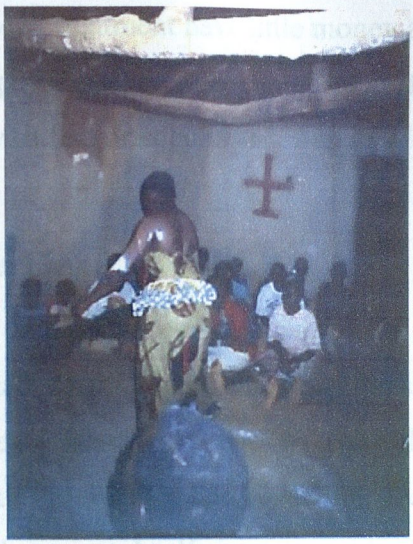
Photograph 4.7: Facilities for patients and their guardians at V.P.'s compound.

The entrance has a red curtain signifying danger for *ŵafwiti* (witches) or menstruating woman who may try to enter, as they are forbidden. Many of his patients are given advice and *mankhwala* from his pharmacopoeia, while others are asked to remain there for treatment with their guardians. He can provide facilities for them, a small brick house pictured in the shade (see Photograph 4.7) for the patient and guardians to stay.

They have access to a *chimbuzi* (pit latrine) and a cooking area, which can be seen at the centre of Photograph 4.7. These facilities are separate from his family's facilities, but shared among the patients and guardians. He can accommodate several patients and guardians at any one time. Guardians are generally adult members of their family who remain with them to provide domestic and nursing care as required. It is not uncommon for the children of the patients to also accompany them.

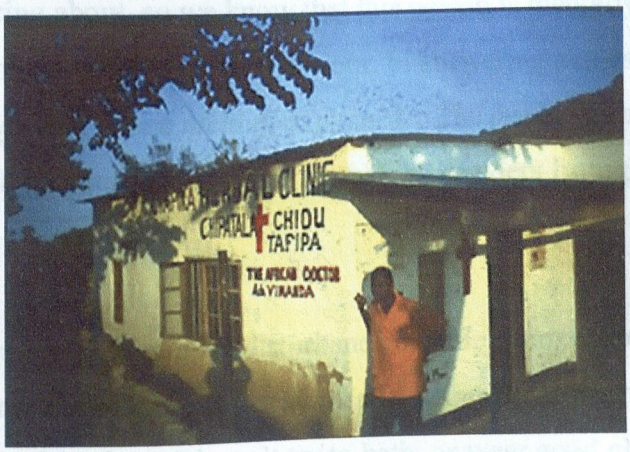
The *templi* (temple), where the healing ceremonies are held, is also marked with a red cross painted on the outside. A series of three red crosses are painted on the back wall. There is a raised platform at the back of the *templi*, and at the forefront of the platform there is a podium-type structure with a fourth red cross painted on the front of it. On the

ground, directly in front of the podium, a large circle is drawn with *ufu* (maize flour) before a ceremony begins, in order to negate the effects of witchcraft and menstruating women. It is in this area that the *vimbuza* dance is danced. Everyone who has come to participate in the ceremony sits in the remaining floor space. Photograph 4.8 illustrates a patient dancing *vimbuza* in the *templi*.



Photograph 4.8: A female patient dancing *vimbuza* in the *templi* at V.P.'s compound.

The circle drawn with *ufu* flour is visible on the ground and one of the red crosses can be seen on the back wall. Others participating in the ceremony can be seen sitting on the ground. An example of this can be viewed in the video, explained in Appendix E. The *vimbuza* ceremony is described in detail later in this section. In 1999, V.P. opened Chapika Herbal Clinic in the town of Nkhata Bay (see Photograph 4.9). He has a supply of *mankhwala* there, which he will dispense to those that require it. However, patients requiring more care will be taken to Chapika Hospital, and treated there as inpatients.



Photograph 4.9: V.P. pictured outside his recently opened clinic.

Patients seek treatment from an estimated 20 km radius. However, the first occasion I stayed at the compound he was treating patients that had travelled from Tanzania to seek treatment specifically from him. Patients are received six days a week; he generally does not treat patients on Sundays.

The majority of those who seek treatment have little money and often treatment is given for free. For those who can pay, small fees are charged and it is common for him to be paid in kind, for example, with fish or eggs.

Indications of mental disturbance

Different degrees of mental disturbance exist. *Kufuntha* (the most severe disturbance) has a literal translation as mad. *Misala* is the chiChewa translation and *vifusi* is the chiNgoni for mad. I often heard these words used by Tumbukas to express *kufuntha. Kuzingilira mutu* literally translates as the head is turning and *mutu yakwenda markora yayi* as the head is not working properly. *Kuzweta mutu, kuzingilira mutu* and *mutu yakwenda markora yayi* are types of mental disturbance considered to be more treatable than *kufuntha.* However, sometimes the terms are used interchangeably. There was broad consensus amongst *ŵasing'anga* on the signs of mental disturbance. The following section is not intended to be exhaustive, but illustrative.

One *ntchimi* describes how it can be evident initially from meeting a person who is disturbed: "… you'll find upon looking at his face that his eyes don't see properly, they turn around and around. And if you talk to him about something, his response is parallel to what you are talking about, so we know that this person is mentally sick" (V.Z.). Many of the symptoms are changes in behaviour. In answering a question "How do you know a person is *kufuntha*?" one *ntchimi* explained: "The deeds, because the brain does not function properly, so the deeds are not normal, he wanders from place to place" (M.B.).

A litany of behaviours which indicate disturbance include *nkhara yiheni* (bad behaviour), for example, throwing stones, violence, using abusive language; diminished concern about personal hygiene, "doesn't try to bath, or wear good clothes" and personal care, "cannot even have a blanket at night". Illustrating further behaviours is

another comment: "If a person is violent, uses abusive language, talks about bad things only, if he gets stones and throws them at people, touches faeces and then touches food, we know that that person's illness is *vifusi*" (W.M.). Other behaviours such as "talking nonsense", "laughing anyhow", "excreting everywhere" were commonly mentioned. Undressing, eating rubbish, talking alone were also mentioned.

Those with a mental disturbance can experience *mboniwoni* (seeing or hearing things that others do not see); they see dead people or ancestors coming to talk to them. V.P. drew a distinction between the *mboniwoni* experienced by *sing'anga* and *mboniwoni* experienced by a mad person:

> If you are a mad person and see *mboniwoni* they do not really exist. If you are a *sing'anga* and see *mboniwoni*, it's true *mbwoniwoni*, it's real talking. People with *kuzweta mutu* have *mboniwoni* who just talk this and that, no pause. *Sing'anga* have pauses. The visions are from ancestral spirits, they are grey like shadows. They can come day or night – mainly in the morning and the late evening, particularly late evening for a *sing'anga*. If the person is *kuzweta mutu* they can come anytime, not pausing, they are *mizimu yiheni* (bad spirits). They can be *mizimu kwenda kwenda nyama*, which look like animals.

It became apparent that a variety of signs can be observed in mental disturbance. Different signs or behaviours can be indicative of different types of mental disturbance. For example, there seems to be a general opinion that disturbance due to bewitchment results in the more severe changes in behaviour: "If a person has been bewitched you will just find that person beating people and abusing people verbally, he undresses and walks stark naked. Upon seeing his acts, as above, we come to know that this person has been bewitched. A person who is mad because of *mizimu* does not say abusive language or dress-off like that. No!" (V.Z.).

On the other hand, a person who appears to have *vifusi,* but in fact has a spiritual illness, can be differentiated from someone who has *vimbuza*: "... But if he has *vifusi* plus spirits we judge this upon his deeds, which include that he talks about spirits of the dead, he explains his dreams, and he talks about the Bible" (W.M.). However, it would not be clear at this stage what was causing the disturbance. If the *ntchimi* thinks this person has *vimbuza*, he will proceed with caution. Initially he will give him *mankhwala* and then "we observe the change in his life" before continuing with further treatment.

With regard to a spirit illness, one *sing'anga* commented: "So when we come to know that the person really has spirits you'll also find out that he runs to the bush and gets some *mankhwala*, he puts them [*mankhwala*] there … As such we know that *mizimu* is troubling this man" (V.Z.) Another symptom which indicates *vimbuza/vinthenda* is a distinctive shriek-like sound emitted from the person: "Hi! Hi! Hi!"

M.M. gives further evidence of how disturbance resulting from bewitchment becomes apparent: "… he [the person who is disturbed] becomes talkative especially when he sleeps, for example, he'll say so and so wanted to stab me with a knife. He has taken a knife, he wants to beat me. That is for the one who has been bewitched. The person who has bewitched him comes to his head."

V.Z. comments that madness resulting from smoking *chamba* can be identified as follows: "… they [the person needing treatment] stop bathing and combing. He dresses according to his wish. As such, you will come to know that it is *chamba* making him mad. And to a greater extent it may make him undress."

Summary of indications of mental disturbance

The *wâsing'anga* interviewed gave a wide variety of examples of indications that a person is mentally disturbed, the majority of which revolved around a change in behaviour, particularly to 'bad' behaviour which included violence and lack of personal hygiene. Other behaviour such as talking nonsense and undressing were common. One healer made a significant point that *mboniwoni* suffered by those who are disturbed are different than the *mboniwoni* experienced by the *ntchimi*. There is an apparent difference in the indications of disturbance caused by bewitchment and those caused by *mizimu*.

Causes of mental disturbance

"What has been the way of this man's illness? Has he been bewitched? Or is *vinthenda* taking charge of him? Or has he got certain bad charms?" (M.M.). These are questions asked by the *sing'anga* regarding the cause of any illness.

Ufwiti (witchcraft), *mizimu* (spirits) or *chamba* (marijuana) were considered to be the primary causes of all types of mental disturbance including *kuzweta mutu, kuzingilira mutu* and *mutu yakwenda markora yayi* as previously described. While a single one of these causes can lead to disturbance, in many cases, one factor is not solely responsible; a combination of these factors can also result in a mental disturbance. A brief description of how the aforementioned causes, as single causal factors, result in mental disturbance will be given, followed by a description of how a combination of these factors can also cause mental disturbance.

Ufwiti

Sanji (jealousy) between family members or co-wives can result in one resorting to *ufwiti* to bring the other down. People are necessarily blood relatives to be able to bewitch one another. In the case of co-wives, they can bewitch each other as they are connected through the exchange of bodily fluids from both having sexual intercourse with their common husband. *Ufwiti* can cause mental disturbance through a variety of routes. One way is directly through "the badness of 'magic' from people" (W.M.). Another *ntchimi* commented: "I tell the patient that for you to be in that state, there's a person who gave you bad medicine so that you became mentally disturbed" (M.B.).

If someone has procured *mankhwala gha ulowe* with the intent of boosting business, mental disturbance can result if the *mankhwala* is not dealt with according to instructions, due to the potency of the ingredients. Another form of bewitchment aimed specifically at a co-wife involves putting the *mankhwala yiheni* on the fire and so when the other wife is lighting the fire or cooking with it she can become mentally disturbed. A *sing'anga* further explicates:

> Sometimes, say like in a polygamous family, if a person, a man, has got two wives or three they can make each other go mad because of jealousy. They can take *mankhwala* and put it on the fire and the other will become mad. That is bewitchment. It may happen that anybody who gets that (uses the fire) may become mentally disturbed.

One *sing'anga,* J.M., the herbalist in Mzuzu, was doubtful as to whether bewitchment could result in mental disturbances, but was convinced of its role in general physical sickness and misfortune. However, he was the only one that diverged from the majority.

Mizimu

As already indicated earlier, *mizimu* can be responsible for mental disturbances, but the role they play varies. The presence of *mizimu ya agogo* does not necessarily implicate them in the disturbance process, as one of the *sing'anga* pointed out: "when someone is mentally disturbed, we think of bad spirits" (V.P.) . Important to acknowledge is that *vimbuza* is not considered madness or mental disturbance, although it might appear as such: "There are a lot of times when the victim has got *vinthenda (vimbuza)* but have not followed proper order so it will apparently be *vifusi*" (M.M.).

However, *vimbuza* can lead to madness or disturbance, for example, if the person has not been treated early enough: "Sometimes it's [mental disturbance] because of *vimbuza*. So, for these, if they have brought the person very late, there's need of putting them in proper order. And this person becomes mentally ill as if bewitched" (V.Z.). Or if treatment has not been followed correctly: "... this [mental disturbance] happens only when the one has *vimbuza,* and the *chilopa* drinking ceremony hasn't been followed as it is supposed to be, for sure this individual will fall sick mentally" (V.Z.).

Or alternatively, it could be the case that *mizimu ya agogo* are being ignored, as M.M. pointed out: "So we find out that it's *vinthenda* and that this man has neglected them that's why they're making him mad." V.Z. states that "there is *vimbuza* that can make a person become mad." Having *vimbuza* does not necessarily cause a mental disturbance, but under particular conditions *vimbuza* can result in such disturbance. One *sing'anga* was emphatic in his statement: "It is not possible to have *vimbuza* and mental illness, mental illness is the end result" (J.M.).

Chamba

For all the *sing'anga* it was a given that *chamba* is one of the major causes of mental disturbance, but I got very little explanation as to the role it played. It does seem to be related in some way to blood, as indicated in the following quotation: "There are some, who after smoking, their blood is weak" (V.Z.) and this is instrumental in their becoming disturbed.

Combined causes

Ufwiti and Mizimu: Witchcraft allows lingering spirits to come in: "After bewitchment bad spirits come. If I am mentally disturbed my good spirits are out, bad spirits are there and they call up other bad ones, lingering spirits like to come to someone with problems and then multiply" (V.P.).

Bewitchment can result in his good spirits leaving: "Bewitchment comes in, if a person has been bewitched to become mad, and it is very strong, plus the spirits that are inside that person come out at the same time. If a person has been bewitched while he has the spirits, he gets better, but if a person has been bewitched without spirits, he does not get better unless he goes to a healer who is fit, then he will get better" (W.M.).

Chamba and Mizimu: While *chamba* can cause mental disturbance by the effect it has on the blood or the head, this problem can be initiated by *mizimu*: "Bad spirits cause you to smoke" (V.P.). On the other hand, it could be lack of protection from your own *mizimu,* who do not intervene to stop you from smoking. If you use *chamba*, you can become vulnerable, and this vulnerability can attract bad spirits, as is highlighted in V.P.'s explanation: "To begin with there is no *mizimu*, after illness, if *chamba* made you ill then you are mentally disturbed that means that the bad spirit is now after you. When you smoke at first they are just silent, they are just saying: this one is coming he wants to call us, we are here. Then later on you will see that we have come."

Other causes

Other causes were not as frequently discussed as *Ufwiti, mizimu* and *chamba.* These are detailed below.

Mahganohgano chomene (thinking too much): Notably, K.M. and J.M., the *sing'anga* situated in a less rural area, both felt that *mahganoghano chomene* (thinking too much), which could be translated into 'worrying' in English, could result in disturbance. They provided examples of difficulties that they thought could cause this situation to arise: "things that affect everyday living" (money, food, health) and more specifically activities in the house, "not moving well, a husband not moving well" (referring to having extra marital affairs). In addition, if someone has learnt a lot (academic type of

learning) mental disturbance can result. Both linked thinking too much with blood flow. One *ntchimi* (V.Z.) explained it in the following terms: "the flow [of blood] affects brain cells, then eventually this individual will be sick mentally" and K.M. simply added to his comments about thinking too much that, as a result, the blood is running faster (*ndopa mbiri chomene*) which is comparable to high blood pressure.

Physical injury: Physical injury to the body can result in mental disturbance, V.P. gave the examples of injuries to the spinal column or the head as a result of being beaten up, or cerebral malaria.

Khumbira la Chiuta (God's will): One of the *ntchimi* (M.B.) said that mental disturbance can come from God's mind. Furthermore, V.P. considered mental disturbance to be God's will, if it was passed on through the family.

Through the family: Of the *sing'anga* that mentioned a family connection, there were two different opinions: that it is passed on through the "family biological hierarchy" (J.M.) or simply that it can be "in the family" (V.P.). In the latter case, it can be passed from grandmother to granddaughter, for example, and as previously mentioned it is God's will for it to be passed on.

Alcohol: Only two of the *sing'anga* felt that alcohol could cause mental disturbance if taken in excess but did not offer an explanation.

Summary

The *ŵasing'anga* interviewed attribute a wide range of causes to mental disturbance. Consensus exists between *ŵasing'anga* for causes such as *ulowe* (bewitchment), different types of spirits and *chamba*; combinations of more than one of these causes create plural explanations for disturbance. Clearly, not only 'supernatural' causes are attributed to mental disturbance, for example, *chamba* and thinking too much cannot be bracketed with the supernatural causes. Fewer *ŵasing'anga* in this study consider causes such as alcohol and *mahganohgano* (thinking too much) as instrumental in causing mental disturbance. Also apparent from the interviews, is that *ŵasing'anga* maintained that spiritual illness can appear to be a mental disturbance, but requires the

appropriate treatment for a spiritual disorder. A person with *vimbuza* is not viewed as being *kufuntha* (mad). According to the *ŵasing'anga* included in this study causes of mental disturbance can also include will of God, physical injury, or illness, a condition passed on through the family and excessive alcohol intake.

Traditional treatment for mental disturbance and spiritual illness

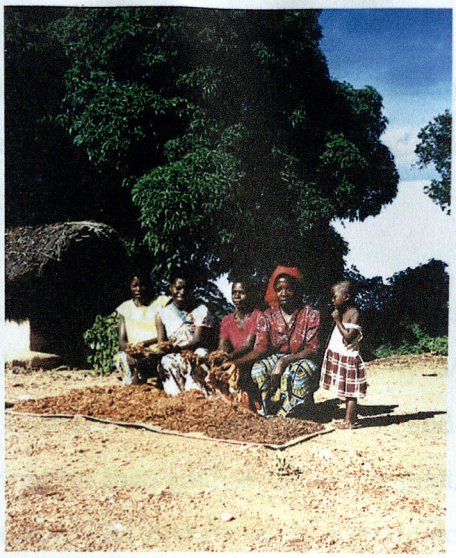
These observations are based on interviews with *ŵasing'anga* and not the systematic observations of treatment with mentally disturbed patients treated by *ŵasing'anga*. This section contains information regarding the use of *mankhwala* in the form of plant medicine and the *vimbuza* ceremony and *chilopa* ceremony.

Mankhwala

Mental disturbance is often treated with *mankhwala*. According to J.M., *mzobala, mkotano,* and *msindila* are plant medicines commonly used to treat mental disturbance. They can be taken in a variety of different ways. The *mankhwala* is decided upon, according to the apparent cause of the disturbance: "So the bewitchment is giving him *vifusi*. The spirits want him to get better. So, we should give medication to lessen the bewitchment and that he should not just remain with his *mizimu ya agogo*. We base our *mankhwala* on that" (M.B.).

Some healers will bring their patients with them to collect their *mankhwala* as illustrated in the following quotation: "So I take the medicine, which we dig together with the patient. After digging, I give them to him … to bathe. Sometimes I apply them by cutting through the skin. So the patient, to whom I have given medicine, will stay for some days or so and change" (M.B.).

The first time I stayed at V.P.'s compound, some of his patients were involved in preparing their own *mankhwala.* Photograph 4.10 shows some patients with *mankhwala* which they had been preparing. The daughter of one of the patients is included in the photograph.



Photograph 4.10: Female patients preparing *mankhwala*

M.B. described the application of *mankhwala* to someone who is mentally disturbed due to spirits. First of all, the hair is shaved off and a cross is cut on the head from the base of the skull and from ear to ear. Some *mankhwala* is rubbed on, then more *mankhwala* is applied which has been boiled in water. The patient then bathes in water with *mankhwala*, and then drinks some more. When the person is being treated, they sit facing the same direction from which they arrived, so that the spirit can leave.

It appears that some healers are of the opinion that the hospital can treat mental illness due to *chamba* more effectively than they can: One *ntchimi* made the following comment:

> That's why we tell his attendants that according to what the spirits have told us, this person has been smoking *chamba* although you do not know. So try to take care of him, but we urge them to take him to the hospital. At the hospital, there are medicines that they give out so that the *chamba* that that person took sometime ago should get out and the person can be back to normal again. But if they can't give him the medicine that casts out the smoke then he remains mentally disturbed. (V.Z.)

Shortly before I left, a *ntchimi* I had interviewed brought one of their patients, whom they regarded as being ill because of *chamba,* to the hospital to seek treatment for them.

K.M. told me that a *sing'anga* was required to ask for help in treating a patient if they were not making progress. Failing to do this is called *wakulera matenda.*

Vimbuza and Chilopa

Confusion arises with the term *vimbuza,* as it has several meanings. Not only is it a type of spirit which causes a particular type of illness, but, in addition, the same word is used to describe the treatment for this spirit illness.

Several references have already been made to both *vimbuza* ceremonies and *chilopa.* They will be discussed in the context of a healing ceremony. My intention in this section is to describe what I observed at these ceremonies, and to include information related to me by *sing'anga*, rather than analyse these treatments as rituals. I believe that two reasons justify this position. The first reason is that I do not believe that I could do justice to the complexities of either ceremony; I witnessed only three *vilopa.* Only one of the *chilopa* was a part of a treatment ceremony of a woman suffering from *vimbuza.* The other two *vilopa* were part of celebratory ceremonies. One was at the opening of a *templi* of a female *ntchimi* and the other as a prescribed part of a *ngwelaweta* ceremony. Furthermore, while I participated[15] in five *vimbuza* ceremonies, on each occasion I understood or witnessed another aspect that contributed to my understanding of what was happening. In my opinion, that would have continued to be the case, particularly until I could understand everything that was being said. The second reason is that, for the purposes of this research, it is not of any real benefit to pursue the analysis to that extent, given the efforts to retain focus on the patient's understanding of disturbance. It is, however, important to consider these ceremonies as an insight to this aspect of treatment provided by *ntchimi.*

Vimbuza

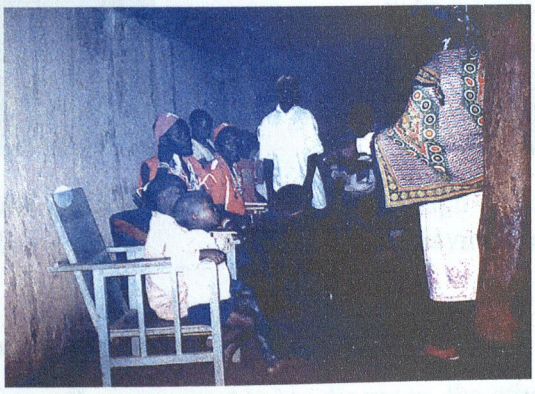
The *vimbuza* ceremonies I attended were conducted by either C.M. or V.P. I attended five in all. Very apparent differences existed between the ceremonies conducted by each of the *ntchimi,* although the same principles were involved. The first difference I noted was that V.P. was the only *ntchimi* present in the ceremonies conducted at his *templi.* At *vimbuza* at C.M.'s compound, there were several *ntchimi* present, with different *ntchimi* diagnosing at different stages of the evening. The *vimbuza* ceremony at V.P.'s was not a regular predictable occurrence. *Vimbuza* was only conducted when he was treating

[15] By participation I mean was present and presence equals contribution to some extent, e.g. clapping.

someone who needed to dance *vimbuza* to get well again, whereas, with C.M., he had a *vimbuza* ceremony every Saturday night. Only if there had been a funeral in the community would it be cancelled, as it is not respectful to the spirits to have a *vimbuza* ceremony under those circumstances. This was also the case with V.P. Everyone in the area was aware of the fixture and anyone who needed diagnosis or treatment would come along. On one occasion I observed that two of the people seeking help were there on behalf of one of their relatives about whom they had concerns. Interestingly, both were mothers with concerns about sons in their late twenties. The reason for attending for a diagnosis did not appear to be restricted to spiritual illness, as I had initially understood it to be. That night, a range of different problems were diagnosed.

Description of vimbuza ceremony

Before darkness falls, the *templi* is prepared. A white circle with the cross marked out with *ufu* (maize flour) is drawn on the ground to protect against witchcraft and menstruating females. Chairs are put in place for the *ntchimi* who lead the ceremony. Young boys warm the drums at the fire.



Photograph 4.11: Young children at a *vimbuza* ceremony at C.M.'s compound

Near the *templi*, the family members of the patient or patients arrive, and the community – from children to *a gogos* (elderly) – congregate in the *templi,* sitting on the floor. Photograph 4.11 illustrates the presence of young children at the ceremony, waiting for the music to begin.

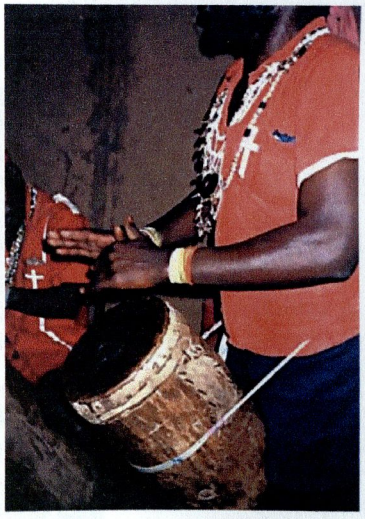
An atmosphere of heightened anticipation prevails; the ceremony will probably last until at least 3 a.m. the following day, if not until dawn. *Vimbuza* ceremony is usually a precursor to *chilopa,* but not all *vimbuza* culminate in *chilopa.* The drum used for

vimbuza has a distinctive pitch. There is a hole (*nembe*) made in the wooden body of the drum, near the base. Traditionally, this hole was covered with the web of a particular common spider found in the roofs of the huts. However, with the arrival of polythene bags in Malawi, a substitute for the web was found. The covered hole creates the special pitch (see Photograph 4.12).

In my experience, although two drums were used in *vimbuza* ceremonies, only one drum with the distinctive *vimbuza* pitch was used. Once the skin on the drum was less taut due to the heat, and the drummers had an opportunity to practise a little, the ceremony could begin.



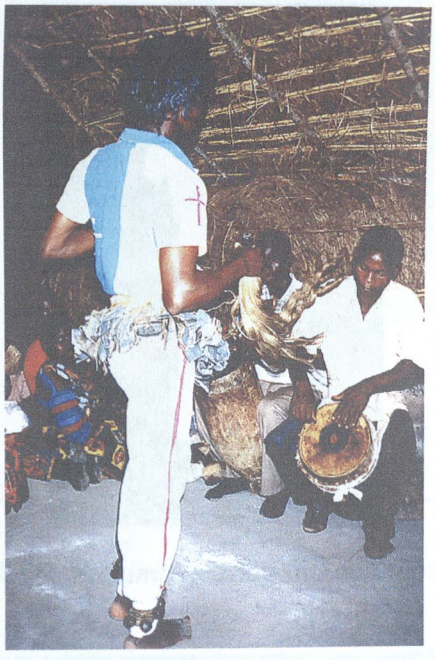
Photograph 4.12: *Vimbuza* drum with *nembe*



Photograph 4.13: *Ntchimi* in uniform playing a *vimbuza* drum

The *ntchimi* who will lead the ceremony will welcome the spirits and thank everyone for coming. If there is more than one *ntchimi* to diagnose, the other *ntchimi* show respect to the most important *ntchimi* who will be leading the ceremony. He will begin to dance in order to 'heat' his *mizimu,* to allow him to enter into communication with the *mizimu* of those suffering from illnesses, including spirit illness. There are particular songs that are traditionally sung at *vimbuza* ceremonies. Christian hymns are also sung. The people gathered sing and clap. There are usually blocks of wood for clapping together as the degree of clapping required can be sore on the hands. Singing and clapping provide support for the person dancing to raise their spirits, in addition to the drum playing (Photograph 4.13).

The *ntchimi* are always in uniform for these occasions. As can be seen in many of the photographs of *ntchimi* in this chapter, uniforms have either a red background decorated with white trimmings or the reverse, a white background with red trimmings. The choice of design is made in accordance with the spirits' wishes. M.B. explained to me that the red signifies the blood of *chilopa* and also the potential danger. The white cloth signifies *mizimu,* which indicates "that God is above all", that the *ntchimi* will be shown the right direction. The combination of the red and white show that blood and the spirits should be together. *Mboni* beads are also often requested by the *mizimu.* The cross signifies protection from North, South, East and West. Some *ntchimi* have an idiosyncratic addition to their uniform. V.P.'s *mizimu* request that he wears a curly, black wig (see Photograph 4.14).



Photograph 4.14: V.P. wearing his black wig at a *vimbuza* ceremony

C.M. wears a very distinctive headdress. I met one *ntchimi* who wears a green and white outfit; again, that was at the request of her *mizimu.*

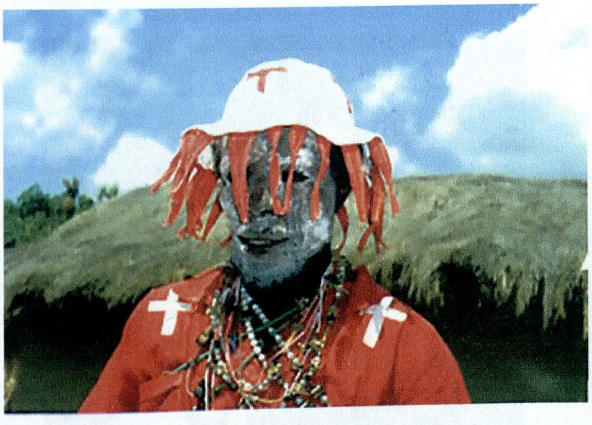
M.B. added that your *mizimu* look upon you properly if you put on what they tell you. *Ntchimi* wear these uniforms to all ceremonial occasions which they attend. When dancing to divine or diagnose, a special 'skirt' is worn (*mazamba*) and a belt with lots of pieces of tin attached, *mang'wanda.* Similar but smaller pieces of tin are attached to bands that are around the ankles of the dancer, known as *nyisi,* as can be seen in Photograph 4.15. The jangly sound provided by the rhythmic movement of the dancer

adds to the 'percussion' with the beat of the drums. The person suffering from *vimbuza* also wears these when they dance. The video (Appendix E) illustrates a *vimbuza* ceremony.

Someone suffering from *vimbuza* dances *vimbuza* to *kukizgha mzimu* (bring the spirits down). *Mizimu akwera* are high spirits. The *ntchimi* will *kuvmizga,* which means talk to the spirits to bring them down. On several occasions, I witnessed dancers, both those with *vimbuza* and *ntchimi*, pasting wet flour on their faces (see Photograph 4.16). This was carried out at the request of the *vimbuza* spirits and is another method of cooling spirits down. Eating raw eggs or putting red clay on the face has the same result.



Photograph 4.15: *Ntchimi* wearing full ceremonial uniform.



Photograph 4.16: *Ntchimi* with wet flour pasted on his face.

Chilopa

A *chilopa* sacrifice is distinct from any other sacrifice, as it involves drinking blood. *Sembe* is the word that describes other sacrifices made to *mizimu*. *Moa* (beer) is a common *sembe* offered to the *mizimu*.

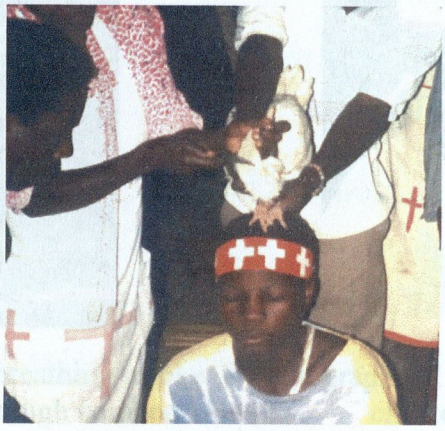
It seemed that *chilopa* ceremonies were always planned in advance. They were not impromptu ceremonies, carried out when the *mizimu* make the request. The actual time it is carried out can be negotiated between the *mizimu* and the *ntchimi*. Often money has to be sourced to pay for the chicken or goat. The following description is from my observations of the *chilopa* ceremony conducted at the *ngwelaweta* ceremony. It was the second *chilopa* I attended, and it was on this occasion that I was able to observe most detail. In this instance, the *chilopa* was a chicken. The ceremony is carried out for the benefit of the trainee. The animal that is sacrificed for the *mizimu* varies depending on the request made by the *mizimu.* Often this depends on the extent of the suffering that is experienced. The smallest *chilopa* would be one of a dove, a chicken is next, then a goat and the most unusual, and largest, sacrifice is a cow. Sometimes *mizimu* specify the colour of the animal, for example, a white chicken. Important to note is that eating meat for the majority of the people in Northern Malaŵi is a rare occurrence.

At 5.30 a.m., five of the *ŵasing'anga* who were involved in the ceremony prepared the chicken for the ceremony. The chicken is feathered (see Photograph 4.17).



Photograph 4.17: Three *ntchimi* preparing chicken for *chilopa*

The important part of the ceremony occurs when the throat of the chicken is slit over the head of the person receiving *chilopa* (see Photograph 4.18) and the blood is drunk at that precise moment, while the chicken is still warm and the heart has not yet stopped.



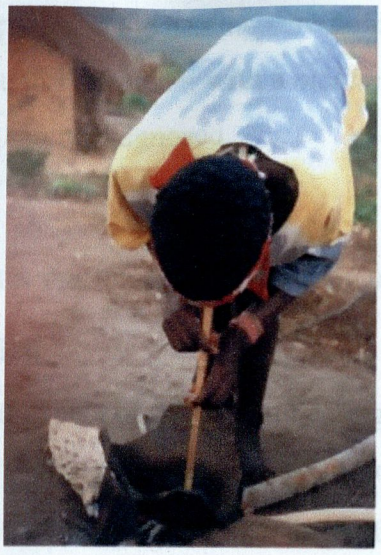
Photograph 4.18: *Ntchimi* holding chicken with the knife poised to cut throat.

The dissection of the chicken begins. The pancreas, testicles, bile, heart, lungs, liver, and breast are removed and put into a *ndengere* (broken pot). Snake skin powder (the *chizimba*) is added with salt (see Photograph 4.19).

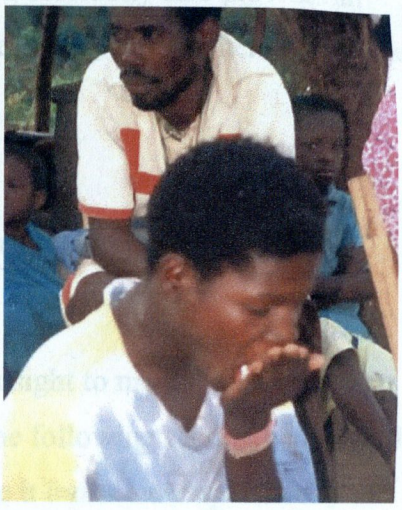


Photograph 4.19: Chicken with a *chizimba* being cooking in a *ndengere*.

The remainder of the chicken is cooked separately. A hoe, an axe head and a stone support the *ndengere* in the fire. Each holds a certain symbolism. The hoe, for example, represents the hope to be able to regain the ability to cultivate when better. This combination is cooked in the *ndengere* until it is charred. While it is cooking, the recipient, in this case the trainee, breathes in smoke through a piece of bamboo held to his mouth (see Photograph 4.19).



Photograph 4.20: Trainee breathing smoke from cooking chicken through bamboo



Photograph 4.21: Trainee eating pieces of chicken with left hand

Also required is a series of jumps over the pot from North to South and from East to West. The significance of this is seeking protection from all directions. In between, he eats pieces of the dissected chicken with his left hand, until only the charred remains are left (see Photograph 4.21).

The chicken cooked separately is shared out among all those involved in the ceremony. Altogether, approximately one hour has elapsed since the chicken was prepared. Afterwards, *mphini* (small incisions) were made on the trainee's upper arm, below his neck, on his upper thigh, near to both his nipples, and on his midriff and *mankhwala* applied. The only difference I noted between this *chilopa* at the *ngwelaweta* ceremony and at the healing ceremony was the method of giving *mankhwala* at the end. The woman who had taken part in the *chilopa* was given *mankhwala wa kugeza.* V.P. had told me that he had to adapt the *mankhwala* for the woman as she was quite elderly. It was too dangerous to give her the regular *mankhwala* as it would be too potent for her.

Summary

The early part of this section describes how herbs can be used to treat mental disturbance based on interviews with *ŵasing'anga.* The second part describes how particular ceremonies are used to treat spiritual illnesses, based on participant observation of these ceremonies and discussions with the *ntchimi* involved. A great deal

of emphasis is placed on the 'ceremonial' aspects, such as uniform and community participation in the healing ceremonies. The *vimbuza* ceremony also provides an opportunity to consult with a *ntchimi* regarding illness and, with his/her *mizimu*, the illness can be diagnosed.

SECTION THREE: EXPERIENCE OF BECOMING A *NTCHIMI*

Overview

Another aspect of traditional healing which offers insight to mental disturbance in Malaŵi is the experience of becoming a *ntchimi*. The following section begins with a synopsis of the pathway to becoming a healer before it looks more specifically at accounts which describe the pathway to becoming a successful *ntchimi,* as related to me in interviews by four *ntchimi*.

Typical path to becoming a *ntchimi*

According to the *ntchimi* I interviewed during the course of this study, a vocation to *ntchimi* is always preceded by a period of illness and suffering, typically initiated by *mizimu a gogo* (ancestral spirits), and *mizimu yakwendakwenda* are often instrumental. Often this type of illness is interpreted as the wish of *mizimu ya agogo* for the person to train as a *ntchimi*, and use their *mizimu* for healing people. In that sense, being a *ntchimi* is viewed as more than just a profession, but also a vocation. Generally, ignoring or disobeying the wishes of the spirits can result in illness. Subsequent to the identification of the link between the suffering and the wishes of the *mizimu*, treatment is sought from a *ntchimi* with a good reputation, who becomes your teacher. After the required period of apprenticeship has been completed, a special ceremony, *ngweleweta*, is organised in the community which includes a test of the ability of the trainee and marks the end of the training period and the beginning of the professional life as a *ntchimi*. The trainee is given two 'tests'. The first requires his/her *mizimu ya agogo* to locate *mankhwala* which has been hidden in the bush (see Photographs 4.22 and 4.23).

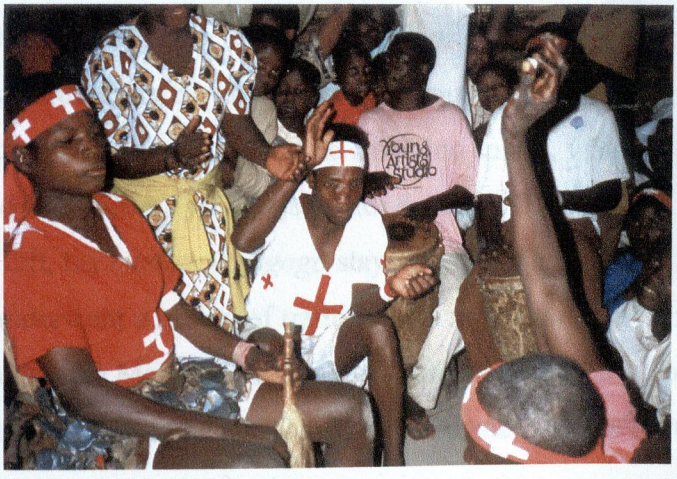


Photograph 4.22: Triumphant trainee returning with *mankhwala*



Photograph 4.23: *Mankhwala* in *mboni* plates before being concealed in the bush

Having successfully completed this, the next step is to know, with the guidance of your *mizimu,* which objects have been hidden on the person of another *ntchimi*, and identify where they are hidden (see Photograph 4.24). Success with completion of both tasks means that the *ntchimi* can *kutwasa* 'graduate' to the status of a *ntchimi*.



Photograph 4.24: Experienced *ntchimi* holding up the coin the trainee successfully located on her person

The experiences of illness and suffering were explored further with some of the *ntchimi* interviewed. The following excerpts of their accounts highlight some of the common strands that emerge through the descriptions of experiences given by *ntchimi*. Attention is drawn to several important themes, providing insights into mental disturbance.

V.P.'s account

V.P. recounts his experience of becoming ill which led to him becoming a *ntchimi*. One night he was fishing on Lake Malawi, his occupation at that time. A very large man, who looked like a ghost, was coming towards him, walking on the water. V.P. was very frightened and was shouting. His companion could see nothing and mistakenly thought that V.P. had been smoking *chamba.* He later tried to sleep for a few hours, but all the while he continued to see the same frightening images. When he returned home, he was in a very distressed and agitated state, still seeing what was not there (*mboniwoni*). His friends and some relatives wanted to bring him to Zomba Mental Hospital, as he appeared mentally disturbed, as a result of *mizimu yikwenda bweka bweka.* He recounted his experience: "Bad ones (*mizimu yiheni*) were talking this and that, 'we want to go here, there', so I was saying 'no, no', so people were thinking that William (V.P.'s birth name[16]) was mad because he was always talking to them, turning to this one [*mizimu*] and then to that one."

He feels that his lingering spirits led him to become mad, for a short period of time. However, his parents intervened, recognising the behaviour as being symptoms typical of *mizimu*. He was brought to a *ntchimi* where he was successfully treated, the lingering spirits were healed through herbs, and he had a *chilopa* of a white dove and a white chicken. At the time of his illness, he had 60 lingering spirits, which were causing his illness; he also had four *mizimu ya agogo*. After the *mizimu yakwenda kwenda* (lingering spirits) left, his *mizimu ya agogo* stayed, which he describes as "doctoring spirits". He then underwent a period of training with a *sing'anga* in Nkhotakhota, Central Malawi, along the Malawian Lakeshore, before successfully completing his *ngwelaweta*. He has gone on to be a healer of some repute, and the District Chairman of HAM.

A. M.'s account

The following is an account of illness preceding the training period for A.M., a female *ntchimi,* serving also as an introduction to several themes that recur through the interviews. The intermingling of biomedical orientated treatment and traditional

[16] *Ntchimi* take on a healing name once they are fully qualified. The name is given to them by their *mizimu ya agogo*.

treatment, and the fact that families are prepared to travel great distances to find the treatment that is going to help the recovery of their relative, are themes that occur frequently. It is also an indication of the importance of the role played, both in sickness and healing, of dreaming (*kulota*). In Northern Malawi, God, the Holy Spirit, angels and the Bible play a key role in healing and in being able to work effectively as a *sing'anga*.

"I started suffering in 1968 and I was in hospital for one month with drip after drip at Rumphi hospital[17], but there was no improvement". A.M.'s late husband then took her to *sing'anga*, in a neighbouring district, but she was too sick to receive treatment. Then they took her to Zambia where she was given treatment that did not work. She was told that she had *mizimu* and that he was not a *sing'anga* for *mizimu*. On returning home, she was admitted again to Rumphi for six months. Her son in Karonga, a Northern district, requested her discharge "to try another treatment". The first treatment was not successful and she went to another *sing'anga* in Karonga and was told she had been bewitched, "that so many things had been put or inserted in my body[18]". She stated that: "At that time, I was not eating or sleeping. I was eating literally no food, not even tea, Fanta, rice or water," and continued: "Mzgoka[19] tried to remove what was put in me and some of the things were removed to let *mizimu* get settled, both in my head and in my stomach. Then I got better."

She told Mzgoka of the dream that she had: "I dreamt about a white goat and a white uniform. My ancestors had sent me a white goat and a white uniform and they wanted me to put it on with a white dove." After that, Mzgoka sent her husband to buy the cloth and the uniform was sewn. The *mizimu* of her mother had asked her to go to the hill. And so she returned to Rumphi. She had another dream while lying out one night: "... four angels visited me, two on either side and one head and toes. Those on my sides carried hymn books, and the others carried Bibles and they were saying we know you are not a *vimbuza* case, what we want is that you be God's messenger." She continued: "In broad daylight I had a dream of my grandmother from Zululand ... telling me to go to C.M., where he will take you to the mountain where you will be healed. I am your grandmother talking." She told her husband and on the same night, she had the same

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17 Government run District hospital, with a biomedically orientated approach to treating illness.

18 This is a reference to bewitchment

19 Mzgoka is a well known healer

dream again. She was told that her name will now be "Mungelo" (Angel). She arrived at C.M.'s place early in the morning. "I was very thin, if it were today, people would have concluded that I have AIDS, but it's because I wasn't eating." Again she had another dream, that she should go to Chipokaoli[20] and "throw a live white dove" and afterwards "make a sacrifice of another white pigeon and that the first uniform that I had should be thrown away, as it was a *vimbuza* one, not a *mizimu* one". Once her spirits were satisfied, she became well again. Part of the trouble she experienced was due to the fact that she was being treated as having *vimbuza*, not as a potential *ntchimi*. Subsequently she trained with C.M. and is now working as a *ntchimi*.

F.N.'s account

A second female *ntchimi* told me her story, and this highlights some of the symptoms she experienced, and her efforts in seeking treatment.

> I started suffering in 1986, while harvesting my field. And when I drawing water, I was hearing people singing under the water. The song was about these people asking Noah to open the Ark so they should enter. I was very terrified, I tried to look this way and that way to trace where the voices were coming from but I still found it was in the water – under the water. Back home when the radio was playing – especially songs by women for Kamuzu[21], my heart was racing and I was feeling like breaking the radio. I later on stopped eating foods, only tea and nuts. I got very thin beyond recognition.

She sought treatment with *Sing'anga* Chauluma, which consisted of *mankhwala* and *chilopa* of a black chicken and a dove with stripes. But did not improve. She explains:

> Then we went to Chikanje and he saw me and knew my illness, and told them [parents] that it was too much for Chauluma. He told us to go and ask Chauluma's permission first before he could do anything. We did and he accepted. And when I came here I stayed for some time and was given *chilopa chambuzi* (sacrifice of a goat) then *chilopa* of a dove, then two chickens, a white hen and a black cock.

She went on to train with Chikanje and is now a practising *ntchimi,* and has remained well since.

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20 Traditionally a very important place for *mizimu* on the Rumphi /Mzimba border, *mizimu* are said to inhabit the surrounding area.

21 Kamuzu is the name given to the Life President of Malawi before independence was gained and Malawi became a multi-party democracy. Women used to sing and dance for him on special occasions.

Dr. M.B.'s account

The following interview shows the problems that occur when the vocation is ignored. Dr. M.B., a *ntchimi*, first experienced his illness in 1969. "I started suffering from the head and the back became bent." His parents took him to a *sing'anga* who told him that his illness was *vimbuza*, and she told them, "he is a person who is aspiring to diagnosing other sick people." And, so a *ntchimi* began his treatment. He continues: "After I took that *mankhwala* she took me to her place and started to try me on drums. As such, she made me dance *vimbuza*. Later she said I should take *chilopa* (sacrifice) of a goat." He continued to be able to diagnose. However, after some time he stopped his work as a *sing'anga*, and he describes the impact of this: "Later because of some poverty I ignored the disease. From there, I started working. While still working the illness was sent to me again that I got mentally confused as the work (of diagnosing) was at a standstill." In order to remedy the situation, he stopped working, returned to the same *sing'anga* and was treated with *mankhwala* "so that my heart would be cooled". He has remained well since that time and continues his work of diagnosing, giving *mankhwala* to those with mental disturbance, and also treats people who like himself have *vimbuza*. He concludes by saying that, "So because of this [ignoring ability to heal], my illness commenced. As of now I am fine, because I also help my friends," emphasising that he is well because he is no longer ignoring his illness.

Summary of *ntchimi's* accounts

These four accounts of becoming *ntchimi* indicate the difficulties experienced by these people and indicate important features about health care in Northern Malawi. Examples of the distances people will travel for treatment, and the lengths their families will go to in seeking treatment, are evident from these accounts. Moreover, the pluralistic approach adopted to seeking treatment is apparent. It is important to note that some of the indications of potential healership described by *ntchimi* could be classified in western psychiatry as hallucinations, both visual and auditory in the case of V.P., and auditory in the case of the second female *ntchimi.*

While it is recognised that some of these accounts date back to the 1960s, and it could be claimed that they would not have had the same experience in the present day Malawi, I would suggest otherwise. I do not have the same degree of detail about the

experience of the trainee who became a *ntchimi* at the *ngwelaweta* that I have often referred to, as I did not feel that it was appropriate on that occasion to ask him for an interview. V.P. informed me he had a serious disturbance for the year preceding his apprenticeship, which he described as "like *kufuntha*", indicating that he appeared mad. In a similar vein to the other accounts, it was only when it was realised that he was neglecting his calling to become a *ntchimi,* and the appropriate steps were taken, did he begin to become well enough to undertake the arduous training he followed to become a *ntchimi.*

SECTION FOUR: PROFESSIONAL STATUS

Once qualified as a *sing'anga* or a *ntchimi,* an application can be made to a professional body. Both of the main informants in the study were District Chairmen of the Herbalist Association of Malaŵi (HAM). Other associations do exist but HAM. appears to be the strongest. C.M. furnished me with the Constitution of the Trustees of HAM. A translated version can be found in Appendix F. He also provided me with documentation of a workshop which 66 *ŵasing'anga* had attended. An abridged and translated version is available in Appendix G. I have included such information to highlight the willingness shown by *sing'anga* to widen the breadth of their knowledge.

At the Annual Regional meeting for HAM in Nkhata Bay District, at least 70 *ŵasing'anga* and *ntchimi* were in attendance. In addition to usual business, the opening of a new *dimba* (area for growing plants) took place. Medicinal plants will be cultivated in the *dimba,* picked as ingredients for making *mankhwala* (medicine), and then the area will be replanted as required, replenishing the available supply of medicinal plants (see Photograph 4.22). This enterprise is an effort to preserve the important medicinal plants in the area, and had been planned by HAM for a number of years. Similar projects are underway in Southern Malaŵi. Such an activity is an example of the activities undertaken by this professional body of healers.



Photograph 4.25: Some of the *ŵasing'anga*, not in uniform, and this researcher, pictured at the opening of the new *dimba*.

SUMMARY

The findings of this study provide a picture of the local extant healing system in Northern Malaŵi, the knowledge base which exists, and the treatment available for mental disturbance in the late 1990s. The rationale for this study developed from the need to understand the cultural context in which Northern Malaŵians' health beliefs are embedded in order to facilitate the analysis process of the data collected in the hospital study. Interviews conducted with *ŵasing'anga* and *ntchimi*, in conjunction with the participant observation in ceremonies, has yielded important information, which will aid the analysis process and will be discussed in Chapter Seven.

The information presented in this chapter has, to some extent, addressed the dearth of information available regarding *ŵasing'anga* and the role they play in the treatment of those who are mentally disturbed in Northern Malaŵi. While the scale of the study was small, many similarities can be drawn between it and the findings of Peltzer (1987) and Morris (1986; 1996). Of course, it must be noted that the findings are reflective of the views and practices of this small number of *wasing'anga*.

It has been established that a network of *ŵasing'anga* who treat mental disturbance still exists in Northern Malaŵi; some are herbalists and some are *ntchimi*. Those who are mentally disturbed, or their families, continue to actively seek treatment from these *ŵasing'anga*. The treatment dispensed can vary, depending on the cause of the mental disturbance, and may involve *mankhwala* from an extensive pharmacopoeia and/or a

ceremony. As Peltzer noted, the use of paraphernalia in diagnosis was typical amongst *ŵasing'anga* in Northern Malaŵi. The striking and decorative uniforms worn by the *ntchimi* as seen in the photographs and video are examples of this. The video also evidences the setting created for the therapeutic process which Morris (1986) describes as instilling the patient with security, hope and optimism. The video provides evidence as to the veracity of Morris's comment that diviners in Malaŵi are skilled in the ceremonial.

Regarding the causes of mental disturbance, the findings of the present study are broadly consistent with Peltzer (1987); mental disturbance is likely to be considered a result of witchcraft or spirits. However, witchcraft and spirits are not the only causes given by *ŵasing'anga*. This finding substantiates Morris's conclusion that the African system of disease causation is broader than the supernatural causes usually focused on (Morris, 1996).

The personal accounts of becoming a *ntchimi* presented in this chapter echo Peltzer's findings that healers experienced a calling from an ancestral spirit or received a special calling in the form of a mental or spiritual disorder, which could be characterised by social withdrawal, possibly accompanied by loss of appetite and weight. Hearing the voices of ancestral spirits is regarded as an accepted part of both the path to becoming a *ntchimi* and practising the profession. In contrast, hearing voices could be considered, in psychiatric terms, as experiencing auditory hallucinations, a symptom important in the diagnostic criteria for several mental illnesses (e.g. schizophrenia, according to DSM-IV).

Taking a comparative look at the healing system in Malaŵi, described in this chapter, and western health care, structural and functional similarities become apparent. An example of a structural similarity would be that a hierarchy exists. There is a professional body which oversees that members conduct their roles with professionalism. To gain entry to the profession, a distinct and prescribed training period is required. From a functional point of view, similarities exist; diagnoses are made based on a system of knowledge. For *ŵasing'anga,* the causal agent responsible for ill health determines the treatment recommended or carried out by the healer, while the psychiatrist, the counterpart in a biomedically orientated system, uses a

classificatory system (e.g. DSM-IV) to identify the illness, using the diagnosis to base his treatment decision on. A major distinguishing feature of these two systems is the context and the origin of the system of knowledge.

A second aim of this study was to yield useful contextual information on the healing system in Northern Malawi on which to base recommendations for the development of a culturally competent mental health service. This information, collected and documented systematically, is of fundamental importance to the development of a culturally competent service for two reasons. Firstly, the information was collected in the local area; no previous study has focused solely on the extant healing system, with particular emphasis on mental disturbance, in the Northern Region. Secondly, it provides current, up to date information, previously lacking in the literature. The implications of these findings for the development of the Service are discussed in Chapter Seven.

CHAPTER 5: METHODOLOGY

INTRODUCTION

This chapter consists of several different sections, including the rationale for combining both qualitative and quantitative methodologies, design of the study, procedure followed, participants, translation, post-interview methodology, ethical considerations, and finally data analysis.

QUALITATIVE AND QUANTITATIVE METHODOLOGIES

With the growth and more widespread use of qualitative methodology in recent years, the literature is abound with debate as to whether these two methodologies, from fundamentally different traditions, can be used together (Bryman, 1988). Questions arise from the premise that these two traditions are deemed to represent highly contrasting views about how social reality should be studied (Bryman, 1988). However, Bryman points out "when qualitative and quantitative research are jointly pursued, much more complete accounts of social reality can ensue" (p. 126), and emphasises that the fusion of quantitative and qualitative styles of research gives considerable weight to both approaches. A synergy can be achieved from the marriage of the two approaches. Steckler, McLeroy, Goodman, Bird and McCormick (1992) sum the situation up neatly: "the outcome of the two used together is greater than the effects of either used separately" (p. 102) and argue that both qualitative and quantitative data have weaknesses compensated by the strengths of each other. The strength of quantitative data is that data which is both repeatable and generalisable to a larger population is provided. The strength of qualitative data lies in the capacity to generate rich, detailed data that embraces the perspectives of the target population. This study incorporated both methodologies.

DESIGN OF STUDY

Background to current study

MacLachlan, Nyirenda and Nyando (1995) conducted the first systematic piece of research documenting patients' attributions for their mental illness and subsequent admission to hospital in Malawi. Stemming from this initial attempt to consider the perspective of Malawian psychiatric inpatients, the current piece of research sought to build on this initial study design, focusing on the perspective of the in-patients in Northern Malawi.

The initial study investigated the beliefs of psychiatric inpatients in Southern Malawi regarding the cause of their admission to Zomba Mental Hospital, described as the only specialist inpatient facility for psychiatric illness in Malawi at that time (MacLachlan, Nyirenda, Nyando, 1995). One hundred and three consecutive admissions to the hospital were studied over a three month period. During their admission interview, the patients were asked to describe "what had caused the problems which led them to be admitted to the hospital" (p. 80). These answers were assigned to predetermined categories: traditional, psychological, medical, plural (a combination of these categories). A further category of 'other' was broken down into: denial, don't know and other. The categories were rated initially by the interviewer, Malawian psychiatric nurses, and subsequently by an expatriate clinical psychologist with clinical experience in Malawi. Categorisations were either confirmed or changed after discussion between the raters.

RATIONALE FOR DESIGN OF CURRENT STUDY

The current study borrows from the methodology in the study conducted by MacLachlan, Nyirenda and Nyando (1995). However, some changes have been made, based on some of their identified shortcomings in the design. Departures from the Zomba study and other methodological considerations are outlined below.

Interview methodology

Different types of research interview exist and, in planning the current study, consideration was given to the type of research interview that would be most appropriate. Semi-structured interviews seek "... to gain a detailed picture of a respondent's beliefs about, or perceptions or accounts of, a particular topic" (Smith, 1995, p. 9).

Conrad (1990) points out that qualitative methodologies are particularly appropriate for studying and understanding both the subjective and the processural (or changing) aspects of illness. From a practical point of view, this issue was an important one, given that the researcher was not from the same culture as the study participants. It was felt that the flexibility of this approach would allow the researcher to gain insights into local culture and would reduce the risk of the interviews being tainted with preconceived notions. With qualitative research, fewer limitations are placed on the responses of the participant, and the participant has a more instrumental role in directing the course of the interaction, allowing a more flexible and accurate method of representing a patient's reality.

Longitudinal design

While the study conducted by MacLachlan, Nyirenda and Nyando (1995) involved a single interview with each participant, it was felt that a more accurate picture of participants' explanations could be obtained in a series of interviews. This approach recognises the processural aspect of illness. Given the potentially fluctuating mental state associated with patients suffering from mental illness, particularly in the acute phase when they are most likely to be hospitalised, a discharge interview and a follow-up interview post discharge were included in the design. This afforded a better opportunity to view how patients' explanations develop over time. Thus, a longitudinal approach was adopted. Participants would be interviewed at admission, on discharge and followed up in the community between six and twelve months later.

Timing of research interview

Patients' attributions in the Zomba study were elicited during the clinical interview on their admission to hospital. As patients are generally more agitated at this juncture of

their illness, and perhaps not as willing to impart information, or participate fully in an interview, it was felt that it would be beneficial to hold the interview when they were in a more settled state. Furthermore, given the need to gather particular information at admission (for clinical and administration purposes), it was felt that an interview done at this time would not be comparable with interviews conducted at discharge and follow-up. Instead of incorporating the research question into the admission interview, it was decided that, as with the discharge and follow-up interviews, a separate research interview should take place that would be independent from any routine clinical interview. This also ensured that the direction of the interview would not be compromised by clinical requirements.

Improvement over time

The Zomba study highlighted the breadth of illness attributions and cognitive tolerance displayed in beliefs about mental illness among a sample that sought treatment in a facility that offered 'biomedical' treatment. A longitudinal study provides the opportunity to explore whether the explanations held regarding disturbance on admission influences improvements in patients' health over time. One way of measuring whether the patient improves over time is to assess the degree of recovery from disturbance. Therefore, an additional dimension of recovery from disturbance was integrated into the design. It was felt that the information that this addition would yield would be relevant to service development.

No standard diagnostic tool was employed in Zomba Mental Hospital; therefore, the participants in the Zomba study were categorised as psychotic or non-psychotic. Although DSM-IV is the standard diagnostic tool used in the hospital in the present study, there is an increasing body of literature which highlights the difficulty presented by using DSM-IV in an African context (for discussion of this issue, see Chapter Two). A psychotic/non psychotic categorisation in a longitudinal study becomes redundant as a measure of recovery over time, as it is not a meaningful measure of improvement in certain illnesses; a patient suffering from a neurotic disorder would be deemed non-psychotic at all stages of their disorder. In the absence of a culturally valid measure to assess recovery over time, rating scales which measure cognitive well-being and emotional well-being were developed to gauge the status of participants at each

interview. A more detailed rationale, and the development and use of these scales are documented later in this chapter.

Translation

In the Zomba study, interviews were carried out in chiChewa, or another local language, by native speakers. The interviews in the present study were to be carried out by this researcher, whose competence level in local languages meant a translator was required. Translation generates several methodological issues, as pointed out in Chapter Two. Translation methodology is discussed at length later in this chapter.

Design of current study

While the present study parallels the Zomba study in terms of research population and the type of information being sought, some important extensions were made. Three additional aspects were incorporated: *firstly*, the present study is of longitudinal design; *secondly*, a specific interview for research purposes is introduced; and *thirdly*, it endeavours to assess the influence of explanation for admission on the efficacy of treatment.

In summary, this piece of research is a longitudinal study using semi-structured interviews. Participants are consecutively admitted patients to the hospital in the aforementioned Mental Health Service, Mzuzu, Northern Malawi. The interviews were conducted at three points in time: on admission to the hospital; on discharge from hospital; and in the community, between six months and twelve months post discharge. The design is illustrated in Figure 5.1. Throughout this thesis, these interviews will be referred to as 'admission interviews', 'discharge interviews' and 'follow-up interviews'.

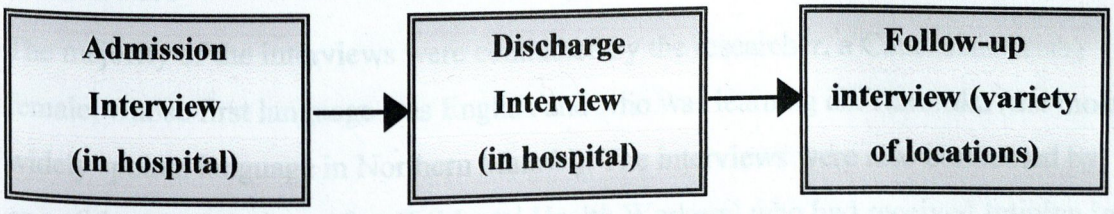

Figure 5.1: Longitudinal Design of the Hospital Study.

PROCEDURE: DATA COLLECTION

Biographical/demographic information

A decision was taken to use the biographical data from the hospital notes. Both the patient and their guardians would have been interviewed on two occasions prior to the admission research interview, and demographic information was elicited on both occasions (for the nursing notes and the clinical notes). It was felt, therefore, that this process need not be triplicated, since doing so would not enhance the interview process, and might, in fact, serve to irritate the participants unnecessarily. Information was crosschecked; any inconsistencies were double-checked and information that had not been recorded was pursued. Information was dependent on the patient and whoever had accompanied them to the hospital, and, in many cases, information such as age and educational level was not actually known, and therefore not available.

Design of the semi-structured interview

As discussed previously, semi-structured interviews were the main method of data collection. The focus in each interview was to elicit the patients' own explanations for admittance to hospital and attributions for their disturbance.

The two questions asked were:

1. Why do you think you are here?
2. What do you think caused your mental disturbance?

The second question was asked only if the response to the first question indicated that the participant felt they were mentally disturbed.

Interviewers

The majority of the interviews were conducted by the researcher, a Caucasian (Irish) female, whose first language was English and who was learning chiTumbuka (the most widely spoken language in Northern Malawi). The interviews were also conducted by one of the two members of staff (Mental Health Workers) who had received training in conducting the research interview.

PARTICIPANTS

As previously described, an acute admissions unit (the hospital) formed part of the mental health service. The study participants were patients in the hospital. Due to time constraints, a time frame for sampling had to be decided upon. Taking into consideration the longitudinal nature of the study, and the previous year's admission figures, ten months was deemed a realistic time frame in which to sample.

One hundred and forty-seven patients were consecutively admitted in this ten month period. Of this original cohort, twenty-seven (18%) could not be included in the final sample for the reasons outlined below:

Fourteen patients were not interviewed: Four patients absconded or were taken from hospital by their relatives shortly after they were admitted, before it was appropriate for an interview to take place. A further two patients were not available for interview on the allocated day, and were discharged before an interview was possible. Two patients who were admitted overnight were discharged the following morning, as it appeared their agitation was due to excessive *chamba* and alcohol. Six patients could not be interviewed. Two of these were too physically ill to be interviewed, one could not speak, one elected to be mute for the duration of her stay, one engaged in minimal verbal communication, and another patient had a learning disability and echolalia.

Seven admission interviews had to be excluded, three because of the quality of the tape recording – in two cases, external noise drowned out a large part of the interview and in one case the quality of sound was too poor to transcribe. One further interview was incomplete as the tape finished before the interview ended. In one interview, the style of interviewing was not compatible with qualitative interviewing techniques, as very direct questions were asked. One participant left the interview before it was complete. One interview was excluded as the patient's mental status prior to interview was misjudged, and his concentration span did not allow an interview to be conducted successfully.

A further six admission interviews were excluded, as they did not meet the required standard of translation when scored by the transcriber. This issue is discussed later in this chapter. Therefore, 120 patients formed the sample.

ACCESSING PARTICIPANTS

The aim was to interview participants on admission to, and discharge from, the hospital, and again between six and twelve months post discharge. Various steps were taken to maximise the possibility of this occurring.

Scheduling interviews

Due to the staffing situation and the necessity for a translator, interviews could not be conducted on a daily basis. Therefore, an agreement was reached whereby interviews could take place on three afternoons a week. Monday, Wednesday and Friday were chosen to minimise the time elapse for weekend admissions, as it was not possible, outside of exceptional circumstances, to conduct interviews over the weekend period.

Informing staff

It was clear that the co-operation of the nursing and clinical staff would be required to ensure the success of this study. Each member of staff was involved in a briefing on the study. During the lead up to the first admission interviews, suggestions and comments were invited as to the most effective means of ensuring interviews.

Admission interviews

The aim of this stage of data collection was to interview participants as soon as was appropriate after admission. A system was put in place whereby the researcher contacted the hospital on a daily basis regarding the number of admissions that day. This was relatively straightforward, as the researcher was an employee of St. John of God, and, although not based in the hospital, was there regularly. Interviews were carried out on the day of admission where possible. However, this was not always possible for the following reasons. Firstly, the patient would have already undergone at least one, if not two, admission interviews (see Ethics section). Secondly, their admission may not fall on an 'interview day'. Thirdly, they may not have been well enough to be interviewed. Under these conditions, the number of days which elapsed between admission and the actual interview varied, but ranged between the day of admission and 30 days.

Discharge interviews

The aim at this stage of data collection was to conduct these interviews on the day of discharge, if possible, or as close to that day as was possible. The same interview days were designated for discharge interviews. Staff at a weekly meeting, which the researcher attended, discussed the progress of each patient. The principle clinical officer, or a representative, was usually present, and this person had ultimate responsibility for authorising discharge of the patients. The likelihood of the discharge of a patient was indicated at that meeting. The following day, a clinical meeting took place where the patient was interviewed and the discharge decision finalised. A staff member who had been present at the clinical meeting was contacted and the discharge status of each patient was confirmed. Although a seemingly effective system, it became apparent that it did not allow for those patients who absconded, or those whose guardians requested that the patient be discharged. Perhaps they wanted to take them elsewhere for treatment, despite the decision of the clinical staff, or, on a more practical level, had managed to arrange transport (which is scarce in Malawi) to bring their family member home. Thus, despite the best efforts of the researcher and staff in the hospital, not all the original participants had a discharge interview.

Follow-up interviews

The aim at this stage of data collection was to locate and interview as many of the participants interviewed at admission as possible. The mixed success experienced by the Service in the follow-up treatment plan offered to clients indicated that this could be an arduous task. As such, it was felt that the time frame for the follow-up interview needed to have some flexibility in order to facilitate interviewing the maximum number of participants. A six to twelve month time frame was thought to be appropriate to facilitate actually locating and interviewing the participants.

Methodological problems with follow-up interviews

Although the majority of participants (93.9%) were from Northern Malawi, this still constitutes a large geographical area, particularly in a country where many rural areas

are quite inaccessible[22], the quality of the roads are poor, and both public and private transport are scarce, unreliable and expensive.

Contacting participants by letter posed some additional difficulties. Both the poor literacy rate and the fact that the existing postal system relies on Post Office boxes as addresses meant that follow-up interviews arranged by letter were impractical. Not everyone in Malawi has an address, particularly in rural areas, and relatives often share Post Office box addresses. Therefore, the letter may not reach the participant directly, as a trip has to be taken to the nearest Post Office to collect the post. The post then has to be distributed to the addressees, who do not necessarily live in close proximity. Consequently, it is impossible to gauge how long it will take a letter to reach the addressee.

Accessing follow-up patients: Bearing in mind the abovementioned constraints, a variety of methods was employed to maximise the number of follow-up interviews, several of which capitalised on the existing service provided for clients. They included home visitation, the rehabilitation programme, monthly appointments, District Hospitals and contact by letter. These are outlined below in more detail:

Home visits: As part of the primary health care approach adopted by the Service, home visits are arranged on a monthly basis for those clients who are infirm or who have a history of non-adherence to treatment. Similarly, for those clients living in outlying areas, monthly outreach clinics are arranged which they can attend. The researcher or another interviewer travelled with the clinical team to conduct interviews with those participants who could be accessed this way.

Rehabilitation programme: A rehabilitation programme, as stated in Chapter One, is available for clients post discharge. Those participants who attended that programme were interviewed there.

Monthly appointments: Clients who were discharged on medication were given monthly appointments to collect their prescribed medication at the drop-in centre and

[22] See roads indicated on map in Appendix A.

those participants who attended their appointment were interviewed afterwards. The clinical staff were given a regularly updated list of the participants who were due for a follow-up interview, so the researcher could be informed if they arrived.

District hospitals: Clients who lived outside Mzuzu were often discharged to the care of their district hospital, where they should attend monthly psychiatric clinics. Arrangements for follow-up interviews at the hospital were made with psychiatric nursing staff through the District Health Officers and matrons in the District hospitals (see Letter in Appendix H). The psychiatric nurse in charge informed the patients, in advance, of the interview. This researcher conducted the interviews and the attending psychiatric nurse translated.

Letter: For those clients who were discharged without treatment, who absconded, or who had failed to keep appointments, there was no other option than to contact them by letter. A record of address is made on admission. Letters were written to those participants who had a postal address, or to their guardians, if the level of literacy of the participant was thought not to be adequate to read and understand the letter. The letter, written in the local language the participant had chosen to speak during the interview, invited them to come for a follow-up interview. Bearing in mind the pitfalls associated with using the postal system outlined above, due consideration was given to the length of time it might take for the letter to reach the participant. A choice of five or more different days was suggested with non-specific times (i.e. 2-5 pm, 8-12 noon, all day), to increase the possibility of attendance for those in the Mzuzu area. For those patients who agreed to attend the outreach clinic as their discharge programme, the next clinic date was suggested as an interview time.

Consequently, the follow-up interviews took place in a variety of settings, generally dictated by where participants lived and the manner in which participants availed of the post discharge service, if at all.

TRANSLATED INTERVIEWS

As previously mentioned, the fact that the researcher was not proficient in a local language meant that a translator was required to conduct the interviews. Some general

consideration has already been given to translation issues in the overview. Issues specific to interviews conducted for this piece of research will be dealt with here.

Identification of translators

As a matter of practicality and in order to ensure confidentiality, the translators were hospital staff, either trained psychiatric nurses or mental health workers. Each of them had a good standard of English, as it was a prerequisite to their employment. Due to staffing arrangements in the hospital and the interview timetable, it was essential to be able to draw on any member of staff to translate. All of the staff would have had some experience in being a translator in a clinical context, given the presence of a number of western staff.

Minimising the difficulties of the translated interview.

Swartz (1998), citing work carried out in South Africa, highlights that, with clinical interviews, it is important to take into consideration the skills of the clinician conducting the interview, not only the interpreter (Muller, 1994). Although these interviews were research based, this factor was acknowledged. The researcher gained some experience in the translated interview setting in the hospital prior to the commencement of the data collection phase. In terms of tackling these issues from the translators' point of view, the following steps were taken:

> A set of guidelines was drawn up (see Appendix I). The translators were also reminded of the specific aim of the interview and it was emphasised that it was a research interview, and that their role would be to listen to what the participant said, but not to counsel or offer advice, as would often be their normal role. They were also reassured that any issue that arose which required further advice could be dealt with appropriately after the interview. The translators were also reminded that, if the participant wanted to leave at any time, they were free to do so. The interviewer should also be informed of this if she was not aware, and under no circumstance should the translator try to persuade the participant to stay.

Structure of the translated interview

A short discussion between the interviewer and translator took place before each interview, reiterating guidelines for translation. The interview was opened in a local language (depending on the ethnicity of the participant). In the case of this researcher, a set piece was said:

> *Zina lane ndine Karen Smyth. Nikufuma ku Ireland, nikupulika chiTumbuka pachoko waka. Awa niwanyane (name), wanovwirenge kung'anamulira vidumbirano vithu.*
>
> My name is Karen Smyth. I am from Ireland and I only understand a little chiTumbuka. This is my colleague (name), who will help me with translation of our discussions.

Post interview, the translator and interviewer discussed the content of the interview, any difficulties that arose and how to deal with them in other interviews. In the initial stages of the research, the translators transcribed the interview from tape after the interview. This proved to be too time consuming when they had other duties, and offered no consistency or accuracy when rating the quality of the translation in the interview. Alternatives were sought, as described in the post-interview methodology section below. The interviews that had been transcribed initially were re-transcribed.

Non translated interviews

There were two types of non-translated interviews:

(a) Interviews conducted by the Malaŵian interviewers were conducted entirely in the language chosen by the participant, invariably a local language and therefore did not require a translator.

(b) As some participants could speak English, they were given the option to have the interview conducted in English, to avoid the frustration of hearing what they said being repeated, and, in effect, listening to questions, and indeed answers, twice. Where a translator was available, they were included in the interview to clarify any misunderstanding and to maintain consistency across the interview situation.

Therefore, four interview situations existed:

1. Conducted in a local language with a translator (three people present).
2. Conducted in English in the presence of a translator (three people present).
3. Conducted in English without a translator (two people present).
4. Conducted in a local language between two Malawians (two people present).

POST-INTERVIEW METHODOLOGY

Transcription

In order to achieve consistency in both the transcription and the rating of the quality of the interview, one person was employed to transcribe, verbatim, each interview conducted in a local language. She was a Malawian secondary school-leaver, a native chiTumbuka speaker, with an excellent command of the English language. In addition, she was local to the area and a reliable source of local information. The advice offered by Duranti (1997) concerning the over reliance on bilingual speakers in a community when conducting research (discussed in Chapter Three) was taken into consideration. All transcriptions were handwritten, as the transcriber had no word processing skills.

Of fundamental importance was the accurate translation of what the participant had said. The transcriber translated the participants' accounts from the tapes. In translation, Brislin (1970; 1980) places particular emphasis on the importance of conceptual equivalence, the meaning of the words and sentences, rather than the literal translation, linguistic equivalence. Although he is uses these terms concerning the translation of research instruments, it is of vital importance in ensuring the process of understanding what the participant is saying. Examples of words taken from the current interviews that literally translate as one meaning, but conceptually have a different meaning, are:

1. *mphepo:* which means ancestral spirit or wind. The difference in significance is very important if you are asking what has caused a person's disturbance.
2. *Nthena panyumba yakwithu wamoyo palije:* which translates literally as there is no-one in this house alive. However, this phrase was described to me as a

euphemism, often applied where abnormality is seen and cannot be taken literally. It can be applied where almost the entire family is seen as having problems of a psychological nature, or where an individual's life is viewed as not normal and affects their social relationships.

The quality of the translation in the interviews was rated against the transcriber's translation. A score was awarded on a 1-10 scale (see Appendix J for rating scale for standard of translation in hospital interviews) by the transcriber and this researcher. Errors made in the translation were noted and the score marked on a 'transcription recording form' where a summary of the pertinent information from the interview was also recorded (see Appendix K). A score of 6 or above was required for the interview to be included. As noted earlier, six interviews were disregarded.

After transcription, each interview was examined by both this researcher and the transcriber. Pertinent passages were identified and the researcher ensured she understood both the translation and the significance of the responses participants had made to the research questions. These were extracted and written on the form, both in the local language and English, thus ensuring the researcher could confidently analyse the data outside of Malawi.

MEASURING IMPROVEMENT OVER TIME

In order to assess whether participants' mental health improved while they were in hospital and in the months following treatment, an indication of their mental status needed to be introduced.

Considerations for methodology

Various methodologies exist regarding assessing the mental status of a participant in research. A method allowing direct comparison between raters was required to include inter-rater reliability. The following possibilities were considered as possible means of assessing the mental status of the participant: co-raters in the interview, video taping the interview, using audio taped interviews, patient records and carrying out the rating in the interview. Each was discounted for a variety of reasons, which are outlined below.

Co-raters in interview: This would involve two other raters being present in the interview setting. However, the inclusion of other raters in the interview was not feasible. Already there was a translator present, and a further two people would not have been appropriate and potentially detrimental to the process of the interview and the quality of the information collected. On a practical level, it would have been difficult to co-ordinate the interviews with the availability of two raters and a translator, given the practical difficulties experienced in organising the interviews.

Video recording interview: Using a video camera was considered to record the interview, as this would enable each rater to watch the video and independently rate the well-being of the participant, both on content of speech and appearance of the participant. Difficulties encountered with this idea were again of an ethical and practical nature. At the time of research, there was no national broadcasting company and television sets were extremely rare. Many of the participants would not be familiar with the concept of being recorded, and it was considered to be invasive and could even be very disturbing for patients, particularly those who were already experiencing paranoia. Secondly, as the local supply of electricity was hydro powered, electricity cuts were frequent, often daily, particularly towards the end of the dry season when the reservoir was low, and when lightening was frequent in the wet season. Aside from the potential loss of supply mid-interview, it could be argued that a video camera, reliant on electricity for power or to recharge the batteries was an unnecessary and wasteful use of an already scare resource.

Using tape recorded interviews: Listening to tape recorded interviews, with the translation, was very cumbersome, and would require more than one listener to rate it effectively. The researcher would immediately have cues as to the identity of the participant (their voice, the setting for example) that may influence the rating, and the other raters would not have that additional information. Each interview would have to be re-recorded, as the name of the participant was at the beginning of each interview when they granted permission to use the tape recorder, and quality could not be guaranteed. Not all the participants agreed to the use of the tape recorder, so therefore the rating across participants (i.e. those with transcripts compared to those with tape recordings) would not be equal.

Patient records: Another potential source of information which could indicate mental status were the patient records. Although notes were written at each change of shift, different members of staff, with different qualifications, were responsible for each patient, and while the notes taken were useful at a clinical and patient management level, they lacked the consistency required for the purposes of this research. Additionally, the staff were trained with DSM-IV, and given the criticisms levelled at DSM-IV (as discussed in Chapter Two) in terms of its clinical applicability outside the western sphere, it was not seen as an appropriate tool to measure improvement.

Rating in the interview: As this researcher did not conduct all the interviews, in order to facilitate a comparison between explanations offered to her and a Malawian interviewer, all of the participants could not be rated on their emotional and cognitive well-being by the same person in the interview setting. The same person is required to make each of the assessments to ensure consistency. Furthermore, reliance on a translator would hinder rating the condition of the participant in the interview setting. Immediate feedback, from the translator, would be required, but there would be no guarantee of the accuracy of this information.

Given these considerations, the final decision arrived at involved using the full transcriptions, with both the English and local language included. In order to achieve consistency, all the interviews had to be rated at the same time. In view of the cultural awareness acquired over the duration of the fieldwork, none of the interviews were rated until after the last one had been conducted. Two independent raters were recruited, in addition to the researcher, to rate the interviews in order to be as rigorous as possible. Further information is given later in this chapter.

Development of scale

Background

Psychiatry uses rating scales that are designed to translate clinical phenomena into objective and quantitative information. The information conveyed by rating scales can be used to arrive at a diagnosis, to document the clinical state of a person at a point in time, or to supplement the information about a patient that is provided by clinical examination, and are often used in a research context (although these scales can also be

useful for clinical care). As such, there are a variety of different scales to choose from (Marder, 1995). For the purposes of this research, the requirement was to use a scale to document the clinical state of a person at a point in time. However, no culturally valid scale existed, therefore, a scale was developed for this particular purpose.

Development of the scale

In psychiatry, according to Kaplan and Sadock (1995), a syndrome is a group of signs and symptoms that occur together as a recognisable condition, which may be less specific than a clear-cut disorder or disease. Signs are objective findings observed by the clinician; symptoms are subjective experiences described by the patient. Most psychiatric conditions are syndromes. Kaplan and Sadock indicate that signs and symptoms of psychiatric illness can be classified into those that affect each of the following mental phenomena: consciousness, emotion, motor behaviour, thinking, speech, perception, memory, intelligence, insight and judgement. Most psychiatric signs and symptoms have their roots in essentially normal behaviour and represent various points on the spectrum of behaviour from normal to pathological (Kaplan & Sadock, 1995).

Bearing these points in mind, it was clear that only signs could be accurately measured without a full clinical interview, and it was decided that a scale which represented a continuum from normal to pathological would be the most appropriate. As transcribed interviews were the medium through which participants were rated, physical signs associated with pathology, such as motor behaviour (stereotypy psychomotor hyperactivity) cannot be observed, speech (e.g. pressurised speech, prosody, poverty of speech) cannot be heard, and memory, intelligence, insight and judgement are not tested. The remaining signs are emotion, thinking and perception (disturbances of perception, hallucinations, for example). As emotion is qualitatively different to thinking and perception, it was decided they should be measured on separate scales. Thinking and disturbances of perception were combined to make one scale which measured emotional well-being on a continuum. The Strength of Evidence for Emotional Well-being Scale (EWS) and similarly cognitive well-being was measured on a continuum scale, The Strength of Evidence for Cognitive Well-being Scale (CWS).

Both scales can be found in Appendix L. An important aspect of the wording of the scale was to move away from the culturally constrained DSM-IV approach.

The research process is summarised in Figure 5.2 and Figure 5.3. Figure 5.2 illustrates the process for those interviews that did not require translation.

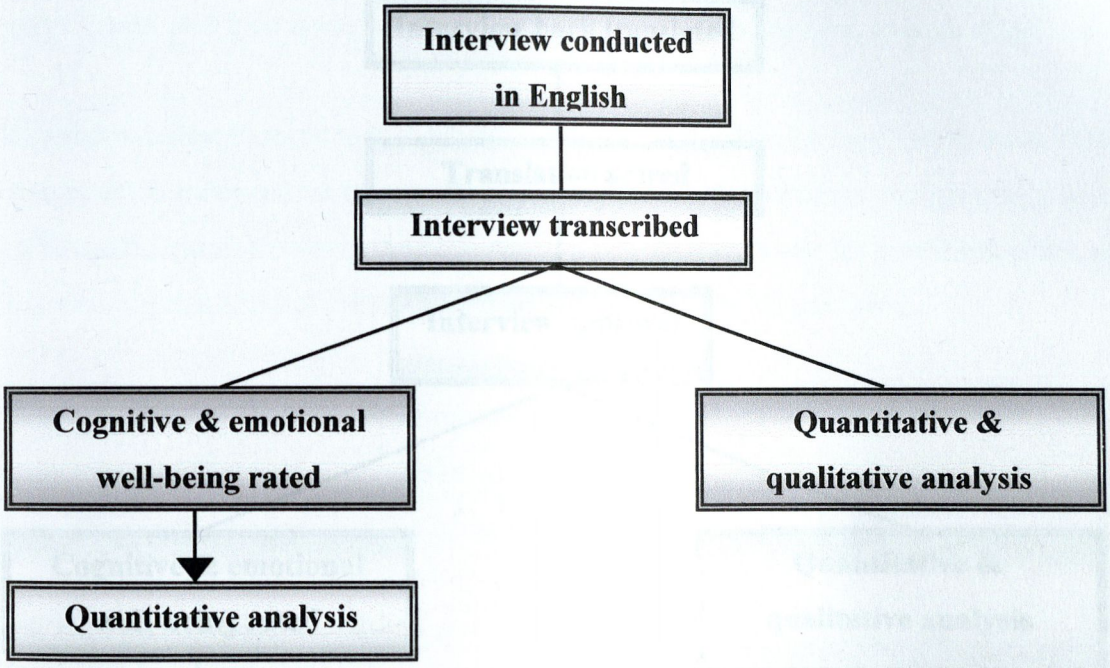

Figure 5.2: Diagram of the research process (Interviews in English)

Figure 5.3 (overleaf) illustrates the research process with the additional steps required for interviews that required translation.

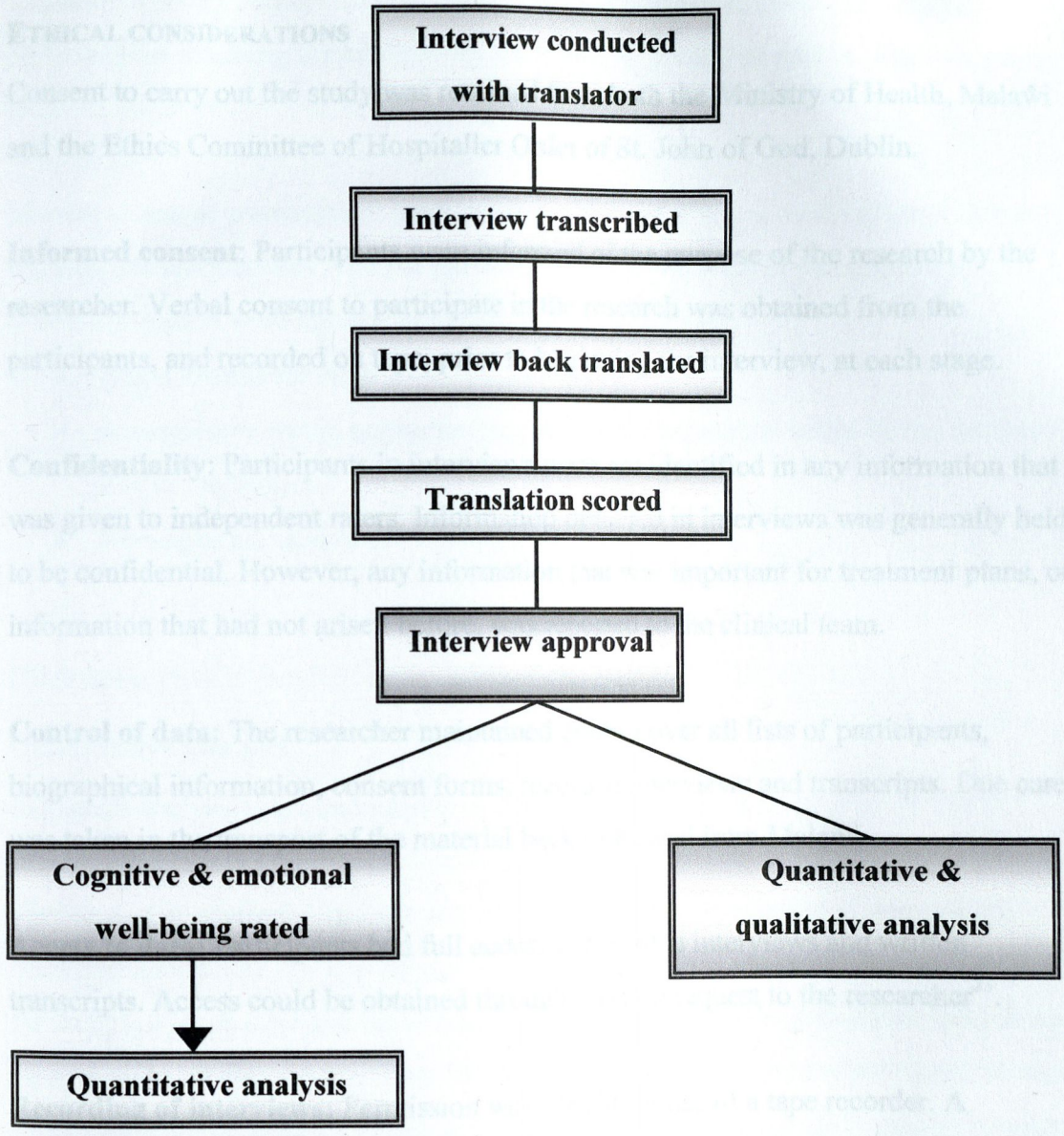

Figure 5.3: Diagram of the research process (Interviews with translator)

ETHICAL CONSIDERATIONS

Consent to carry out the study was received from both the Ministry of Health, Malawi and the Ethics Committee of Hospitaller Order of St. John of God, Dublin.

Informed consent: Participants were informed of the purpose of the research by the researcher. Verbal consent to participate in the research was obtained from the participants, and recorded on tape, prior to beginning the interview, at each stage.

Confidentiality: Participants in interviews were not identified in any information that was given to independent raters. Information obtained in interviews was generally held to be confidential. However, any information that was important for treatment plans, or information that had not arisen before, was reported to the clinical team.

Control of data: The researcher maintained control over all lists of participants, biographical information, consent forms, recorded interviews and transcripts. Due care was taken in the transport of the material back to Ireland from Malawi.

Access to data: Participants had full access to recorded interviews and written transcripts. Access could be obtained through a verbal request to the researcher[23].

Recording of interviews: Permission was sought for use of a tape recorder. A demonstration of how a tape recorder works was given. Usually, the participants said a few words or phrases which were recorded and then played back to them. This also served to ensure the quality of the recording. For those who agreed, they were requested to grant permission verbally, which was recorded. If they desired, this was replayed to them (literacy rates may have precluded some participants from reading and signing a written permission form). Participants were informed that they could listen to the tape when the interview was complete, and the majority of participants did so. For those who did not agree to the interview being recorded, permission was sought to write down what they said in the interview.

[23] Two participants in the study requested and read copies of written transcripts. Both participants had refused permission to be taped.

Expense: The researcher was also conscious that no expense should be incurred to the participant in returning for a follow-up interview, as it was not part of their treatment plan.

Mental status of participant: Staff on duty were consulted as to the appropriateness of carrying out an interview with the participant on the proposed day of interview. The following criteria were applied in assessing appropriateness:

- Non-violent behaviour
- Awake (they would not be woken up) and alert (patients could be too drowsy due to medication)
- Non-agitated behaviour

DATA ANALYSIS

Quantitative analysis

Statistical analysis was conducted on the quantitative data using SPSS, Version 9. Descriptive statistics were used to establish a detailed profile of both the total sample interviewed at admission and the sub sample who were interviewed at admission, discharge and follow-up. Chi-square analysis was used to explore differences between the sample at each time and the cohort of participants who were present for interviews on admission, at discharge and on follow-up. When necessary and where appropriate, categories were collapsed to meet the conditions required for the chi-square procedure. Yates continuity correction was used in instances where the chi-square was unreliable due to small expected frequency values, despite collapsing categories. In some instances, it was still not possible to conduct tests of statistical significance. In these instances, descriptive statistics only are given.

Explanations for illness

Content analysis was conducted on each interview in accordance with the analysis employed by MacLachlan, Nyirenda and Nyando (1995). Independent analysis was conducted on 20 per cent of the admission interviews by a psychology doctoral student familiar with the area of culture and health. The interviews were randomly selected. The predetermined categories used by MacLachlan, Nyirenda and Nyando (1995) can be

found in Appendix M. Instructions provided for inter-rater analysis are found in Appendix N. Inter-rater reliability was calculated by percentage agreement between the rater and the researcher. There was 100 per cent agreement between the independent rater and this researcher on whether the participants saw themselves as mentally disturbed and 89 per cent agreement regarding the categorisation of explanations offered by the patients.

Rating scales

Independent raters

Two independent raters were recruited. The basic requirement was that they had lived in Northern Malawi, had knowledge of both local health beliefs, particularly regarding mental disturbance, and at least one local language. A psychiatrist and medical anthropologist who fulfilled these criteria were identified. The instructions given to each of the raters can be found in Appendix O.

Reliability of data

The three raters each coded 100 per cent of the interviews to ensure rigour. The actual inter-rater reliability is included in the Results section to facilitate ease of understanding of ensuing analysis. As the scales were ordinal, the Friedman test (non–parametric equivalent of a one-sample repeated measures design or a two way analysis of variance) was conducted to identify difference in ratings across all three interviews for each rater. The Wilcoxon test was conducted to identify differences between ratings at admission and discharge interviews, discharge and follow-up interviews, and admission and follow-up interview for each rater.

Qualitative analysis

The goal of qualitative analysis is to derive meaning from data (Bailey, 1997). Throughout data collection, the researcher was aware of the complexities of the material arising in the interviews. This researcher felt that qualitative analysis was required to derive accurate meaning from the participants' responses, as it appeared quantitative analysis would not adequately represent the meaning in the data collected.

Recalling that conducting quantitative analyses was based on methodology employed by MacLachlan, Nyireda and Nyando (1995), two further reasons for using qualitative analysis existed:

1. MacLachlan et al. (1995) identified a shortcoming in their content analysis of patients' attributions for mental disturbance. They acknowledge that the method of giving labelled categories for interviewers to ascribe patients' attributions to, may have encouraged interviewers to simplify patients' explanations in order to make them fit the pre-determined categories. It was hoped that qualitative analysis would overcome this methodological issue.

2. Additionally, patients in Zomba Mental Hospital would be predominantly from the Central or Southern region of Malaŵi, while the majority of participants in this research were from the Northern region. As previously noted, these two regions are culturally distinct, with different language, histories and economies. Therefore it is quite possible that explanations of mental health and illness will differ in the two regions. As pointed out in Chapter Two, Peltzer (1987) found that the spirit illness *vimbuza* in the Northern region was more common than spirit illnesses such as *malombo, majini* and *nantongwe* that exist in the Central and Southern regions. He also found that *vimbuza* had a wider range of symptom descriptions. Consequently, the categories employed by MacLachlan et al. (1995) could prove inadequate to reflect accurately the explanations offered by Northern Malaŵians.

Thematic analysis was conducted on each of the transcripts in accordance with a 'grounded theory' approach (Glaser & Strauss, 1967; Henwood & Pidgeon, 1996; Strauss & Corbin, 1998) (see Methodology section in Chapter Four for a full description of grounded theory). Although this approach can be used to generate theory, in this study the analysis is used only to generate themes and meaning.

Analysis was conducted in a series of stages. As pointed out previously, data collection and data analysis are not discrete activities, but rather movement between data collection and analysis of data that informs later avenues of inquiry. Strauss and Corbin (1998) emphasise the importance of maintaining a balance between objectivity and sensitivity to the data while immersed in it. Unlike in quantitative research, qualitative researchers acknowledge the researcher's own role in the research process and are explicitly concerned about the impact of researchers' biases and pre-conceived notions

on the data. One must recognise that the "researcher's understanding are often based on the values, culture, training and experience that they bring to the research situation and that these may be different from their respondents" (Strauss & Corbin, 1998, p. 43). A key concern in this study was the possible impact of the researcher's cultural background and training. Strauss and Corbin (1998) suggest a number of measures that can be taken:

1) Gathering multiple viewpoints: This refers to a measure taken in data collection which then impacts on analysis. Data gathered through participant observation at traditional healing ceremonies, in-depth interviews with traditional healers and informal discussions with neighbours, colleagues and friends, broadened the researcher's perspective and lessened potential cultural bias, hopefully increasing both sensitivity and objectivity.

2) Thinking comparatively: Comparing incident to incident in the data is one approach, turning to the literature to compare the data with existing findings is another example of thinking comparatively.

Analysis involved a "fluid and skilful application" (Strauss & Corbin, 1998, p. 46) of appropriate techniques. As such, the following procedure was applied, based on procedures recommended by Strauss and Corbin (1998) and Pidgeon and Henwood (1996).

1. After the transcription of the interview, all passages pertinent to a participant's reason for admission to hospital and explanation of mental disturbance were extracted as mentioned earlier in this chapter. Repeated reading of these extracts generated a list of emerging themes.

2. The interviews, in their entirety, were re-read several times and sections identified as relevant (sometimes the whole interview) were word processed, including the local language, to facilitate analysis. Repeated readings of these sections led to the addition of a few further themes. Memo writing was employed (see Chapter Four for explanation) which allowed the researcher to record ideas about emerging themes.

3. Preliminary category names were revised to fulfil the criteria of providing a recognisable description of the data in the name.

4. Once all the interviews had been coded, the coded text was copied and pasted under the corresponding theme label (using Microsoft Word software package). This ensured all occurrences of a theme were grouped together. A theme was considered "saturated" (Strauss & Corbin, 1998, p. 136) when no new information seemed to emerge during coding.

5. The material collected in each theme was then reread. Themes were integrated or further split as appropriate.

6. A process of "constant comparison" (Glaser & Strauss, 1967), which involves exploring similarities and differences in the corpus of data collected in the transcripts, was utilised.

7. Finally, the transcriptions were reread to ensure that the identified themes reflected the content of the participants' replies and therefore validate analysis.

SUMMARY

The methodology of this study is based upon a study conducted by MacLachlan, Nyirenda and Nyando (1995) in Zomba Mental Hospital. This chapter describes the ways in which the methodology they employed was adapted appropriately for the current study. Both the rationale behind adopting a longitudinal design for this study and the reasons for using semi-structured interviews were detailed. The process of accessing participants for this study was described. The methodological issues arising from using translators in interviews, the process of transcription and back translation of interviews were explained. The development of two scales to measure the emotional and cognitive well-being of participants over time was described. Finally, the methods of both quantitative and qualitative analysis were given.

CHAPTER 6: RESULTS OF HOSPITAL STUDY

INTRODUCTION

The results chapter is divided into three main parts:

- Participant information and circumstance of interview
- Analysis of interviews
- Improvement of mental health

Each part has several subsections. The order in which these sections are presented does not follow the conventional pattern; qualitative and quantitative analysis are presented in alternation as opposed to each being housed in separate sections, thus reflecting the intertwined analytical procedure followed.

Part One: Participant information and circumstance of interview

This will be dealt with under the following headings:

- Nature of sample
- Participant information
- Attrition of sample
- Interview circumstances

The first section details the nature of the sample. The second section presents participant information, including demographic and treatment information. Under the third heading, *Attrition of Sample*, variables that may have contributed to attrition are examined. *Interview Circumstances* describes the interview circumstances, which include the language through which the interview was conducted, who conducted it and whether the interview was taped or transcribed.

Part Two: Analysis of interviews

Part Two focuses on the findings that emerged following analysis of the interviews. This will be dealt with under the following headings:

- Personal accounts
- Reasons for admission
- Explanations for disturbance

Personal accounts introduces the participants' perspectives, providing accounts of six participants' explanations for their mental disturbance, which convey both the variety and nature of the explanations offered by the participants. The reader is given the opportunity to 'hear the voice' of the participants. *Reasons for admission* presents both the qualitative and quantitative analysis of the first main question asked in the interview. The final section offers both the quantitative analysis based on the categories used by MacLachlan, Nyirenda and Nyando (1995) and the findings of the qualitative analysis of participants' explanations for mental disturbance.

Part Three: Improvement of mental health

The analysis of the data collected from the two rating scales (EWS and CWS) employed is presented under the following four headings:

- Research questions
- Inter-rater reliability
- Changes in emotional and cognitive well-being
- Impact of explanation for mental disturbance on well-being

Firstly, the pertinent research questions are briefly revisited. The inter-rater reliability achieved for both scales is then presented under the second heading. The third section examines the changes in emotional and cognitive well-being during treatment and post discharge. The impact of participants' explanations on their mental disturbance is presented under the fourth heading.

PART ONE: PARTICIPANT INFORMATION AND CIRCUMSTANCE OF INTERVIEW

Nature of sample

Due to the difficulties identified in Chapter Five, not all of the participants who were interviewed on admission could be interviewed at discharge and follow-up. At discharge, the number of participants interviewed was reduced from 120 to 53, for the following reasons. Five patients absconded, two patients were transferred to another hospital, three participants' families decided to request discharge, either to care for them at home or bring them to a traditional healer. In an unusual case where *folie à deux* was diagnosed, one patient was escorted out of the hospital to separate her from the patient

with whom she 'shared the psychosis'. One patient discharged himself. Poor translation during the interview meant that six interviews could not be included. The remaining participants were lost because they left immediately after discharge was granted or through a failure in the system described in Chapter Five. The number of participants was further reduced in the follow-up interviews. Four of the original sample had passed away and a further two had left Malawi. Two participants replied to the letters sent out and indicated that they could not make the interview appointment. Table 6.1 shows the number of participants who were interviewed at admission, discharge, and follow-up. It also shows the number of participants interviewed at admission only and those interviewed at all three times.

Table 6.1: Number of participants interviewed at admission, discharge, and follow-up, at admission only, and at each interview time.

Interview(s)	Number of participants
Admission interview	120
Discharge interview	53
Follow-up interview	46
Admission interview only	47
Admission & discharge & follow-up	24

It is clear from the figures in Table 6.1 that, although this is a longitudinal study, the sample cannot be treated as such, since not all the participants were interviewed at each point. Of the 120 patients interviewed on admission, 47 participants were not interviewed at any other time. Fifty-three participants were interviewed at discharge and 46 were interviewed at follow-up. The fact that not all of the participants interviewed at discharge were interviewed at follow-up, and not all those interviewed at follow-up had been interviewed at discharge presents further complications. There were, however, a core number of participants who were interviewed all three times (n=24). This is a relatively small sample size on which to conduct statistical analysis. The nature of the sample therefore produces problems for meaningful statistical analysis. The majority of the analyses are therefore of a descriptive nature. The variables were examined for accuracy and fit between their distributions and the assumptions of relevant statistics, and analysis has been conducted where it is appropriate. Analyses are conducted on those participants who were present at admission interviews, at discharge interviews,

and at follow-up interviews. As these participants together constitute the 'total sample', they will be referred to as such. Separate analyses are conducted on the core group of 24 participants who were interviewed at all three times. This group constitutes the 'longitudinal group' and will be referred to as such. The 'admission sample' refers to the 120 participants who were interviewed at admission.

Participant information

Participant information includes demographic information and treatment information. In this section, descriptive statistics are provided for the admission sample (n=120), and the longitudinal group (n=24).

Participant information for admission sample:

Demographic information

***Gender*:** There were more males admitted to the hospital than females. Males constituted 60% of the sample.

***Age group*:** The average age of the participants was 30 years, the youngest being 15 years old and the oldest 65 years old (S.D.= 10.91) as indicated in Table 6.2. In 19 cases (15.8%) the age was unknown. Either the participant, or their guardian if they had one, did not know their date of birth, and as a result, it was omitted from the records. Of the remaining participants, the majority were aged between 15 and 35 (74.3%). This figure was almost evenly divided between the 15-25 year age group (37.6%) and the 26-35 year age group (36.6 %). Those aged between 36 and 45 years constituted 17.8% of the sample and 6.9% were aged between 45 and 55 years. The remaining 1% were aged between 56-65 years.

Table 6.2: Mean, median, mode, range and standard deviation (SD) of age of participants in years

Mean	Median	Mode	Range	SD
30.19	28	16, 26	15-65	10.91

***Religious affiliation*:** The extensive list of religious affiliation was reduced by forming broad categories. The breadth of religious affiliation presented difficulties in appropriate categorisation. Actual denomination was not the important issue in this piece of research. Of interest in this study was whether participants were affiliated to a missionary religion, as this, in theory, would preclude attending *ŵasing'anga* for healing (see Chapter Four). The actual religions each of the participants are affiliated to can be seen in Appendix P. The categories were divided in the following way.

The most common religious affiliation was to mainstream missionary religions, which included for example Central Church of African Presbyterian, Roman Catholic, Anglican Church, which accounted for 65.5%. Non-missionary religions accounted for 30% of the sample, such as Church of the Living Waters and *Chipangano*, and one participant was a Rastafarian. A small proportion of the participants said they had no religion (3.7%), while one participant (0.8%) described himself as Pagan.

***Education*:** Table 6.3 shows the breakdown of the level of education attained by the admission sample. The level of education attained by 15% of the participants is not known; they or their guardians did not know, or were unclear, about what level they had attained. Of those who gave definite replies, only 3.3% had never received schooling, 44.2% had received or were receiving primary education and 30.9% had received or were receiving secondary school education (4.2% had completed secondary school, but had not taken their studies further). Currently in, or having completed, third level education comprised 6.6% of the participants. This includes those who attained a professional qualification, such as nursing.

Table 6.3: Level of education attained by participants in admission sample

Education	No. of participants	% of participants
No schooling	4	3.3
Primary school	53	44.2
Secondary school	32	26.7
Completed secondary school	5	4.2
Third level/professional training	8	6.6
Unknown	18	15.0
Total	120	100

Occupation: In terms of occupation, the most common category was that of student (19.8%), describing practically one-fifth of the participants. Farming accounted for 16.2% of the sample, and housewives for 15.3% (all females). While 6.3% described themselves as home dwellers (staying at home), 14.4% said they had no occupation and 6.3% described themselves as unemployed. A small percentage worked in a trade (6.3%). A very small number (1.7%) described the work they did as piecework, essentially working at a job for which they are remunerated on a daily basis, which does not provide consistent employment. Cutting wood or harvesting crops are examples. An equivalent percentage described their work as business, which was selling from a stall (*mistali)* in a market on the side of the road. Professional jobs accounted for 11.7%. Although this does not concur with the numbers who have had professional training, one can work as a teacher in Malawi, having only completed secondary education, such is the shortage of teachers in the country.

***Place of origin*:** The majority of the participants (93.9%) were from Northern Malawi (56% rural, 37.9% urban). One participant (0.9%) was from outside Malawi, from the neighbouring country of Zambia. The remaining 5.2% were from either central or southern regions of Malawi.

***Marital status*:** Just over half of the participants were single (51.3%). Almost one-third (32.2%) were married. Of the women that were married, 2.6% were in a polygamous marriage and described themselves as co-wives (i.e. their husband had more than one wife). The remaining participants had been married. However, 5.2% had been widowed, 3.5% were separated, and 7.8% were divorced.

Treatment information

Attended traditional healers: Over half of the patients (55%) had attended a *sing'anga* (traditional healer), 16.7% had not. This information is not known for the remainder of the population (28.3%). Participants were not asked at the time of admission, as there was a concern that they may not have felt comfortable divulging this information in an obviously biomedically orientated service. Some participants, however, volunteered this information or it became apparent during the course of the interview, although not explicitly asked. This question was integrated into the follow-up interview.

Previous admissions to hospital: For 75% of the participants, this was their first admission to St. John of God's Hospital. The remaining 25% had been previously admitted.

Mode of admission: Information was available for 85.7% of the participants. Mode of admission was not clear from the notes in 14.3% of the cases. The majority of participants had been physically brought to the hospital by their families (73.3%). Equal percentages (0.8%) of participants brought themselves to the hospital, were accompanied by workmates, or were accompanied by friends. A variety of referral agents had a role to play in the admission of 15% of participants, although these agents only accompanied 10% of the participants. Table 6.4 indicates these figures.

Table 6.4: Number and percentage of patients referred to hospital by various referral agents

Referral agent	**No. of participants**	**% of participants**
Mission Hospital	6	5%
District Hospital	4	3.3%
Drop-in centre	1	0.8%
Police	6	5%
Army	1	0.8%
Total referred	**18**	**15%**

Duration of admission: Duration of admission in hospital refers to the number of days which elapsed between the participant being admitted and discharged from the care of the hospital. Information was available for 114 participants. Table 6.5 presents mean, median, mode, range, standard deviation (SD) and standard error (SE) of duration of admission for the admission sample.

Table 6.5: Mean, median, mode, range, standard deviation (SD) and standard error (SE) of duration of admission in days

	Mean	**Median**	**Mode**	**Range**	**SD**	**SE**
Admission sample (n=120)	32.35	27	18	2-103	21.05	1.95

The mean number of days participants were admitted for was 32.35, which is just over a month. A large range existed, spanning from the shortest stay of two days to the longest stay of 103 days, which is almost three and a half months.

Type of disorder: Given the criticism levelled at DSM-IV as a diagnostic tool in Africa and elsewhere, diagnoses were not used in the analysis. A simpler classification, although not flawless, was employed. The type of illness was defined by whether or not they displayed psychotic features as in MacLachlan, Nyirenda and Nyando (1995). Almost three-quarters (70%) were classified as psychotic, the remainder as non-psychotic.

Participant information for the longitudinal sample

Demographic information

Gender: Males constituted 62.5% of participants; the remaining 37.5% were female.

Age group: The mean age of the participants was 30.5 years (S.D.=11.83), ranging from 16 to 65 years, as can be seen in Table 6.6. In this sample, information was only missing for one participant (4.2%). The majority of the participants were aged below 35, with 33.2% aged between 15 and 25, while 41.6% were in the 26-35 age group. The 46-55 age group comprised of 4.2% and the 56-65 category comprised of 8.5% of the participants. The remaining 8.5 % falls into the 36-45 age group.

Table 6.6: Mean, median, mode, range and standard deviation (SD) of age of participant in longitudinal group

Mean	Median	Mode	Range	SD
30.50	28.00	22	49 (16-65)	11.83

Religious affiliation: The majority of the participants were affiliated to Missionary religions (87.5%), while 12.5% were members of non-Missionary religions.

Education: Information was not available for 16.7% of the participants. A small percentage (4.2%) had never received schooling. Over one-third (37.5%) had received primary education, or were in primary school at the time of the study (minimum five

years). A further 33.3% received, or were receiving, secondary education, 8.3% of participants had completed second level education. Third level education or professional training had been pursued by 8.3% of the participants.

Occupation: Equal percentages of participants were students (20.8%) and farmers (20.8%). Housewives accounted for 16% of the participants. Those who were unemployed at the time of the study accounted for 8.3%, and a further 8.3% had no occupation. Teachers were the only professionals in this group and accounted for 8.3%. The remaining participants described their occupation as a trade (4.2%), business (4.2%), piecework (4.2%) and home dwellers (4.2%).

Place of origin: Over half of the participants in this group were from a rural background (58.3%) and the remaining 41.7% were from an urban area. All the participants in the follow-up sample were from Northern Malawi.

Marital status: More than half of the participants were single (56.5%), only 21.7% were married. Of the women that were married, 8.7% were in a polygamous marriage and described themselves as co-wives. The remaining participants had been married; however, 4.3% had been widowed, and 8.7% were divorced.

Treatment information

Attended traditional healer: The majority of participants had been to a traditional healer (58.3%). Only 16.7% had not consulted a healer. For a substantial percentage (25%), it was not clear whether they had consulted a healer.

Previous admission to hospital: For 70.8% of the participants, it was the first time they had been admitted to this hospital. The remaining 29.2% had been admitted at least once before.

Mode of admission: Information was missing for three of the participants (12.5%) in this group. Family or friends were responsible for bringing the participant to hospital in 66.7% of the cases. The remainder (20.8%) were brought by a referral agent. Of those

referred, one participant had been referred by a mission hospital, one by a district hospital, one by the drop-in centre and two by the police.

Duration of admission: As can be seen from Table 6.7, the average stay was almost 40 days. The duration of admission ranged from 12 days to 101 days.

Table 6.7: Mean, median, mode, range, standard deviation (SD) and standard error (SE) of duration of admission

	Mean	Median	Mode	Range	SD	SE
Longitudinal Sample (n=24)	39.7	33.5	20	89 (12-101)	22.61	4.62

Type of disorder: Two thirds (67%) of the participants received a diagnosis of a psychotic disorder on discharge. A diagnosis of non-psychotic disorder was given to the remaining 33%.

Attrition of sample

As previously pointed out, not all of the 120 participants interviewed were involved in interviews at each discharge and follow-up. Table 6.8 illustrates the number of participants interviewed at admission only, admission and discharge, admission and follow-up and on all three occasions. In order to ascertain whether any demographic or treatment variables influenced attrition of the sample, statistical analysis using chi-square procedures or independent t-tests was conducted. The aim of this analysis was to identify differences in demographic or treatment variables that may exist between those who participated in interviews and those who did not participate at various interview stages.

Table 6.8: No. of participants interviewed at admission only, admission and discharge, admission and follow-up and at admission, discharge and follow-up

No. of participants	Admission	Discharge	Follow-up
73	X		
53	X	X	
46	X		X
24	X	X	X

Table 6.9 shows the results of the independent t-tests conducted on each of the four groups and the duration of admission.

Table 6.9: Results of t-tests for duration of stay in hospital across each group

	t	df	p
Admission interview only	.922	114	ns
Discharge interview	-.433	114	ns
Follow-up interview	-2.146	114	p>0.05
All interviews	-1.677	114	ns

Note: ns means not significant

Independent t-tests revealed that a significant difference exists between the duration of the hospital stay of those who were interviewed at follow-up and those who were not. Participants in follow-up interviews had a significantly longer stay in hospital than participants who were not interviewed at follow-up. There was no significant difference in the duration of admission between the following groups:

- Participants interviewed on admission only and participants interviewed again
- Participants interviewed at discharge, and participants who were not
- Participants interviewed at all three interviews and participants who were not

The demographic variables examined were: *age group*, *district lived in* (as a measure of proximity to the hospital) *education*, *gender*, *marital status*, *place of origin*, *religious affiliation*. The treatment variables were *previous attendance at traditional healers*, *previous admission to hospital*, *mode of admission*, and *type of illness* treated. Each of the variable names and the categories are shown in Table 6.10.

Table 6.10: Variable name and categories with which chi-square analysis was conducted

Variable Name	Category	Category	Category
Demographic			
Age group	15-25	26-45	46-65
District lived in	Mzimba District	Other District	-
Education	No schooling	Primary/Secondary education	-
Gender	Male	Female	-
Marital status	With a spouse	Without a spouse	-
Place of origin	Urban	Rural	-
Religious affiliation	Mainstream Missionary	Non missionary religion	-
Treatment			
Previous admission to hospital	Yes	No	-
Previous attendance at traditional healer	Yes	No	Unknown
Mode of admission	Referred	Not referred	-
Type of disorder	Psychotic	Non-psychotic	-

Note: Dashes indicates that a third category was not used.

Table 6.11 shows the results from the 11 chi-square procedures conducted to ascertain whether a significant difference existed between those participants who were only interviewed at admission (and did not continue to participate in the study) and those who continued to participate at discharge and/or follow-up. Analyses were conducted with the following variables: *age group*, *district lived in, education*, *gender*, *marital status*, *place of origin*, *religious affiliation, previous attendance at traditional healers*, *previous admission to hospital*, *mode of admission*, and *type of illness.* This series of chi-square analyses indicates that there is no significant difference between these groups concerning their demographic or treatment profiles.

Table 6.11: Results of chi-square analyses conducted on demographic and treatment variables of participants interviewed only at admission and participants interviewed again

Variables	**χ2**	**df**	**p**
Demographic			
Age group	3.979	4	ns
District lived in	.001	1	ns
Education	1.46	2	ns
Gender	.421	1	ns
Marital status	.926	1	ns
Place of origin	.628	2	ns
Religious Affiliation	.218	1	ns
Treatment			
Previous admission to Hospital	1.970	1	ns
Previous attendance at traditional healer	.908	1	ns
Mode of admission	.659	1	ns
Type of disorder	.000	1	ns

Note: ns means not significant

Table 6.12 shows the results of the 11 chi-square procedures conducted to ascertain whether a significant difference existed between participants interviewed at discharge and those who were not. Analyses was conducted with the following variables: *age group*, *district lived in, education*, *gender*, *marital status*, *place of origin*, *religious affiliation, previous attendance at traditional healers*, *previous admission to hospital*, *mode of admission*, and *type of illness.* This series of chi-square analyses indicates that no significant difference exists between these groups concerning their demographic and treatment profiles.

Table 6.12: Results of chi-square analyses conducted on demographic and treatment variables of participants interviewed at discharge and participants who were not

Variables	χ2	df	p
Demographic			
Age group	3.494	2	ns
District lived in	.006	1	ns
Education	.172	2	ns
Gender	1.928	1	ns
Marital status	.001	1	ns
Place of origin	.000	1	ns
Religious Affiliation	1.26	1	ns
History of treatment			
Previous admission to Hospital	.001	1	ns
Previous attendance at traditional healer	3.086	2	ns
Mode of admission	.000	1	ns
Type of disorder	0.58	1	ns

Note: ns means not significant

Table 6.13 shows the results of 11 chi-square procedures carried out to ascertain whether a significant difference existed between those who were interviewed at follow-up and those who were not. Analyses were conducted with the following variables: *age group*, *district lived in*, *education*, *gender*, *marital status*, *place of origin*, *religious affiliation*, *previous attendance at traditional healers*, *previous admission to hospital*, *mode of admission*, and *type of illness*. Chi-square analyses indicate that no significant difference exists between these groups concerning their demographic and treatment profiles.

Table 6.13: Results of chi-square analyses conducted on demographic and treatment variable of participants interviewed at follow-up and participants who were not

Variable	$\chi 2$	df	p
Demographic			
Age group	.537	2	ns
District lived in	.051	1	ns
Education	2.503	2	ns
Gender	0.01	1	ns
Marital status	2.648	1	ns
Place of origin	1.049	1	ns
Religious affiliation	.011	1	ns
History of treatment			
Previous admission to Hospital	3.008	1	ns
Previous attendance at traditional healer	7.23	2	ns
Mode of admission	1.869	1	ns
Type of disorder	.015	1	ns

Note: ns means not significant

Table 6.14 shows the results of 11 chi-square procedures carried out to ascertain whether a significant difference existed between those who were interviewed on all three occasions and those who were not. Chi-square analyses indicates that there is no significant difference between exists between these groups concerning their demographic and treatment profiles.

Table 6.14: Results of chi-square analyses conducted on demographic and treatment variables of those interviewed at all three interviews and those who were not

Categories	$\chi 2$	df	p
Demographic			
Age group	.397	2	ns
District lived in	.002	1	ns
Education	.162	2	ns
Gender	.000	1	ns
Marital status	.012	1	ns
Occupation	.000	1	ns
Place of origin	.016	1	ns
Religious affiliation	1.134	1	ns

Categories	$\chi 2$	df	p
History of treatment			
Previous admission to Hospital	.000	1	ns
Previous attendance at traditional healer	.1087	2	ns
Mode of admission	.223	1	ns
Type of disorder	.000	1	ns

Note: ns means not significant

Summary

Independent t-tests revealed that a significant difference exists between the duration of the hospital stay of those who were interviewed at follow-up and those who were not. Participants in follow-up interviews had a significantly longer stay in hospital than participants who were not interviewed at follow-up. There was no significant difference in duration of admission between participants who continued to participate in the study after the admission interview and those who did not, between those who were interviewed at discharge and those who were not, and those who participated in interviews at all three times, and those who did not.

Chi-square procedures were conducted to ascertain whether demographic or treatment profiles had a role to play in the attrition of the sample. Analyses suggests that no significant difference in demographic or treatment variables exists between participants who continued to participate in the study after the admission interview and those who did not. Furthermore, there is no significant difference in demographic or treatment variables between those who were interviewed at discharge, at follow-up, or those who participated in interviews at all three times, and those who did not. This suggests that neither demographic nor treatment variables influenced continued participation in the study.

Interview circumstances

Interview circumstances describes the manner in which the interviews were conducted, who conducted the interview, the language in which they were conducted, whether or not they were translated and the method of recording. Descriptive statistics are given for the interviews conducted on admission, on discharge and on follow-up in Table 6.15.

Table 6.15: Descriptive statistics for interview circumstances

Interview information	**Admission (n=120)**	**Discharge (n=53)**	**Follow-up (n=46)**
Ethnicity of interviewer			
Malawian	30 (25%)	17 (32.1%)	12 (26.1%)
Irish	90 (75%)	36 (67.9%)	34 (73.9%)
Language			
Local language	91 (75.8%)	40 (75.5%)	31 (67.4%)
English	29 (24.2%)	13 (24.5%)	15 (32.6%)
Type of interview			
With a translator	78 (65%)	17 (32.1%)	19 (41%)
Without a translator	42 (35%)	36 (67.9%)	27 (59%)
Method of recording			
Tape recorder	102 (85%)	50 (94.3%)	38 (82.6%)
Transcription	18 (15%)	3 (5.7%)	8 (17.4%)

Over the course of the interviews, this researcher conducted between 67.9% and 75 % of the interviews, with between 25% and 32.1% being conducted by a Malawian. At admission and discharge, three quarters of the interviews were conducted in a local language, chiTumbuka, chiChewa or chiTonga. The remainder were conducted in English. The percentage of interviews conducted in English increased in the follow-up interview, with almost one third of these interviews being conducted in English. Consequently, the number of translated interviews decreases over time, from 65% on admission to 41% at follow-up. Chi-square procedure shows a significant difference in the proportion of translated interviews across time ($\chi 2=51.93$; df=2; $p<0.001$). Significantly more interviews were translated at admission than at discharge or at follow-up. The majority of interviews were taped, increasing from 85% on admission to 94% at discharge, dropping slightly at follow-up to 82.6%.

Descriptive statistics for the longitudinal sample are displayed in Table 6.16 below.

Table 6.16: Descriptive statistics for interview circumstances (longitudinal sample)

Interview information	Admission (n=24)	Discharge (n=24)	Follow-up (n=24)
Ethnicity of interviewer			
Malawian	3 (12.5%)	6 (25%)	6 (25%)
Irish	21 (87.5%)	18 (75%)	18 (75%)
Language conducted			
Local language	19 (79.2%)	18 (75%)	16 (64.7%)
English	5 (20.8%)	6 (25%)	8 (33.3%)
Type of interview			
Translated	16 (67%)	12 (50%)	10 (42%)
Not translated	8 (33%)	12 (50%)	14 (58%)
Method of recording			
Tape recorder	20 (83.3%)	20 (88.3%)	22 (91.7%)
Transcription	4 (16.7%)	4 (16.7%)	2 (8.3%)

The majority of the interviews were carried out by this researcher with a translator, 87.5% at admission and 75% at both discharge and follow-up. The remainder of the interviews were conducted by a trained Malawian. The majority of the interviews were conducted in a local language (chiTumbuka, chiChewa, chiTonga) although this decreased from 79.2% on admission to 64.7% at follow-up. With the decrease in local languages spoken, fewer interviews were translated at follow-up that at admission. Two thirds of the interviews on admission were translated, 50% at discharge and 42% at follow-up. The majority of interviews were taped (83.3%), only 16.7% expressed a preference for the interview to be written both at admission and discharge. This figure increased at follow-up, with 91.7% of the interviews being tape-recorded.

PART TWO: ANALYSIS OF INTERVIEWS

Personal accounts

Aim

The aim of this section is to convey a range of the explanations held by the participants regarding the mental disturbance they experienced. Presenting the data collected in the interviews in this format serves two purposes. Firstly, it draws attention to the fact that the data has arisen through the personal experience of the participants. Secondly, it illustrates the general tenor of the information collected, providing a broader context

from which to understand the findings of the analysis. In total, six personal accounts are presented, drawn from those participants that had an interview at admission, discharge, and follow-up. Each account is divided into the following three sections:

Background: This section provides some background information about the participant and his previous history with treatment for mental disturbance where available. Also included in this section is information about the interviews for example, the language the interview was conducted in. Finally, each series of interview illustrates different patterns of explanation; the patterns these particular participants are thought to illustrate are stated.

Explanation for mental disturbance: Included in this section are the reasons why the participant felt they were admitted to hospital and the explanation they hold for the disturbance they experienced at the time. It should be noted that where appropriate, the participants own words are used to illustrate their explanations. The sentence structure of these quotations may appear unusual, as a Malawian has translated the interviews into English, or they are the spoken words of a Malawian who speaks English as a third, fourth or possibly fifth language. Expressions or turns of phrase are therefore different than those used by a native English speaker.

Synthesis: The synthesis provides an integration of the information from the previous two sections and in addition contains some comments and observations.

Personal account I

Background

E.B., a Tongan male, in his mid thirties was brought to the hospital by his family. He was single and unemployed at the time of admission, although he had attained third level education standard. He was from a rural area. His history reveals one previous admission to the hospital and treatment by *ŵasing'anga* for mental disturbance. He referred to his previous disturbance as a "psychological illness". At discharge he received a diagnosis of a psychotic illness. He recounted that one day nine spirits including his uncle and grandmother had appeared, and that he had been praying a lot to

Jesus. His relatives took him to *wâsing'anga*, and he believes some of them have healed him.

The follow-up interview was conducted in the Drop-in centre when he came to collect his regular monthly medication. This series of three interviews illustrate explanations that *remain constant throughout*. The first interview was conducted in chiTonga and chiTumbuka, the other two were conducted in English.

Explanation for disturbance

On admission, he did not feel he was disturbed saying: "I know myself that I am O.K. now, haven't I put my clothes on rightly." Although not saying that he has a problem at the moment he comments "I do not know my problem, some say it is *maskawi*, (spirit illness) some madness, some whatever. I do not know."

At discharge, the reason he gave for being in hospital was that he had a "mental problem". He described difficulties he experienced when he was alone at night, "I could find myself running after something which I do not know." He did not experience this during the day while he was in company.

He felt there were two reasons that caused his mental problem. Firstly, his disturbance, in his words had occurred "partly because of distress". He described how he had been unemployed for a long time, and now was uncertain as to where he was going to live. He had been staying with a relative who had died, and then with another relative who had emigrated to Britain, "... thinking too much ..." about what he would do in these circumstances caused his illness.

Reading the Bible too much was the second explanation he offered for his disturbance. He recalls sleeping for "50 minutes out of 24 hours" and "becoming very close to God in communication". He commented that "Some people were saying I was mad". When asked if he thought he was mad, he gave a very interesting reply: "I was not mad, but my thinking capability had gone so fast that people could not understand me in society. There's a difference in being mad and mentally ill." Thus, acknowledging that while a

change had occurred in his thinking capability, people had mistaken him as mad, because they could not understand him.

His responses in the second and third interview were consistent. In the follow-up interview, he maintained that he had a mental problem. This problem was caused by thinking too much about being unemployed and family problems, such as his sister having to look after him in addition to several other people. He said that he "was worried about my future life". He maintained that reading too much could cause a mental problem. He was taking the medicine from the hospital and really thought it was helping, commenting "It's really working because I don't see myself being worried again. My body is very straightforward these days." Furthermore, he observed: "It [the medicine] is helping in keeping my temper moderate, because this disease involves tempers. If the tempers go high it comes, while your temper is low it comes again."

Synthesis

Initially E.B. was unsure about the cause of his disturbance, and had previously attended both traditional treatment and hospital treatment. His explanations were consistent at discharge and follow-up. It appears that he is taking his prescribed hospital medicine regularly.

It must be noted that the level of his exposure to western ideas and concepts would be significantly greater than many Malawians. It could be surmised that his high level of education would have introduced him to many western ideas. Additionally, at least one member of his family, with whom he lived has gone to Britain.

Personal account II

Background

T.M. is a Tumbuka woman who is over 50 years of age. She is married, a co-wife in a polygamous marriage. Her education level is Standard 6[24], and she lives an urban area and is a member of C.C.A.P. Her history reveals that she has had previous admissions to District hospitals for her disturbance and has consulted *ŵasing'anga.* She described an

[24] Sixth year of Primary education.

earlier experience, in 1990, of being "attacked by the disease" when she "could not get out of the house, I could not talk, I could not even eat" and talks of *vyanusi* (type of spirit) who "get a hold of you by the mouth and don't let you speak." After discharge, she attended the rehabilitation programme within the Service. She received a diagnosis of non psychotic illness at discharge. Her follow-up interview was conducted in the Rehabilitation centre.

This account illustrates a *movement away from explanations concurrent with traditional beliefs*. Her initial explanation involved *ulowe* (bewitchment) and *mizimu ya a gogo* (ancestral spirits). Her willingness to engage in the interview resulted in one of the more expansive interviews, offering insight into her understanding of her illness and the interaction between bewitchment and *mizimu ya agogo*.

Explanation for mental disturbance

In the admission interview, she pinpointed the behaviour she thought had led to her admission: "… walking naked … people were amazed why I was doing this because I was very smart and always dressed smartly." She attributed her illness, which she referred to as *vifusi,* to bewitchment. Her *mizimu ya agogo* had intervened to save her. She believed that her husband had asked her co-wife to put magical charms in her food. She explained that she felt her husband no longer wanted her to stay with him but wanted her to return to her own village. However, the *sing'anga* she consulted informed her she had been bewitched by her father-in-law. He wanted her to stay at his village to cook good food.

When asked to explain a little more about her *vifusi*, she said it was *vyanusi* (spirit illness). She explained that her spirits had rescued her from the *mankhwala gha ulowi* (bewitchment medicine). *Sembe* (a sacrifice) is offered to the spirits and the person improves. Already she has planned to offer beer or tea as a *sembe* on her return home. She was wearing *mboni* beads[25] while she was in the hospital.

Another repercussion of the intervention of *mizimu ya agogo* is that her body becomes rigid sometimes. The spirit of her grandmother calls upon the spirit of her father to

[25] Wearing *mboni* beads would indicate a belief in *mizimu*.

come to her rescue. After the *mizimu ya agogo* have "touched her", she gets better. She recounted her experience of dying and returning to life[26] in Rumphi hospital when previously treated for this illness. When she reached heaven, she saw a man dressed in a khaki uniform with a register in his hand, who informed her that her name was not on the register. She was sent back, and that is how she arose from being dead. She makes an interesting comment, regarding *vyanusi*; she does not like having *vyanusi,* but she has to accept it.

In her discharge interview, she dates her first experience of bewitchment to 1971. She also related another episode of *vyanusi*. Her *vimbuza*[27] began in 1962, her *mizimu* have remained with her and love her a lot. Her *mizimu* become angry if she is not respectful to others; for example, her *mizimu* will trouble her and she will become physically ill. Similarly, if she is not respectful to the *mizimu* they will trouble her. Giving *mizimu* a white cloth at the grave annually and brewing beer for them make them happy. Beating the drums cool *mizimu* when they are high. In this interview, she said that she is very happy to have *mizimu ya agogo*, as they protect her: "If they decided to leave me, I can be gone [dead]."

Her third interview, which took place after she had been in the rehabilitation programme for some months, was distinctly different. She described her illness as *mutu ukazingilira* (mentally confused). This mental confusion is not a result of *mizimu ya agogo.* She attributes her mental confusion to thinking too much and no longer believes that bewitchment led to her illness.

I commented on the absence of her *mboni* beads, that she had worn while she was in the hospital. She told me she "had just thought to remove them" and did not have any other explanation. It is not known whether she had a *sembe* for her *mizimu ya agogo.*

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[26] It would appear that this is a reference to *kachecura*, a struggle between her *mizimu ya agogo* and the *vimbuza* or *vyanusi mizimu*, although it is not specifically stated by her.

[27] She used the terms *vyanusi* and *vimbuza* interchangeably.

Synthesis

It would appear that the disturbance suffered by T.M. is chronic in nature. Although on admission and discharge she held explanations that involved traditional beliefs, she continued her treatment in the Service after discharge. Her apparent conviction regarding the role her *mizimu ya gogo* and bewitchment played, both in her life and her disturbance, seemed deep seated. Nonetheless, it would appear that she disregarded her traditional beliefs to the extent that she no longer wore her *mboni* beads, representing a considerable shift in her approach.

Firm beliefs she had held about her illness were at odds with her religion, CCAP. It is possible to be excommunicated for attending *ntchimi*, particularly for beliefs concerning spirits and bewitchment. However, this participant is not unusual in retaining traditional beliefs, which Missionary religions would reject.

It must be acknowledged that one plausible explanation for her change in beliefs about her illness is a direct result of the interview situation. She may have felt uncomfortable to express her real beliefs in the Rehabilitation Centre, while receiving medical treatment. This discomfort may also explain why she removed her *mboni* beads. On the other hand, it is also possible that she has actually changed her beliefs and feels that the medication she received worked.

Personal account III

Background

J.Mt., a Tumbuka male, aged 26 years was brought to the hospital by his mother. He is from a rural area and is a farmer. He received primary education to Standard 7. He is a Born Again Christian. His history reveals previous admissions to this hospital, Zomba Mental Hospital and consultations with *ŵasing'anga.* The last time he was in Zomba Mental Hospital, he absconded.

His treatment after discharge was to be continued at his local district hospital. However, at the time of follow-up he had not attended any monthly appointments at the District hospital. He was contacted by letter, as described in the Chapter Five. He came to the

District Hospital for his follow-up interview. Each interview was conducted in chiTumbuka.

This series of three interviews evince the *complexity of explanations held by some of the participants*. The plural nature of this participant's explanation, and indeed the uncertainty experienced by him is evident in his interviews.

Explanations for disturbance

In his admission interview, he said he was in the "hospital for mad people". Concerning the cause of his mental disturbance he replied: "I don't know how it started. I just know I am sick."

On discharge, he stated that: "The main problem is thinking. Thinking troubles me in this way. This part of my brain does not function properly, because even if I am talking to another person we seem to be disconnecting"

When asked what had caused his disturbance, he responded that it was just a disease. When asked where it came from, he offered the following explanation:

> This mental disturbance, I can't think properly what my problem is. At one time, I was a driver and I was involved in car accidents. So, I can't know whether this disease came from God, or it's how it is with all people who suffer from mental disturbance. That's why I have been sent here to the whites so they may find out is this how I have been in the past … at home if I look at my foes[28], my heart does not feel well[29] as I am here, I feel secured because my enemies are away.

He continues to explain that African black people "rely on trees (*mankhwala*) so that they can send me evil spirits or change me as they wish" and furthermore, "at home I am one of the bright sons. So they have seen that this one is progressing or thinking about doing something in which he can prosper, their hearts are not at peace. They want themselves to prosper not others"

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28 A reference to people who are likely to bewitch him. It is common not to express this directly.

29 This phrase does not literally mean his heart does not feel well. He is conveying a sense of unease as opposed to a physical compliant.

He recounts that the *sing'anga* told him that a man "wants to kill you and put you in his estate for its prosperity[30]" The *sing'anga* did not reveal the identity of this person[31]. When asked to clarify the how a car accident may have affected his illness he explained in this way:

> Because of the car accident, I believe the illness started. The time we were involved in a car accident our heads became confused so we ran mad. We fell down. The second time I was coming from the South, I sustained knee injuries after a car bumped into me … due to the cruelty of the Black people[32].

When he was "coming from the South", he had actually absconded from Zomba Mental Hospital. The follow-up interview reveals uncertainty about the cause of his disturbance. Examples of speculation are peppered throughout, such as: "I don't know whether or not it is an illness from God", " I don't know what is causing it, *mizimu*, or because I have been involved in car accidents." and " I don't know exactly what the real cause is."

Frequent references to the possibility of bewitchment are made: "Mainly I think it is because of the relatives because they want to kill me." And "People in the village[33] look at me in an envious way".

He describes his experience of being ill as "I feel all the people staying in the world are breathing and stepping on me, so I get confused." In terms of treatment, he explained that "I was taking Modecate[34], which I got from the hospital but now I have lost it. I don't even know where the documents are."

Synthesis

As stated at the outset this participant's account was chosen because his explanations highlight the plurality of some participants' explanations. He has sought both biomedical treatment and treatment from traditional healers, which is not surprising as

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30 This is a reference to the use of parts of the human anatomy as a *chizimba* for *mankhwala* to attain prosperity

31 Professionally *wasing'anga* are obliged not to reveal the identity of the person, it is considered very bad practice.

32 A further inference to bewitchment.

33 In a patrilocal system people in a man's village are always his relatives.

34 Modecate is a neuroleptic medication.

his explanation straddles both approaches. If it is an illness from God then it should be amenable to biomedical treatment.

It could be surmised from the account of J.Mt. that he does not adhere to biomedical treatment very well, having absconded from one mental hospital and discontinued his medication after discharge from this hospital. The underlying theme in J.Mt.'s explanation is one of bewitchment, although very often it is not mentioned directly, as could be considered characteristic of many Malawians.

This series of interviews exemplifies two research issues. These interviews, amongst others, served to highlight the potential difficulty a participant may have in identifying causes of their disturbance. Secondly, these interviews indicate how the interviewer's own bias from her background could intrude and change the meaning of the explanation. Once J.Mt. had mentioned a car accident I presumed he was going to explain how he sustained head injuries and became mentally ill as a result. However, on the contrary, for him this scenario provides a perfect example of how the root cause is bewitchment, mediated through a car accident.

Personal account IV

Background

L.N. is a Tumbuka woman from a rural area, and is aged over 50 years. She is a co-wife in a polygamous marriage. She has primary school education up to Standard 8 and is a member of CCAP. This is her second admission to hospital for her mental disturbance. She received a psychotic diagnosis at discharge. She has also consulted a *sing'anga.*

L.N. related a previous experience of mental confusion in her discharge interview which provides useful context to the account she gives regarding this episode of mental disturbance. She described a previous episode of mental confusion which had occurred in 1978, while she was breastfeeding her fifth child. While lighting the fire, all of a sudden, something burst from the fire and she rushed off to get a rope to hang herself. She went to a *sing'anga* who told her she had been bewitched. She was of the opinion that her co-wife was responsible. When the *sing'anga* made *mphini* (tiny incisions) he

found black blood[35], which according to that *sing'anga* indicates bewitchment. This could be the result of people "coming to me at night and magically beating me hard on the head."[36]

This account is an example of a *change from lack of awareness of her condition on admission to acceptance of disturbance* at follow-up. Additionally, she represents one of several cases who returned to a traditional explanation in the follow-up interview. The follow-up interview was conducted in the Drop-in centre.

Explanation for mental disturbance

In her admission interview she felt that the reason she was in St. John of God Mental Hospital was because there were no spare beds in the neighbouring hospital, which deals with physical illness. As far as she was concerned she was in hospital for *nthenda na sugar* (diabetes) and problems with her heart, although she was aware that she was being treated with Modecate[37] which helps a "person not talk anyhow" (not to talk nonsense) and helps to make a person well again. Therefore, no explanation for mental disturbance was elicited.

On discharge, she had incorporated being mentally confused into her reason for having been in hospital. One explanation she offered was that her niece had made her angry, and her last born was not heeding her advice, which also made her angry. Part of her confusion had been dreaming about her dead brothers and "sometimes I could dream about Jesus and Heaven."

Adamant that this admission was not related to bewitchment, she did however describe periods when her confusion relapses whenever she goes to her home village in Karonga, and this she thought was due to bewitchment. She did suggest that thinking too much about bewitchment might have been instrumental in causing her disturbance this time: "Possibly it's because I think I am going to be bewitched again. I become afraid when I go to Karonga." She says that when she is "in Karonga the people are too happy to see

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35 Not all *sing'anga* accept this. V.P. for example refutes this idea.

36 Reference to witches coming to her at night

37 Anti-psychotic medication

me, they greet me happily" and continues "so, this makes me think that they just want to fool me when in fact they want to bewitch me again. They make me think too much." However nowadays, she continues, "I don't think that the people are going to bewitch me again, unlike past days."

On her last visit to Karonga, prior to admission she found that all her things, bed sheets, clothes and other things had gone amiss. She told me: "This angered me and I got mentally confused again."

She felt she had been a "mental case" while she was in hospital "… so that's why I was in hospital, to get *mankhwala* to make me better." Bewitchment caused by her co-wife was again her explanation for her disturbance. She described her disturbance in terms of *kufuntha* or *misala* (madness). She believes that the *sing'anga* are right, but she is going to continue to take the hospital medicine and pray to God to get better.

Synthesis

An interesting pattern emerged from L.N.'s explanations. Her initial denial of mental disturbance, progressed to acceptance that she was suffering from a mental disturbance, which in the past had been a result of bewitchment but on this occasion it was caused by anger and thinking too much about the possibility of being bewitched. However, at follow-up she appeared to have reconciled the conflicting explanations and treatments. Her follow-up interview demonstrates the eclectic approach that many participants adopt. Her deep rooted belief that bewitchment caused her disturbance prevailed, but despite this she has decided that she will continue to take hospital medicine and in addition pray to God to get well again. She did not say whether she was taking traditional treatment also.

The prevailing theme in L.N.'s explanation is the fear instilled by the possibility of being bewitched. For many Malawians who believe in bewitchment this is a reality. L.N.'s recognition of this fear as a contributing to her disturbance may be well founded. Bewitchment may occur when she returns to her village because it is members of one's own family that bewitch each other.

She provides another example of a participant affiliated to a staunch Missionary Church, but yet her traditional beliefs prevail in relation to her illness and indeed her outlook.

Personal account V

Background

L.M. is a male, aged 35. He is divorced, a member of the Last Church and describes himself as a businessman. His standard of education is not known. The police brought him to the hospital, handcuffed. While he has attended traditional healers in the past, this is his first time to be treated in hospital. He was admitted for a six-week period.

The reason for choosing the account offered by this participant diverges a little from that of the other accounts. While the pattern of explanation is similar to that of L.N. in Personal Account IV, an added significance exists as this participant had at one point begun his training as a traditional healer. Inclusion of such an account was felt to be valuable, given the strong link between the experience of mental disturbance and becoming a healer[38] (see Chapter Four for accounts of mental disturbance experienced by *ŵasing'anga*). The first interview was conducted in chiChewa, the others were conducted in chiTumbuka. A Malaŵian, a Clinical officer in the hospital, conducted the discharge interview. His follow-up interview was conducted by this researcher in the Drop-in centre, ten months after discharge.

Explanation for mental disturbance

In his admission interview, he was aware that his actions had led him to be arrested by the police and that they were responsible for bringing him to hospital: "The Police brought me here because they say I was a problem … It's also because I was beating people a lot …" He believed that God had called him "to start Armageddon." However, he did not agree that he was mentally disturbed; he felt that the reason he was in hospital was that "the police mistook me for a mad person." Furthermore, he said: "I do

[38] Two other participants had felt they were traditional healers or had the potential to become one. One participant had been told by traditional healers that his illness was an indication that he should become a healer, although he did not believe it could be so and chose to ignore their advice on beginning training.

not agree [that he is mentally disturbed], the head can't be disturbed without God's word."

By discharge, he felt he was in hospital because he was mentally confused. He realised he was mentally confused because he "was doing things quite contrary to what my friends were doing". He thought that "God's spirit had come unto me like on the day of Pentecost." which had resulted in his disturbance. He thought that it was the medicine he received at the hospital that had helped him to get better, and he added "... and also the food which we take here is better than at home."

At follow-up, he still felt that he had been mentally confused (*mutu ukazingilira*), describing himself as "I was like the mad people. I was mentally confused." It was only at his follow-up interview that it became apparent that he had been in the process of training as a traditional healer. When asked what he thought had caused his confusion he said that it was his *mizimu,* and when asked which spirits had been responsible he pinpointed *vimbuza* spirits. He was even more specific, when he continued. "My mother's spirits. When they have not been attended to ceremoniously[39], one is likely to fall ill mentally." When asked if he knew why the spirits had been troubling him, he acknowledged that he did and continued when asked: "Yes, I can tell you a little bit, in the past I was sick with *mizimu*, *vimbuza* with which we are able to tell what somebody is suffering from, what we call *mizimu.* So because I did not follow the recommended process[40], I fell ill."

He describes *vimbuza* as: "the spirits of people that are dead, especially your relatives, which if you are in trouble, and they want to protect you, they come into your body and start to make you divine (diagnose)."

It was at this point that he indicated that he had been in the process of training to be a healer. Although he continues to have dreams like a traditional healer, he is no longer in training: "Somehow I still feel they [*mizimu*] are troubling me to a certain extent because at time I dream that I have gathered people for me to tell their problems and at

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[39] Referring to a *sembe, vimbuza* or *chilopa* ceremony, whichever the *mizimu* is requesting.

[40] A further reference to the ceremonies noted in footnote 15.

time I dream that I gather people to give them medicine." Despite this background, he is of the opinion that the *ŵasing'anga* failed in the treatment of his *vimbuza.* He had been taking *mankhwala gha vimbuza* (*vimbuza* medicine), and had danced *vimbuza* also. In terms of his medication from the hospital, he said: "At first I was getting the medicine, but the medication is making me restless, I fail to sleep, so since that time I have gone back."

He does not think he has completely recovered and attributes the persistence of what he describes as a headache to "the spirits were not attended to ceremoniously".

Synthesis

Initially, L.M. did not think that he was mentally disturbed. At discharge, he did think he was mentally confused, caused by the spirit of God. At follow-up, he appeared convinced that it was *vimbuza*, but felt that neither traditional, nor biomedical treatment had helped him. Nonetheless he reason he identified for his lack of a full recovery was because his *mizimu* had "not been attended ceremoniously." He however gave no indication as to whether he would redress the situation by doing so.

As previously mentioned the pattern of explanations bears resemblance to that of L.N.'s account, they do diverge however at the point of treatment. While L.N. says she will continue with biomedical treatment and pray to God even though she is holding a traditional explanation, L.M. indicates that he has abandoned both forms of treatment.

Again, the information obtained in the interview with L.M. highlights the benefits of a fluid interview process where new unanticipated questions can be incorporated into the interview as required. Moreover, the analysis of this interview emphasises the advantage of conducting the traditional healers study, providing an example of how richer data can be gathered and understood in perspective.

Personal account VI

Background

D.C. is a Tumbuka man who lives in Mzuzu. He is single, 26 years old and lives in an urban area. He has a relatively high standard of education, having reached Form Three[41]. Despite this achievement, he has no specific occupation, doing piecework to earn money. It is his first admission to the hospital. He received a non psychotic diagnosis at discharge. He has not consulted a *sing'anga*, although his family arranged for one to come to him at home.

This series of interviews introduce the explanation of *drug abuse*, both *chamba* (marijuana) and a pharmaceutical type drug, Mandrax. The first and third interview was conducted in English, the remaining one in chiTumbuka. He attended the rehabilitation programme after discharge and it was there his follow-up interview took place.

Explanation for mental disturbance

In his admission interview, he said he had been admitted to hospital because he was *kuzingilira mutu*, (mentally disturbed). Smoking *chamba* was the explanation he held for his disturbance: "*Chamba*, I think *chamba* is the causer of the whole disease. I stopped smoking *chamba,* at least I am doing reasonable things." In describing the influence of *chamba* he makes an analogy to the physical disease of cancer, not common in Africa: "I have been told it (*chamba*) ruins the brain, but I do not know, it does that, something like cancer." He was also taking Mandrax and he considered it to have "supported" his illness.

In addition, he thought head injuries might have had a role in his illness: "Maybe fights. I remember one time I was beaten by people with sticks on the head. So I think that also caused the illness ... internal injuries to the brain ... damage to the brain."

His stance does not change in his discharge interview. He gives a slightly fuller explanation for how head injuries can result in disturbance: "The injuries gave room for very bad air because what I think is not O.K."

[41] Third, and penultimate year of Secondary Education.

In his follow-up interview, he offers explanations additional to the previous two interviews. For example, he says: "Before I became mentally confused I was just staying idle with nothing to do. So this also contributed to my becoming mentally confused, because when I sat I usually thought about smoking."

He is not interested in "Black medicine", as he describes it, although a *sing'anga* came to him once. Interestingly after the *sing'anga* was mentioned, he told me: "The other reasons [for his disturbance] are problems concerning our family as a whole." However when I asked him about this he said that it had caused him to become mentally disturbed, but was unwilling to say anymore as "you see, it is dangerous to discuss it." Therefore, it was pursued no further, however it could be construed as a reference to bewitchment, but there is no other evidence to substantiate that.

Synthesis

Throughout the interviews, D.C. maintained that *chamba* and Mandrax were responsible for his mental disturbance, although not necessarily the sole reasons. A further reason was introduced at discharge, that of a head injury.

Family have an instrumental role to play in the treatment sought for a family member who is mentally disturbed. In this instance, even though D.C. has no interest in "Black medicine", his family brought a *sing'anga* to see him. It is not clear whether D.C. does believe in witchcraft, as only a mere hint is given in his interview. His reluctance to discuss an issue could of course be attributed to paranoia. However, no other evidence of paranoid thoughts was evident in the interview.

Conclusion

It is evident from the six personal accounts presented that a variety of different explanations for mental disturbance exist. A variety of patterns of explanations also emerged from the interviews. Clearly, each one of these accounts has unique qualities, although they were chosen because they were representative of themes that became apparent during analysis. Analysis highlights similarities and differences, however it is important to acknowledge that the account given by each participant was distinctive, born of the participants previous history, experience of treatment, personal

circumstances and demographic characteristics, to mention but a few of the factors involved.

Reasons for admission to hospital

Overview

The first question asked of the patients "Why do you think you are here?" sought to elicit the reasons participants held regarding their admission to hospital. This section provides the results from the qualitative and quantitative analysis of the responses given. The findings from the qualitative analysis are presented first. In the quantitative analysis, reasons offered by the total sample and the reasons offered by the longitudinal sample are considered separately. In addition to examining the reasons given at each time the pattern of change between interviews is also examined for both the total sample and the longitudinal group. Chi square procedures were conducted, where appropriate.

Qualitative findings

Analysis of the transcripts was conducted as described in Chapter Five. Two distinct types of responses were given by the participants. There were those who felt they had been admitted to hospital because they were mentally disturbed and there were those who clearly felt that they were not mentally disturbed. In analysis, two major themes emerged, 'feels mentally disturbed' and 'does not feel mentally disturbed'. Both themes are composed of smaller sub-categories, which are indicated below.

In keeping with the guidelines for presenting qualitative analysis (Elliott, Fischer & Rennie, 1999), I have provided examples of the data for each of the themes that emerged. Codes allotted to each participant accompany each quotation. The demographic information for each participant can be viewed in Appendix P. A list of the themes and a description of each one can be found in Appendix Q.

1. Feels mentally disturbed

Feels mentally disturbed: This theme was the most common. The quotations included highlight the variations in expression of mental disturbance. Replies like the following one were most typical: "My head is not functioning properly." A few participants

described their mental disturbance in psychological terms: "I am here because I was thinking too much. I had so many things to browse and because I didn't want to forgive my husband who is very far from here. And because of these I got some psychological trenchment as well as it happened that I was confused" (G.C.) Another example is: "I don't know the type of illness but it was a psychological problem" (K.M.). Only one participant throughout used DSM-IV category to describe his disturbance: "I am a schizophrenic" (L.Z.). The following responses indicate the variety of expressions used to describe mental disturbance: "I was ill, mental illness" (J.N.), "I had a mental problem" (E.B.), "I am suffering from a mental disturbance" (M.M.), "I was mad" (J.K.), "I was suffering from a great serious disease, a mental illness. It was too severe on me, that's why I came to the hospital" (E.S.). The following quotations illustrate how some participants differentiated between degrees of disturbance: "I was not mad, I had a mental problem" (E.B.), "I was in hospital and I had mental illness a little bit" (F.M.). It is very apparent that the participants have a broad repertoire of expressions from which they articulate their diagnosis of themselves.

Vimbuza / Vinthenda

Although this theme was not very common, I felt it important to keep it as a separate theme as *vimbuza* can be experienced as a mental disturbance but is not viewed as a mental illness, or a physical illness. This participant acknowledged that she was sick "I am sick in the head. I have headache and *vinthenda*" (A.M.), so that precluded her from the other main theme of not feeling mentally disturbed.

2. Does not feel mentally disturbed

Others see mental disturbance: This theme incorporates a variety of 'others' who the participant identifies as viewing them as mentally disturbed. This participant sees her husband as the person instrumental in her admission: "I am here because my husband says I am sick. I don't think I am sick but it's the power of the Holy Spirit that fills me" (N. K). In the case of this participant he blames the police: "They [the police] thought of putting me here because they thought that I was mentally ill. It's because the police mistook me for a mad person" (L.M.). Hospital staff were identified as the reason why another participant has been hospitalised: "I am not sick only that I was just seen here because of the two white men. They thought I am sick and told me to come to the

hospital" (E.N.). The parents, in collaboration with other people, admitted this participant to the hospital: "I was talking too much I was not socialising. So, my parents and other people thought of taking me to the hospital to seek treatment" (C.M.).

These examples demonstrate that the participants do not see themselves as mentally disturbed, but their families and other agencies, like the police, feel that they require assistance.

Physical illness: The responses that contributed to the development of this theme were composed of a variety of different physical illnesses, such as those that follow: "I … am suffering from gonorrhoea (M.N.). And "I have a severe headache, all day and all night … I also have a severe stomach ache" (W.S.). They do not believe they have been admitted for the treatment of a mental disturbance.

Don't know: The answers that contributed to the development of this theme were very clear-cut as can be seen with the following examples: "I don't know [why I am here]" (J.N.). "I don't know [why I am here], I have been forced to come here," and "I don't know why" (C.G.). It is abundantly clear that these participants had no idea why they had been admitted.

No reason: Although there is only one instance of this it was retained as a theme because it was quite distinct from any other: "I have been taken by surprise. I have no reason to know why I am here" (E.R.).

Behaviour: A number of participants stated that they had been admitted to hospital due to specific behaviours, although they did not see themselves as mentally disturbed. Two examples illustrate this theme: "I undressed and urinated before the public. So they said urinating shouldn't be done in public so they brought me here" (F.N.). "I am here because I hurt my mother in the evening while we were eating our supper" (R.N.).

Other: This theme is made up from a conglomeration of reasons for being admitted given by participants with no apparent common thread running between them, or with any of the explanations in other themes. It could be surmised that they are indicative of some degree of mental disturbance but it is difficult to state that with any certainty.

Examples of such: "I came to release my grandparents and see if all the Whites are clever and so can tie me," (H.L.) and "It's because since my sister got divorced we are always quarrelling. So I thought it was wise to come here so that when my sister goes back home I shall also go back home" (F.N.).

Summary

It is evident from the descriptions of the themes which emerged from the data that there is a broad range of reasons offered by the participants in this study for their admission to hospital. Although the responses are divided into two broad umbrella themes, there are smaller themes encompassed in each. The first broad theme incorporates the theme 'feels mentally disturbed' and '*vimbuza/vinthenda'*. The second broad theme, 'does not feel mentally disturbed' houses five sub themes which all share the common feature that the responses that contributed to the development of the themes indicate that the participant does not feel mentally disturbed. Qualitative analysis was undertaken with the aim to present a richer, more detailed picture of the perspective of the participants in the study.

Results of quantitative analysis

Reasons given for admission to hospital: Total sample

Thematic analysis identified a number of reasons given by participants for their admission to hospital. The full range is evident in Table 6.17, which compares the percentage of participants reasons cited at admission, discharge and follow-up interviews.

Table 6.17: Reasons for admission to hospital given at admission, discharge, and follow-up interviews by total sample

Reason	Admission (n=120)	Discharge (n=53)	Follow-up (n=46)
Feels mentally disturbed	46%	78%	88%
Others see mental disturbance	22%	4%	2%
Physical illness	14%	2%	2%
Don't know	7%	0%	2%
No reason	1%	0%	0%
Other	8%	6%	6%
Vimbuza/vinthenda	2%	2%	0%
Behaviour	0%	8%	0%
Total	100%	100%	100%

Note: Percentages have been rounded to the nearest whole figure

Reasons given on admission: Less than half of the participants (46%) attributed their admission to feeling mentally disturbed. Effectively the remainder did not see themselves as being mentally disturbed. Over one fifth, (22%) said that others seen them as mentally disturbed and had brought them here. Physical illness was the reason offered by 14%, while *vinthenda / vimbuza* was cited by 2% of the participants. One participant (1%) could offer no reason for being there, while 7% didn't know why they were there. A variety of reasons constituted the 'other' category, accounting for 8% of the sample, examples of which can be found in the qualitative section. These figures are graphically displayed in Figure 6.1.

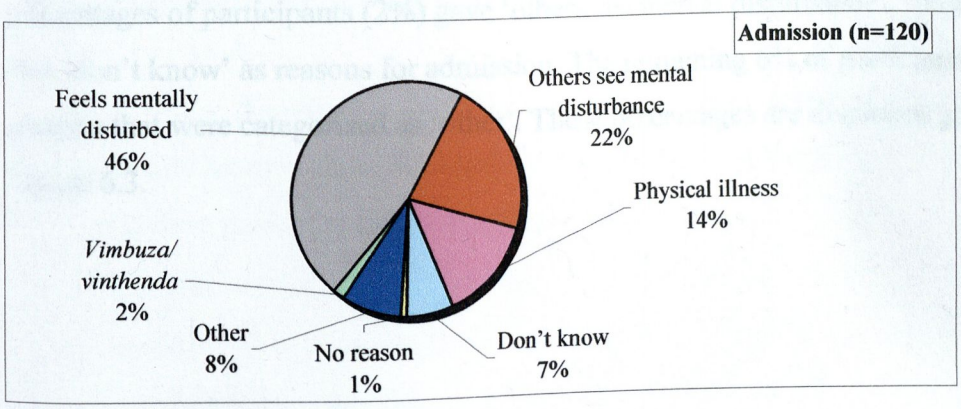

Figure 6.1: Reasons for admission to hospital given at admission

Reason for admission on discharge: The most common reason given by participants for admission to hospital was that they felt mentally disturbed (78%). Their behaviour prior to admittance was cited by 8% of the total sample. A small proportion felt that other people had seen that they were mentally ill (4%), physical illness and *vimbuza* were both given by 2% of the participants. Reasons that were described as 'other' were given by 6%. Examples of such reasons can be found in the qualitative section. The figures are graphically displayed in Figure 6.2.

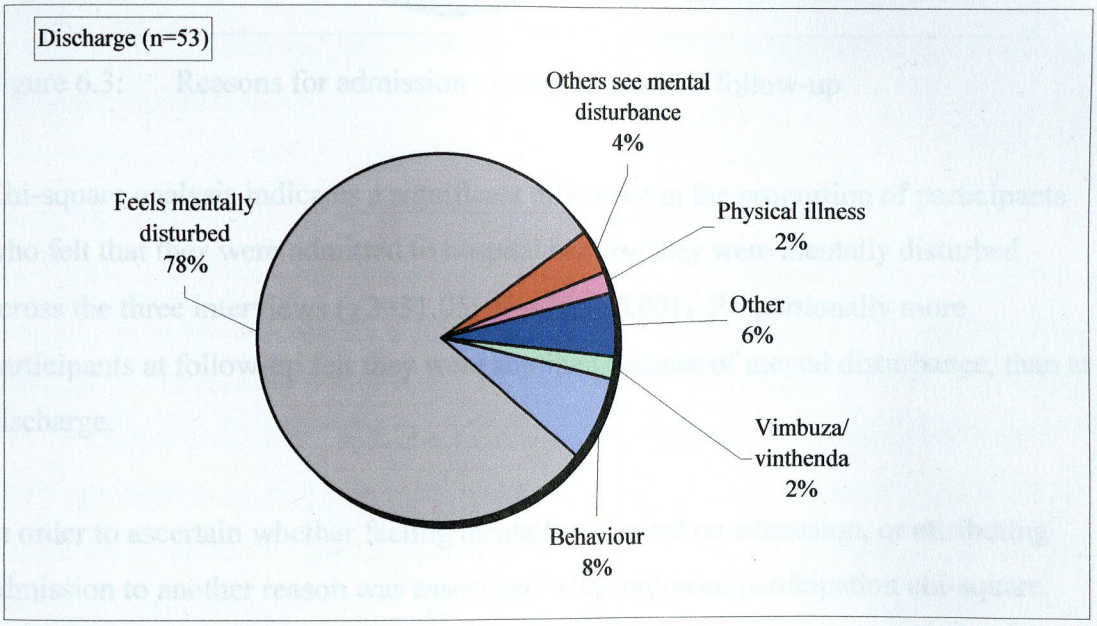

Figure 6.2: Reasons for admission to hospital given at discharge

Reasons given for admission at follow-up: The vast majority of participants felt they had been admitted to hospital because they felt mentally disturbed (88%). Equal percentages of participants (2%) gave 'others see mental disturbance', 'physical illness' and 'don't know' as reasons for admission. The remaining 6% of participants had reasons that were categorised as 'other'. These percentages are displayed graphically in Figure 6.3.

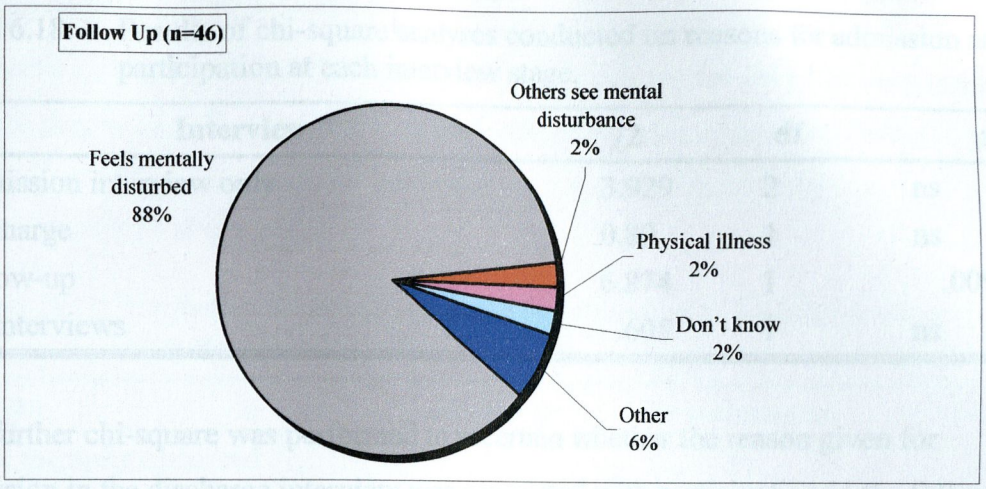

Figure 6.3: Reasons for admission to hospital given at follow-up

Chi-square analysis indicates a significant difference in the proportion of participants who felt that they were admitted to hospital because they were mentally disturbed across the three interviews ($\chi 2=31.05$; df = 2; $p< 0.001$). Proportionally more participants at follow-up felt they were admitted because of mental disturbance, than at discharge.

In order to ascertain whether feeling mentally disturbed on admission, or attributing admission to another reason was associated with continued participation chi-square procedures were conducted on the following groups:

- Participants interviewed only on admission and participants interviewed again
- Participants interviewed at discharge, and participants who were not
- Participants interviewed at follow-up and participants who were not
- Participants interviewed at all three interviews and participants who were not

These results are displayed in Table 6.18. There was only one significant finding. Proportionally more of those who had not seen themselves as mentally disturbed at admission were present at follow-up interviews.

Table 6.18: Results of chi-square analyses conducted on reasons for admission and participation at each interview stage.

Interview	$\chi 2$	df	p
Admission interview only	3.929	2	ns
Discharge	0.80	1	ns
Follow-up	6.874	1	.009
All interviews	.605	1	ns

One further chi-square was performed to ascertain whether the reason given for admission in the discharge interview was associated with participation in the follow-up interview. No association was found ($\chi 2$= .000; df=1; p =ns).

Changing patterns of reasons for admission across time

It is apparent that reasons given for admission change across time. It is important to observe which reasons change. Participants were classified as those who changed their explanation between each interview (changers), and those who did not change reasons between interviews (non changers). Trends were examined between admission and discharge interviews, and admission and follow-up interviews. It should be noted that the figures given for the changes between the discharge and follow-up apply to both the total sample and longitudinal group. This occurs because participants must have participated in both interviews for a change to be noted, those who participated at both discharge and follow-up interviews were interviewed at admission and are therefore the same group as the longitudinal group. The changing patterns between participants from discharge and follow-up are located in the following section that details the descriptive statistics for the longitudinal group.

As can be seen in Table 6.19, approximately equal numbers of participants changed their reason and retained their reason for admission to hospital. The majority of those participants who felt they were mentally disturbed on admission retained their response, only two of the original 26 changed their reason. Those who felt they were mentally disturbed account for almost half of the participants. Of those participants who did not feel that they were mentally disturbed, the largest group was 'others see mental disturbance', and in most cases, they had changed their reason from that given at admission. Those who originally cited, 'physical illness' 'no reason' and 'don't know'

changed their reason. Five participants originally cited 'other' reasons and all but one changed their explanation at discharge. A single participant felt they had been admitted because they were suffering from *vimbuza/vinthenda*, and they retained their explanation. No participant cited 'behaviour' as a reason for admission.

Table 6.19: Frequency of changing reasons for admission to hospital between admission and discharge interviews.

Reason	**Changers**	**Non-changers**	**Total**
Feels mentally disturbed	2	24	26
Others see mental disturbance	9	2	11
Physical illness	7	0	7
Don't know	2	0	2
No reason	1	0	1
Other	4	1	5
Vimbuza/vinthenda	0	1	1
Behaviour	0	0	0
Total	**25**	**28**	**53**

Table 6.20 shows that participants who changed their explanations greatly outweighed those who did not. Almost three quarters of the participants changed their reason from admission to follow-up. The most common explanation within this group was 'feels mentally disturbed', closely followed by 'others see mental disturbance'. Notably, 13, of the 14 participants who felt they were mentally disturbed on admission retained that reason. Each of the participants who felt they had been admitted because others viewed them as mentally disturbed, changed their explanation. All the participants whose responses were categorised as 'physical illness', 'don't know', 'no reason', 'other' and '*vimbuza/vinthenda*' changed their reason. No participant in this group had cited 'behaviour' as a reason. It is clear that between admission and follow-up, the only participants who retained their reason were those who had felt that that the reason for their admission to hospital was mental disturbance.

Table 6.20: Frequency of changing reasons for admission to hospital between admission and follow-up interviews

Reason	Change	No change	Total
Feels mentally disturbed	1	13	14
Others see mental disturbance	13	0	13
Physical illness	8	0	8
Don't know	4	0	4
No reason	1	0	1
Other	4	0	4
Vimbuza/vinthenda	2	0	2
Behaviour	0	0	0
Total	**33**	**13**	**46**

Reasons given for admission: Longitudinal sample

Examination of the reasons for admission to the hospital given by the longitudinal group facilitates an examination of how reasons change at the different interviews. From Figure 6.4 it is apparent that the most dramatic trend was a swing from participants feeling that their admission was not because they were mentally disturbed to feeling that the reason they had been admitted was because they did feel mentally ill. Not all the reasons cited were evident at each time. For example, behaviour was not cited as an example until discharge. And while 'physical illness' and 'don't know' constituted a substantial proportion of the responses at admission these reasons were not given at discharge, however by follow-up they had reappeared. 'others see mental disturbance' and *vimbuza/vinthenda* were not used at follow-up. One participant still did not know why they had been admitted at the time of follow-up.

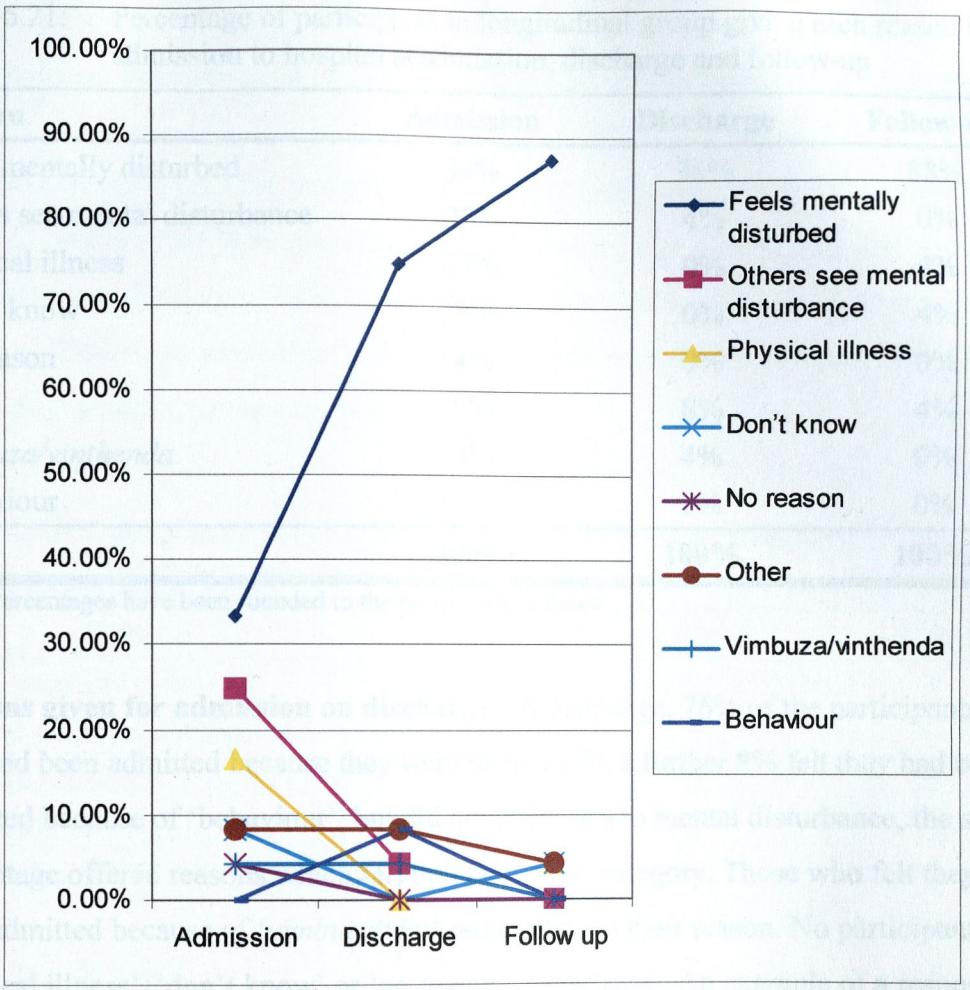

Figure 6.4: Percentage of participants in longitudinal group giving each reason for admission to hospital at admission, discharge and follow-up

The percentage of participants who gave each of the reasons at admission, discharge, and follow-up are displayed in Table 6.21.

Reason given for admission on admission: Only one third of the participants felt they had been admitted because they were mentally disturbed. A further one-quarter of the participants felt that other people thought they were mentally disturbed. Admission due to physical illness was cited by 17%, while 8% didn't know why they were admitted. A small percentage didn't think that there was any reason why they should have been admitted (4%), and the same percentage thought that they had been admitted with *vimbuza/vinthenda*, (neither a physical illness or mental disturbance). Additionally, 8% cited reasons that fell into the 'other' category such as "I came also to release my grandparents and see if all the Whites are clever and so can tie me"(H.L.).

Table 6.21: Percentage of participants in longitudinal group giving each reason for admission to hospital at admission, discharge and follow-up

Reason	**Admission**	**Discharge**	**Follow-up**
Feels mentally disturbed	34%	76%	88%
Others see mental disturbance	25%	4%	0%
Physical illness	17%	0%	4%
Don't know	8%	0%	4%
No reason	4%	0%	0%
Other	8%	8%	4%
Vimbuza/vinthenda	4%	4%	0%
Behaviour	0	8%	0%
Total	**100%**	**100%**	**100%**

Note: Percentages have been rounded to the nearest whole figure

Reasons given for admission on discharge: By discharge, 76% of the participants felt they had been admitted because they were mentally ill, a further 8% felt they had been admitted because of 'behaviour', but did not relate this to mental disturbance, the same percentage offered reasons which fell into the 'other' category. Those who felt they had been admitted because of '*vimbuza/vinthenda*' retained their reason. No participant gave 'physical illness', 'don't know' or 'no reason' at discharge. An example of a response which was categorised as 'other' was "I came here to see a sick person. But I am not sick" (C.J.), given by a participant whose family had told him they were taking him to visit his sister in hospital.

Reason given for admission on follow-up: By the follow-up interview an increasing percentage of participants felt they had been admitted because they were mentally disturbed (88%), equal percentages (4%) gave 'don't know', 'other' or 'physical illness' as reasons for admission, no participants had given either 'don't know' or 'physical illness' on discharge. An example of a reason which was categorised as 'other' was the reply given by J.M. who had no recollection of having been in the hospital.

Using the same method employed for the total sample the changes across time were examined. Trends are examined between admission and discharge, discharge and follow-up and admission and follow-up. Examination reveals that the 67% of the participants changed their reason between admission and discharge, the remaining 33%

retained their reason. Between discharge and follow-up the reverse occurred, with only 29% changing their reason as while 71% retained the reason they cited at discharge.

As shown in Table 6.22 the majority of those participants who had felt they were admitted because they were mentally disturbed retained that reason, only one changed their reason on discharge. All of the participants who at admission cited, 'don't know' 'physical illness' 'no reason' or 'other' changed their reason. The one participant who had cited '*vimbuza/ vinthenda*' retained that reason.

Table 6.22: Frequency of changing reasons for admission to hospital between admission and discharge interviews

Reason	Change	No change	Total
Feels mentally disturbed	1	7	8
Others see mental disturbance	5	1	6
Physical illness	4	0	4
Don't know	2	0	2
No reason	1	0	1
Other	2	0	2
Vimbuza/vinthenda	0	1	1
Behaviour	0	0	0
Total	**15**	**9**	**24**

As is clear in Table 6.23 none of those participants who felt their admission was due to being mentally disturbed changed their mind between admission and follow-up. All the participants who cited any reason other than feeling mentally disturbed changed their original reason between admission and follow-up interviews. No participant had cited 'behaviour' at admission.

Table 6.23: Frequency of changing reasons for admission to hospital between admission and follow-up interviews

Reason	Change	No change	Total
Feels mentally disturbed	0	8	8
Others see mental disturbance	6	0	6
Physical illness	4	0	4
Don't know	2	0	2
No reason	1	0	1
Other	2	0	2
Vimbuza/vinthenda	1	0	1
Behaviour	0	0	0
Total	**16**	**8**	**24**

As can be seen in Table 6.24, only two participants who had cited feeling mentally disturbed changed their reason. Those who cited '*vimbuza/vinthenda*', 'others see mental disturbance' and 'behaviour' changed their reasons. Sixteen of the eighteen participants who cited 'feel mentally disturbed' as their reason for admission retained their answers. One participant who had cited a reason which fell into the 'other' category retained their reason and one changed their reason.

Table 6.24: Frequency of changing reasons for admission to hospital between discharge and follow-up interviews

Reason	Change	No change	Total
Feels mentally disturbed	2	16	18
Others see mental disturbance	1	0	1
Physical illness	0	0	0
Don't know	0	0	0
No reason	0	0	0
Other	1	1	2
Vimbuza/vinthenda	1	0	1
Behaviour	2	0	2
Total	7	17	24

Summary

A range of reasons was given by the participants for their admission to hospital. Broadly speaking, the participants' reasons could be divided into two groups: those that felt their admission was due to mental disturbance and those that did not feel that their admission was a result of mental disturbance. At admission, the majority felt that their admission was due to a reason other than mental disturbance. Most of participants who held reasons other than mental disturbance regarding their admission to hospital changed their reason at discharge or follow-up interviews, indicating that they felt they had been admitted to hospital because of a mental disturbance. The vast majority of participants who originally felt that the reason for their admission was mental disturbance retained their reason. These trends existed in both the total sample and longitudinal group.

EXPLANATIONS FOR MENTAL DISTURBANCE

Overview

The primary aim of the interview was to elicit the explanations participants hold for the mental disturbance for which they were admitted to hospital. The results from the quantitative analysis are presented first as the need for qualitative analysis became apparent through the quantitative analysis. The results from the quantitative analyses are reported in the same manner as the results in the previous section; both the total sample and longitudinal group are dealt with separately and the pattern of change across time is also examined. A brief summary is provided at the end of the section. The findings of the qualitative analysis are then presented.

Participants' explanations were categorised according to the categories used by MacLachlan, Nyirenda and Nyando (1995): *'Traditional', 'Medical', 'Psychological', 'Don't know', and 'Other'*. The criteria for each category can be found in Appendix M. Their original categories had to be extended to incorporate those who did not think they were mentally disturbed and therefore had no explanation, and those that had no reason. Table 6.25 shows the range of explanations and the percentages of participants who explained their disturbance in this way. Pie charts illustrate the information for each interview time.

Table 6.25: Range of explanations for mental disturbance and percentage of participants holding explanations at admission, discharge, and follow-up interviews

Explanation	Admission (n=120)	Discharge (n=53)	Follow-up (n=46)
Not mentally disturbed	45%	9%	6%
Don't know	13%	18%	21%
Traditional	13%	17%	21%
Other	6%	7%	8%
Medical	10%	11%	8%
Plural	6%	17%	17%
Psychological	5%	17%	19%
No reason	2%	4%	0%
Total	**100%**	**100%**	**100%**

Note: Percentages have been rounded to the nearest whole figure

The breakdown of the different explanations for mental disturbance as shown in Table 6.25 are outlined below for each of the interview times. Pie charts illustrate the figures for each interview time.

Explanation for mental disturbance on admission: As can be seen in Table 6.25, and Figure 6.5 almost half of the participants (45%) did not see themselves as mentally disturbed, so explanations were not elicited, 13% didn't know how their illness was caused, and 2% of the participants felt that there was no reason that could account for their illness. A traditional explanation was offered by 13%, a medical explanation was offered by 10%. A psychological explanation comprised 5% of the sample. 'Other', miscellaneous explanations, accounted for 6% of explanations and 6% of participants accounted for their illness using a combination of explanations. An example of the responses categorised as category 'other' is as follows: "I think it is natural, I don't think and I can't say it is caused by such and such a thing, but it is natural" (M.M.).

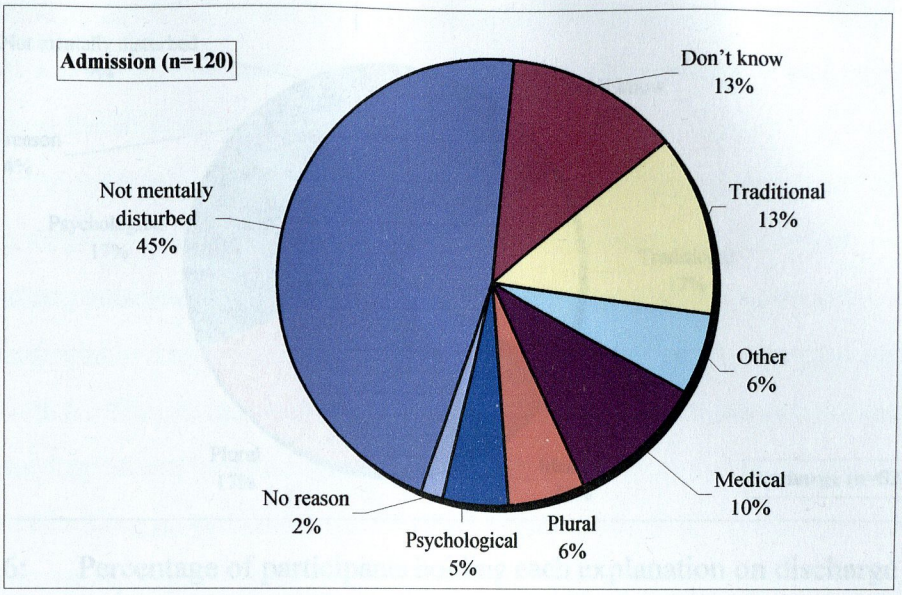

Figure 6.5: Percentage of participants holding each explanation on admission

Explanation for mental disturbance on discharge: Figure 6.6 illustrates the percentages given in Table 6.25 for explanations for mental disturbance on discharge. Relatively speaking there was quite an even spread of explanations offered for mental disturbance, traditional, psychological and plural categories each accounted for 17% of the participants, however 18% did not know what could have caused their disturbance, 9% did not feel mentally disturbed and 4% did not think that there was any reason for their disturbance. Medical explanations were given by 11% of the participants and a variety of 'other reasons' were given by 7% of the participants. An example of an explanation that was categorised as 'other' is as follows: "What caused this mental disturbance I am quite sure it's 'encouragement' so that I should be at a better stand … This was all encouragement from God, so that I should pay quickly through mental disturbance" (H.K.).

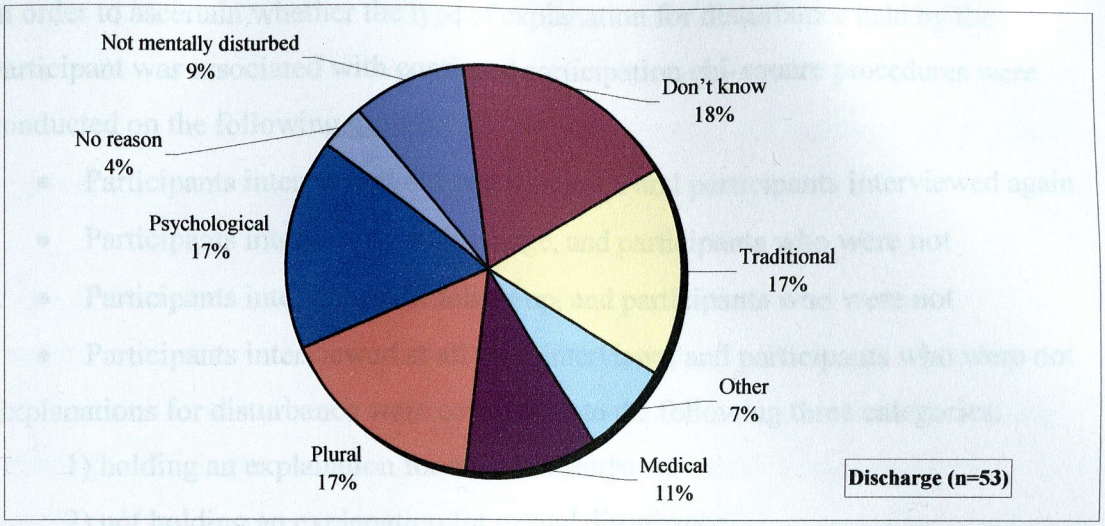

Figure 6.6: Percentage of participants holding each explanation on discharge

Explanation for mental disturbance at follow-up: Figure 6.7 illustrates the percentages given in Table 6.25 for explanations for mental disturbance at follow-up.

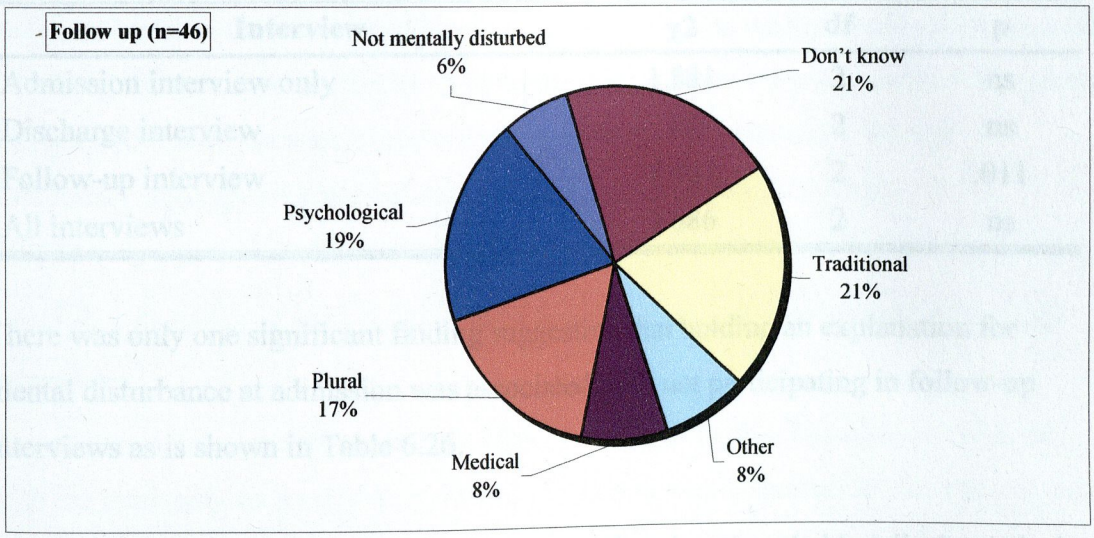

Figure 6.7: Percentage of participants holding each explanation at follow-up

At this point, 21% of the participants did not know what could have caused their disturbance and 6% did not think they had been mentally disturbed. Traditional explanations accounted for 21%, closely followed by the psychological category (19%). The combined category of plural made up 17% of the explanations, the majority of which had a traditional component. Medical explanations were offered by 8% of the participants and a variety of 'other' explanations accounted for 8% of the explanations such as "I am fulfilling my parents wishes" (H.Ls.).

In order to ascertain whether the type of explanation for disturbance held by the participant was associated with continued participation chi-square procedures were conducted on the following groups:

- Participants interviewed only on admission and participants interviewed again
- Participants interviewed at discharge, and participants who were not
- Participants interviewed at follow-up, and participants who were not
- Participants interviewed at all three interviews, and participants who were not

Explanations for disturbance were collapsed into the following three categories:

1) holding an explanation for mental disturbance
2) not holding an explanation for mental disturbance
3) not seeing oneself as mentally disturbed.

The results are displayed in Table 6.26

Table 6.26: Results of chi-square analyses conducted on explanations for mental disturbance and participation at each interview stage

Interview	$\chi 2$	df	p
Admission interview only	1.881	2	ns
Discharge interview	.458	2	ns
Follow-up interview	8.967	2	.011
All interviews	1.686	2	ns

There was only one significant finding suggesting that holding an explanation for mental disturbance at admission was associated with not participating in follow-up interviews as is shown in Table 6.26.

A further chi-square was conducted to ascertain if explanations held at discharge had an association with participation at follow-up. The finding was not significant ($\chi 2 = 1.183$. df = 2 p=ns).

Ethnicity of interviewer and type of explanation for mental disturbance

It was important to ascertain whether the ethnicity of the interviewer had any bearing on the type of explanation for mental disturbance offered by the participant, particularly regarding traditional explanations. In order to perform the chi-square procedure

categories were combined as follows: 1) traditional explanation 2) other explanation. No association was found between the ethnicity of the interviewer and the type of explanation offered at admission ($\chi 2 = .879$; df = 1; p=ns) at Discharge ($\chi 2 = .228$; df = 1; p=ns) or at follow-up interviews ($\chi 2 = .000$; df = 1; p=ns)

Type of disorder and type of explanation for disturbance

In order to ascertain whether explanations held at admission, discharge and follow up were associated with the type of disorder the patients were diagnosed as having (e.g. psychotic or non- psychotic) chi-square analysis was planned. However, due to unacceptably low expected cell frequencies, chi-square could not be reliably performed. Thus, the categories of explanation were collapsed to traditional and non-traditional (all explanations bar traditional). Due to the small numbers of patients diagnosed with non-psychotic disorders, chi-square could still only be reliably performed on the admission sample. The finding was not significant ($\chi 2 = .207$ =df=1 p=.649) As there is no association between type of disorder and whether or not the participant holds a traditional or non-traditional explanation, this suggests that the type of disorder does not impact on the participants explanations of their disturbance. (See Appendix S for tabular and graphic representations of the crosstabulation of explanations for mental disturbance and type of disorder at admission, discharge and follow up).

Changing patterns of explanations between admission, discharge and follow-up interviews

An analysis similar to that carried out with the reasons for admission was conducted with the explanations participants offered for their mental disturbance over the various interviews. Each participant was classified as a changer (if they changed their explanation between interviews) and non-changer (if they did not change their explanation). The changing patterns between participants at admission and discharge, and admission and follow-up are described. The changing patterns between participants from discharge and follow-up are located in the section which gives the descriptive statistics for the longitudinal group, as those who are present at discharge and follow-up, have necessarily been present at admission and therefore are the longitudinal group.

As is shown in Figure 6.8 the majority of participants changed their explanation for disturbance.

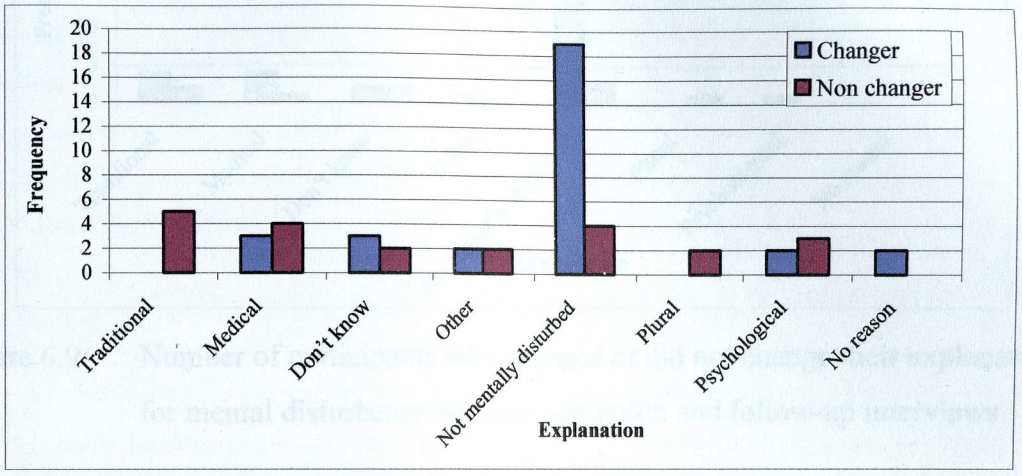

Figure 6.8: Frequency of changing explanations for mental disturbance between admission and discharge interviews

The most common explanation in this group was 'not mentally disturbed'. The majority of these participants had changed their explanation by discharge, with only four participants retaining that explanation. Each of the participants who held either a 'traditional' explanation or a 'plural' explanation retained it. Both participants who had 'no reason' for admission had changed their explanation by discharge. The remaining categories of explanation, 'medical', 'don't know', 'psychological' and 'other' were quite evenly split in terms of the number of participants that changed or retained their explanation.

Figure 6.9 indicates the number of participants who changed, or did not change their explanation for mental disturbance between discharge and follow-up interviews.

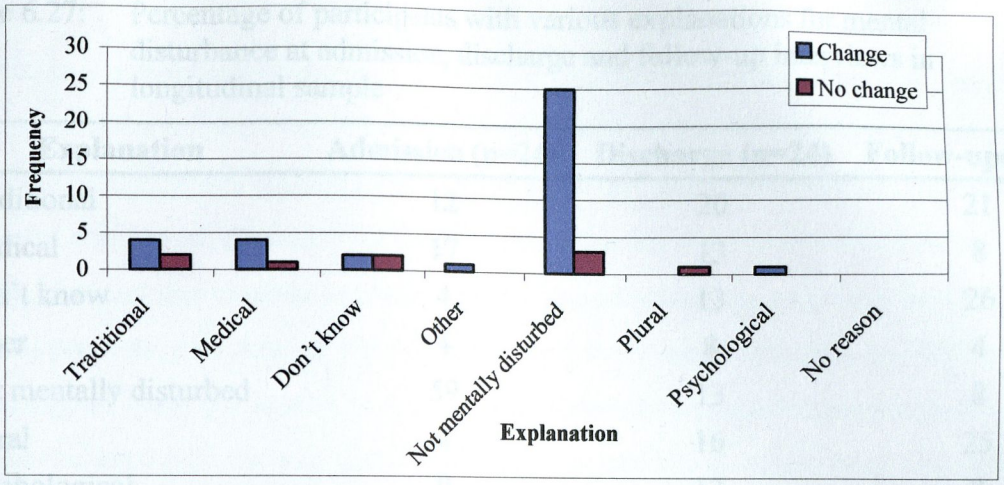

Figure 6.9: Number of participants who changed or did not change their explanation for mental disturbance between admission and follow-up interviews

Approximately two-thirds of the participants changed their explanations. The most common explanation was that of 'not being mentally disturbed', and the majority of those participants holding that explanation at admission had changed their explanation at follow-up. The least common explanations were 'psychological' 'other' and 'plural'. The single participants whose explanations were categorised as 'psychological' and 'other' changed while the participant with a plural explanation retained it. No participant cited 'no reason'. Four of the six participants who gave a 'traditional' explanation changed, while four of the five participants who gave a 'medical' explanation changed their explanations. The four participants who had given 'don't know' as their explanation on admission were split evenly in terms of changing and retaining their explanations.

Longitudinal sample

Examining the responses of the longitudinal group allows comparison over time with the same group of participants. Table 6.27 shows the percentage of participants whose responses were categorised as being 'traditional', 'medical', 'don't know', 'other', 'not mentally disturbed', 'plural', 'psychological' and 'no reason' at admission, discharge and follow-up interviews.

Table 6.27: Percentage of participants with various explanations for mental disturbance at admission, discharge and follow-up interviews in longitudinal sample

Explanation	Admission (n=24)	Discharge (n=24)	Follow-up(n=24)
Traditional	12	20	21
Medical	17	13	8
Don't know	4	13	26
Other	4	8	4
Not mentally disturbed	59	13	8
Plural	4	16	25
Psychological	0	13	8
No reason	0	4	0
Total	**100%**	**100%**	**100%**

Note: Percentages have been rounded to the nearest whole figure

The pattern of the responses of this group are represented graphically in Figure 6.10.

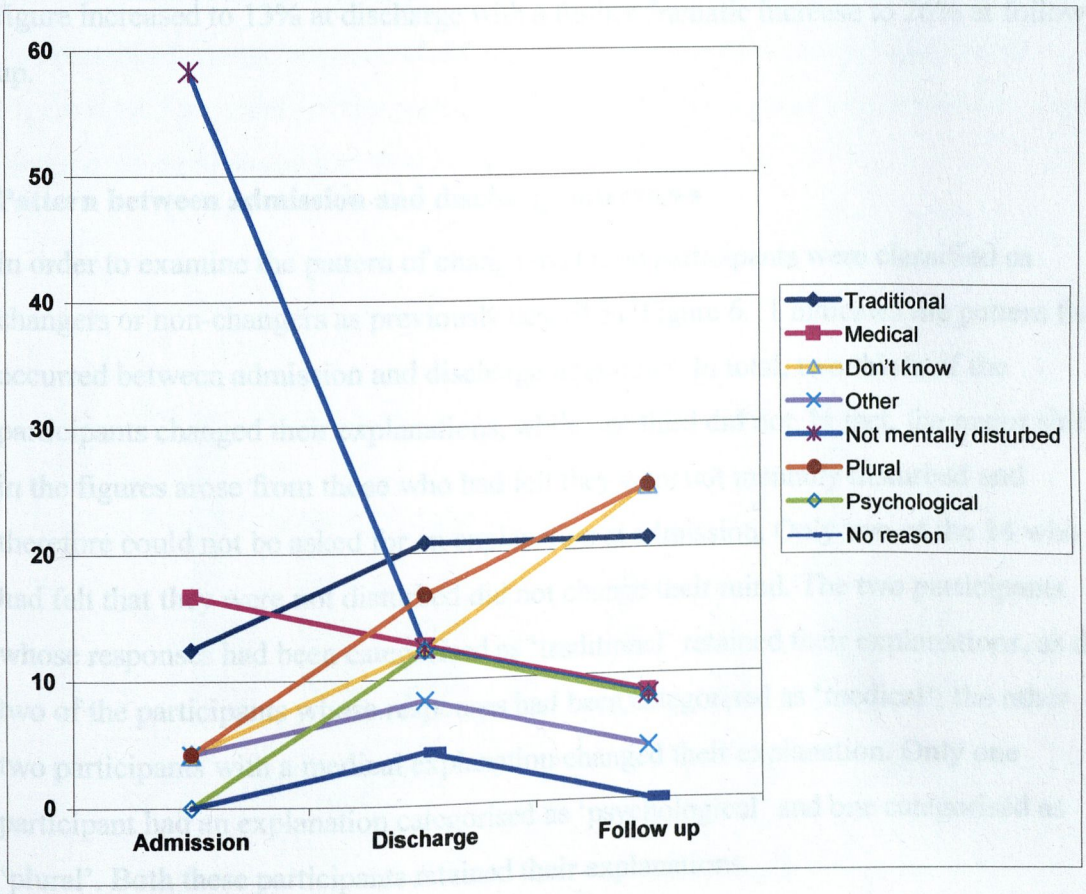

Figure 6.10: Pattern of explanation between admission, discharge and follow-up interviews

On admission, over half of the participants said that they were not mentally disturbed. This decreased over time, to 13% on discharge and 8% at follow-up. No explanation for mental disturbance was elicited from those who did not see themselves as disturbed. The most common explanation for mental disturbance on admission was a medical one (17%), however this explanation became less common overtime, with only half of the original percentage explaining their disturbance in those terms at follow-up. While the percentage of participants who gave a medical explanation decreased overtime, the reverse occurred with the traditional explanation. A traditional explanation was offered on admission by 12% of the participants, this increased overtime to a consistent 20% on discharge and 21% at follow-up. Explanations of disturbance in plural terms also increased overtime rising from 4% to 25% at follow-up. No participant explained their disturbance in psychological terms on admission, however 13% of participants did on discharge, with fewer (8%) using such an explanation at follow-up. Notably, while only 4% of participants did not know what could have caused their mental disturbance, this figure increased to 13% at discharge with a further dramatic increase to 26% at follow-up.

Pattern between admission and discharge interviews

In order to examine the pattern of change over time participants were classified as changers or non-changers as previously described. Figure 6.11 indicates the pattern that occurred between admission and discharge interviews. In total, two thirds of the participants changed their explanations, while one third did not. In fact, the major shift in the figures arose from those who had felt they were not mentally disturbed and therefore could not be asked for an explanation at admission. Only two of the 14 who had felt that they were not disturbed did not change their mind. The two participants whose responses had been categorised as 'traditional' retained their explanations, as did two of the participants whose responses had been categorised as 'medical'; the other two participants with a medical explanation changed their explanation. Only one participant had an explanation categorised as 'psychological' and one categorised as 'plural'. Both these participants retained their explanations.

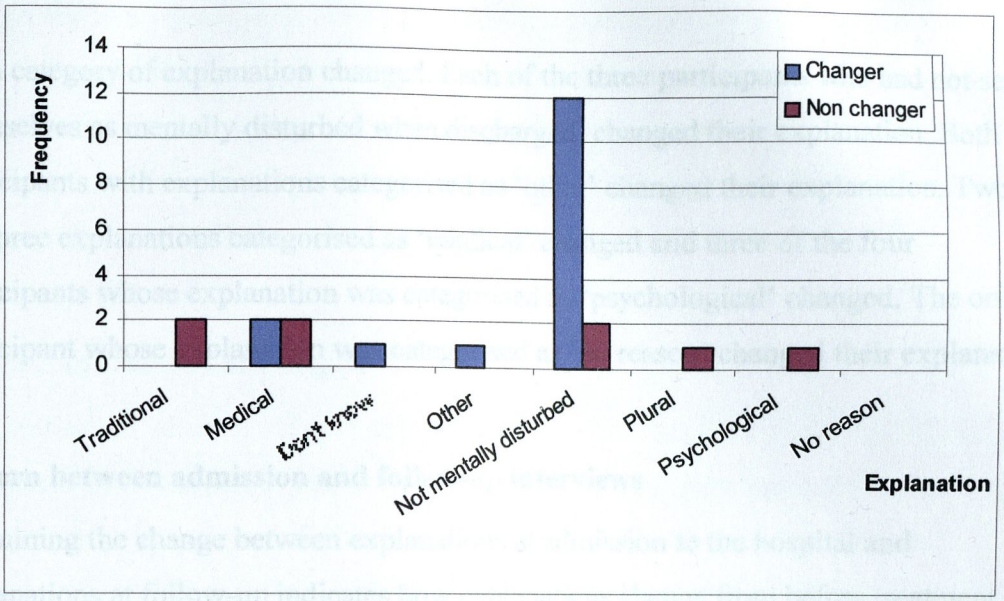

Figure 6.11: Number of participants who changed or did not change their explanation for mental disturbance between admission and discharge interviews

Pattern between discharge interview and follow-up interviews

The pattern of change between discharge and follow-up interviews is indicated in Figure 6.12. Two thirds of the participants changed their explanations, while one third retained the explanation they had in their discharge interview.

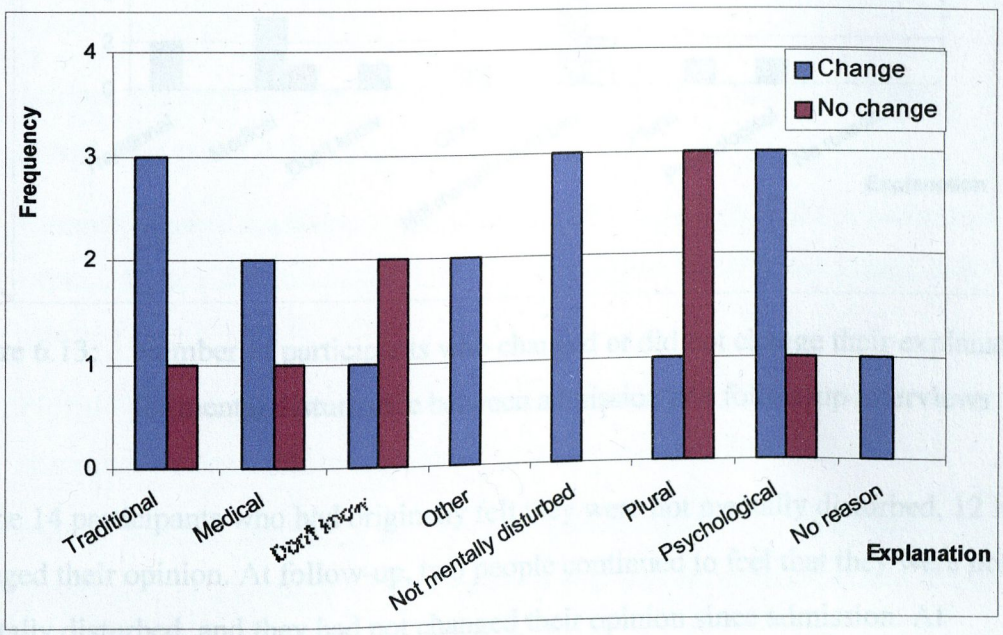

Figure 6.12: Number of participants who changed or did not change their explanation for mental disturbance between discharge and follow-up interviews

Each category of explanation changed. Each of the three participants who had not seen themselves as mentally disturbed when discharged, changed their explanation. Both participants with explanations categorised as 'other' changed their explanation. Two of the three explanations categorised as 'medical' changed and three of the four participants whose explanation was categorised as 'psychological' changed. The only participant whose explanation was categorised as 'no reason' changed their explanation.

Pattern between admission and follow-up interviews

Examining the change between explanations at admission to the hospital and explanations at follow-up indicates how explanations change from before treatment and after treatment. As can be seen in Figure 6.13 the vast majority of participants changed their explanation between admission and follow-up.

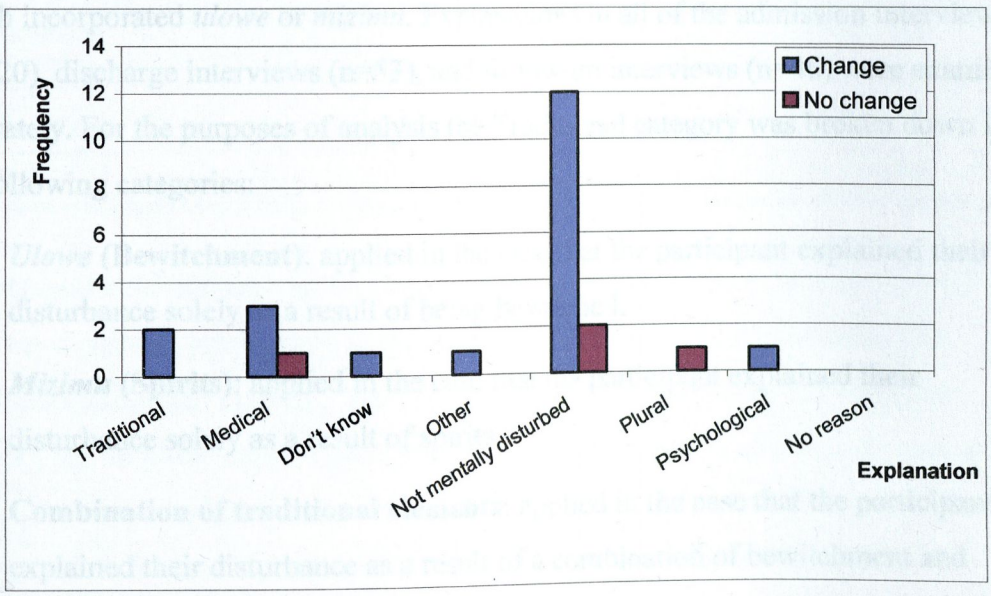

Figure 6.13: Number of participants who changed or did not change their explanation for mental disturbance between admission and follow-up interviews

Of the 14 participants who had originally felt they were not mentally disturbed, 12 had changed their opinion. At follow-up, two people continued to feel that they were not mentally disturbed, and they had not changed their opinion since admission. At admission the explanation given by four participants was categorised as 'medical', however three of those participants had changed their explanation by follow-up. The

only participant who in their admission interview did not know what the cause of their disturbance was changed to offering an explanation. One participant's explanation was categorised as 'psychological', which changed between the admission interview and follow-up interview. No explanation was categorised as 'No reason' at admission, that category was only introduced when it appeared in the discharge interviews.

Analysis of traditional category

An explanation which involves either *ulowe* (bewitchment) or *mizimu* (spirits) fills the criteria for the 'traditional' category. These causal agents share some commonality, for example, they are not part of a biomedical explanation for mental disturbance. However, they represent very different modes of becoming disturbed and the 'traditional' category glosses over this. For this reason analysis of this compounded category was carried out. Analysis was conducted on the explanations that were categorised as 'traditional' including the explanations that were categorised as 'plural' which incorporated *ulowe* or *mizimu*. Explanations in all of the admission interviews (n=120), discharge interviews (n=53), and follow-up interviews (n=46) were examined separately. For the purposes of analysis the Traditional category was broken down into the following categories:

***Ulowe* (Bewitchment)**: applied in the case that the participant explained their disturbance solely as a result of being bewitched.

***Mizimu* (Spirits)**: applied in the case that the participant explained their disturbance solely as a result of spirits.

Combination of traditional elements: applied in the case that the participant explained their disturbance as a result of a combination of bewitchment and spirits.

Plural/*Ulowe*: applied in the case that the participant explained their disturbance as a result of bewitchment combined with one or more additional causes.

Plural/ *Mizimu*: applied in the case that the participant explained their disturbance as a result of spirits combined with one or more additional causes.

Traditional explanations on admission: Of the total number of participant interviewed at admission (n=120), almost one fifth (19.2%) of participants' explanations were categorised as 'traditional' or incorporated a traditional cause. Table 6.28a shows the percentage of explanations that involved traditional elements.

Ulowe as a single factor is given as a cause of disturbance more frequently than *mizimu* and when plural/*ulowe* is incorporated, *ulowe* is clearly held responsible for a greater number of participants than *mizimu*. Only one participant explained their disturbance using a combination of *mizimu* and *ulowe*.

Table 6.28a: Frequencies and percentages of explanations categorised as traditional explanations at admission interview

Cause	Frequency	Percentage
Ulowe/Bewitchment	9	7.5
Mizimu/Spirits	7	5.8
Combination	1	0.8
Ulowe/plural	5	4.2
Mizimu/plural	1	0.8
Total	**23**	**19.1**

Traditional explanations on discharge: As indicated in Table 6.28b, of the total number of patients interviewed at discharge (n=53) 26.4% had explanations that included a traditional element. '*Mizimu'* as a sole cause were more common than '*ulowe'*, but no plural explanations included *mizimu*. Although *ulowe* alone accounted for 7.54% of the explanations, when combined with plural explanations, *ulowe* was seen as responsible for causing mental disturbance for 16.9% of the participants.

Table 6.28b: Frequencies and percentages of explanations categorised as traditional explanations at discharge interview

Cause	Frequency	Percentage
Ulowe /Bewitchment	4	7.54
Mizimu/Spirits	4	7.54
Combination	1	1.9
Ulowe/plural	5	9.4
Mizimu/plural	0	0
Total	14	**26.4**

Traditional explanations at follow-up interview: Of the total number of participants interviewed at follow-up (n=46) there was an increase in the number of participants interviewed who explained their mental disturbance in terms of traditional beliefs (34.9%) compared to discharge. Fewer patients were interviewed at follow-up than in either of the other groups. At follow-up '*ulowe*' is clearly a more common explanation than '*mizimu*', both as a single explanation as a plural explanation. The most common single explanation is '*ulowe*' accounting for 15.5% of the explanations, while '*mizimu*' as a plural explanation are the least common. These results are indicated in Table 6.28c.

Table 6.28c: Frequencies and percentages of explanations categorised as traditional explanations at follow-up interview

Cause	Frequency	Percentage
Ulowe/Bewitchment	7	15.2
Mizimu/Spirits	4	8.7
Combination	1	2.2
Ulowe/plural	3	6.6
Mizimu/plural	1	2.2
Total	**16**	**34.9**

Gender differences in explanations for disturbance

Given that the literature indicates that females are more likely to experience spirit possession, analysis of the gender differences in traditional explanations was conducted on the participants who were interviewed on admission, discharge, and follow-up.

Table 6.29: Gender breakdown among participants who indicated a traditional explanation on admission

Gender	*Ulowe*	*Mizimu*	Combination	*Ulowe* / plural	*Mizimu*/ plural	Total
Female	3	5	1	0	0	**9**
Male	6	2	0	5	1	**14**

Table 6.29 compares traditional explanations given by males and females on admission. In total, 23 participants responded with traditional explanations. More males (14) indicated a traditional belief compared to nine females. Notably female participants did not employ plural explanations. *Mizimu* as an explanation was more frequently indicated than *ulowe* by females. In contrast, *ulowe* was the most frequently explanation indicated among male participants and appeared in both the singular and plural explanations.

Table 6.30: Gender breakdown among participants who indicated a traditional explanation on discharge.

Gender	*Ulowe*	*Mizimu*	Combination	*Ulowe* / plural	*Mizimu*/ plural	Total
Female	2	2	1	1	0	**6**
Male	2	2	0	4	0	**8**

In total, 14 participants indicated a traditional explanation, which is 26% of all participants. As can be seen in Table 6.30, more males than females offered a traditional explanation. Consistent with the figures for admission, no females had a plural explanation, which involved *mizimu*, however some differences are apparent. In this case, one female had a plural explanation which involved *ulowe*. In total, when both single and plural explanations of *ulowe* are combined, *ulowe* constitutes half of the explanations, a single explanation of *mizimu* makes up the remainder.

Males use *ulowe* as an explanation more often than females, in total six men employed it as an explanation. Only two men used *ulowe* alone, the remainder were part of a plural explanation. Interestingly, no males incorporated *mizimu* into a plural explanation on discharge. Equal numbers of men and women employed *mizimu* as an explanation.

Table 6.31: Gender breakdown among participants who indicated a traditional explanation at follow-up.

Gender	*Ulowe*	*Mizimu*	Combination	*Ulowe* / plural	*Mizimu*/ plural	Total
Female	3	3	1	0	0	7
Male	3	1	0	4	1	**9**

As can be seen in Table 6.31, 16 participants in total had given a traditional explanation at follow-up. This accounts for 34.9% of all participants in the total sample. This figure represents an increase on the figures at discharge. No females had a plural explanation involving a traditional explanation. Unlike the figures at admission and on discharge, more women have an explanation of *ulowe* than *mizimu*. As before, there is a greater distribution of explanations among males than women. *Ulowe* is clearly the most frequent explanation offered.

Summary

A brief summary is given here of the information contained in the quantitative analyses of the explanations for mental disturbance, as the section is quite extensive, containing a large amount of descriptive statistics. On admission, almost half the participants did not see themselves as mentally disturbed, however this figure decreased dramatically amongst those interviewed at discharge, and at follow-up. As this percentage decreased those who offered an explanation increased. Despite the fact that the participants were being treated for mental disturbance in a biomedically orientated service, the percentage of those who explained their disturbance in terms of a medical explanation remained low from admission to follow up, even decreasing slightly from 10% on admission to 8 % on follow-up. Conversely, those with a traditional explanation outnumbered those with a medical explanation and continued to increase over the course of the interviews. The percentage of participants who did not know what had caused their mental disturbance also increased substantially over time. Plural explanations, which were not common on admission also increased between admission and discharge, and follow-up. Similar trends were found in the longitudinal sample, although there were initially more participants who cited a medical explanation that, as with the other sample decreased over time. The majority of those who felt they were not mentally disturbed at admission changed their explanation.

Further analysis of the traditional category show that 19.2% of the participants on admission have a traditional explanation, or one that incorporates a traditional explanation; this figure increases to 26% at discharge and rises again to 34.9% at the follow-up interview and that a greater proportion of males cite a traditional explanation. *Ulowe* (as both a sole explanation and as part of a plural explanation) was consistently more common. A greater proportion of males cite *ulowe* as an explanation for mental disturbance, although interestingly the proportion of females citing *ulowe* increased at follow-up.

Chi-square analyses suggest that the ethnicity of the interviewer did not influence the explanation given by the participant. It appears that there is an association between the type of explanation offered by a participant at admission and whether they are present at follow-up.

EXPLANATIONS FOR MENTAL DISTURBANCE: QUALITATIVE ANALYSIS

Introduction

Qualitative analysis was conducted on transcripts of interviews in accordance with grounded theory. Thirteen distinct themes emerged. These themes expand upon the *a priori* categories on which the quantitative analysis was conducted. Some of the original categories correspond directly to themes, such as 'Plural' explanations and 'Don't Know'. Some themes separate the original category, into more meaningful themes. 'Traditional' has been split into '*Mizimu*' (Spirits) and '*Ulowe*' (Bewitchment). 'Medical' has been divided into 'Physical Injury', '*Chamba*', 'Excessive Alcohol', and 'Hereditary'. The original 'Psychological' category has been renamed in keeping with the vocabulary used by the participants to 'Thinking Too Much', but essentially contains exactly the same information. The miscellaneous category of 'Other' in quantitative analysis subsumes a diversity of explanations which are deserving of their own theme: 'Caused by God', 'Natural', 'Third Party understanding' and 'Indecision'.

These themes are presented here. In keeping with the guidelines for presenting qualitative analysis (Elliott, Fischer & Rennie, 1999), I have provided examples of the data for each of the themes that emerged. Quotations from participants are drawn from

admission, discharge and follow-up interviews. Each quotation is accompanied by a code, allotted to each participant. Demographic information is available for each participant in Appendix P. Participants are listed alphabetically according to the first initial ascribed to them. A list of the themes and the corresponding explanation for each can be found in Appendix R.

Three replies to the question "What do you think caused your mental disturbance?" were quite conspicuous, and gave me, as the researcher an important perspective from which to consider the analysis.

- "That's a very difficult question to answer" (Th.K.)
- "It's a simple question but somehow tough, because it could be so hard for me to say this was that, I don't know the foundation" (K.N.).
- "I don't know it, do you?" (E.C.)

Perhaps some of the participants had never thought about what the cause of their mental disturbance could be, or had never been asked before; this may have been their first time to verbalise their opinion. The following themes emerged.

***Ulowe* (Bewitchment)**

Some participants simply stated that that their mental disturbance was a result of bewitchment: "I am being bewitched by people" (F.Z.) while others were more specific, indicating the person who was responsible for the bewitchment as the following example shows: "My co-wife has bewitched me" (C.B.).

Some participants were quite oblique about the cause and without understanding the cultural context it would be easily misunderstood: "I fell ill because some people threw medicine on my fire" (L.N.). This is a typical method used by co-wives to bewitch each other.

Bewitchment resulting from jealously was prevalent. This explanation provides a good illustration of bewitchment based on jealously: "The one who bewitches me is unknown but I suggest it is because at home we have a lot of cattle which they want to inherit and

pay *lobola*[42] for their wives … and I shouldn't have a part". When asked if there was any other reason he replied: "Yes there might be another reason: because I am at school most people wish I would be speaking Tumbuka and so that I might forget about school" (A.Ng.). The insinuation here is that it is a member of his family who has bewitched him so they may inherit the cattle. A.Ng. believes that the fact that he is receiving education and speaking English is a further reason for his bewitchment.

This participant explains how she was bewitched because someone, who remains unidentified, wanted to improve their business and required a *chizimba* to make the *mankhwala* effective. She believes they used her brain as the *chizimba*: "I really think that if a person has removed your brain from the head, can the head function properly?" She further explains that: "The one who took the brain wanted to use it in his *mistali* (business). We have revenged it with *mankhwala* we got from the *sing'anga* so that he shouldn't play [interfere] with us … I have really been bewitched" (L.G.). Furthermore, she sought revenge, which attests to the strength of her belief. The bewitchment of one person so that another person can advance, such as described above occurred frequently.

To conclude, the answer given by one participant illustrates a core issue regarding bewitchment being seen as a cause of mental disturbance: "To me, I think as an African, sometimes we Africans believe in witchcrafts, so according to my customs, I think I was bewitched" (C.C.).

***Mizimu* (Spirits)**

The role of spirits in becoming mentally disturbed emerged as a theme. For some participants it was clearly spirits who were instrumental in causing disturbance, as illustrated by this quotation: "Nothing apart from *mizimu.*" had caused her mental disturbance. But explanations are not expanded upon. More explicit explanations are offered by others: "My mother's spirits, when they haven't been attended to ceremoniously, one is likely to fall ill mentally" (V.M.). Furthermore, the explanation offered by some participants allows an insight into their current life situation. A good

[42] Paying *lobola* to the parents of a girl who is getting married is a custom in Northern Malaŵi, which is described by Msiska (1998) as a sign of gratification and thankfulness as well as an honour to the parents of the girl.

example of this is provided by M.Nl., who is firm that she is not mentally ill but is suffering from *vinthenda*. She describes how her *vinthenda* is caused by "my *mizimu ya agogo* were coming to me saying that I should prepare the gramil[43] flour for them. And I have done that." She maintains that her *mizimu ya agogo* are the cause of her *vinthenda* and have told her they will not be satisfied (she will remain disturbed) until her husband has provided her with a new black and white uniform for the Apostolic Church. She says: "Mr. C., my husband does not fulfil my demands. He can't buy me the uniform and a sandal like that girl dressed in brown so that I can look smart. This is what the spirits have told me to do in order to satisfy them", and she continues: "I've failed to get better the possible way [preparation of flour for *mizimu*]. I … can get cured if the uniform can be bought, then I can get better. That's what the spirits tell me". This is an unusual request for *mizimu* to make, but it would appear that the issue of uniform holds some significance for her, and offers an avenue for further exploration of her life situation.

It is clear that although the root cause for disturbance is understood to be *mizimu*, different participants have different interpretations of the role *mizimu* play.

***Maghanoghano chomene* (Thinking too much)**

Thinking too much or worrying was a common theme. Some participants simply said they were worried, without stating the reason: "I was thinking too deeply. I was worried and thinking too much" (H.J.). Excerpts from the interviews such as those that follow characterise the theme of thinking too much: "I was thinking deeply, my father was neglecting me; he couldn't buy me clothes, so I was thinking of means of helping myself" (H.L.) and "I was thinking too much about school. I wanted to be in a better positioning in the near future. I was reading too much" (H.Lu.). Some participants did not offer any particular problem, which they were preoccupied with: "They [thoughts] confused my brain" (J.P.). One man, whose face had been disfigured, identifies a number of areas in his life, which causes him to think about too many things: "I feel that my face has changed and that is making me feel depressed. Because I'm grown up, I am facing reality. Actually, because I have a new life where I think about many things, how to make my family happy, how to make myself happy, but I end up being depressed" (S.C.). On the other hand, some participants have quite a complex view of how thinking

[43] Gramil is a brand of maize flour used for making *nsima* which is staple diet in Malawi.

too much can result in mental disturbance. One woman relates that there have been pressures in her life that began a long time ago and have been accumulating without her realising. She continues: "The pressures I am talking about have affected the whole body … The brain must be affected very much, because if what I am saying is a psychological thing, it must cover the brain because the thinking capability and everything we do is controlled in the brain … So, it can't happen that the brain cannot be affected" (G.C.).

Within this theme, the range of explanations varies between those who simply stated that they had been thinking too much and those who expand, specifying the issues that have been thinking about too much, causing them to become mentally disturbed. Furthermore, some participants explain the role that thinking too much played in causing their mental disturbance.

Physical injury

Several participants felt that their disturbance was a result of a physical injury to their brain. Excerpts from three interviews highlight the various conceptualisations participants have about the brain, and the manner in which physical damage can result in mental disturbance: "I am here because my friend pushed me down in a fight that I damaged my medulla oblongata. So I did not feel OK, I felt weak. I was also mentally disturbed" (B.N.).

B.N.'s explanations, naming a specific part of the brain contrasts with J.Mp.'s explanation which loosely identifies areas of the brain with specific functions. "I think it is the accident that caused damage to my brains, and damaged the part that that makes it either intelligent or dull" (J.Mp.). A further example that also has a biological slant is provided by this participant. "Yes, I had an accident. I had some head injuries when I fell from my motor cycle …. Blood ran inside my head but did not go to the brain" (T.M.).

Although each of participants shares the same broad cause of their disturbance each has a different understanding of how the brain becomes affected.

***Chamba* (Marijuana)**

Smoking *chamba* was believed by some participants to have caused their mental disturbance. Some participants simply state that they think *chamba* has caused their disturbance: "Now that I am OK, I am quite certain it was because of *chamba*" (J.K.), "Since this was my tobacco I used to smoke from morning to evening, thus up to 20–30 cigarettes a day" (D.P.). One participant explains how gradually smoking *chamba* began to cause him problems: "It [mental disturbance] all started because I was smoking *chamba*. At first my head was functioning properly, but that was 1972. But around the 90s I saw that it was more powerful on me. And in 1993, the confusion started to be too much" (G.T.). Another participant describes how *chamba* has had a direct result on his brain: "… it could be a mental illness because I am having some clotting in my brain because I was smoking *chamba*, I have got some depositions of protein in my head" (B.P.).

Another participant clarified how *chamba* affected him: "First of all the bad effect was on my brain, because my brain could not function properly …. After taking *chamba* I felt some other powers. It was eating my brain." When asked for clarification on what was meant by eating his brain he said: "Simply it was damaging my brain. The power of *chamba* was bad on me, it was disconnecting my brain" (C.M.).

These excerpts illustrate the range of explanation within this theme. Some participants merely acknowledge it is *chamba* while others have a more complex, quite biological interpretation regarding the effect of taking *chamba*.

Excessive alcohol

Some participants felt that drinking alcohol excessively was responsible for causing their mental disturbance. The responses were fairly standard, for example: "Too much drinking of beer. I was drinking too much alcohol" (L.M.) and "There's no other reason apart from drinking beer because I don't smoke. I think the causer is drinking beer excessively" (J.N.). No participants provided an explanation for how excessive alcohol could cause mental disturbance.

Hereditary

Several participants understood the cause of their disturbance as a result of being passed through the family, as illustrated in the following quotations: "I don't think of any cause but I have taken it after our family members since my grandfather is a mental case. So, I can also be a mental case. Since I am his grandson I must have taken after some of his character" (M.Mv.) and a second example: "... it is just hereditary because in the family especially in my mother's, there are these psychological disorders" (Ju.M.).

It was observed however that this was more often incorporated into a plural explanation than offered as a single explanation.

Don't know

Not knowing what has caused their illness is a predicament common to many participants. Little variation existed among the responses in this theme, as can bee seen in the following quotations: "I can't know how it started. I just know that I am sick" (J.Mt.), "I can't know that, I just found myself admitted" (C.J.) and "I can't know I just found myself having a severe headache" (C.G.).

Natural

This is an uncommon theme amongst the participants. Responses that illustrate this theme are: "I think it is natural, I don't think and I can't say it is caused by such and such a thing, but it is natural" (Mv.M). "What caused it was that I was just staying for a long time and the illness found me" (H.Lu.). "There is nowhere I think I got this illness" (F.N.). So although these patients acknowledge that they are disturbed, this theme indicates that these participants see themselves as having played a very passive role in becoming mentally disturbed, in contrast with some of the other explanations which suggest specific agents as the cause of the disturbance. Furthermore, it is not that they do not know what caused their disturbance, they view it as something that just happened to them.

Caused by God

This was not a very common theme among the participants. For some participants they felt that it was simply God's wish: "It's his [God's] wish" (V.M), "It's God who is giving us bad fortune" (L.G.). Among some of the responses there was a definite

element of retribution involved. For example: "The mental disturbance comes from God. He strikes me because he wants me to abstain from my bad ways" (H.K.) and another example: "What caused this mental illness I am quite sure it's 'encouragement' so that I should be at a better stand. This happened because I stayed a long time without building an iron-roofed house and without paying *lobola* for my wife. This was all encouragement from God, so that I should pay quickly through mental illness" (H.Ls.).

It can be seen that participants hold two different interpretations for the role God has to play in causing mental disturbance. Some participants see their disturbance as his wish, while others understand that it is retribution for misdemeanours.

Plural explanations

This theme represents amalgamations of different causes of mental disturbance, which are employed by participants to explain their disturbance. While three examples are included here, a variety of other combinations existed in the responses of the participants.

L.Z. describes himself as a schizophrenic and offered an interesting combination of explanation, juxtaposing a biological genetic explanation of how the spirit illness *vimbuza* has been passed on to him. In addition, he includes God in his explanation: "The first thing is heritage, hereditary, because my mother too was schizophrenic or something like schizophrenia, she was one of the dancing party that we called *vimbuza* or *maskawi*. He continued, referring to the hereditary element: "Yes, hereditary, passed on to me through the genes of the parents. Apart from that it is not all that does that … I think it's because of my forefathers' spirits are speaking through me and thirdly, Jehovah the Almighty has been speaking and appearing to me, saying that what you are suffering from is me" (L.Z.).

A combination of smoking *chamba*, drinking too much alcohol, and bewitchment is J.K.'s explanation of how he became mentally disturbed. His explanation of bewitchment describes how he believes he became bewitched, although the *mankhwala* had been intended for his mother, the first wife of his father. The second wife wanted to bewitch the first wife to become mad, her hope being that her husband would then divorce his first wife. The *mankhwala* worked, but the second wife failed to remove the *mankhwala* and it also caused the mental disturbance of J.K.

> In the first place, it is because I smoke *chamba* and I drink too much. Secondly, I have been bewitched by my stepmother. Because my real mother is the first wife, the second wife had forgotten the *mankhwala* that was used to bewitch my mother too. So she is also mad in order to divorce my father. So, we are living with our stepmother. This is why I believe I have been bewitched. (J.K.)

One participant summed up the causes of her disturbance very succinctly: "One it is hereditary, two it is my workmates[44] and three it is stress."

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[44] Referring to bewitchment by workmates. It transpired later in the interview that she experienced their "growing enmity" and believed that they had given her poison – *mankhwala* for bewitchment.

Indecision

One of the issues that presented difficulties in the quantitative analysis that could be addressed in the qualitative analysis was the issue of indecision. Some of the participants mentioned a range of possible causes but were not sure which, if any, were responsible for their disturbance. I have included extracts from two interviews, as to accurately illustrate this theme requires more than just a quotation:

KS: Any idea of the cause?

KC: Maybe thinking too much.

KS: About what?

KC: The problems that come my way and how to solve them.

KS: Is there any other reason apart from thinking too much?

KC: Maybe bewitchment, but I doubt.

KS: Why do you think maybe bewitchment can be the cause?

KC: Because I was at school maybe.

This participant is unsure about both thinking too much and bewitchment as causes for his illness. The second extract is slightly more complex:

CM: I feel that I was mentally disturbed and also, I feel that African witchcraft has taken advantage of me because this is my fourth time to suffer from the same disease. So it must be birthright, maybe I adopted it from somebody else, but other people have taken advantage.

KS: So you think you have been bewitched?

CM: Yes, not really. I feel I have adopted a certain father. Because my grandfather was mentally disturbed or else people have taken advantage of me.

KS: How do you think your grandfather could have passed that on to you?

CM: Blood.

KS: What word in chiTumbuka would you use to describe a mental disturbance which has been passed on by blood?

CM: *Kupokera* or *Kwambala, kukozga*, that's passed through blood.

KS. Thank you. So you think you must have got your mental disturbance because your grandfather passed it on by blood or you have been bewitched?

CM: Actually, I have not proved that whether it's adoption or witchcraft.

It is clear that this participant is hovering between bewitchment and the mental disturbance having been passed on by blood, unsure which it is.
These explanations are distinct from plural explanation, as they are undecided as to what is responsible for their mental disturbance, whereas in a plural explanation, different factors are seen as working together to result in mental disturbance.

Third party understanding

The theme 'third party understanding' emerged as it became clear that not all participants have their own opinion about the cause of their mental disturbance. An example which illustrated this theme very well is that of one participant who did not know what had caused her illness as her family hadn't told her what they thought had caused it. Another participant said this by way of explanation: "I don't know, but at home, they say it is because of thoughts" (S.M.). Other participants offered the explanation given to them by traditional healers. For example, M.K. said "We went to a traditional healer who said I was bewitched." Whereas L.C. is less specific: "... people are saying it's the people who made me like this because they don't want me to be learned[45]."

None of these participants own the explanations they give. They are based on the opinions of other people, be they family, *wasing'anga*, or unspecified 'people'.

SUMMARY

Presented in this section are the 13 themes that emerged through qualitative analysis. As commented at the outset, asking someone who is suffering from a mental disturbance for an explanation of the cause of their disturbance is a difficult question if they have never given this question any thought. However, the breadth of explanations offered

[45] Reference to bewitchment

suggests that many of the participants had already given this some consideration. Qualitative analysis was initiated as I felt that predetermined categories did not accurately represent the explanations of the participants. The multiplicity of explanations offered by the participants is very evident on exploration of the themes, highlighting how the initial categories subsume the important differences between explanations. However, perhaps what is most striking from examining these themes is not the diversity of themes, but the different levels of understanding of the role of the causal agents held responsible for mental disturbance within each of the themes, and how it reflects the socio-cultural context from which it arises. Responses of those who believed *chamba* caused their mental disturbance illustrate the different levels of explanation reported by participants. While the majority felt that *chamba* just caused it, others had formed a picture of how *chamba* was causing damage to their brain. The theme of bewitchment will be used to illustrate how the socio-cultural context of the participant becomes apparent. Some participants simply felt that they had been bewitched but had no further explanation, while some participants elaborated further explaining how or why they had been bewitched, by their co wife or through jealousy. Such information is very helpful in understanding the social situation of a patient in hospital, and the understanding that the patient has of their own social circumstances. Dismissing such information given in a clinical history in the hospital, as it falls outside the purview of the biomedical realm, means that those treating the disturbance are at risk of neglecting important information. Furthermore, judging a patient as having a delusion of persecution based on this information, without taking the cultural context into consideration could lead to misdiagnosis. Patients who believe that their disturbance has been caused by *mizimu ya agogo* are at similar risk of being judged as having auditory hallucination, and the important information about their social situation ignored.

The theme 'third party understanding' illustrates the extent of the role the family and others have not only in caring for the sufferer but also in their understanding of the cause of their mental disturbance.

PART THREE: IMPROVEMENT OF MENTAL HEALTH

Research questions

This section addresses the following research questions:

- Does the mental health of patients admitted to the hospital improve while they are hospitalised?
- Do explanations held by patients regarding the cause of their illness impact on the improvement of their mental health?
- If improvement occurs, is it maintained post discharge?

In order to address these questions two rating scales were developed as described in Chapter Five. The scales assess how participants' well-being improved between their admission interview, discharge interview and follow-up interview. The rating scales' measure Strength of Evidence for Emotional Well-being and Strength of Evidence for Cognitive Well-being. They will be referred to as Emotional Well-being Scale (EWS) and Cognitive Well-Being Scale (CWS) for ease of reference. The results from the analysis are presented in four sections. Firstly, the inter-rater reliability for each of the scales is considered. Results pertinent to each of the three research questions are then presented.

Inter-rater Reliability

Inter-rater reliability was calculated for each scale using percentage agreement. Percentage agreement between the raters for the interviews at admission, at discharge, and follow-up for both scales can be seen in Table 6.32.

Table 6.32: Percentage agreement for two raters on EWS and CWS for admission, discharge, and follow-up interviews

	Admission	Discharge	Follow-up
EWS	92%	95%	98%
CWS	78%	72%	98%

Note: These figures have been rounded to the nearest whole number

As indicated on Table 6.32 percentage agreement on the EWS was 92% for admission interviews, 95% for discharge interviews and 98% for follow-up interviews between two or more raters. Inter-rater reliability was highest for follow-up interviews. For the

EWS percentage agreement between two or more raters was 78% for the admission interview, 72% for the discharge interviews and 98% for follow-up interviews. Inter-rater reliability was highest for follow-up interviews. A notable difference exists in percentage agreement at admission and discharge on the different rating scales, however the percentage agreement was exactly the same at follow-up. Comparatively, the percentage agreement was higher on the CWS at both admission and discharge.

Inter-rater reliability: Concordance between disciplines

***Emotional Well-being Scale* (EWS)**

As each of the three raters were trained in a different discipline it is of interest to consider the agreement which exists between each of them. Table 6.33 indicates the breakdown of the agreement between raters on the EWS for admission, discharge and follow-up interviews. Raters are identified by the discipline in which they are trained in i.e.: Medical Anthropology, Psychiatry, and Psychology.

Table 6.33: Percentage agreement on strength of EWS for admission, discharge and follow-up interviews

	Admission	Discharge	Follow-up
Agreement between each discipline	40	51	40
Psychology & Medical Anthropology	15	16.4	20.9
Psychology & Psychiatry	17	20	20.9
Psychiatry & Medical Anthropology	20	7.3	16.3
No agreement between any discipline	8	5.5	2.3

As can be seen from Table 6.33 percentage agreement at admission and discharge was constant at 40%, increasing to 51% at discharge. The percentage of disagreement was very low, decreasing over time from 8% to 2.3%. Considering inter-rater agreement between two raters the following patterns emerged:

Psychiatry and Medical anthropology had the highest agreement on admission (20%), psychology and psychiatry (20%) on discharge and both psychiatry and medical anthropology had equal agreement rates with psychology (20.9%). The lowest agreement between pairs was with medical anthropology and psychology on admission (15%), medical anthropology and psychiatry on discharge (7.3%) and follow-up (16.3%).

***Cognitive Well-being Scale* (CWS)**

Percentage agreement between the raters for cognitive well-being at admission, discharge and follow-up interviews is shown in Table 6.34.

Table 6.34: Percentage agreement on evidence of CWS at admission, discharge and follow-up interviews.

% Agreement	Admission	Discharge	Follow-up
Agreement between all disciplines	17.4	18.8	21.4
Psychology & Medical Anthropology	26.1	28.3	35.7
Psychology & Psychiatry	16.5	17	26.2
Psychiatry & Medical Anthropology	18.3	7.5	14.3
No agreement between any discipline	21.7	28.3	2.4

Complete agreement was lower on the CWS than on the EWS, although agreement increased over time ranging from 17.4% at admission to 21.4% at follow-up. No agreement between raters was relatively high in comparison with the ratings for EWS, increasing from 21.7% at admission to 28.3% at discharge and dramatically falling to 2.4% at follow-up. There was more agreement between psychology and medical anthropology on admission (26.1%) on discharge (28.3%) and follow-up (35.7%) than any other combination of pairs. Psychology and psychiatry had the poorest agreement at admission (16.5%) anthropology and psychiatry at discharge (7.5%) and follow-up (14.3%).

As both EWS and CWS are ordinal scales, the mean ratings given by each rater cannot be calculated and compared. The median, mode and range of each of the raters at each interview time for both scales are displayed in Tables 6.35 to 6.37.

Table 6.35: Median, mode and range of scores given by each of the raters for admission interviews for the total sample

	Medical Anthropology	Psychiatry	Psychology
EWS			
Range	1-4	1-5	1-4
Median	2	2	2
Mode	2	2	2

	Medical Anthropology	Psychiatry	Psychology
CWS			
Range	1-5	1-5	1-5
Median	1	2	2
Mode	1	2	1

Table 6.35 shows that the range of scores is wider for cognitive well-being than emotional well-being on admission. Neither the rater trained in psychology nor medical anthropology rated any participant as showing 'evidence of a severe emotional disturbance' throughout the interview. The median and mode are consistent for all raters on the EWS, indicating 'no evidence of emotional well-being or emotional disturbance'.

There is less consistency for the median and mode for cognitive well-being on admission. Both the median and mode ratings from the rater with a background in medical anthropology are the highest possible rating on admission, indicating 'no evidence of emotional disturbance'. The median and mode ratings from the rater with a background in psychiatry are slightly lower.

Table 6.36: Median, mode and range of scores given by each of the raters for discharge interviews for the total sample

	Medical Anthropology	Psychiatry	Psychology
EWS			
Range	1-3	1-3	1-4
Median	2	2	2
Mode	2	2	2
CWS			
Range	1-5	1-5	1-4
Median	1	2	1
Mode	1	2	1

Table 6.36 shows the range, median and mode of ratings given by each rater, for both scales on discharge. The range of ratings is slightly narrower at this point than on admission for the EWS. The rater with a background in psychology has a slightly broader range than the other two raters. The median and mode are consistent, both the

median and the mode for each rater indicating 'no evidence of emotional well-being or emotional disturbance'.

The range of ratings is broader for the CWS, the full range is employed by two of the raters. Overall, the median and mode ratings are lower on the CWS than EWS, although the median and modes are equal on both scales for the rater trained in psychiatry. The median and modes of the raters trained in psychology and anthropology indicated 'evidence of cognitive well-being'.

Table 6.37: Median, mode and range of scores given by each of the raters for follow-up interviews for the total sample

	Medical Anthropology	**Psychiatry**	**Psychology**
EWS			
Range	1-2	1-3	1-3
Median	2	2	2
Mode	2	2	2
CWS			
Range	1-4	1-5	1-5
Median	1	2	1
Mode	1	2	1

Table 6.37 shows the ratings given by each rater on both scales for the follow-up interviews. The range of ratings for the EWS is narrower than in previous interviews. The mean and mode are consistent across all raters, indicating 'no evidence of emotional well-being or emotional disturbance'.

The range of ratings given by the raters with a background in psychiatry and psychology extend from the highest rating to the lowest rating on the CWS. As with the admission and discharge interviews, median and mode ratings from the rater trained in psychiatry are lower than either of the other two raters. The mean and mode ratings are for the raters with a background in medical anthropology and psychology are ' no evidence of cognitive disturbance'. The median and mode of the ratings given by all of the raters for the EWS are constant and correspond to 'no evidence of emotional well-being or disturbance'.

In summary, the median and the mode of the ratings given by the raters trained in psychology and anthropology are significantly higher than those given by the rater trained in psychiatry on the CWS.

In order to ascertain whether a difference existed between the ratings given at admission, discharge and follow-up the Friedman test was conducted for each of the raters. The results are shown in Table 6.38.

Table 6.38: Difference in ratings across interviews for each rater for EWS and CWS

Background of Rater and Scale	$\chi 2$	df	p
Medical Anthropologist EWS	10.302	2	.006
Medical Anthropologist CWS	10.667	2	.005
Psychiatrist: EWS	8.419	2	.015
Psychiatrist: CWS	7.645	2	.022
Psychologist: EWS	4.962	2	.085
Psychologist: CWS	4.962	2	.085

The ratings given by the medical anthropologist and psychiatrist were significantly different across the three interviews on both the EWS and CWS (see Table 6.38). The ratings given by the psychologist were approaching significance, across the three interviews for the EWS or the CWS.

The Wilcoxon Test was conducted to ascertain whether significant differences existed between the ratings given between admission and discharge interviews, discharge and follow-up interviews and admission and follow-up interviews for each rater. Table 6.39 shows that ratings by the medical anthropologist on EWS were higher at discharge than admission (Wilcoxon Test, $z= 2.811$, $p=.005$) and higher at follow-up than admission (Wilcoxon Test, $z = 2.855$, $p< .004$). Ratings on the CWS were higher at discharge than admission (Wilcoxon Test, $z= 2.511$, $p < .02$) and higher at follow-up than admission (Wilcoxon Test, $z = 3.616$, $p<.01$). There was no significant difference found in the ratings between discharge and follow-up on either EWS or CWS.

Table 6.39: Difference in ratings given by medical anthropologist between each interview for EWS and CWS

	z	p
Medical Anthropologist EWS		
Admission-Discharge	2.811	.005
Discharge-Follow-up	1.184	.236
Admission-Follow-up	2.855	.004
Medical Anthropologist CWS		
Admission-Discharge	2.511	.012
Discharge-Follow-up	.816	.414
Admission-Follow-up	3.616	.001

Table 6.40 shows that the ratings by the psychiatrist on EWS were significantly higher at discharge than admission (Wilcoxon Test, $z = 3.174$, $p < .002$) and higher at follow-up than admission (Wilcoxon Test, $z = 2.872$, $p < .004$). Ratings on the CWS were higher at discharge than admission (Wilcoxon Test, $z = 3.369$, $p < .001$) and higher at follow-up than admission (Wilcoxon Test, $z = 2.933$, $p < .003$). There was no significant difference found in the ratings between discharge and follow-up on either EWS or CWS.

Table 6.40: Difference in ratings given by psychiatrist between each interview for EWS and CWS

	z	p
Psychiatrist EWS		
Admission – Discharge	3.174	.002
Discharge – Follow-up	.707	.480
Admission – Follow-up	2.872	.004
Psychiatrist CWS		
Admission –Discharge	3.369	.001
Discharge – Follow-up	.616	.538
Admission – Follow-up	2.933	.003

Table 6.41 shows that ratings by the psychologist on EWS were significantly higher at follow-up than admission (Wilcoxon Test, $z = 1.069$, $p = .05$) but were not significantly different between admission and discharge or discharge and follow-up. Ratings on the CWS were higher at discharge than admission (Wilcoxon Test, $z = 2.129$, $p < .033$) and

higher at follow-up than admission (Wilcoxon Test, $z = 2.502$, $p < .012$). No significant difference was found between discharge and follow-up.

Table 6.41: Difference in ratings given by psychologist between each interview for EWS and CWS

	z	p
Psychologist EWS		
Admission – Discharge	1.674	.094
Discharge – Follow-up	1.069	.285
Admission – Follow-up	1.069	.050
Psychologist CWS		
Admission – Discharge	2.129	.033
Discharge – Follow-up	.637	.524
Admission – Follow-up	2.502	.012

Summary

The Wilcoxon Test reveals that the ratings given by the raters with a background in medical anthropology and psychiatry were found to be significantly higher between admission and discharge interviews on both scales. No significant difference was found between the ratings given by the rater with a background in psychology on either scale between admission and discharge. No significant difference was found between ratings given by any of the raters between discharge and follow-up interviews. Significant differences were found between ratings given by each of the raters at admission and follow-up.

Changes in emotional and cognitive well-being

In order to ascertain whether an improvement occurred while participants were hospitalised (between admission and discharge interviews) and if improvement was maintained post-discharge (between discharge and follow-up interviews and admission and follow-up interviews), the participants were classified in the following way:

"**Improvement**" if two or more raters' scores indicated an improvement in well-being

"**Decline**" if two or more raters' scores indicated a decline in well-being

"**No change**" if two or more raters indicated no change in well-being

"No agreement" if there was no concordance between three raters' scores (e.g. one rater's score indicated a decline, another no change and a third an improvement).

Participants who received a rating of '1', the highest rating, clearly could not improve and would therefore be classified as not showing any change. Similarly, those who received a rating of '5', the lowest rating could not decline, and would also be classified as not having changed. To present a true reflection of the figures and avoid the inaccurate inflation of the 'no change' classification, those instances were identified. Hence, in Table 6.42 and 6.43 there are two figures for 'no change'. The total percentage of participants who were classified as not having changed is given in brackets, next to the percentage of participants who were classified as not having changed and did not score '1'. All participants rated at '5' on the EWS or CWS were classified as improvers. The findings for both the total sample and the longitudinal group are presented.

Table 6.42 shows the percentage of participants in each of the four classifications between admission and discharge interviews and admission and follow-up interviews for both rating scales. Percentages of participants between discharge and follow-up interviews are included with the longitudinal sample.

Table 6.42: Percentage of participants who improved, declined and showed no change in EWS and CWS between interviews in the total sample

	Between admission & discharge (n=53)	**Between admission & follow-up (n=46)**
Emotional well-being		
No change	73.1 (75)	60 (60)
Improvement	19.6	26.6
Decline	3.6	4.4
No agreement	1.8	9
Cognitive well-being		
No change	28.5 (48.2)	36.2 (53.3)
Improvement	30.4	29
Decline	7.1	2.2
No agreement	14.3	15.5

Note: Figures in brackets indicate the total percentage of participants classified as 'not changing', including those that scored '1'.

Total Sample: Improvement in well-being during admission to hospital

As can be seen from Table 6.42, 19.6% of participants were classified as showing an improvement in emotional well-being. More than three quarters of the participants were classified as not improving or showing a decline.

Table 6.42 shows that the percentage of participants classified as showing an improvement in cognitive well-being was greater (30.4%), over a third did not change or their well-being declined. There was agreement amongst the raters on the emotional well-being on all but 1.8% of the participants. However, there was a lower rate of agreement between raters on the CWS, no agreement was reached for 14.3% of participants.

It can be seen in Table 6.42 that between admission and follow-up interviews, the classifications indicate that the emotional well-being of 26.6% of the participants improved, 60% of the participants did not change, and that the emotional well-being of a small percentage (4.4%) declined. Similar percentages of participants were classified as showing improvement and a decline in cognitive well-being. The cognitive well-being of 36.2% of the participants did not change. No agreement existed between the ratings for the remaining 15.5% of participants.

Longitudinal group

Consensus was reached by two or more raters for each of the participants in the Longitudinal sample. Table 6.43 shows the percentage of participants who improved, declined and showed no change in emotional well-being and cognitive well-being between admission and discharge interviews and between discharge and follow-up interviews for longitudinal group.

Table 6.43: Percentage of participants who improved, declined and showed no change in EWS and CWS between interviews (longitudinal group)

	Between admission & discharge (n=24)	Between discharge & follow-up (n=24)	Between admission & follow-up (n=24)
Emotional well-being			
No change	53.4 (58.3)	66.4 (79.2)	62.5 (62.5)
Improvement	41.7	8.3	29.2
Decline	0	12.5	8.3
Cognitive well-being			
No change	24.3 (54.2)	30.1 (62.5)	24.3 (54.2)
Improvement	37.5	37.5	37.5
Decline	8.3	16.7	8.3

Note: Figures in brackets indicate the total percentage of participants classified as 'not changing', including those that scored '1'.

Longitudinal group: Improvement in well-being during admission to hospital

Just over half the participants were classified as not showing any change in emotional well-being. The remainder showed an improvement. No participant was classified as showing a decline in their emotional well-being. This is the only stage that no participants were classified as showing a decline in well-being on either scale. Over one third of the participants were classified as having shown an improvement in cognitive well-being. Combining 'no change' and 'decline' indicates that almost one third did not improve, the remaining third had been rated as '1' on admission, and had maintained that during admission.

Longitudinal group: Improvement in well-being post-discharge

As can be seen in Table 6.43 a substantial majority of the participants were classified as not showing any change in emotional well-being, and a small minority (8.3%) were classified as improving, a slightly higher percentage (12.5%) were classified as showing a decline. The percentage of participants classified as showing an improvement in cognitive well-being was slightly lower (37.5%) and 16.7% were classified as showing a decline in cognitive well-being. Excluding those who had been rated '1', 24.3% were classified as showing no change.

Table 6.43 shows that the majority of participants were classified as not showing any change in emotional well-being between admission and follow-up. Almost one-third were classified as showing an improvement, and only a small percentage (8.3%) a decline.

A slightly higher percentage of participants were classified as showing improvement in cognitive well-being between admission and follow-up. Only a small percentage was classified as showing a decline (8.3%). Despite this, a third of the participants did not improve.

Summary

Between admission and discharge interviews, the outcome for the longitudinal group was more favourable on both scales than for the total sample, with a higher percentage of participants being classified as showing an improvement and a lower percentage showing a decline.

Again comparing emotional and cognitive well-being from admission to post discharge, the longitudinal group generally showed better outcomes in terms of improvement. In general, the percentage of participants who showed improvement was disappointing.

Impact of explanations for disturbance on improvement of mental health

In order to ascertain the answer to this question chi-square analysis had been planned. However, the numbers were further reduced as those participants who had not been rated consistently by the raters were excluded from the analysis. Consequently, in the vast majority of cases when categories were collapsed meaningfully the data did not meet the requirements of chi-square analysis (i.e. some of the cells were empty). Chi-square could be reliably performed when the variable regarding change of well-being was collapsed into these categories:

1) improvement;
2) no improvement (included no change and did not improve)

and when the variable "explanations for mental disturbance" at admission was collapsed in the following ways:

1) not mentally disturbed 2) all other explanations

and

1) traditional explanation 2) non-traditional explanations

In order to make this analysis viable, plural explanations which incorporated a traditional element were included in the traditional category.

Chi-square analysis was conducted for change in well-being for both scales between admission and discharge, discharge and follow-up and admission and follow-up. The results are shown in Table 6.44 and Table 6.45.

Table 6.44: Results of chi-square analyses of the impact of patients' explanations (feeling mentally disturbed or not) on emotional and cognitive well-being

Explanation on Admission: (mentally disturbed /not mentally disturbed)	$\chi 2$	**df**	**p**
Emotional Well-being Scale			
Admission and Discharge	.000	1	ns
Admission and Follow-up	.000	1	ns
Cognitive Well-being Scale			
Admission and Discharge	2.175	1	ns
Admission and Follow-up	.000	1	ns

As can be seen in Table 6.45 no significant association was found between participants who improved, or did not improve on either the EWS or CWS and whether they felt that they were not mentally disturbed or held an explanation for their mental disturbance.

Table 6.45: Results of chi-square analyses of the impact of patients' explanations (traditional or non-traditional) on emotional and cognitive well-being

Explanation on Admission (traditional /non-traditional explanation)	$\chi 2$	**df**	**p**
Emotional Well-being Scale			
Admission and Discharge	.000	1	ns
Admission and Follow-up	.458	1	ns
Cognitive Well-being Scale			
Admission and Discharge	.000	1	ns
Admission and Follow-up	.027	1	ns

As can be seen in Table 6.45, no significant association was found between participants who improved or did not improve on either the EWS or CWS and whether they held a traditional explanation or a non-traditional explanation for their mental disturbance. A series of tables containing cross-tabulations of explanation held for disturbance and changes in emotional and cognitive well-being between interviews are presented and commented upon. A summary of the findings is then provided.

Crosstabulations of explanations for mental disturbance and changes in emotional well-being.

Table 6.46: Crosstabulation of explanation for disturbance at admission and changes in emotional well-being between admission and discharge (total sample)

Explanation	Improvement	No change	Decline	Inconsistent
Not mentally disturbed	5	18	0	0
Traditional	1	4	0	0
Medical	1	5	1	0
Psychological	1	3	1	0
Don't know	1	4	0	0
Other	1	3	0	0
Plural	0	1	0	1
No reason	1	1	0	0
Total	**11**	**39**	**2**	**1**

Table 6.46 shows that the majority of the participants who did not see themselves as mentally disturbed were not classified as showing a change in their emotional well-being. Each of the explanations for mental disturbance were represented among participants who were classified as showing an improvement, with the exception of the one participant with a plural explanation. Equally however, each of the explanations held for mental disturbance were represented among the participants who were classified as showing no change. Participants who held a psychological or medical explanation were the only participants classified as showing a decline in their emotional well-being. Only one of the five participants who held a traditional explanation was classified as having shown an improvement.

Table 6.47 indicates that participants who held 'traditional', 'medical' and 'plural' explanations and those who did not see themselves as mentally disturbed were classified

as showing an improvement in their emotional well-being between admission and follow-up. With the exception of the 'plural' explanation, participants who held these same categories of explanations were also classified as showing a decline in their well-being. For two participants holding traditional explanations, two participants who did not see themselves as mentally disturbed, and two who did not know what could have caused their mental disturbance an inconsistency existed between raters.

Table 6.47: Crosstabulation of explanation for disturbance at admission and changes in emotional well-being between admission and follow-up interviews (total sample)

Explanation	Improvement	No change	Decline	Inconsistent
Not mentally disturbed	8	16	1	2
Traditional	2	2	1	2
Medical	1	4	0	0
Psychological	0	1	0	0
Don't know	0	2	0	2
Other	0	1	0	0
Plural	1	0	0	0
No reason	0	0	0	0
Total	**12**	**26**	**2**	**6**

Cross tabulations of explanation for mental disturbance and changes in cognitive well-being

Table 6.48: Crosstabulation of explanations for disturbance at admission and changes in cognitive well-being between admission and discharge interviews (total sample)

Explanation	Improvement	No change	Decline	Inconsistent
Not mentally disturbed	9	12	1	1
Traditional	1	2	1	1
Medical	2	1	2	2
Psychological	0	2	0	3
Don't know	1	4	0	0
Other	3	1	0	0
Plural	1	1	0	0
No reason	0	1	0	1
Total	**17**	**24**	**4**	**8**

Table 6.48 shows that a slightly greater number of participants who did not see themselves as mentally disturbed were classified as not changing than those showing an improvement. Only one of these participants declined. Five of the categories of explanation are represented among the eight patients for whom no consistency exists between raters. Participants who were classified as showing improvement held a variety of explanations. All explanations are represented amongst those participants classified as showing no change.

Table 6.49: Crosstabulation of explanations for disturbance at admission and changes in cognitive well-being between admission and follow-up (total sample)

Explanation	**Improvement**	**No change**	**Decline**	**Inconsistent**
Not mentally disturbed	10	10	1	8
Traditional	1	4	0	1
Medical	1	4	0	0
Psychological	0	1	0	0
Don't know	0	3	0	0
Other	0	1	0	0
Plural	1	0	0	0
No reason	0	0	0	0
Total	**13**	**23**	**1**	**9**

Table 6.49 shows that equal numbers of participants who did not see themselves as mentally disturbed were classified as showing an improvement and showing no change between admission and follow-up. All but one of the participants for whom there was no consistency between raters, did not see themselves as mentally disturbed; they attributed their disturbance to a traditional explanation. One participant who held a traditional explanation, one who held a medical explanation and one who held a traditional explanation were classified as showing an improvement. All explanations were represented amongst those participants who were classified as showing no change, with the exception of 'plural ' and 'no reason'. Only one participant was classified as showing a decline and they had not seen themselves as being mentally disturbed.

Crosstabulations of explanations held for mental disturbance and changes in emotional well-being for longitudinal group

Table 6.50: Crosstabulation of explanation for disturbance at admission and changes in emotional well-being between admission and discharge (longitudinal group)

Explanation	Improvement	No change	Decline
Not mentally disturbed	4	10	0
Traditional	1	1	0
Medical	1	3	0
Psychological	1	0	0
Don't know	1	0	0
Other	1	0	0
Plural	1	0	0
No reason	0	0	0
Total	**10**	**14**	**0**

The most notable finding evident from Table 6.50 is that no participants were classified as showing a decline. Participants who held explanations from all categories are classified as showing an improvement, with the exception of 'no reason'. The bulk of those did not see themselves as mentally disturbed at admission were classified as not showing any change.

Table 6.51 shows that each category of explanation is represented, with the exception of 'no reason', amongst those participants classified as not showing any change in emotional well-being between admission and follow-up. Only those who did not see themselves as mentally disturbed at admission were classified as showing a decline. Only those participants who held an explanation of 'not mentally disturbed', 'traditional' and 'medical' were classified as showing a decline.

Table 6.51: Crosstabulation of explanation for disturbance at admission and changes in emotional well-being between admission and follow-up (longitudinal group)

Explanation	Improvement	No change	Decline
Not mentally disturbed	4	8	2
Traditional	1	1	0
Medical	2	2	0
Psychological	0	1	0
Don't know	0	1	0
Other	0	1	0
Plural	0	1	0
No reason	0	0	0
Total	**7**	**15**	**2**

Table 6.52: Crosstabulation of explanation for disturbance at discharge and changes in emotional well-being between discharge and follow-up (longitudinal group)

Explanation	Improvement	No change	Decline
Not mentally disturbed	0	3	0
Traditional	0	4	0
Medical	2	1	0
Psychological	0	3	1
Don't know	0	2	1
Other	0	1	1
Plural	0	4	0
No reason	0	1	0
Total	**2**	**19**	**3**

As can be seen from Table 6.52 only participants who held a medical explanation at discharge were classified as improving between discharge and follow-up. Each category of explanation was represented among the participants who were classified as not changing. Only three participants were classified as showing a decline, they held explanations of 'psychological', 'don't know' and 'other'.

Crosstabulations of explanations for mental disturbances and changes in cognitive well-being for longitudinal group

Table 6.53 shows that those participants who don't see themselves as mentally disturbed are the largest group that show no change. Neither of the two participants with a traditional explanation show any change, while two of the participants with a medical explanation show improvement, one a decline and one no change. The single participants who did not know what caused their disturbance or whose explanation was classified as 'other' were classified as showing an improvement.

Table 6.53: Crosstabulation of explanations for disturbance at admission and changes in cognitive well-being from admission to discharge (longitudinal group)

Explanation	Improvement	No change	Decline
Not mentally disturbed	5	8	1
Traditional	0	2	0
Medical	2	1	1
Psychological	0	1	0
Don't know	1	0	0
Other	1	0	0
Plural	0	1	0
No reason	0	0	0
Total	**9**	**13**	**2**

It can be seen from Table 6.54 that the majority of participants showed no change in their cognitive well-being, notably those who did not feel mentally disturbed. However, some participants, who did not feel mentally disturbed improved, but were also the only group who showed a decline in their cognitive well-being. Two participants who held a medical explanation improved and two were classified as showing no change. One a plural explanation were classified as showing improvement. One participant who held a traditional explanation was classified as showing an improvement, one was classified as showing no change.

Table 6.54: Crosstabulations of explanation for disturbance at admission and changes in cognitive well-being between admission and follow-up (longitudinal group)

Explanation	Improvement	No change	Decline
Not mentally disturbed	4	8	2
Traditional	1	1	0
Medical	2	2	0
Psychological	0	1	0
Don't know	1	0	0
Other	0	1	0
Plural	1	0	0
No reason	0	0	0
Total	**9**	**13**	**2**

Table 6.55 indicates that more participants show a decline between discharge and follow-up than between admission and discharge and admission and follow-up. Five categories of explanation were represented among the five participants who were classified as showing an improvement, including 'not mentally disturbed', 'traditional', 'medical', 'plural' and 'no reason'. All categories of explanation were represented among participants who were classified as showing no change. Participants who held 'traditional', 'don't know' and 'not mentally disturbed' explanations were classified as showing a decline.

Table 6.55: Crosstabulation of explanations for disturbance at discharge and changes in cognitive well-being between discharge and follow-up (longitudinal group)

Explanation	Improvement	No change	Decline
Not mentally disturbed	1	0	2
Traditional	1	2	1
Medical	1	2	0
Psychological	0	4	0
Don't know	0	2	1
Other	0	2	0
Plural	1	3	0
No reason	1	0	0
Total	**5**	**15**	**4**

Summary

It is very difficult to pinpoint any specific trends in this data. Looking broadly at the participants holding various explanations and whether they are classified as showing an improvement, no change, or a decline in emotional or cognitive well-being the following comments can be made. A greater number of participants who did not see themselves as mentally disturbed on admission were classified as not showing improvement, than those classified as showing an improvement. Participants who held a traditional explanation were often classified as showing an improvement, but also classified as showing no improvement. In only three instances were they classified as showing a decline. Some participants who held a medical explanation for their disturbance were classified as showing an improvement, but more often they were classified as showing no change. Participants holding a psychological explanation rarely improved. Participants who did not know the cause of their mental disturbance typically did not show any change. Participants holding a plural explanation, no reason, or an explanation classified as 'other' were the only participants never classified as showing a decline, however, these participants are few in number. Similarly, the only ratings for participants with 'no reason' or 'other' were never classified as inconsistent. No tangible conclusion can be drawn from this information. The statistical analysis, where it was possible, did not show any significant differences between participants holding an explanation or not, or between holding a traditional explanation as opposed to any other.

CHAPTER 7: DISCUSSION

OVERVIEW

This chapter is divided into five sections. The first section reviews the research questions that this thesis seeks to answer. A summary of the findings and conclusions drawn from the traditional healers study are contained within the second section. The third section discusses the empirical findings of the hospital study, dealing individually with each of the five research questions this thesis sought to address. Methodological issues arising from this research are dealt with in the fourth section. Concluding remarks are made in the fifth section.

REVIEW OF THE RESEARCH QUESTIONS

The research questions this thesis sought to answer were rooted in a theoretical question: What are the experiences of people with a mental disturbance, when they are introduced to a health care system which is ontologically distinct from their own cultural beliefs about health?

The literature review conveyed the ontological differences that exist between health and illness as understood from both a traditionally African perspective and a biomedically orientated perspective. The St. John of God Mental Health Service in Northern Malawi, a biomedically orientated service, was established in a region where mental disturbance is predominately treated by traditional healers. This setting provided an ideal context in which to address this central research question.

This theoretical question was operationalised through the following research question: In what ways may the establishment of a Mental Health Service in Northern Malawi, which adheres to a biomedically orientated framework, meet the needs of those requiring treatment for mental health problems in Northern Malawi? This broad research question was broken down into five questions:

1. How do patients explain the cause of their mental disturbance?
2. Does the mental health of patients admitted to the hospital improve while they are hospitalised?

3. Do explanations held by patients regarding the cause of their illness impact on the improvement of their mental health?
4. If improvement occurs, is it maintained post discharge?
5. What recommendations can be made for the development of cultural competent health services in Northern Malawi?

It became apparent that in order to facilitate the process of analysing the data collected in the hospital study a clearer understanding of the cultural context in which Northern Malawians health beliefs are embedded was required. This motivated the inclusion of a parallel study that explored the extant healing system. As the findings from this study feed into the findings of the hospital study, the summary and conclusion of this study are presented first.

TRADITIONAL HEALERS STUDY

Summary of findings

The findings of this study provide a picture of the local extant healing system in Northern Malawi, the knowledge base that exists and the treatment available from *wasing'anga* for mental disturbance in the late 1990's. It is clear that a buoyant and extensive network of traditional healers exists in Northern Malawi and that those who are mentally disturbed, or their families, continue to actively seek treatment from *wasing'anga*.

My observations at various functions, such as the opening of the *dimba* project, coupled with information I was given by the *wasing'anga* (e.g. the Herbalist Health Workers Training Day, 1996), interviews, and conversations suggest that the *wasing'anga* in Northern Malawi are progressive in their outlook.

Reservations that I had held regarding the feasibility of carrying out a study with traditional healers proved to be unfounded. The *ntchimi* and *wasing'anga* that were involved in the study were very willing to participate and were open to my research, despite the fact that I was attached to a biomedically orientated mission hospital. The choice of Naturalistic Inquiry as a research design facilitated a systematic method of

collecting information that ensured distortions in the data collected were kept to a minimum. Furthermore, this approach allowed for the flexibility required to conduct this study and advocated an appropriate method of data analysis.

The analysis of the interviews conducted with the *ŵasing'anga* reveals that they have identified a wide range of causes of mental disturbance. These are not confined to supernatural causes and in some instances would not be excluded from a biomedical model (e.g. hereditary element). This finding leads me to question the usefulness and appropriateness of the term 'traditional' when referring only to supernatural causes of disturbance. This term was used by MacLachlan. Nyirenda and Nyando (1995) in their study for this purpose and subsequently adopted for quantitative analysis in the hospital study in this research.

Mental disturbance is treated by both *ŵasing'anga* and *ntchimi*. In the cases where a person needs particular attention from the *sing'anga*, they stay at his compound. Facilities for a guardian to stay with them are available. Guardians help in their care, learning more about how to manage the treatment of the person who is disturbed. The type of treatment decided upon by the *ŵasing'anga* depends on the identified cause of the disturbance (e.g. physical injury, *ulowe*). A variety of herbal medicine can be used, and in the case of mental disturbance caused by *mizimu ya agogo*, a *vimbuza* ceremony may be arranged at their request. *Mizimu ya a gogo* may request a *chilopa* if further treatment is required.

Although spiritual illness may appear to be a mental illness according to DSM-IV, *vimbuza* is not considered as such in Malaŵi, although if ignored can cause the person to become 'mad'. Furthermore, the experience of becoming a *ntchimi*, as related by a number of *ntchimi* in the study, highlights that in some cases hearing the voices of *mizimu ya agogo* is part of an initiation into their profession (and not necessarily an auditory hallucination). This lends support to the argument that the global application of western taxonomies of psychiatry is not appropriate, and that the development of a context specific classificatory system, as has been undertaken by other countries (such as Cuba) could be beneficial.

Conclusion

One main contribution this study has made is that it has taken a step towards addressing the dearth of information available regarding *ŵasing'anga* and the role they play in the treatment of those who are mentally disturbed in Northern Malaŵi. The role of *ŵasing'anga* in contemporary Malaŵian society has been neglected, not only in terms of the contributions they can make to care of those who experience mental disturbance, but also those who are physically ill.

Interviews conducted with *ŵasing'anga*, in conjunction with participant observation in ceremonies, yielded important information, giving me a clearer understanding of the context in which the health beliefs of Northern Malaŵians are embedded, thus enhancing the integrity of the process of analysis in the hospital study.

However, this study was exploratory in nature and restricted by time. There is no doubt that there is scope for further studies in this area, not just in the field of mental disturbance but also physical health and illness. It would appear that the time is ripe for pursuing further research with the current level of willingness demonstrated by the *ŵasing'anga*. Some recommendations are made later in this chapter.

HOSPITAL STUDY

This section begins with an observation regarding the demographics of the participant population. The findings pertaining to each research question are summarised and commented upon.

Demographics

In making comparisons with the Housing and Population Census (1998) figures and the participant population some interesting differences are noteworthy. Assuming the accuracy of the census figures, a disparity between the proportion of males and females in the Northern region and the participants in the study exists. A disproportionate number of participants are from urban areas, all categories of religious affiliation are not represented among the participants, and a disproportionate number of participants have

received higher levels of education than the population in general. These differences are expanded upon here and possible explanations for their occurrence posited.

Contrary to the ratio in the population, where females outnumber men by 30,000, males constituted 60% of the hospital sample. Peltzer's findings suggested that men are more likely than women to seek treatment in a biomedically orientated service. In contrast women are more likely to seek treatment from traditional healers (Peltzer, 1987). The gender ratio in the hospital study suggests that this pattern continues two decades later. Peltzer (1987) suggested that women were more likely than men to attend traditional healers, for a number of reasons, including that they are less educated and more likely to attribute illness to supernatural causes. According to both Schoffeelers (1997) and Peltzer (1987), spirit illnesses are likely to be more prevalent in women than men in patrilineal societies in Malawi. In Northern Malawi psychological difficulties may manifest themselves as *vimbuza* or other spirit illnesses and therefore are more likely to be brought to a *sing'anga* for treatment than the hospital. Although it has not been documented in this study, it has been observed among the hospital staff that men present as more violent and aggressive than women when admitted to the hospital. Aggressive behaviour may be viewed as more threatening than other behaviour associated with mental disturbance, for example, social withdrawal, and would be less tolerated in the community. Perhaps the hospital is viewed as a more appropriate environment for these men, accounting for the greater proportion of men being brought to the hospital.

The recent census indicates that the majority (87%) of the population in Northern Malawi live in rural areas (Housing and Population Census, 1998). However, just over half of the hospital population are from rural areas. This suggests that the hospital population has a greater proportion of people from urban areas compared to the general population. It may be argued that the difficulties with transport experienced in Malawi contribute to this situation. These difficulties become more complicated when the practicalities of transporting a person with a mental disturbance are taken into consideration. The fact that the hospital is based in an urban area, coupled with the fact that transport is more available in urban areas could account for the higher proportion of people from urban areas.

A disparity is evident between the educational achievements of the participants and of those in the region generally. It would appear that the participants in this study have received a higher level of education than the population as a whole. This finding could suggest that those with more education are more likely to attend a biomedically orientated service. However, to assume this could be misleading. A closer look at the demographics reveals that practically one fifth of all the participants were currently in education. Many secondary schools are in urban areas; therefore, accessibility may also play a role in this figure. Furthermore, many of the schools are run by missionary organisations and so are aware of the St. John of God facility. The school may play an influential role in the family's decision making in terms of seeking treatment. A combination of accessibility, education, and information may result in a more educated hospital population. Again further exploration of this area could prove useful to the Service. On the other hand, the number of students admitted may suggest that those in education are vulnerable to mental disturbance. Some participants did attribute their disturbance to school related problems; for example, one student explained his disturbance as follows: "*It's because I failed my J.C. exams.*" Despite this, it could be argued that it is not that students are any more vulnerable to mental disturbance, but that accessibility and information, as mentioned before, result in the high number of students admitted.

In terms of religious affiliation, as categorised by the Housing and Population Census (1998), all but one category was present in the hospital sample; no participant was affiliated to Islam. Given that this religious group is a minority in the general population, the likelihood was not very high. However, other minority religious categories with even fewer numbers, such as 'no religion' were at the time of the study, represented in the hospital population. This indicates that those who are mentally disturbed in the Islam community seek treatment elsewhere. A potential reason that could account for their absence is that the Christian ethos of the St. John of God Mental Health Service is not appropriate.

Acknowledging the differences between the general population and the participant population is of primary importance as it emphasises that those who seek treatment in the hospital are not representative of the population as a whole. Furthermore, the findings of this study are reflective of this particular sector of the population, not the

general population. On the other hand, this sample is an accurate reflection of those who seek treatment for mental disturbance in a biomedically orientated service. While the explanations offered here for the disparities between the hospital population and the general are speculative, based on this researcher's knowledge of the context, other factors may contribute to these differences. Further exploration of these observations could provide useful information for the Service in terms of the profile of those who seek treatment there and those who do not.

Summary of findings of hospital study

How do patients explain the cause of their mental disturbance?

This question was addressed in the context of a semi-structured interview. The first question asked in the interview was "Why do you think you are here?" In the total sample, the most notable finding is that on admission less than half the participants felt they were mentally disturbed. The majority of those interviewed at discharge and follow-up had felt that their admission had been because they were mentally disturbed. In most cases, those who had felt that their admission was due to mental disturbance retained that reason. A similar trend was found in the longitudinal group. The patterns of change of reasons between interviews were examined. Generally, those who felt they had been admitted because they felt mentally disturbed retained their reason. While the participants who had cited reasons which indicated they did not feel mentally disturbed changed their reason, to being mentally disturbed, both between admission and discharge and discharge and follow-up. Four explanations can be offered for this finding, in this context. One explanation would be that being hospitalised for a mental disturbance, and the intervention offered encourages insight into their condition. An alternative explanation would be that those who do not see themselves as mentally disturbed realise that there is less likelihood of being discharged, unless it is acknowledged by the patient that they are mentally disturbed. Thirdly, a possible explanation would be that the impact of being in a medicalised environment cannot be underestimated; blood pressure being measured every morning, receiving medicine from a medicine trolley, being treated by staff in uniforms, and receiving meals provided at scheduled mealtimes, may also have influenced how participants viewed their condition. Fourthly, the role the family plays is vital. Perhaps it is through talking

to family members who visit the hospital that the participants come to understand their situation.

While each of these explanations may have influenced different participants, I would suggest that the final explanation is the most likely to have influenced the majority. If the participants developed the insight suggested in the first explanation, one would expect that a greater number would continue with this form of treatment, with greater success, and adopt a biomedical explanation for their disturbance, which has not been demonstrated with these participants. No evidence from this study can substantiate the second and third explanation. It could be argued, applying the concept of cognitive tolerance to this circumstance, that it is the cognitive tolerance of the family that has been instrumental in the participant's shift to seeing themselves as mentally disturbed. Bourguignon (1989) would suggest that accessing treatment for a relative, in a biomedically orientated service, does not necessarily indicate that the family understands mental disturbance from a view ontologically similar to that of the hospital. It could be surmised then that the participant accepts the view, shared by both the family and the hospital, that they are mentally disturbed, but understands their mental disturbance from the perspective of their family, which may be more closely aligned with the extant healing system than the hospital. The influence of the family could then account for the low percentage of medical explanations and the increase in culturally embedded explanations such as *ulowe* and *mizimu*.

The findings regarding the explanations participants held for their mental disturbance are now considered. The way in which participants' explanations for being mentally disturbed are embedded in the context in which they live are richly illustrated in the personal accounts of six of the participants included in the qualitative findings. These accounts also highlight the different explanations that Malawians hold for their mental disturbance, the plurality of the explanations held by participants, the changing pattern of explanation which occurs across the three interviews, and the pattern of previous treatment sought.

Content analysis was based on the categories developed by MacLachlan, Nyirenda and Nyando (1995).

Analysis revealed some interesting findings. On admission, almost half the participants did not see themselves as mentally disturbed, this however decreased dramatically amongst those interviewed at discharge, and at follow-up. Obviously as this percentage decreased those who offered an explanation increased. An unexpected pattern occurred regarding the explanations held. Despite the fact that the participants were being treated for mental disturbance in a biomedically orientated service the percentage of those who explained their disturbance in terms of a medical explanation remained low from admission to follow-up interviews, even decreasing slightly from 10% on admission to 8% on follow-up. Conversely, those with a traditional explanation outnumbered those with a medical explanation and continued to increase over the course of the interviews to 34.9%, when plural explanations with a traditional element were included. This finding is similar to that of MacLachlan, Nyirenda and Nyando (1995) in Zomba mental hospital, where the largest number of participants attributed their mental disturbance to traditional factors. However, one distinction between these two studies is the higher proportion of participants in the current study who did not see themselves as mentally disturbed.

Also notable, is that the percentage of participants in this study, who did not know the cause of their mental disturbance increased over time. Plural explanations, which were not common on admission also increased between discharge and follow-up. Similar percentages were found in the longitudinal group, although initially there were more participants who cited a medical explanation in this group, the percentage of participants holding a medical explanation decreased over time. It could be surmised that the increase in plural explanations is a result of the participants incorporating the information they receive at the hospital into their own framework of beliefs, as opposed to replacing their own.

It would appear from these figures that seeking treatment in a biomedically orientated service does not mean that a more biomedical approach is likely to be adopted. These findings provide further support for the existing literature, which suggests that belief in one system, does not preclude using another system (Bourguignon, 1989). Further support comes from the fact that at least 55% of the participants in the present study have also attended traditional healers. This figure is substantially higher than the figures found by Zoller (1997) in Ghana and Gureje, Acha and Odejide (1995) in Nigeria.

Being treated in a biomedically orientated hospital for mental disturbance does not appear to change, or eliminate a traditional belief in the cause of mental disturbance. Quite the contrary, more participants at follow-up had a traditional belief than when they were admitted. Considering that those participants traced for interview at follow-up were generally those patients who had maintained a link with the hospital, or responded to letters requesting a follow-up interview, this figure is quite high. It could be surmised that this figure would be higher had the original admission sample been traced. The extent to which the participants in this study endorsed traditional views regarding the causes of their mental disturbance testifies to the continued existence of these beliefs, even in a sample with a higher level of education than the population in general. Lund and Swartz (1998) suggest that patients use their explanatory models with pragmatism and chose treatment modalities, or a combination that are the most effectual for their needs. Perhaps this is the case in Malawi. Seeking treatment from the hospital is not an indication that patients are willing to substitute biomedical beliefs for their own beliefs, but that they are willing to avail of a service, which can contribute in some way to relieving their symptoms.

Mizimu (spirits) and *ulowe* (bewitchment) combined formed the traditional category in quantitative analysis. However, it became clear through analysis that the role that each of these elements is believed to play in a person becoming mentally disturbed represents two different modes of becoming disturbed. In simple terms, it can be said that in the case of *ulowe,* someone else is seen to be responsible for a person becoming ill. In relation to *mizimu*, it is understood that *mizimu ya agogo* have been neglected, which means that the person has some responsibility for their condition. Therefore, in analysis, the traditional category was further divided into *mizimu* and *ulowe,* both as single reasons and as part of a plural explanation, and where *mizimu* and *ulowe* are combined as an explanation for mental disturbance.

Given the higher rate of spirit illness in Northern Malawi, particularly among women, indicated in the literature (Schoffeelers, 1997; Peltzer, 1987) it was deemed important to look more closely at the breakdown of the traditional category, both in terms of the type of explanation ascribed to and gender. Analysis showed that a greater proportion of males cited a traditional explanation. *Ulowe* (as both a sole explanation and as part of a plural explanation) was consistently more common. A greater proportion of males cited

ulowe as an explanation for mental disturbance, although interestingly the proportion of females citing *ulowe* increased at follow-up. The reason for this is not clear. The following quotation expresses a sentiment very evident in many of the explanations that attribute mental disturbance to bewitchment:

> ... at home I am one of the bright sons. So they have seen that this one is progressing and thinking about doing something in which he can prosper, their hearts are not at peace. They want themselves to prosper, not others.

In the opinion of this participant, he was bewitched to become mentally disturbed in order to present an obstacle to his prosperity. MacLachlan, Nyirenda and Nyando (1995) identified similar elements of jealousy of achievement in the responses of the participants of their study in Zomba. They explained this in terms of a theme evident in the Chewa[46] culture of trying to harm someone who has done better than oneself. The figures from the study conducted by the St. John of God research group in 1997/8 in Mzimba District in Northern Malawi, indicate that 86% of the one hundred participants involved believed that bewitchment could cause mental disturbance.

Further research conducted in Malawi on 'motivational gravity' suggests that in the workplace there is a recognised tendency for co-workers to 'pull-down' others who attempt to improve and a 'push down' from superiors to those trying to do well (Carr, MacLachlan, Zimba & Bowa, 1995). While their study was conducted in the realm of management of human resources in organisations, Carr and MacLachlan (1997) suggest that the burden of working in such situations can have health consequences, such as admission to psychiatric hospital. It could be argued that as long as such jealousy is identified in the workplace, and outside, Malawians will continue to attribute misfortune in whatever form, to bewitchment. Perhaps this is one reason that the attribution of bewitchment as a cause of illness has remained so pervasive. Indeed, it could be further argued that the change in work setting that results from urbanisation (more people employed outside the home or village, for example) possibly perpetuates the attribution that bewitchment causes illness, instead of weakening it, as has been suggested by others (e.g. Peltzer, 1987; Ebigo & Ihueze, 1981).

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[46] Largest ethnic group in Malawi.

Concerning women's traditional explanations, in all but one case, mental disturbance was explained solely as a result of *mizimu*, as opposed to part of a plural explanation. One woman explained the cause of her mental disturbance in terms of *ulowe* and *mizimu*. Only two female participants employed a traditional explanation in a plural form. Schoffeelers (1997) suggested that spirit possession is more prevalent in patrilineal societies. Perhaps it is not surprising that fewer men explain their disturbance in terms of spirits, if it is viewed as a female domain in Northern Malawi, and a greater proportion of women understand their experience of mental disturbance as being afflicted by spirits. Interestingly, two of the men who attributed their disturbance to *mizimu* felt that it was preparation for becoming a *wasing'anga*. None of the women reported this view. Perhaps this is in keeping with Schoffeelers' finding in Southern Malawi that the only type of spirit possession where men outnumber females is territorial mediumship. This particular type of spirit possession is described as being politically orientated, and the political realm is populated by men. Although this type of spirit illness does not appear to exist in the North, spirit illness leading to becoming a *ntchimi* does occur. A parallel could be drawn between the kudos associated with these two types of spirit illness. It cannot be denied that there is a certain kudos associated with being a *wasing'anga* in Northern Malawi.

Analysis, conducted in accordance with grounded theory, generated several themes in the explanations offered by the participants. These themes expanded on the five categories employed in the quantitative analysis. The two main departures made from the categories used by MacLachlan, Nyirenda and Nyando (1995) were 'third party understanding' and 'indecision'. A closer inspection of the responses reveals that all participants do not necessarily employ the same cause in a unitary way. Examples of two different ways of becoming mentally disturbed through bewitchment, described by participants, illustrate this. Bewitchment can occur because one individual is jealous of another (e.g. jealous of their status or financial situation). Or bewitchment of one individual by another in order to become more successful may require a body part (as a *chizimba*) to make the appropriate *mankhwala* to succeed. While some participants just named a cause, without having any further explanation of the mechanisms involved, others extended their explanations, demonstrating their understanding of the manner in which it impacts on their mental disturbance. Different explanations employed in explaining the role of *chamba* in causing mental disturbance provide a useful example

of this point. This suggests that perhaps it is not only the category or theme that the explanation falls into which is important. The way in which the participant utilises the explanation, and their level of understanding may also be of fundamental significance. A danger exists that staff trained in a biomedically orientated model may dismiss not only the cause put forward by the patient, but also the information associated with it, if it falls outside the purview of the model they have been trained in. This issue is returned to later in this chapter.

Using the *a priori* categories assumes that all participants will have thought about what has caused their disturbance, and arrived at a conclusion. As pointed out previously, an increasing number of participants did not know what had caused their disturbance. Using qualitative analysis, two themes emerged which reflected that some participants had not formulated their own opinion, and others had not decided which of a number of factors had caused their disturbance. 'Third party understanding' emerged where a patient's explanation was not based on their own opinion, but on that of a third party, such as a family member. Not only do family members exert a good deal of influence in determining the treatment chosen for the person who has a mental disturbance, as demonstrated in the reasons participants gave for admission to hospital, but they can also influence, to some extent, the explanation the sufferers hold for their disturbance. 'Indecision', which describes the response of a participant undecided about which one of a number of categories could explain their disturbance, is distinct from a plural explanation, which would indicate interaction of causal factors. The numbers of participants who did not know what had caused their disturbance and the emergence of these two themes would indicate that, in fact, participants have not necessarily developed an explanation of their disturbance. This highlights one advantage of using qualitative analysis in this study.

Does the mental health of patients admitted to the hospital improve while they are hospitalised?

In order to assess whether the mental health of participants improved during hospitalisation two scales were developed, Strength of Evidence for Emotional Well-being Scale (EWS) and Strength of Evidence of Cognitive Well-being Scale (CWS), as no appropriate scale existed for this purpose. It appears from the findings, that while the

cognitive and emotional well-being of some participants improved, the majority of the participants were rated as not showing an improvement in their emotional and cognitive well-being, between admission and discharge interviews in both the longitudinal and total sample. A decline in the emotional and cognitive well-being of a proportion of the participants occurred; however, the majority were rated as not showing any change. As this is the first time this scale has been used there is no population with which to compare findings, and therefore difficult to draw any firm conclusion from these figures. However, one would have anticipated that the percentage of those who improved would have been greater.

If improvement occurs, is it maintained post discharge?

Considering the findings for the longitudinal sample, only a very small minority of the participants showed improvement between discharge and follow-up, 8.3% on the EWS and 37.5% on the CWS. A greater percentage of participants declined in the time that elapsed between their discharge and follow-up interview than between any other set of interviews . For those who were classified as showing a decline between admission and follow-up interviews, their cognitive and /or emotional well-being is actually poorer than before they were admitted. For those participants interviewed between admission and follow-up the percentages of those who improved increased, ranging from only 8.3% on the EWS and 37.5% on CWS for the longitudinal sample. The total sample fared a little better with improvement rated for 26% on EWS and 29% on CWS. However, the majority of the participants were either classified as showing no change or a decline. These figures would suggest that the improvements in well-being gained by a small number of participants while hospitalised is not maintained by a substantial percentage of those participants. The majority of participants in the follow-up interview had kept some contact with the Service, allowing them to be traced. This would suggest that the follow-up treatment offered, or taken up by the Service, or the District hospital is even less successful than that given in the hospital. Taking the figures at face value suggests that a greater number of participants show an improvement in their cognitive well-being. This finding could be attributed to the fact that more of the participants in the both the total sample and longitudinal group were admitted for a psychotic illness as classified by their diagnosis. Hallucinations and other symptoms of psychosis were included on the CWS. Therefore, perhaps these figures suggest that those participants

whose cognitive well-being has been severely affected do show improvement. The participants whose cognitive well-being was less affected have remained unchanged. An extensive literature search suggests no comparable studies have been conducted. Patel (2000) highlights the lack of evidence-based treatment for mental health problems in the developing world. It is therefore not possible to assess how these outcomes compare to similar situations.

Do explanations held by patients regarding the cause of their illness impact on the improvement of their mental health?

Disappointingly, the statistical analysis planned to address this question could not be performed to the extent that had been hoped. Reduced numbers mitigated against such analysis. The limited analysis that could be conducted suggested that no association existed between improvement of either cognitive or emotional well-being and the holding of a traditional explanation. Furthermore, there did not appear to be any association between improvement in well-being and whether participants felt they were mentally disturbed or not. Holding an explanation for mental disturbance as opposed to not feeling mentally disturbed did not appear to impact on improvement of well-being.

Synthesis of the traditional healers study and hospital study

Qualitative analysis of data gathered in both the hospital study and the traditional healers study allows comparison between the findings of both studies. In terms of causes for mental disturbance, considerable correspondence exists between those who are suffering mental disturbance and those who treat it. '*Ulowe*', '*mizimu*' and '*chamba*' all feature predominantly in both groups. 'Thinking too much', 'hereditary' and 'caused by God' are also shared concepts of what causes mental disturbance, but to a lesser extent. Many of these causes are quite distinct in some respects from causes that a biomedically oriented service would accept as having a role in causing mental disturbance. In comparing the explanations for mental disturbance offered by the *ŵasing'anga* and the participants in the hospital study it becomes apparent that the explanations for mental disturbance held by these two groups are more closely aligned than the hospital approach and the participants in the hospital study. From a therapeutic point of view, such findings have particular implications. As was noted in Chapter Two, Frank and Frank (1991) identified four features which result in effective psychotherapy.

These features are revisited here: 1) an emotionally charged, confiding relationship with a helping person (often with the participation of a group) 2) a healing setting 3) a rational, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them 4) a ritual or procedure that requires the active participation of both patient and therapist and which is believed by both to be the means of restoring the patient's health. Given the close correspondence of causes attributed to mental disturbance by *ŵasing'anga* and participants in the hospital study, it would appear that *ŵasing'anga* in Malaŵi can provide psychotherapy which fulfils these features. The findings from the hospital study do not indicate that the biomedically orientated approach of this hospital corresponds as closely to the explanations held by many of the participants in the study. Therefore, offering a patient a plausible explanation for their symptoms and an appropriate procedure, which the sufferer believes in, to treat it becomes more difficult.

Although the causes *ŵasing'anga* attribute to mental disturbance is ontologically different from those of biomedicine, it can be argued that a biomedical model would not exclude some of the causes they attribute to mental disturbance. Examples of such common causes would include physical injury to the head and a hereditary component which could lead to mental disturbance.

What recommendations can be made for the development of culturally competent health services in Malaŵi?

It must be recognised that Guarnaccia and Rodriguez (1996) identified several important components in the development of a culturally sensitive service and this study focussed on only one of those areas, patients' views of mental disturbance. For a balanced and holistic development of the Service consideration must be given to the other five factors that were specified, discussion of which are beyond the scope of this thesis. Attention will be drawn to a number of key issues that emerged from this research upon which a number of recommendations will be based. Suggestions for further research are also made.

1. Clients attending service: It has already been observed that differences exist between the general population of Northern Malaŵi and those in the study. The Service

should consider the reasons why this situation arises. Perhaps their health promotion targets those who are Christian, male and more educated and does not reach other sections of the population. On the other hand perhaps those who are instrumental in making decisions in seeking treatment exercise discretion in their choice and decide that the hospital does not meet the needs of the person as adequately as a *ŵasing'anga* can. These questions posed cannot be answered by this thesis but are worthy of further exploration by the Service.

2. Training of staff: Malaŵian staff immersed in a biomedical model of psychiatric illness, which may be at odds with their own belief system, may experience difficulties in treating patients purely in a biomedically orientated manner (Smyth, 1998; 2001). Certainly some of the staff I knew sought treatment for themselves or family members from *ŵasing'anga*, often travelling many miles to their home village. Mindful of the difficulties described by Madu (1997) in using western psychotherapy in Africa, perhaps sending staff to South Africa and Ireland for training in biomedically orientated methods, and consequently perpetuating the biomedical cycle needs to be reassessed. Some consideration should be given to the skills staff could usefully learn from the available resources in Malaŵi.

3. The role of the family: The role of the family, both in seeking treatment for someone with a mental disturbance, and the influence they have in the participants' explanations emerged in this study. Traditional healers and other Mission hospitals accommodate a guardian for the patient during their admission. The guardian becomes familiar with the treatment and management of the patient during this period. It could be surmised that this experience may assist the guardian in providing a stronger support system post-discharge. Given the low rate of improvement post-discharge found in this study, adopting such a policy may be a step forward in maintaining the well-being of the patient once they have been discharged.

4. Embracing what is positive in the local community: The study I conducted with the *ŵasing'anga* has furnished the Service with current information regarding the extant healing system. As quoted earlier in this thesis Dejarlais, Eisenberg, Good and Kleinman (1995) recommend that the application of current psychiatric knowledge in low-income countries should strive "... to enhance existing local strengths rather than

attempt to eliminate what might be viewed as irrational or traditional from the perspective of contemporary biomedicine" (p. 54). The guiding principles laid down by the Service state "that priority should be given to the promotion of mental health rather than to the treatment of illness *per se*", that an individual and community sense of mental and emotional well-being should be promoted, using local resources where possible and they have made a commitment to embrace what is positive about traditions, beliefs, customs and cultural heritage of the local community. Peltzer (2001) highlights the "rich indigenous mechanisms of promoting health in Africa" (p. 172); it is important that these mechanisms are identified in Malawi to contribute to cultivating the mental health of the population. The exploratory study of the local healing systems conducted is the only the first step in this identification process. It is clear from my experience with *ŵasing'anga* in the area that they are open and willing to talk about their profession. The Service should therefore embrace the willingness of the *ŵasing'anga* to be open and discover what the existing local strengths are for treating those who are mentally disturbed. The opportunity exists for the Service to approach the Herbalist Association of Malawi (HAM) to initiate dialogue between the Service and the local healing network, in an effort to identify the positive aspects of both the Service and the local healing systems, and consider the ways in which these aspects can be harnessed.

5. Developing a constructive alliance between the Service and the extant healing system: The findings of this thesis provide further supporting evidence for 'cognitive tolerance' in Malawi. Carr and MacLachlan (1994a) point out that often this pluralism has been viewed as presenting problems in providing healthcare. They, on the other hand, view cognitive tolerance as positive in developing appropriate health care in Malawi and other developing countries. They state that: "If medical and traditional beliefs about health and illness can sit comfortably in the mind of sufferers, then there is no reason to exclude either traditional or modern medical approaches from the treatment ..." (p. 43). It could be argued that the responsibility for taking the initiative lies primarily with the Service as the 'newcomers' in mental health care. Careful consideration of the approach is required. Although the local situation in Northern Malawi is unique, lessons can be learnt from the approach of other African countries. For example, in South Africa various arguments have been put forward for the inclusion, and indeed exclusion of traditional healers in health care provision. A range

of possible approaches have been suggested (Freeman and Motsei, 1992). Hopa, Simbayi and duTriot (1998) describe prejudice and suspicion, among both western and traditional practitioners, about their counterparts as the major stumbling block to successful integration and emphasise the need to reduce these counterproductive feelings. Kilonzo and Simmons (1998) writing with reference to Tanzania see the development of the most appropriate strategies for integration of traditional healing systems into the western service as an important challenge for mental health services. Tsey (1997) cautions against the 'incorporation' of one system into another. He emphasises the importance of recognising the potential for 'cooperation' between systems in treating mental illness. MacLachlan (1996a) highlights the value in integrating the two systems. In doing so, the intrinsic strengths in each system can be acknowledged. Arriving at a solution for Malawi will not be a smooth journey. However, the demonstrated willingness of the *wasing'anga*, the information provided by this thesis, and the expressed commitment by the Service in their guidelines, behoves the Service to rise to the challenge and begin to seek opportunities to develop and promote a constructive alliance between the local extant healing system and the St. John of God Mental Health Service.

6. Problem Portrait Technique: One of the most striking observations from the qualitative analysis of the participants' explanations for their disturbance was the information regarding the socio-cultural context of the participant that emerged in connection with their explanation of their mental disturbance. The possibility that the information pertaining to the cause of illness may be dismissed if it does not fit into a biomedically orientated approach has already been pointed out. One way to counteract this problem and enhance the quality of the information received by staff involved in the treatment of the patient would be to utilise the Problem Portrait Technique (PPT), (MacLachlan, 1997). The aim of the PPT is to aid the clinician in achieving a truer impression of the understanding a patient holds regarding the cause and treatment of their condition. Three stages are involved in this technique. Initially the clinician explores the explanations the patient holds for his/her problem, before moving on to the view of the family. Thus, a picture of the context in which the patient experiences the problem emerges. The second stage involves finding out the strength of belief attached to each of the beliefs or explanations. Finally, appropriate treatments are discussed which correspond to the ontology of the problem as it has emerged in the first and

second stage. The appropriateness of each treatment can then be rated by the patient. Consequently, the treatment process may incorporate a number of different approaches. Although this tool was developed by MacLachlan (1997) to facilitate communication between a patient and clinician who come from different cultures, it is equally applicable in this Service. Although the clinicians in the hospital are Malawians they have been trained in a biomedical approach. It has been argued in this thesis that biomedical beliefs are ontologically different from those held by many Malawians, and it has been demonstrated that the hospital population in general does not hold biomedically orientated beliefs. Therefore, the introduction of this tool would assist staff in taking on board pertinent information and suggesting appropriate treatment.

7. **Evidence-based treatment:** Findings from the hospital study indicate that the treatment outcome for participants was disappointing. Patel (2000) in a recent editorial laments the absence of evidence to indicate efficacy of psychiatric treatment in developing countries and asserts that lack of treatment evidence impedes the introduction of appropriate interventions in these countries. He advocates that evidence based research is required in developing countries to inform clinical practice, and that the transfer of findings from the other parts of the world is not applicable. At this juncture in the development of the Service it would be appropriate to introduce measures to assess the efficacy of the treatment provided on an ongoing basis. The scales developed for this study CWS and EWS would be a useful tool in such an endeavour, particularly in the absence of a culturally competent alternative.

8. Using what works: MacLachlan (2001) advocates an approach of pragmatic vernacularism. This simply translates as using "what works"(p.10). At times indigenous healthcare 'works' in the context in which it has developed, and the introduction of external ideas is not effective. Borrowing ideas from healthcare developed in a different context can however help "to unstick a community from the context which prohibits their well-being" (p. 10). Extending this idea to the future development of the Service requires an empirical basis. One suggestion as to how this could be achieved, utilising the patient's perspective, is outlined here. The systematic exploration of the experience and satisfaction of patients and their families with services rendered by both *ŵasing'anga* and the service in Northern Malawi would provide valuable information to inform a constructive alliance between the Service and the local healing system. Similar

research has been conducted by Ensink and Robertson (1999) in South Africa to inform service development regarding the role of indigenous healing in health care provision.

METHODOLOGICAL ISSUES

Given the cultural differences between the researcher and the participants as outlined in Chapter Three and Chapter Four, and the implications that can have on the authenticity of responses from participants (Brislin, Lonner & Thorndike, 1973) great emphasis was placed on taking the required steps to enhance the authenticity of responses given by participants. Assessing the results of such endeavours presents difficulties. In the context of the traditional healers study the *ŵasing'anga* did not seem to be inhibited about discussing any area of their work, despite the fact that the researcher was attached to a biomedically orientated service. I was also invited to several ceremonies, indicating that the measures described had resulted in a positive outcome, in that I was accepted by the *ŵasing'anga*. One main concern I had was that participants would not divulge explanations that involved *ulowe* and *mizimu* to a researcher from a different culture. However, statistical analysis suggests that there was no association between the ethnicity of the interviewer and the type of explanation offered, indicating the measures taken were effective. However, Lund and Swartz (1998) comment that the clinic setting where they conducted their interviews may have influenced the responses of the participants. The impact of conducting the research interviews in the present study in the hospital cannot be overlooked. The follow-up interviews were conducted in a variety of different settings. Furthermore, these interviews differed from the first two interviews in that the participants weren't hospitalised at the time. Perhaps the participants felt more free to express explanations that involved *ulowe* and *mizimu* than previously. Of course, one further explanation for the increase in traditional explanations given by the participants at follow-up is that they may have returned to the traditional healing sector for treatment, and thus are more likely to now hold an explanation which corresponds to the *ŵasing'anga* as opposed to the hospital. Although statistical analysis indicated that there was no association between the ethnicity of the interviewer and the type of explanation, the setting in which the study took place could not be controlled for by virtue of the fact that it required patients who had been hospitalised. If indeed it is the case that explanations of disturbance which involve causes related to bewitchment and spirits are withheld in the hospital this imbalance

needs to be redressed. Introduction of the PPT, as discussed earlier, could help overcome this problem.

As Duranti (1997) advised, concerted efforts were made to become familiar with the local language, as detailed Chapter Three. In my experience in conducting this piece of research there is no doubt that not being fluent in the local language presents a handicap, particularly in a region where a number of different languages are spoken. Naturally, with time and sustained effort a better level of fluency was achieved and participants replies became more understandable in the interview setting. The experience of translated interviews in these studies leads me to agree with Swartz (1998) that such interviews introduce difficulties and extend the time required to conduct an interview. The introduction of a stringent translation methodology that included back-translating interviews, scoring quality of translation, rejection of interviews which did not meet required standard, counteracted the fact that the researcher was not a native speaker.

Participants in the study were not selected to be representative of the entire population, but specifically people who attend a biomedically oriented service for treatment for mental disturbance. While the number of participants originally interviewed on admission for the study was quite large (n=147) this number was reduced to 120 for the final sample. As indicated in Chapter Five, numerous steps were taken to maintain the number of participants in the sample at discharge and follow-up. Despite these steps, the numbers declined further at discharge and follow-up. In total, the truly longitudinal sample (those interviewed on all three occasions) was relatively small (n=24). Ironically, while the total number of interviews (229), was extraordinarily large for qualitative analysis, they were untenably small for much of the quantitative analysis which has been planned. The attrition of the sample could not be explained in terms of demographic profiles of participants. Participants who were admitted for a longer period were more likely to be included at the follow-up interview. An association existed between those interviewed at follow-up and those participants who did not feel mentally disturbed on admission. No other significant differences were found between those participants who were interviewed or not at different interviews.

An advantage of employing a longitudinal design in this study is that mental well-being could be compared at different stages. Although the sample which was truly longitudinal in the study, was smaller than had originally been anticipated, useful information emerged. This is the first such study to be conducted with a hospital population in Malawi.

Qualitative analysis was pursued due to my concern that using *a priori* categories did not adequately represent the meaning in the data collected. In addition, the original categories were developed in other regions in Malawi. It has been outlined previously that the Northern Malawian context is distinct from other regions. The resulting themes present a much richer picture of the explanations held by the participants. Where possible the names of the themes reflect the vocabulary used by the participants; terms such as 'traditional', which I have been critical earlier in this chapter were therefore not used. The themes expanded on the categories used for quantitative analysis. The information yielded from quantitative analysis was not as informative as had been anticipated at the outset, due to attrition in sample size. As qualitative analysis helped clarify what could not be elucidated by quantitative analysis, this research did benefit from the combination of quantitative and qualitative approaches, which complemented each other in the hospital study.

Concern that the use of information from DSM-IV would not be appropriate in the context of this research given the criticism levelled at its lack of cultural sensitivity another measure of the participants mental health had to be developed. Two rating scales Strength of Evidence of Emotional Well-being and Strength of Cognitive Well-being were developed and employed in this study. This approach was viewed as the most appropriate method for the context, although it had some shortcomings. Rating the cognitive and emotional well-being from a transcribed interview that is not conducted to assess either of these elements is not ideal, as pointed out in Chapter Five. In order to be as rigorous as possible three raters, from different disciplines rated all of the interviews. Inter-rater reliability for both scales was lower than might have been anticipated. It is difficult to pinpoint what may have caused this. Certainly in rating such a large number of interviews intra-rater reliability may be slightly reduced, which could impinge on the inter-rater reliability. But perhaps more pertinent to this research, and more likely, is that the disciplines of the different raters influenced their scoring. The fact that the inter-

rater reliability is lower for the cognitive rating scale, and that the psychologist and medical anthropologist consistently agreed on a score more often than any other combination of raters, suggests that the psychiatrist is operating on a different framework.

Although the scales were developed in a move towards a more culturally competent method of assessing mental status, it is acknowledged that that these scales are only a step in this direction and that these scales have potential to be adapted to have greater cultural competency. It must also be remembered that these scales were used to assess mental status, based on transcribed interviews. The scope of both scales could be extended for use as part of an interview process.

The mode and median at admission indicated that there was no evidence of well-being or disturbance in the interview. It could be surmised that in some cases the acute state that led to admission may have lessened before a research interview was conducted, which may have produced a higher rating than would have been the case had the interview been conducted immediately after admission.

Qualitative methodology and analysis was used in both studies. Many of the criticisms of qualitative research concern its lack of objectivity. However, the dependability of the present study was enhanced by a well-documented and systematic approach to both data collection and analysis. One of the main methodological strengths of this thesis lies in the synergy created by being able to analyse the interviews in the hospital study in the light of the culturally relevant information gathered in the traditional healers study. Without such background knowledge, some of the information gathered may have appeared meaningless and consequently have been overlooked. Data may have been open to misinterpretation, a more dangerous methodological fault, (e.g. references to being poisoned actually refer to bewitchment) if the provision had not been incorporated into the design.

CONCLUSION

The contribution this thesis makes to both theory and practice is now highlighted. Attention is turned to the theoretical question underpinning this research was: "What is

the experience of people with a mental disturbance when they are introduced to a health care system, ontologically distinct from their own cultural beliefs about health?" Findings indicate that in the main, service users understanding of the causes of their mental disturbance are ontologically more closely aligned to that of the extant healing system on admission and remain so post-discharge. In fact, it would appear from these findings that not only is this ontological alignment preserved, it is also strengthened despite hospitalisation in a Service with ontologically distinct beliefs regarding health. These findings also substantiate the concept of 'cognitive tolerance' (MacLachlan & Carr, 1994a). This research reiterates the importance attached to understanding health in the context of which healthcare is provided (Landrine & Klonoff, 1992; Berry 1997; MacLachlan, 1997). It further emphasises the importance ascribed to the benefits of taking into consideration patient's understanding of their mental disturbance, in providing appropriate health care (MacLachlan, Nyirenda & Nyando, 1995; Pederson, 1995; Lund & Swartz, 1998) and developing a culturally competent health service (Guarnaccia & Rodriguez, 1996).

This thesis operationalised this question in terms of measuring the change in the cognitive and emotional well-being of participants. This piece of research implies that the experience of the users of the Service is disappointing in terms of treatment outcomes; the findings suggest that the treatment provided meets the needs of only the minority of those seeking biomedical treatment for mental disturbance in Northern Malawi. Unfortunately, this study was unable to demonstrate whether explanations held by service users for their mental disturbance impacted on their emotional or cognitive well-being.

Based on the findings of this thesis it can be stated that the Service is built on views, regarding the causes of mental disturbance, which are ontologically different from the majority of the community it serves. The participant population in this study differs in some respects from the general population of the region suggesting that not all sectors of the population chose to be treated there, or are not aware of the facility.

Recommendations have been made in this thesis that have the potential to redress this imbalance and facilitate the Service in meeting the needs of the people who require treatment in Northern Malawi, in a more culturally competent manner. It is

acknowledged that this is only one aspect of users experience. As suggested earlier, further research is required, with the emphasis remaining on the actual experience of patients in the hospital.

In spite of the limitations discussed, there is inherent value in this piece of research. Perhaps one of the most important assets this research has is the fact that the interviews conducted with the participants in the hospital were analysed in the light of understanding of the ways in which Northern Malawians health beliefs are embedded in their cultural context.

The material gathered in the traditional healers study has provided valuable and contemporary information regarding the local extant healing system, information specific to the Northern region, an area which has been neglected by researchers. Furthermore, this research has contributed to a better understanding of how those who are mentally disturbed understand their condition in Northern Malawi; it has offered practical recommendations to guide the Service in becoming more culturally competent and has paved the way for continued research.

CONCLUDING REMARKS

In distilling the interviews to their very essence, it is in fact not the patients' understanding of the cause of their disturbance that prevails. A more fundamental issue permeates the interviews; the expression of the suffering endured by the participants. While the interviews did not address this issue directly, evidence of the distress experienced percolates to the surface. Recalling some of the descriptions testify to the distress the sufferers experience: "Of course, when someone is mentally ill they do not know what they are doing, they are just twisting this side, this side and they can shout, they can do this thing and that thing and can do everything that they think is normal, but it is not normal", "I feel like horses are walking on my head", "I feel like all the people staying in the whole world are breathing and stepping on me", "I am walking naked and everyone is surprised as I am usually smartly dressed" and "I see terrible things" are all expressions that resonate with distress. To dilute this aspect of the interviews is to ignore the core issue. Developing a service that can accommodate the views of the

patient and relieve suffering is a goal that must not be forgotten in the midst of the research.

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APPENDICES

APPENDIX A: MAP OF MALAWI



Source: http://www.sas.upenn.edu/African_Studies

APPENDIX B: MISSION STATEMENT, PHILOSOPHY STATEMENT AND GUIDING PRINCIPLES OF ST. JOHN OF GOD

Mission statement

Our Mission is to contribute to the development of "Health for All"(Alma Alta Declaration) by the promotion of Community Mental Health.

We endeavour, in partnership with government, health care providers, the community and family to provide mental health services which are

- Affordable
- Accessible
- Flexible
- Sustainable

We are dedicated to those we serve, their families, and to each other.

We strive to maintain the values inherent in the life of St. John of God:

- Respect
- Dignity
- Compassion
- Advocacy
- Holistic Care

Philosophy statement

The philosophy governing the St. John of God Mental Health Services is that people are a creation of God, with intrinsic value and inherent dignity. This philosophy is based on the beliefs and values of St. John of God, Founder of the family of St. John of God.

The spiritual and human value of this philosophy influences all activities and obliges us to keep the dignity of the individual central to our planning, delivery and evaluation of services.

Guiding principles

Mental Health should be developed as a component of primary health care

Priority should be given to the promotion of mental health rather than to the treatment of illness *per se.*

An adequate health must produce more than freedom from disease. It must promote an individual and community sense of mental and emotional well being.

When ill, people should be treated within or as close to their family as possible to their family or community, using local resources where possible.

An indigenous system of mental health promotion and care should embrace what is positive in the traditions, beliefs, customs and cultural heritage of the local community.

Time and resources should be invested in the training and preparation of Malaŵian mental health staff so they can be central to the initiative.

APPENDIX C: GLOSSARY OF TERMS

Chamba:	Marijuana
Chilopa:	Blood sacrifice to *mizimu*
Chilopa chimbuzi:	*Chilopa* with a goat as the sacrifice
Chizimba:	Ingredient required to make some *mankhwala* active
Kachekura:	Temporary death due to good spirits and bad spirits struggling
Khumbira la Chiuta:	Will of God
Kuchima:	To divine or diagnosis using mizimu
Kuchizga:	To treat/heal
Kufuntha:	Madness (chiTumbuka)
Kusuzgo:	To be troubled (by ancestral spirits)
Kuzingilira mutu:	Mental disturbance
Kuzweta mutu :	Mental disturbance (lit. spinning head)
Maghanoghano chomene:	Thinking too much
Mankhwala:	Broad term to describe a wide range of treatments and medicine
Mankhwala gha ulowe:	Witchcraft medicine
Mankhwala wa kugeza:	Medicine which is added to bathing water
Mankhwala ya chifipa:	African medicine
Mankhwala yiheni:	Bad medicine
Mankwhala ya muzungu:	Western medicine
Mboniwoni:	Visions experienced by *ntchimi*/ Hallucinations
Misala:	Madness (chiChewa)
Mzimu (pl.mizimu):	Spirit
Mizimu uheni:	Bad spirits
Mizimu ya agogo:	Ancestral spirits
Mizimu Yakwendakwenda:	Lingering spirits
Mizimu yiweme:	Good spirits
Mphini:	Tiny incisions made in the skin where *mankhwala* is applied

Mutu yakwenda markora yayi:	Mental disturbance (lit. head is not working properly)
Ngwelaweta:	Ceremony which tests the skills of a trainee *ntchimi*
Ntchimi:	Traditional healers who divine/diagnose with their spirits (*mizimu ya agogo*) and may also be a herbalist.
Sadaka:	Ceremony *ntchimi* hold to show respect to their spirits
Sembe:	Sacrifice to appease *mizimu ya agogo* to prevent or treat illness
***Sing'anga* (pl. *wâsing'anga*):**	Broad term including all types of traditional healers and used specifically to refer to herbalist.
Templi:	Temple (where healing ceremonies take place)
Ufu:	Maize flour
Ufwiti:	Witchcraft
Ulowe:	Bewitchment
Vilopa:	Plural form of *chilopa* – treatment ritual which includes blood sacrifice
Vimbuza:	Type of spirit, name of spirit illness and ritual to treat it
Vinthenda:	Spirit illness (general term)
Wâfwiti:	Witches
Wâsing'anga	Broad term which means traditional healer; also specifically herbalist

APPENDIX D: PARTICIPANT INFORMATION: TRADITIONAL HEALERS STUDY

***Ntchimi* M.B.**

Male *ntchimi*, living in a rural area in Mzimba District. He has been practising for more than 25 years. Treating mental disturbance is one of his specialties. He also treats *vimbuza*. His training was supervised by C.M. and he is a member of HAM. His account of becoming a *ntchimi* is documented in Chapter Four. He speaks chiTumbuka, and some English.

***Ntchimi* W.M.**

Female *ntchimi*, living in a rural area of Mzimba District, close to Rumphi District. She began to treat patients in 1993. She treats mental disturbance and a variety of physical illnesses, but does not treat HIV/AIDS. Her training was supervised by C.M and she is a member of HAM. She speaks chiTumbuka.

***Ntchimi* M.M.**

Female *ntchimi*, living in a rural area in Mzimba District. She has been practising since 1990 and specialises in *vimbuza*, mental disturbance and treats other physical illness also. Her training was supervised by CM. She is a member of HAM. She speaks chiTumbuka.

***Ntchimi* V.Z.**

Female *ntchimi*, living in a rural area of Mzimba District. She started to diagnose people in 1981. She treats mental disturbance in addition to physical illnesses. Her training was supervised by CM. She is a member of HAM. She speaks chiTumbuka.

African Doctor: B.N.

Female *sing'anga* who is primarily a traditional birth attendant (TBA) living in Mzuzu. She has been practising "for many years." While issues related to pregnancy and childbirth are her specialist areas she also treats mental disturbance and children who have *visi lisi* (epilepsy). Her knowledge of herbalism was passed from her parents and

she is guided by dreams, but not by *mizimu ya agogo.* She speaks chiTumbuka and Ng'oni.

***Sing'anga* J.M.F.M.**

Male sing'anga (herbalist) with a stall situated in the centre of Mzuzu. He has been practising since 1960. He became a *sing'anga* as he was having dreams that indicated that it is what he should do. No details regarding his training. He has recently attended training given to health workers in conjunction with Mission and Government funded hospitals for prevention of HIV/AIDS. He treats STDs, predominantly, but also treats mental disturbance with his *manhkwala* when appropriate. He is a member of *Chizgani*, an association of herbalists. He speaks chiTumbuka.

Dr. K.F.M.

Male *ntchimi* living in a peri-urban area in Mzimba District. He has been practising as a *ntchimi* for more than 15 years. Prior to becoming a *ntchimi* he had trained and worked as a medical assistant in a Mission Hospital. During his time working in the hospital his *mizimu ya agogo* were visiting him in his dreams and advising him to become a *ntchimi*, which he subsequently did. He is a member of HAM committee. He speaks chiTumbuka and his English is of a good standard.

***Ntchimi* A.M.**

Female *ntchimi*, living in Mzimba District. Although originally from South Africa, she has lived in Malaŵi since 1959. She has been practising for almost 30 years and specialises in treatment of mental disturbance, but treats other problems. Her training was supervised by C.M. Her account of becoming a *ntchimi* is documented in Chapter Four. She speaks chiTumbuka.

***Ntchimi* F.N.**

Female *ntchimi*, living in a rural area of Mzimba District. She has been practising for almost 10 years. She treats mental disturbance amongst other problems. Her training was supervised by CM. Her account of becoming a *ntchimi* is documented in Chapter Four. She speaks chiTumbuka.

APPENDIX E: VIDEO TO ACCOMPANY CHAPTER FOUR: EXTANT HEALING SYSTEM

The *Vimbuza* Ceremony

This was filmed during participant observation fieldwork conducted in 1999. The rationale for including this video is to provide a visual context for some of the information in Chapter Four, The Extant Healing System; using images instead of words to describe what was observed. The aim was not to analyse the material, but provide visual images and convey the atmosphere of such ceremonies. It should be viewed not as a documentary, but rather a 'moving photograph'.

This material was filmed at three different locations:

- *Vimbuza* ceremony at C.M.'s *templi* (Clips 1-6)
- *Vimbuza* ceremony at V.P.'s *templi* (Clip 7)
- *Vimbuza* ceremony at *Ngwelaweta* in Nkhata Bay District (Clip 8)

Vimbuza *Ceremony at C.M.'s* templi

These six clips are from different stages of the ceremony, shown in consecutive order:

The first clip shows the early part of the *vimbuza* ceremony. As the community gathers, the *ntchimi* who heads the ceremony leads the singing, encouraging the *kwaya* (choir).

In the following clip, the drummers have joined the *kwaya* (choir) and the ceremony is underway. In this particular ceremony, the *ntchimi* who is to diagnose the problems the attendees bring is still under supervision; her supervisor is the *ntchimi* who is leading the ceremony.

The third clip shows the *ntchimi* dancing to warm up her *mizimu ya agogo,* so that she can diagnose.

In the remaining clips show a consultation between the female *ntchimi* and male attendee that was not successful. Her supervisor had to step in. Later in the ceremony, a

couple have approached her for a diagnosis. At one point, she begins to dance again. This is to further 'heat' her *mizimu ya agogo* and strengthen her communication with them, to facilitate a full and accurate diagnosis.

Vimbuza *ceremony at V.P. 's* templi

In this *vimbuza* ceremony, it is not a *ntchimi* who is dancing, but a patient who had been staying at his compound. V.P. planned this *vimbuza* ceremony to ascertain whether this patient had a spirit illness. This ceremony will facilitate communication with her *mizimu ya agogo* who would indicate what is required for her to become well again. However, it transpires that her *mizimu ya a gogo* are not forthcoming, which leads V.P. to conclude that it is not a spirit illness, but a physical illness, and treats her accordingly.

Vimbuza *ceremony at* Ngwelaweta *in Nkhata Bay District*

The final clip shows a trainee at his *ngwelaweta*. In contrast to previous ceremony, his *mizimu ya agogo* have been raised. He is just about to go out to look for the *mankhwala* hidden in the surrounding area. He has been dancing to strengthen his *mizimu ya agogo* so that they may guide him to the *mankhwala*. This is his second and final opportunity, to locate the *mankhwala* and progress to the second stage of his *ngwelaweta*.

APPENDIX F: CONSTITUTION OF THE REGISTERED TRUSTEES OF THE HERBALISTS ASSOCIATION OF MALAWI (HAM)

(1) This association is for all herbalists registered with H.A.M.

(2) Duties of the H.A.M. include:

To try and follow good methods of taking care and treating the patients.

To welcome new herbalists to the association

To encourage herbalists to send patients to the hospitals near them when they know that they cannot treat them. And they should co operate with those working at the hospitals.

To co-operate with those who are trying to find ways of using the *mankhwala* (Chancellor College, University of Malawi).

To raise funds through different means and to get money from the government and different organisations.

To do any work that is recommended by the association wholeheartedly.

(3) Any person who wishes to become a member of the association should be appointed by the first member and his vice. Anyone who is suggested as a member should have his name registered with the Secretary who in turn will surrender it to the committee. The committee has the power to accept or reject him. Anyone who has been appointed becomes a full member after paying a yearly fee.

APPENDIX G: AGENDA FOR HERBALIST HEALTH WORKERS REGIONAL MEETING FOR THE NORTH 16-19TH JUNE, 1996

Collaborations between Herbalists and Health Workers (Dr. G. Phiri – Chairperson for HAM)

Discussion: Collaboration importance.

Presentation: Nutrition and malnutrition

Video: Vitamin A deficiency

Presentation: Family planning.

Video: on Today's Culture

Other topics to be covered: Disease surveillance, Malaria and Diarrhoea.

A list of 66 delegates who attended was included in the original document.

APPENDIX H: EXAMPLE OF LETTER OF REQUEST TO DISTRICT HOSPITAL

Hospitaller Order of Saint John of God

House of Hospitality	**332495/411**	**PO Box 744**
St John of God Centre:	**332690**	**Mzuzu**
Residence:	**332347**	**Malawi**
		Fax: 332690

Nkhata Bay District Hospital
Box 4
Nkhata Bay

Dear Matron,

I am a psychologist, working with St. John of God Mental Health Service. As part of my work I am carrying out quite a large scale research project. The main focus for the research is to explore patients' explanations for their illness and whether or not these explanations change over time. I have already interviewed patients on admission to and discharge from our hospital. All that remains now is to follow-up the patients that were treated in our hospital between July 1997 and May 1998.

A substantial number of our patients have been discharged to their home areas so I am writing to all the District Hospitals seeking permission to make an appointment to see each of these clients when they attend the psychiatric nurse for their treatment at the monthly clinic. I understand that there will be a clinic 16th September, 1998 which I would be available to attend, if possible. I have enclosed the names and addresses of the patients I wish to see. Unfortunately, despite my efforts my chiTumbuka is not of a very high standard, so I would hope that the psychiatric nurse would be available to translate for me.

I have spoken briefly to Mrs. E. Lungu, your mental health coordinator at the recent quarterly meeting, at St. John of God, and she advised me to seek your permission for this project.

I would be very grateful if you could facilitate me in this matter and could contact me at your earliest convenience to let me know if it is possible. I would appreciate if you could forward the enclosed list of patients to Mrs. Lungu.

If you have any queries, please do not hesitate to contact me at the above numbers. I am most frequently available at 332690. Thank you in advance for your cooperation.

Yours sincerely,

Karen M. Smyth
Research Psychologist

APPENDIX I: GUIDELINES FOR TRANSLATING INTERVIEWS

1. Recount the information in a way that is as true to what the participant has said as possible:
    a. Do not add to the answer, even if you think the participant has not said enough, or you think you know what they are trying to say.
    b. Do not summarise the answer. If the answer is becoming too long to remember the details, chose an appropriate moment to ask the participant to pause and relay the information.
    c. Do not leave out information, even if you think it is not relevant.

2. Ask my question in the same manner, in so far as possible, as I have in English. If my question is inappropriate for whatever reason, advise me on a better way to approach it.
3. Speak to the participant using the same vocabulary as they use especially pertaining to their expression of disturbance (i.e. if they describe themselves as '*nili mulwali*', I am sick; do not assume they mean that they are mentally ill because that is their diagnosis). Likewise, if they describe themselves as '*kuzungilira mutu*' (head is turning) continue to use that expression and do not replace it with, for example, '*kufuntha*' (mad) which is a stronger word.
4. If the translator has a question they would like to ask or feel is necessary for clarifying a point, let me know the question before they ask it.
5. Keep words that are Malawi specific such as *vimbuza*.

APPENDIX J: RATING SCALE FOR STANDARD OF TRANSLATION IN HOSPITAL INTERVIEWS

1. Significant amounts of pertinent information from the participant are omitted/substituted/interpreted.
2. Significant interpretation/substitution of pertinent interviewer questions
3. Frequent omission / interpretation /substitution of participant's responses.
4. Frequent amounts of information are omitted /substituted but are not pertinent
5. Evident lack of conceptual equivalence.
6. Occasional interpretation / substitution / of interviewer questions, that are not pertinent.
7. Occasional omission /interpretation/substitution of participant's responses (but not pertinent information).
8. Occasional grammatical errors but do not distort pertinent information
9. Incidental divergence from interviewers comments e.g. greetings or thank you but same meaning conveyed
10. Almost perfect translation

APPENDIX K: TRANSLATION RECORDING FORM

Translation Recording Form.

Name of tape: _____ ***Date transcribing:*** _____

Number on tape at the beginning and end of interview: _____/_____

Name of subject: _____ ***Subject No.:*** _____

Score: _____

Instructions:

a) Please attach transcription of the interview.

b) For the following sections add further paper where necessary.

Please indicate any poorly/ inadequately / wrongly translated sentences, recording the number on the tape dial:

Reasons given for being in hospital in patients' own words:

Causes of mental disturbance in patients' own words:

Signed: _____

APPENDIX L: RATING SCALES

Please complete the rating scales below in consultation with the definitions supplied.

I. D. number on interview:_____

Initials of rater: _____

A. Strength of evidence for EMOTIONAL well-being:

1 Evidence of emotional well-being

2 No evidence of emotional well being or emotional disturbance

3 Evidence of mild emotional disturbance in some parts of the interview

4 Evidence of mild emotional disturbance throughout the interview OR severe emotional disturbance in some parts of the interview.

5 Evidence of severe emotional disturbance throughout the interview

B. Strength of evidence for COGNITIVE well-being

1 Evidence of cognitive well-being

2 No evidence of cognitive well-being or cognitive disturbance

3 Evidence of mild cognitive disturbance in some parts of the interview.

4 Evidence of mild cognitive disturbance throughout the interview OR severe cognitive disturbance in some parts of the interview.

5 Evidence of severe cognitive disturbance throughout the interview

APPENDIX M: CATEGORIES EMPLOYED FOR QUANTITATIVE ANALYSIS

'Traditional' refers to an explanation that involves ideas that are seen as traditional in Africa e.g. witchcraft, or the influences of ancestral spirits.

'Medical' refers to an explanation that involves biological ideas (e.g. physical illness).

'Psychological' refers to an explanation that involves psychological ideas (e.g. stressful experiences)

'Don't know' refers to a situation where the patient doesn't know what has caused the mental disturbance that has led to their admission to hospital.

'Other' refers to an explanation that cannot be appropriately described by one of the above categories.

APPENDIX N: INSTRUCTIONS FOR CATEGORISATION

Instructions for categorisation

I conducted a piece of research looking at the explanations people gave for mental disturbance, which led to their admission to hospital in an African country.

In the following pages, you will find a sample of some of the interviews, randomly selected using the numbers you chose at random earlier. These interviews were conducted with patients, shortly after they were admitted to a hospital which deals with people who are mentally disturbed.

The aim of this exercise is to categorise the patients' explanations. There are no right or wrong answers, what is important is your understanding of what they have said. After each interview, you will find 2 short sections to fill in; there is no time limit, spend as much time as you require.

Below are the 2 sections you will find at the end of each interview, and the information required to fill them in.

Section A

Acceptance of mental disturbance ☐

Denial of mental disturbance ☐

Section B

Patient's explanation	
Traditional	
Medical	
Psychological	
Don't know	
Other (specify)	

Instructions:

Section A

Please tick the appropriate box. Only **one** box should be ticked.

Acceptance of mental disturbance is applicable to a patient who acknowledges that they are in hospital because they are mentally disturbed.

Denial of mental disturbance is applicable to a patient who does not think they are in hospital because they are mentally disturbed. They may give another reason e.g. physical illness.

Section B

Please tick each option that you think is applicable. Some patients have more than one explanation; therefore, more than one option can be ticked.

'Traditional' refers to an explanation that involves ideas that are traditional in Africa, and would not ordinarily be used as an explanation by an Irish person (e.g. witchcraft, or the influences of ancestral spirits).

'Medical' refers to an explanation that involves biological ideas (e.g. physical illness) that result in mental disturbance

'Psychological' refers to an explanation that involves psychological ideas (e.g. stressful experiences)

'Don't know' refers to a situation where the patient does not know what has caused the mental disturbance that has led to their admission to hospital.

'Other' refers to an explanation that cannot be appropriately described by one of the other categories. Please specify what you understand their explanation to be.

Many of the interviews were conducted in local languages and were translated; the local language is in italics. Others were conducted in English; please bear in mind that English is not the mother tongue of those being interviewed.

Where indigenous terms are used, or culture specific details are embedded in the explanation definitions and explanations are supplied.

You may want to read through all the interviews first, before beginning to categorise the explanations. Remember, there are no right or wrong answers.

If you have any queries at any stage please do not hesitate to ask me. Thank you for taking the time to complete this task. It is much appreciated.

APPENDIX O: INSTRUCTIONS FOR RATING STRENGTH OF EVIDENCE FOR EMOTIONAL WELL-BEING SCALE & STRENGTH OF EVIDENCE FOR COGNITIVE WELL-BEING SCALE

Thank you for agreeing to rate these interviews. The information necessary to rate the interviews is outlined below. If you have any queries or need clarification on any point please do not hesitate to contact me.

Background to the research:

This is a longitudinal study. Efforts were made to interview the participants on three occasions, this will be evident from the questions asked in the interviews.

The majority of the interviews were conducted in a local language; the transcripts have both the original language and the English translation. A number of the participants chose to speak English; therefore, not all of the interviews are in both languages.

Instructions

- Please read each interview with a view to rating the degree of disturbance evident in it. The rating scales are shown below:

Strength of evidence for EMOTIONAL well-being

1 Evidence of emotional well-being
2 No evidence of emotional well-being or emotional disturbance
3 Evidence of mild emotional disturbance in some parts of the interview
4 Evidence of mild emotional disturbance throughout the interview OR severe emotional disturbance in some parts of the interview.
5 Evidence of severe emotional disturbance throughout the interview

Strength of evidence for COGNITIVE well-being

1 Evidence of cognitive well-being
2 No evidence of cognitive well-being or cognitive disturbance
3 Evidence of mild cognitive disturbance in some parts of the interview
4 Evidence of mild cognitive disturbance throughout the interview OR severe cognitive disturbance in some parts of the interview.
5 Evidence of severe cognitive disturbance throughout the interview

- Both scales contain a five-point continuum, on one of the scales disturbance pertains to emotional disturbance and on the second scale disturbance pertains to cognitive disturbance. The definitions for the various points on the scales are on pages 3 & 4.
- It is important that you familiarise yourself with this description before rating the interview, and refer to it often to ensure consistency.
- Having read the interview, please circle the number on the scale, which most accurately reflects what you have understood from reading the interview, in

accordance with the following description of what each point represents on the scale.

- You can circle only ***one*** number.
- Rate the two scales independently of each other.

There are no right or wrong answers. Aim for the highest degree of consistency possible in your rating across all the interviews, as this is of crucial importance.

If you have any comment to make, please do so.

Thank you very much for sharing your time, effort and expertise.

Yewo chomene, tawonga.

Definitions of points on the scale:

Strength of evidence for EMOTIONAL well-being

Emotional well being – indicated by expression of positive feelings

EXAMPLE:

- talks optimistically about the future
- describes self or others in positive terms
- appears to be engaged in participating in the interview

Mild emotional disturbance – indicated by loss of interest or lack of feeling.

EXAMPLE:

- uses passive and bland description of self and others
- describes self as upset but does not focus on emotions
- low self esteem

Severe emotional disturbance – indicated by being consumed by own feeling.

EXAMPLE:

- cries continuously
- focuses on own distress throughout the interview
- displays excessive jubilation and /or optimism

Definitions of points on the scale:

B. Strength of evidence for COGNITIVE well-being

Cognitive well-being – indicated by appropriate information processing:

EXAMPLE:

responds clearly and coherently to questions

- uses clarifying statements and examples to describe information
- initiates appropriate discussion

Mild cognitive disturbance – indicated by distortions and biases in information processing.

EXAMPLE:

underestimating ability to cope with threatening situations
adopting an overly negative view of things
concern with excessively ritualistic or repetitive thoughts or behaviours

Severe cognitive disturbance – indicated by a breakdown of normal information processing or loss of touch with reality.

EXAMPLE:

- delusions or hallucinations
- flight of ideas
- thought derailment

APPENDIX P: PARTICIPANT INFORMATION

Initial	Gender	Age Group	Education	Occupation	Place of Residence	Marital Status	Attended sing'anga	History	Type of Illness	Religion
A.B.	male	26-35	Std. 5-7		.	.	unknown	first admission	psychotic	
A.C.	male	15-25	Std. 5-7	farmer	urban(northern)	married	yes	first admission	psychotic	
A.Ma.	female	26-35	Form 4	trained	urban(central/southern)	single	unknown	first admission	psychotic	Deeper Life
A.Mb.	female	36-45	Std. 2-4		rural(northern)	married	yes	first admission	non psychotic	roman catholic
A.Ng.	male	15-25	Form 2-3	student	rural(northern)	single	no	first admission	non psychotic	roman catholic
A.N.	male	36-45	completed form 4		rural(northern)	married	yes	first admission	psychotic	ccap
B.N.	female	36-45	Std. 1	housewife	rural(northern)	married	no	previously admitted	psychotic	other
B.Ny.	male	26-35		farmer	rural(northern)	married	unknown	first admission	non psychotic	
B.P.	male	15-25	3rd level educ.	student	urban(northern)	single	unknown	first admission	psychotic	none
C.B.	female	46 - 55	Std. 1	unemployed	urban(northern)	co wife	no	previously admitted	non psychotic	roman catholic
C.C.	male	15-25	Form 4	student	urban(northern)	single	no	first admission	psychotic	Rasta
C.G.	female	26-35	Std. 8	unemployed	rural(northern)	single	yes	first admission	psychotic	other
C.H.	male	15-25	Std. 2-4	trade	rural(northern)	married	no	first admission	psychotic	other
C.J.	male	15-25	Std. 5-7	farmer	rural(northern)	married	yes	first admission	psychotic	chipangano
Co.J.	female		completed form 4	professional	rural(northern)	single	no	first admission	psychotic	other
C.M.	male	26-35	Form 4	none	urban(central/southern)	single	no	previously admitted	psychotic	Christian unspecified
C.Mb.	male		Form 2-3	farmer	rural(northern)	married	yes	first admission	psychotic	ccap
C.Mk.	male	15-25	Form 2-3	student	urban(northern)	single	unknown	first admission	psychotic	ccap
C.Mp.	female	26-35	Std. 8	housewife	rural(northern)	married	yes	previously admitted	psychotic	other
D.C.	female		Form 2-3	teacher	rural(northern)	single	unknown	first admission	psychotic	New Apolostlic
D.Ch.	male	26-35	Form 2-3	piece work	urban(northern)	single	unknown	first admission	non psychotic	
D.L.	female	15-25	Form 4	student	rural(northern)	single	yes	first admission	psychotic	other
D.M.	female	26-35	Std. 5-7	housewife	urban(northern)	married	yes	first admission	psychotic	ccap
D.N.	male	26-35	Form 4	unemployed	urban(northern)	single	no	previously admitted	psychotic	ccap
D.Nh.	male	26-35	Form 2-3	none	urban(northern)	single	unknown	first admission	psychotic	roman catholic
D.P.	male	36-45	Std. 5-7	farmer	.	.	unknown	first admission	non psychotic	roman catholic
E.B.	male	26-35	3rd level educ.	farmer	rural(northern)	single	yes	previously admitted	psychotic	other
E.C.	male	15-25	Form 1	student	urban(northern)	single	unknown	first admission	non psychotic	ccap
E.Ch.	female	15-25		student	rural(northern)	single	yes	first admission	psychotic	Baptist
E.G.	male	46 - 55	3rd level educ.	professional	urban(northern)	married	unknown	previously admitted	psychotic	ccap

Initial	Gender	Age Group	Education	Occupation	Place of Residence	Marital Status	Attended sing'anga	History	Type of Illness	Religion
E.K.	male	26-35		business	urban(northern)	married	unknown	first admission	non psychotic	ccap
E.Ku.	male	36-45	3rd level educ.	professional	urban(central/southern)	widowed	unknown	first admission	psychotic	roman catholic
E.M.	male	46 - 55	Std. 2-4	none	urban(northern)	single	unknown	first admission	psychotic	roman catholic
E.N.	male	15-25	Std. 5-7	piece work	rural(northern)	single	unknown	previously admitted	psychotic	ccap
E.S.	female	56-65		housewife	urban(northern)	married	yes	first admission	psychotic	ccap
E.T.	male		Form 4	trade	urban(northern)	single	no	first admission	psychotic	roman catholic
F.Ma	male	26-35	Std. 8	farmer	rural(northern)	divorced	unknown	first admission	psychotic	Pagan
F.My.	male	15-25	Std. 5-7	unemployed	urban(northern)	divorced	yes	previously admitted	non psychotic	ccap
F.N.	male	36-45	Form 4	homedweller	rural(northern)	single	unknown	first admission	psychotic	ccap
F.T.	female	15-25	Std. 8	none	rural(northern)	single	yes	first admission	psychotic	Christian unspecified
F.Z.	male	15-25		none	urban(northern)	single	yes	previously admitted	non psychotic	none
F.Zi.	male	15-25	Std. 2-4	none	rural(northern)	single	yes	first admission	non psychotic	none
G.C.	female	26-35	Form 4	professional	urban(northern)	separated	no	previously admitted	psychotic	church of the living waters
G.M.	female	15-25	Form 2-3	student	rural(northern)	single	unknown	first admission	psychotic	ccap
G.T.	male	26-35	Std. 5-7	farmer	rural(northern)	separated	yes	first admission	non psychotic	ccap
H.J.	male	15-25	Form 2-3	student	urban(northern)	single	no	first admission	non psychotic	ccap
H.K.	male	36-45		trade	urban(northern)	married	yes	first admission	psychotic	seventh day adventist
H.L.	male	15-25	Std. 8	student	rural(northern)	single	yes	first admission	non psychotic	ccap
H.Ls.	male	26-35	Std. 8	none	rural(northern)	divorced	yes	previously admitted	psychotic	ccap
H.S.	male		0 Form 4	student	rural(northern)	single	no	first admission	psychotic	ccap
I.C.	female	26-35	Std. 8	housewife	urban(northern)	widowed	no	first admission	psychotic	roman catholic
I.K.	female	46-55	Std. 2-4	housewife	urban(northern)	married	yes	first admission	psychotic	seventh day adventist
J.B.	female	26-35	3rd level educ.	nurse	urban(northern)	single	unknown	first admission	psychotic	seventh day adventist
J.G.	male	26-35	technical school	trade	urban(central/southern)	married	unknown	first admission	psychotic	other
J.H.	male	26-35	Std. 5-7	homedweller	rural(northern)	divorced	unknown	first admission	non psychotic	none
J.K.	male	26-35	Std. 5-7	farmer	rural(northern)	married	yes	first admission	non psychotic	seventh day adventist
J.M.	female	36-45	Form 2-3	teacher	urban(northern)	co wife	yes	first admission	psychotic	ccap
J.Mp.	female	26-35	Std. 8		rural(northern)	married	yes	first admission	psychotic	ccap
J.Ms.	male	26-35	Std. 8	farmer	rural(northern)	single	yes	first admission	psychotic	roman catholic
J.Mt.	male	26-35	Std. 5-7	farmer	rural(northern)	single	no	first admission	psychotic	Born Again Christian

Initial	Gender	Age Group	Education	Occupation	Place of Residence	Marital Status	Attended sing'anga	History	Type of Illness	Religion
J.N.	male	26-35	completed form 4	trade	urban(northern)	married	yes	first admission	psychotic	roman catholic
J.P.	female	15-25	Std. 8	housewife	urban(northern)	married	yes	first admission	psychotic	ccap
Je.Mv.	female	15-25	Std. 2-4	homedweller	rural(northern)	single	no	first admission	non psychotic	ccap
Jo.Mv.	male	26-35	Std. 2-4	none	urban(northern)	single	yes	previously admitted	psychotic	ccap
Ju.Mt.	female				rural(northern)	single	unknown	first admission	psychotic	
K.C.	male	15-25	completed form 4	student	urban(northern)	single	no	previously admitted	psychotic	Deeper Life
K.K.	male	15-25	Std. 5-7	student	urban(northern)	single	unknown	first admission	psychotic	ccap
K.Ka.	female	15-25	Std. 2-4	student	urban(northern)	single	yes	first admission	psychotic	ccap
K.M.	male	15-25	Form 2-3	student	rural(northern)	single	yes	first admission	psychotic	ccap
K.N.	male	15-25	Form 4	unemployed	urban(northern)	single	yes	first admission	psychotic	Baptist
L.C.	male	15-25	Form 1	student	rural(northern)	single	yes	previously admitted	non psychotic	ccap
L.G	female	26-35	Std. 2-4	unemployed	rural(northern)	single	yes	first admission	psychotic	ccap
L.K	female	36-45	Std. 5-7	none	urban(northern)	single	unknown	first admission	psychotic	ccap
L.M.	male	26-35		trade	rural(northern)	single	unknown	first admission	non psychotic	ccap
L.Mt.	female		3rd level educ.	professional	urban(northern)	divorced	yes	first admission	psychotic	
L.Mw.	female	15-25	Form 2-3	student	rural(northern)	single	yes	first admission	non psychotic	ccap
L.N.	female		Std. 8	none	rural(northern)	co wife	yes	previously admitted	psychotic	ccap
L.P.	female	36-45		none	rural(northern)	married	unknown	previously admitted	non psychotic	
L.Z.	male	36-45	Form 4	professional	urban(outside malawi)	married	yes	first admission	non psychotic	Jehovah's witness
Le.Mw.	male	26-35		business	rural(northern)	divorced	yes	first admission	non psychotic	Last Church
Lu.Mw.	female	15-25	Std. 5-7	housewife	urban(northern)	married	yes	first admission	non psychotic	other
M.B.	male	26-35	Std. 8	farmer	rural(northern)	married	yes	first admission	psychotic	other
M.L.N.	female	56-65	never at school	housewife	urban(northern)	widowed	yes	previously admitted	psychotic	ccap
M.Mh	male	15-25	Std. 8	student	urban(northern)	single	unknown	first admission	non psychotic	roman catholic
M.Mu.	male	15-25	Form 2-3	none	rural(northern)	single	yes	first admission	psychotic	ccap
M.Mz.	male	15-25	Std. 5-7	homedweller	rural(northern)	single	yes	first admission	psychotic	New Apolostlic
M.Nl	female	36-45	Std. 8	housewife	rural(northern)	married	yes	first admission	psychotic	New Apolostlic
M.Nh.	female	15-25		student	urban(central/southern)	single	yes	first admission	non psychotic	roman catholic
M.Nk.	female		never at school	housewife	urban(northern)	widowed	yes	previously admitted	psychotic	ccap
M.Nt.	female	15-25	Form 2-3	student	rural(northern)	single	unknown	first admission	non psychotic	ccap

Initial	Gender	Age Group	Education	Occupation	Place of Residence	Marital Status	Attended sing'anga	History	Type of Illness	Religion
M.S.	male	26-35		homedweller	rural(northern)	single	unknown	first admission	non psychotic	roman catholic
N.K.	female	26-35	Std. 5-7	housewife	rural(northern)	married	yes	previously admitted	non psychotic	Baptist
N.M.	female				.	.	yes	first admission	non psychotic	
P.H.	male	15-25	Std. 8	none	urban(northern)	single	unknown	previously admitted	psychotic	New Apolostlic
P.N.	female	26-35	never at school	housewife	rural(northern)	married	yes	first admission	psychotic	roman catholic
R.K.	female	15-25	completed form 4	teacher	urban(northern)	married	yes	first admission	psychotic	New Apolostlic
R.N	male	46 - 55		unemployed	rural(northern)	single	yes	first admission	psychotic	ccap
S.C.	male	36-45	Form 4	homedweller	rural (central/southern)	single	no	previously admitted	psychotic	New Apolostlic
S.Ma.	male	15-25	Form 1	student	rural(northern)	single	unknown	first admission	psychotic	roman catholic
S.Mb.	female	15-25	Std. 5-7	student	rural(northern)	single	yes	first admission	psychotic	chipangano
S.Ms.	male	36-45	Form 2-3	farmer	rural(northern)	married	yes	first admission	psychotic	other
S.P.	male	15-25	Form 1	farmer	rural(northern)	single	no	previously admitted	psychotic	ccap
S.S.	male	56-65		farmer	rural(northern)	.	yes	previously admitted	psychotic	ccap
Sah.P.	female	36-45	Std. 8		rural(northern)	divorced	unknown	first admission	psychotic	ccap
St.M.	female	36-45	3rd level educ.	teacher	urban(outside malawi)	separated	unknown	first admission	psychotic	roman catholic
T.K.	female	26-35	Std. 8	housewife	rural(northern)	married	yes	first admission	non psychotic	ccap
T.M.	male	26-35	Form 4	professional	rural(northern)	divorced	unknown	first admission	psychotic	ccap
T.Mu.	female	46 - 55	Std. 5-7	housewife	urban(northern)	co wife	yes	first admission	non psychotic	ccap
T.P.	female	26-35	Std. 5-7	none	rural(northern)	divorced	yes	first admission	non psychotic	chipangano
Th.K.	male	46 - 55	Form 2-3	trade	urban(northern)	married	yes	previously admitted	non psychotic	ccap
V.M.	male	26-35		none	urban(northern)	married	no	previously admitted	psychotic	seventh day adventist
V.Mh.	male				.	.	yes	first admission	psychotic	
V.Mu.	male	26-35		none	urban(northern)	married	no	previously admitted	psychotic	seventh day adventist
V.N.	male	15-25	Std. 5-7	farmer	rural(northern)	single	yes	previously admitted	psychotic	New Apolostlic
V.N.	male	15-25	Std. 5-7	farmer	rural(northern)	single	yes	first admission	psychotic	New Apolostlic
Ve.M.	female	36-45	Std. 2-4	housewife	rural(northern)	widowed	yes	previously admitted	non psychotic	ccap
Vr.M	female	36-45	Std. 2-4	housewife	rural(northern)	widowed	yes	first admission	non psychotic	ccap
W.So.	male	15-25	never at school	farmer	rural(northern)	single	yes	first admission	psychotic	ccap
Wi.S.	male	26-35	Std. 8		rural(northern)	single	yes	first admission	psychotic	ccap

APPENDIX Q: REASON FOR ADMISSION TO HOSPITAL: QUALITATIVE THEMES

1. **Feels mentally disturbed**
    - **Feels mentally disturbed**: Participant attributed admission to mental disturbance
    - ***Vimbuza/Vinthenda***: Participant attributed admission to *vimbuza/vinthenda*
2. **Does not feel mentally disturbed**
    - **Others see mental disturbance**: Participant did not feel mentally disturbed. Other people viewed them as mentally disturbed which led to their admission.
    - **Physical illness:** Participant identified physical illness as the reason for their admission
    - **Don't Know:** Participant did not know why they had been admitted.
    - **No reason:** Participant felt that there was no reason for their admission

      Behaviour: Participant felt that their behaviour had resulted in admission to hospital
    - **Other:** Reasons that did not fall into any of the other categories

APPENDIX R: THEMES: EXPLANATION FOR MENTAL DISTURBANCE

Listed below are the themes that emerged during qualitative analysis:

- ***Ulowe* (Bewitchment):** Bewitchment caused mental disturbance
- ***Mizimu* (Spirits):** Spirits caused mental disturbance
- ***Maghanoghano chomene* (Thinking too much):** Thinking too much about a particular issue or several issues caused mental disturbance
- **Physical injury:** Receiving a physical injury caused mental disturbance
- ***Chamba* (Marijuana):** Smoking chamba caused mental disturbance
- **Excessive alcohol:** Excessive alcohol consumption caused mental disturbance
- **Hereditary:** Other members of the family were mentally disturbed and it has been passed on
- **Don't know:** Participant does not know what caused their mental disturbance
- **Natural:** Participants understand their mental disturbance as a natural occurrence
- **Caused by God:** God wish or power had caused mental disturbance
- **Plural explanations:** A combination of two or more of the above themes
- **Indecision:** Participants were undecided about the cause mental disturbance
- **Third party understanding:** Participants did not have an explanation for mental disturbance. They employed causes that other people had suggested.

APPENDIX S: CROSSTABULATIONS FOR EXPLANATIONS FOR DISORDER AND TYPE OF DISORDER WITH SAMPLE AT ADMISSION, DISCHARGE AND FOLLOW-UP

Table S.1: Crosstabulation of explanation for disturbance at admission and type of disorder

Explanation	Psychotic	Non Psychotic
Traditional	11	5
Medical	5	7
Psychological	5	1
Don't know	9	6
Other	5	2
Not mentally disturbed	42	13
Plural	5	2
No reason	2	0
Total	**84**	**36**

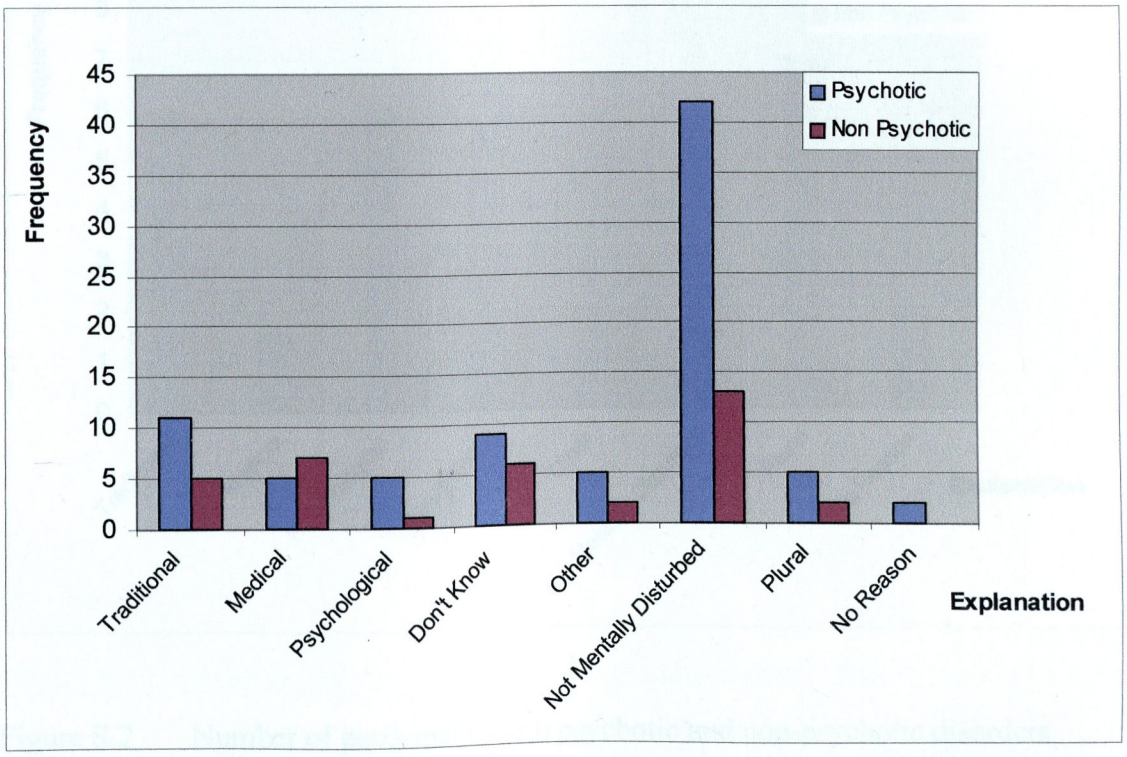

Figure S.1 Number of participants with psychotic and non-psychotic disorders holding explanations for mental disturbance at admission

Table S.2: Crosstabulation of explanations for disturbance at discharge and type of disorder

Explanation	Psychotic	Non Psychotic
Traditional	6	3
Medical	2	4
Psychological	6	3
Don't know	8	2
Other	2	2
Not mentally disturbed	3	2
Plural	7	1
No reason	2	0
Total	**36**	**17**

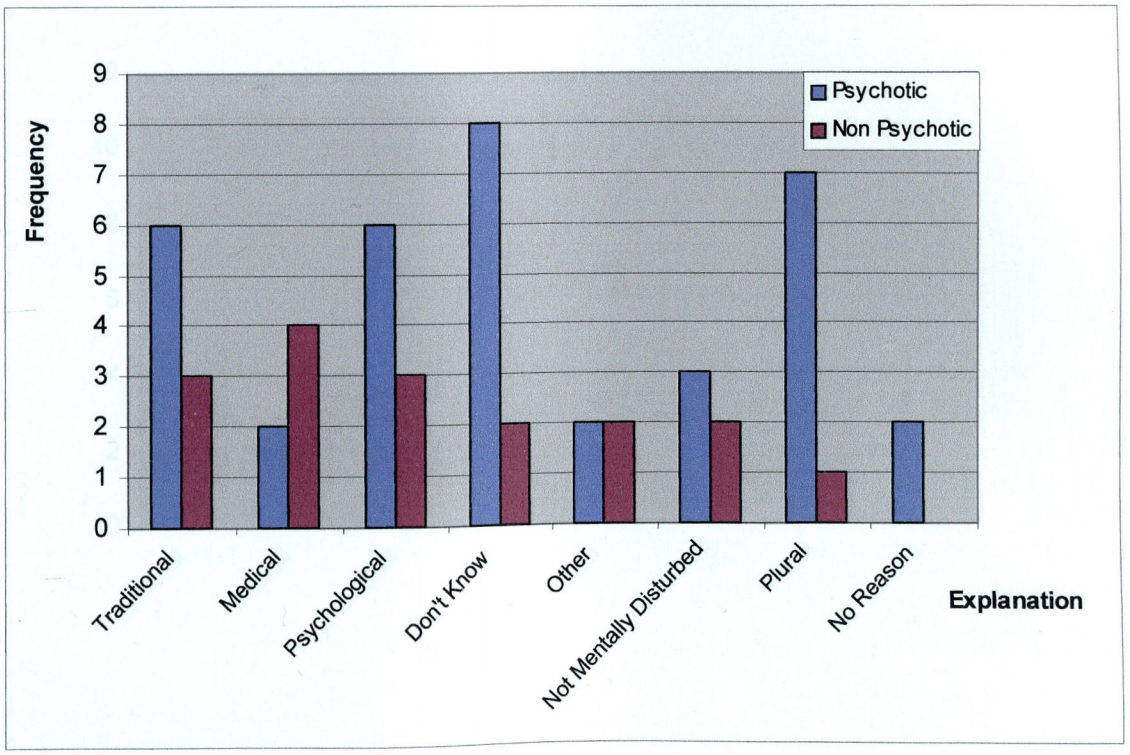

Figure S.2 Number of participants with psychotic and non-psychotic disorders holding explanations for mental disturbance at discharge

Table S.3: Crosstabulation of explanations for disturbance at follow-up and type of disorder

Explanation	Psychotic	Non Psychotic
Traditional	5	5
Medical	1	3
Psychological	7	2
Don't know	10	0
Other	2	0
Not mentally disturbed	3	0
Plural	5	3
No reason	0	0
Total		

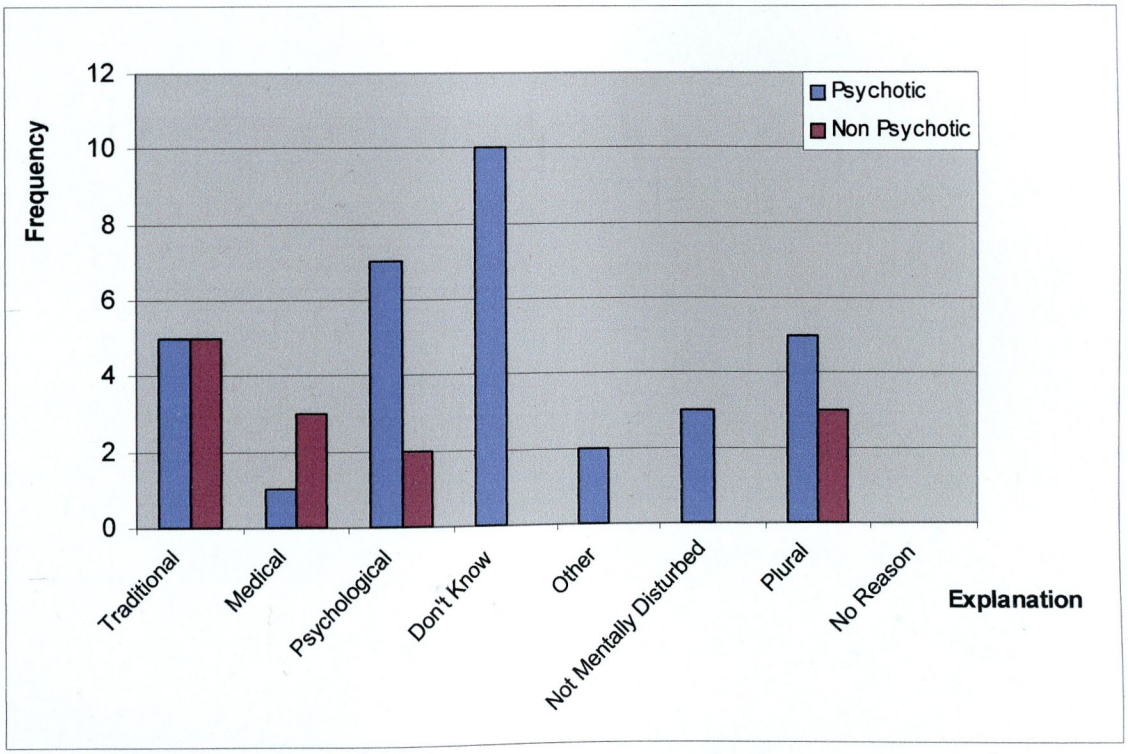

Figure S.3 Number of participants with psychotic and non-psychotic disorders holding explanations for mental disturbance at follow-up